King's College Hospital
NHS Foundation Trust

ANNUAL REPORT and ACCOUNTS 2025/26

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GLOSSARY

ACRONYM	MEANING
BAF	Board Assurance Framework
BREEAM	Building Research Establishment Environmental Assessment Method
BAME	Black, Asian and Minority Ethnic
CCU	Critical Care Unit
CDEL	Capital Departmental Expenditure Limit (the Trust's capital budget)
CHP	Combined Heat and Power
CIP	Cost Improvement Programme
CO2	Carbon Dioxide
CDO	Chief Delivery Officer
CQC	Care Quality Commission
DH	Denmark Hill Site (King's College Hospital, Denmark Hill)
DHSC	Department of Health and Social Care
DIPC	Director of Infection Prevention and Control
DNA	Did Not Attend
DSPT	Data Security and Protection Toolkit
ECS	Emergency Care Standard (four-hour target)
ED	Emergency Department
EDS	Equality Delivery System
EMS	Environmental Management Scheme
EPR	Electronic Patient Record
ESR	Electronic Staff Record
FFT	Friends and Family Test
FTSUG	Freedom to Speak Up Guardian
H&S	Health and Safety
HFMA	Healthcare Financial Management Association
HR	Human Resources
ICO	Information Commissioner's Office
ICT	Information Computer Technology
IFRS	International Financial Recording Standards
JSCC	Joint Staff Consultative Committee
KCH	King's College Hospital
KCL	King's College London
KE	King's Executive
KFM	King's Facilities Management

KHP	King's Health Partners
LGFC	Lambeth GP's Food Co-op
LGBT	Lesbian, Gay, Bisexual, Transgender
MyChart	The digital portal through which patients access their medical records.
MRSA	Methicillin-resistant staphylococcus aureus
NCEPODS	National Confidential Enquiry into Patient Outcome and Death Studies
NED	Non-Executive Director
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
NOF	National Oversight Framework
SEL ICS	South East London Integrated Care System
PDC	Public Dividend Capital
PRUH	Princess Royal University Hospital
PSF	Provider Sustainability Fund
PTL	Patient Tracking List
QI	Quality Improvement
R&I	Research and Innovation
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RTT	Referral to Treatment
SDEC	Same Day Emergency Care
SHMI	Standardised Hospital-level Mortality Index
SIRO	Senior Information Risk Owner
SLAM	South London and Maudsley NHS Foundation Trust
UCC	Urgent Care Centre
ULEZ	Ultra Low Emission Zone
WRA	Workplace Risk Assessment
WRES	Workforce Race Equality Scheme

INTRODUCTION

Chairman's Statement

Over the past year, I have had the privilege of getting to know the Trust better and deepening my understanding of our people, services and partners, and the communities we serve.

The care and dedication of colleagues across the organisation, and the pride they take in their work, continues to impress and inspire me. They are committed to improving the experience and care provided to our patients in Lambeth, Southwark and Bromley, plus those accessing our services from further afield.

Like many NHS Trusts, we face numerous challenges, on a variety of fronts, but despite this, we have made real progress over the past year, and it is important that we celebrate our successes, and the positive impact our teams make every day.

Our teams provide outstanding care to patients, and this is reflected in our clinical outcomes, which we track and measure on a regular basis to ensure we are providing safe, high-quality care. During 2025/26, our clinical outcomes data show that our mortality rates are similar to or better than national average and that other clinical outcomes, such as visual acuity after cataract surgery, the health of babies born to women with diabetes and our critical care outcomes, remain amongst the best in the country. Our key challenge, and our aim as we move forward, is to understand better the outcomes that matter most to our patients and to ensure these become the key focus of our quality monitoring and improvement work.

Real Progress

As an organisation, we were pleased to exit NHS England's National Oversight Framework (NOF) segment 4 in April 2026. This reflects the significant work undertaken by colleagues across the Trust, and the progress made in recovering our financial position, and delivering improvements in key areas such as strategy, operational performance, and leadership and culture

At the same time, the publication of four Care Quality Commission (CQC) service inspection reports during the course of 2025/26 illustrated that the improvements we've put in place are not universal, and that we need to work harder to ensure all patients receive the high standard of care they deserve.

As Chair of the Trust, I am clear that the Board must recognise both the progress made but also the significant challenges faced by our teams, particularly with demand for healthcare services increasing all the time. It is important that, as an organisation, we sustain and embed improvements across our services, whilst also ensuring clear ownership, accountability and sufficient pace in areas where standards are not yet where they should be.

Partnerships

As we look ahead, partnership will be essential to our future as an organisation. We published our new five-year strategy in June 2026, which supports the national shift in focus the NHS is making at a national level towards prevention, care in the community and digital technology.

Developing strong, successful partnerships is a key ambition in our new strategy, and working with patients, stakeholders and partner organisations is the only way we will be able to provide accessible and coordinated healthcare services that are responsive to local needs.

Ultimately, our success must be judged by the difference patients, families and carers experience in their care, and in their journey through our hospital services. This is where our focus will remain as a Trust Board; and it will be reflected through our oversight of the Trust's priorities, and support for the delivery of our new strategy.

Finally, I would like to thank our partners, volunteers, governors and local communities for their support and constructive challenge throughout the year. I also want to praise the brilliant staff at King's for their continued dedication and professionalism. King's staff care deeply about the patients under their care, and as a result, it is vital that we continue to champion the work they do, and support them in their roles.

I was particularly pleased that the latest NHS Staff Survey results published in March 2026 show that King's ranked in the top five most improved Trusts compared to the previous year. This is real progress, but we mustn't be complacent, and improving the working lives of our people must always be a top priority for our organisation.

I am especially grateful to Professor Clive Kay for his support during my first full year as Chair. As this will be Clive's final Annual Report before his retirement, I know I speak on behalf of the entire Trust Board, and the wider organisation, when I say his leadership, commitment and service to the Trust have been greatly valued, and I wish him all the very best for the future.

Sir David Behan
Chair, King's College Hospital NHS Foundation Trust

PERFORMANCE REPORT

Chief Executive's Statement

This will be my final introduction to the Trust's Annual Report and Accounts, ahead of my planned retirement in June 2026.

It has been a true honour to lead this superb organisation, and I leave with many positive memories of our work here at King's, in particular the hard work, courage and commitment shown by staff, day in and day out, often in the face of challenge and adversity.

It has been another busy year, and we have made real progress over the past 12 months. Our clinical outcomes continue to rank among the very best nationally, and in some cases, internationally, but we have also improved access to our services, so they are more responsive to the needs of the communities we serve.

As you will see from this report, we have significantly reduced the number of patients experiencing long waits for planned care. Our teams also delivered a major reduction in the number of people waiting for diagnostic tests, with improvements also seen in terms of patient access to emergency care, and cancer services, with work underway to improve on these successes.

As well as improving access to the services our teams provide, we have also taken important steps forward in terms of making the Trust financially sustainable for the future. We are no longer in segment 4 of the NHS Oversight Framework, which is reserved for the most financially challenged organisations. We have also been removed from NHS England's Recovery Support Programme, which demonstrates increased confidence in our organisation, and the work we are doing. However, we mustn't be complacent, and it is important we maintain focus and momentum for the year ahead.

Also, within the year, six of our services were assessed by the Care Quality Commission (CQC) and four of the inspection reports for these were published in March 2026. The services included maternity, medical care (including older people's care) and services for children and young people at King's College Hospital, and maternity at the Princess Royal University Hospital (PRUH). Each were rated as 'Requires Improvement' overall. While the inspections did show our teams are providing high quality care in many areas, it is clear that in some areas, we need to do more, and the work to deliver improvements will continue at pace.

As always, our teams have achieved a huge amount over the past year. For example, during 2025/26, our teams have continued to make effective use of technology, with surgeons at King's College Hospital performing their 1,000th case of robotic-assisted surgery during the past year, which has reduced delays and led to speedier recovery times for patients.

2025 was also a record-breaking year for liver transplants at King's, with 277 life-saving transplants carried out at King's College Hospital between 1 January and December 2025. This was a superb achievement for our liver team, who run one of the largest transplantation programmes in Europe, treating both adults and children.

Investing in our services

Investing in our estate to improve patient care and ensure our facilities are fit for the future also remains an essential part of the work we do, and I am pleased that we have seen some major milestones this year.

The brand-new Endoscopy and Diagnostic Centre at the PRUH was completed and recently opened to patients. Also at the PRUH, a major upgrade to neonatal services has taken place. We now have a Local Neonatal Unit, which is a level above the Special Care Unit that previously existed at the hospital. It means colleagues can care for babies of a smaller weight and greater prematurity than before.

At King's College Hospital, we refurbished a neurosurgical ward to provide a dedicated space for teenagers and young adults requiring brain or spinal surgery. Establishing this facility was in direct response to feedback from a patient's family.

There were also upgrades to the Radiology Department, including the opening of a new neuro-angiography biplane suite. This next generation software enhances efficiency and increases vessel visualisation during procedures, whilst lowering radiation exposure for patients.

In the autumn, we also launched a new digital check-in service within the Emergency Department at King's College Hospital. This involves appropriate patients using new self-service kiosks when they arrive in the department to share information about their condition. This information is fed directly into Epic, our electronic patient record system, which supports our clinicians to triage patients more quickly, and direct them to the best place for their care.

Brilliant People

The amazing work which takes place at the Trust is down to our incredible people and it is always fantastic when they are recognised for the work they do.

For example, Dani Nebres, Lead Nurse in our Clinical Research Facility, was awarded a Florence Nightingale Leadership Scholarship in 2025. One of 48 scholars from across the globe, Dani is undertaking a quality improvement project as part of this initiative, which is focussed on the implementation of equality, diversity, and inclusion (EDI) training for more than 200 research staff the Trust.

Elsewhere, King's College London confirmed that Tracey Carter, Chief Nurse and Executive Director of Midwifery at the Trust, had been made a Professor of Practice in the Faculty of Nursing, Midwifery and Palliative Care. The professorship recognised Tracey's sustained achievements as a senior nurse in maintaining patient safety, upholding nursing and midwifery standards, and student education.

We continue to establish innovative partnerships across geographies and specialties. A positive example this year which supports our local communities is the weekly drop-in sessions now running at Brixton Library and Lewisham Shopping Centre. Run by our Viral Hepatitis Nursing team, the sessions offer Hepatitis testing and liver health checks for anyone

who tests positive, together with general health advice. The initiative is delivered in partnership with the Caribbean and African Health Network (CAHN), and Hepatitis B test kits are funded by King's College Hospital Charity

Innovation remains a key part of our identity at King's, and there are so many examples that I am simply unable to mention all the projects here, but they include trialling a new technology to treat vascular disease, and treating the first adult patients with groundbreaking new gene therapy for T-cell leukaemia.

A significant part of our work this year has been developing our new five-year strategy for King's, which has involved extensive engagement with patients, local communities, partners and a range of other stakeholders. Listening to what matters to people and involving so many in what we have been doing has positively shaped our strategy and future direction, and I believe the strategy we have developed is right for the Trust, our patients and our staff.

Reflecting on my time here will always make me proud. This Trust is a local institution, treasured and trusted by the communities it serves, nationally respected and internationally recognised. It has been a true honour and privilege to lead Team King's.

I would like to thank the Board of Directors, Governors and all our partners for their unwavering support. It is difficult to put into words my level of gratitude for the encouragement I have received during my time as Chief Executive, and the NHS benefits from so many committed, skilled and professional people. I would like to wish my colleagues and my successor all the very best for the next chapter of King's.

Best wishes

Professor Clive Kay
Chief Executive Officer, King's College Hospital NHS Foundation Trust

An overview of King's College Hospital NHS Foundation Trust

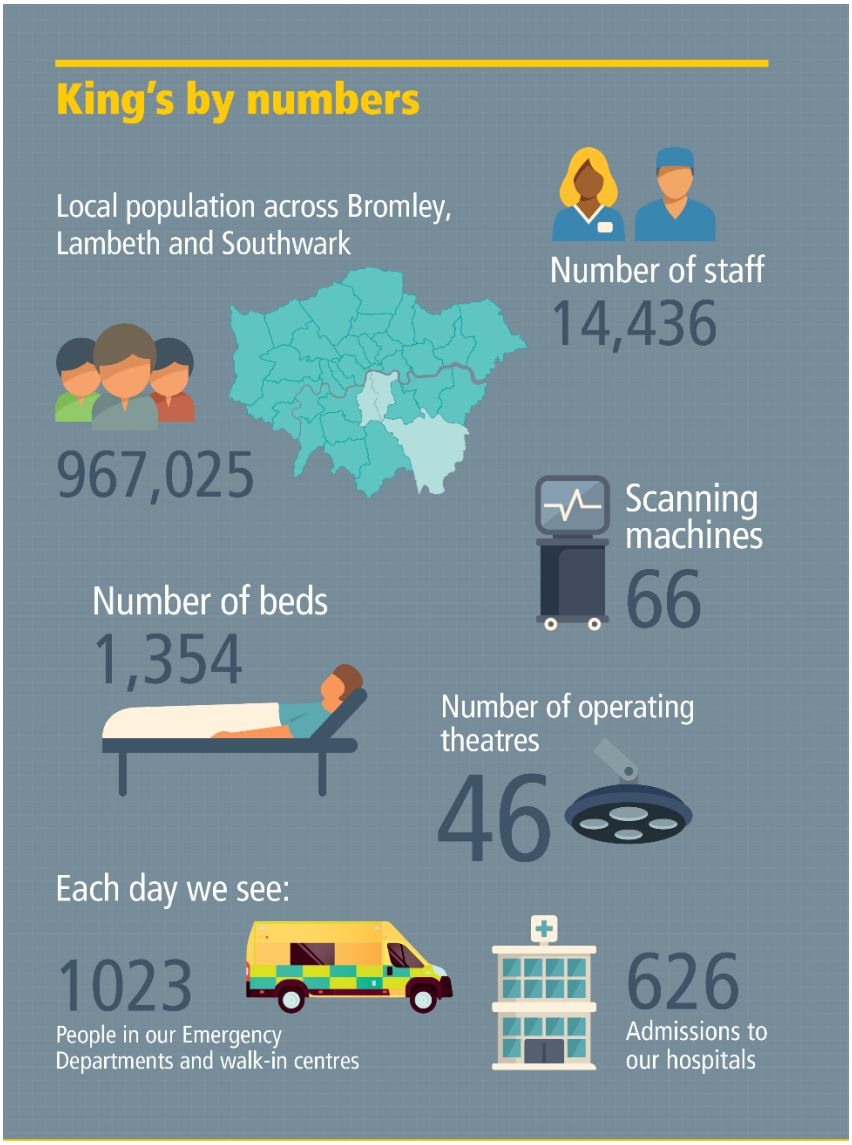
This section provides information about the Trust, its history, purpose, structure, strategic objectives and key risks.

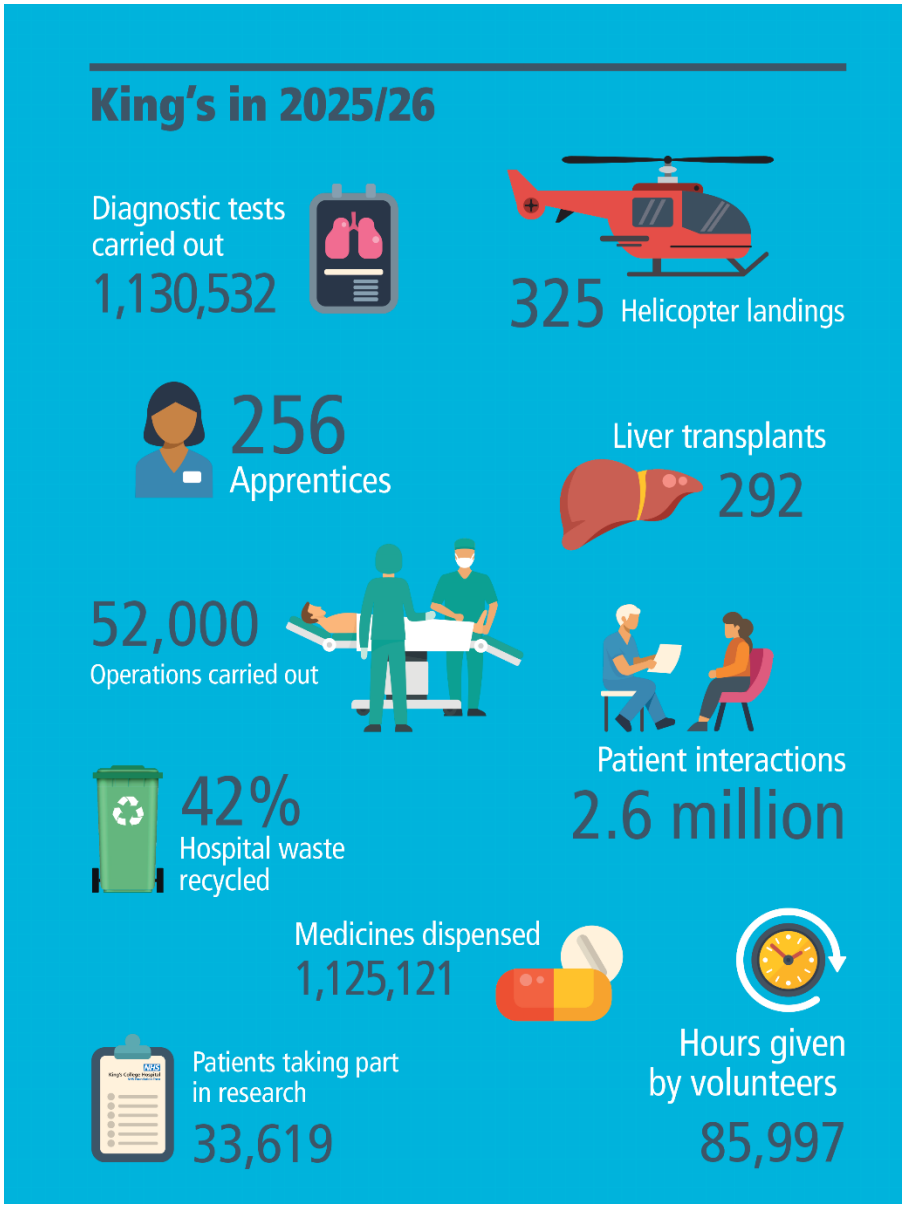
Purpose

King's College Hospital NHS Foundation Trust has as its principal purpose the provision of goods and services for the purposes of the health service in England.

About King's

The graphic below summarises at a glance, some of the key numbers that give a sense of life across our hospitals as of March 2026.





Activities

The Trust provides services to local residents of the London Boroughs of Lambeth, Southwark, Bromley, Bexley and Lewisham from its sites at King's College Hospital (Denmark Hill), Princess Royal University Hospital, Farnborough Common, and Orpington Hospital. It also provides services at Beckenham Beacon and Queen Mary's Hospital, Sidcup. These include accident and emergency services, maternity, care of the elderly, orthopaedics, diabetes, ophthalmology, oncology, dermatology and many more. The Trust also provides some community-based services including dentistry and dialysis.

For people across south-east London and Kent, King's College Hospital is the designated major trauma centre, as well as a heart attack centre and the regional hyper-acute stroke centre. The helipad at King's College Hospital, which opened in November 2016, has reinforced the hospital's position as a major trauma centre for the south of England.

King’s College Hospital NHS Foundation Trust is renowned for the international reputation of its specialty services. These include a number of tertiary services including treatment for liver disease and transplantation, neurosciences, diabetes, cardiac services, haematology and fetal medicine.

The Trust has a reputation as a pioneer in medical research, with a record of innovation in a number of key fields. It is home to leading clinical units and research centres, such as the Clinical Age Research Unit, the HIV Research Centre, the Cicely Saunders Institute and the Harris Birthright Centre.

King’s College London was founded in 1829. Clinical teaching in the medical faculty was dependent upon the Middlesex Hospital until 1839 when King’s College London gained its own hospital in Portugal Street.

Established in 1840, the original King's College Hospital – a former workhouse – was based on Portugal Street, Holborn, close to Lincoln’s Inn Fields in central London. It was first used as a training facility for students at King's College London, but quickly developed into a major hospital for the area. The hospital moved to its current Camberwell site in 1913.

King’s became part of the NHS in 1948 as a teaching hospital. The 1960s saw the introduction of a new dental school, maternity block (now the Ruskin Wing) and the King’s Liver Unit. This was followed by the Normanby College of Nursing, Midwifery and Physiotherapy. In 1995 the UK’s first specialist Motor Neurone Disease Care and Research Centre was established, and the Weston Education Centre was opened in 1997, accommodating the medical school, library and lecture theatres. A new Accident and Emergency Department was opened in the same year.

King’s College Hospital gained Foundation Trust status on 1 December 2006. Following the dissolution of South London Healthcare Trust, King’s formally acquired the Princess Royal University Hospital (PRUH) and Orpington Hospital in October 2013.

The Trust is one of London's leading trauma centres, saving lives by providing immediate specialist care to the most urgent, life-threatening cases. The helipad, opened in 2016, has transformed trauma care across south east London and Kent, and serves more than 4.5 million people. In 2019, King's became the first major trauma centre in London to be granted permission for air ambulances to land at night, ensuring patients have access to highly-specialised treatment any time of the day.

King's is recognised globally as a world-leading innovation centre. From conducting the UK's first bone marrow transplant to helping to establish the world's first voluntary blood donor service, King's has been at the forefront of new healthcare for over a century. Over 50 years ago, King's established one of the first liver units in the country, and has since been a major European transplant programme, completing over 6,000 successful liver transplants.

We are a founding member of King's Health Partners (KHP) - one of eight accredited Academic Health Science Centres in the UK committed to delivering better health for all

through high impact innovation. King's is also a member of the Shelford Group - a group of the top 10 teaching and research-active NHS Trusts.

Structure
The Trust operates a divisional structure, with three clinical divisions. The Trust has twenty-two care groups, aligned to the divisional structure as well as a number of pan-Trust corporate and clinical services such as Workforce, Finance and ICT.

By organising in this way, the Trust is able to group the resources required for delivering similar types of care so that it could improve patient pathways and increase the efficiency of service delivery. It also aims to provide clearer accountability.

More about the Trust governance model can be found on page 45.

The Trust's Strategic Objectives 2025/26

The Trust delivered the final year of its five-year Strategy, Strong Roots, Global Reach in 2025/26. Our vision is for King's to be BOLD:

Brilliant People: we will attract, retain and develop pasionate and talented people, creating an environment where they can thrive.

Outstanding care: We deliver excellent health outcomes for our patients, and they always feel safe, cared for and listened to.

Leaders in Research, Innovation and Education: we continue to develop world-class research, innovation and education, providing the best teaching, and brining new treatments and technologies to patients.

Diversity, Equality and Inclusion at the heart of everything we do: we proudly champion diversity and inclusion at King's, and act decisively to deliver more equitable experiences and outcomes for our patients and people.

The Performance Analysis section on page 25 provides further information on how we have delivered against these objectives in 2025/26.

Risks to achieving our strategic goals
The Trust's approach to managing risk is outlined in the accountability report later in this document Through its Board Assurance Framework, the Trust has identified several risks that could affect the delivery of its strategy including:

- **Workforce** If the Trust is unable to transform the workforce and develop new ways of working in order to deliver the new Trust operating model, financially sustainable services will not be delivered, adversely impacting patient outcomes and staff engagement and patient experience

- **King's Culture and Values** If the Trust is unable to transform the culture of the organisation to become more inclusive and positive, staff engagement and well-being may deteriorate, adversely impacting our ability to provide culturally intelligent, compassionate care to our patients and to each other.
- **Financial Sustainability** If the Trust is unable to improve the financial sustainability of the service it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future
- **Critical Infrastructure:** If the Trust is unable to protect and maintain its critical infrastructure (estate, ICT and medical equipment) our ability to deliver safe and sustainable services will be adversely impacted
- **Research and Innovation** If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre.
- **High Quality Care** If the Trust does not have adequate arrangements to support the delivery and oversight of high-quality care, this may result in an adverse impact on patient outcomes and patient experience and lead to an increased risk of avoidable harm
- **Partnership Working** If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely impact our ability to improve services for local people and reduce health inequalities
- **Demand and Capacity** If the Trust is unable to transform services, improve productivity and sustain sufficient capacity, patient waiting times may increase potentially resulting in an adverse impact on patient outcomes and an increased risk of avoidable harm.
- **IT Systems** If the Trust's IT infrastructure is not adequately protected, systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data

King's Health Partners

The Trust is part of King's Health Partners (KHP), one of the UK's first and foremost Academic Health Science Centres. The partnership was established in 2009, incorporating King's College London and King's College Hospital, Guy's and St Thomas', and South London and Maudsley NHS Foundation Trusts.

Integrated Care System

King's is a partner in the South East London Integrated Care System that covers the London boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark. This comprises local authorities, acute provider Trusts and primary and community care providers.

Acute Provider Collaborative

In partnership with Lewisham and Greenwich NHS Trust, and Guy's and St Thomas' NHS Foundation Trust, King's established an Acute Provider Collaborative (APC) in May 2020. The initial focus of the APC has been to develop a system-wide response to the backlog of patients waiting for treatment in key high volume, low complexity areas. Overseen by a Committee-in-Common, the APC is working to establish specialty-based hubs across South East London, to ensure that all capacity in the system is utilised as far as possible.

Details of Overseas Operations and Subsidiaries

King's Commercial Services Limited has continued to diversify income by expanding commercial activities both in the UK and overseas. It has now been in operation for over 10 years. KCS delivered a surplus of £0.7m to the Trust in 2025/26 including income from its ownership of the Synnovis LLP pathology joint venture.

KCH Management Limited continues to develop a hospital management and consultancy business both in the UK and overseas, predominantly in the Middle East. There are currently two outpatient clinics, an ambulatory centre and a full-scale inpatient hospital open in Dubai, with several other facilities in development in the Middle East, Asia and Africa. The company also delivers education programmes. The company delivered a surplus of £0.1m to the Trust.

King's Facilities Management LLP (KFM) was created to provide a fully managed service across nine diagnostic and treatment facilities. These include theatres, adult critical care, radiology, cardiac catheter laboratories, liver laboratories, endoscopy, renal dialysis, children's critical care and dental. KFM maintains these facilities and equipment, and provides consumables, implants and devices used during clinical procedures.

Separately, KFM provides an end-to-end procurement and supply chain function for the Trust, working with operational leads to identify future requirements for equipment and consumables. KFM seeks to contribute to the Trust through the identification and delivery of cost improvement programme savings through more focused contract management. Since 2019, KFM has managed the outpatient pharmacy service on behalf of the Trust.

The Trust has consolidated a contribution of £14.5m from KFM for 2025/26.

Going Concern

King's College Hospital NHS Foundation Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents

Review of the Year - Showcasing our successes

Throughout the year, King's College Hospital NHS Foundation Trust has continued to deliver outstanding, life-changing care to patients and their families. From pioneering treatments and complex specialist interventions to compassionate, personalised support, the stories that follow illustrate the breadth and impact of our work across all our sites. They highlight not only our clinical excellence and innovation, but also the dedication of our staff and the trust placed in us by the communities we serve.

15 years of major trauma at King's

Thursday 3 April 2025 marked 15 years since King's became a designated Major Trauma Centre, dealing with the most serious injuries and life-threatening conditions. One patient who has benefitted from trauma care at King's is 12-year-old Ryan Sinclair who suffered life-threatening injuries after he was knocked down by a car. Ryan, from Folkestone in Kent, was transferred to the Emergency Department at our Denmark Hill site after the incident left him

with two skull fractures, a build-up of blood on the surface of his brain (subdural haematoma), and a fractured pelvis. Dr Malcolm Tunnicliff, Clinical Director for Major Trauma at King's, said: "We often see patients when they are at their very worst, and unfortunately Ryan had a number of serious injuries. When he was admitted, we were uncertain if he would make a good recovery, and it is wonderful that he has now returned home to his family."

Super Saturday in surgery to tackle waiting lists

The neurosurgical team at Denmark Hill is trialling a new way of working to reduce the time patients are waiting for routine surgery. High intensity theatre (HIT) lists are being tested on Saturdays to safely treat a greater number of patients with neck and spinal problems. Recently, the team carried out eight procedures in one day compared to an average of two cases on a standard single list. Mr Gordan Grahovac, Consultant Neurosurgeon, who has been operating during a HIT list, said: "Careful planning to select the most suitable patients, coupled with streamlined processes, is key to the success of HIT lists."

NHS collaboration allows patient with severe autism to enjoy first holiday

A 19-year-old patient with severe autism and learning difficulties will be able to enjoy his first family holiday after clinicians at King's College Hospital and University College London Hospital worked together to administer yellow fever, rabies and typhoid vaccines.

PRUH Diabetes service receives national accreditation

The Inpatient Diabetes service at Princess Royal University Hospital (PRUH) has received a Diabetes Care Accreditation Programme (DCAP) from the Royal College of Physicians, becoming the second DCAP accredited service in the UK. Dr Adrian Li, Clinical Lead for Diabetes at PRUH, said: "Everyone in the team here at the PRUH is immensely proud of this accreditation. To be the second nationally accredited inpatient diabetes service in the UK is a fantastic achievement. The PRUH Diabetes team have worked incredibly hard to forge pathways to support diabetes inpatients in every corner of the hospital."

PRUH nurse shines at the 2025 Starlight Play in Healthcare Awards

Raquel Duncombe, staff nurse at PRUH has been announced as joint winner of the Protector of Play Award in the 2025 Starlight Play in Healthcare Awards, for using the power of play to transform experiences for children facing emergency surgery. Raquel said: "It is surreal – it's my first ever award. I've just been doing what I can to help our department and make things better for the children. I encourage all my colleagues to use play. It's a way to connect with the child – it helps the child and helps them to do their job."

New app helps families stay connected to premature babies

A new video messaging app has launched at King's College Hospital and PRUH to support families who aren't always able to be with their baby. Dr Anusha Arasu, Consultant in Neonatal Medicine at King's, said: "A stay on a neonatal unit can be one of the most stressful times for a family, but we can now support parents to be more involved, and more connected to their baby's care, as well as making a positive impact in delivering family centred care, even when they are not able to be at hospital."

Bishop of Southwark has face rebuilt by King's surgeons

Former Bishop of Southwark, Christopher Chessun, spoke about the treatment he received at King's following a road traffic accident, saying: "Although it was a significant and traumatic injury, once I was in the care of Professor Fan and her team, I received exceptional and compassionate care.

"Throughout the whole experience, I had absolute confidence and trust in the skill and expertise of Professor Fan and her team and I am also grateful to the nursing staff and for the excellent follow-up post-surgical care. I really can't thank them enough – they not only reconstructed my face – they saved me from life-changing repercussions."

King's brings Hepatitis tests closer to home for South Londoners

People from African and Caribbean communities living in South East London now have easier access to free, quick, and confidential Hepatitis testing, with weekly drop-in sessions provided by the King's Viral Hepatitis Nurses team. Kathryn Oakes, Clinical Nurse Specialist at King's, said: "While community Hepatitis C testing has been available for a number of years, we are delighted to now be able to provide free and confidential Hepatitis B testing to local communities where we know there is an increased risk."

New organ donation memorial is unveiled at PRUH

A new installation highlighting the importance of organ donation opened on Friday 26 September 2025 at the PRUH. Professor Clive Kay, Chief Executive of King's, said: "Organ donation saves lives, and I'm proud that King's is one of the leading Trusts in the UK for organ donation. I would like to thank the talented students from Camberwell College of Arts for the thought and care they have put into their design of the new memorial garden at the PRUH, which highlights the importance of organ donation, and will continue to do so for years to come."

Health Minister hails 'powerful new option for people at risk of HIV' during visit to King's

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

Liam Conlon MP visits PRUH diabetes service

Liam Conlon, MP for Beckenham and Penge, paid a visit to the diabetes service at PRUH to discuss the number of people in the borough of Bromley with diabetes and associated health issues, the effects of alcohol on diabetes, gestational diabetes and diabetes linked to social deprivation. Dr Adrian Li, Clinical Lead for Diabetes at PRUH, said: "Everyone in the diabetes team here at PRUH is immensely proud of the accreditation we achieved earlier this year, and we were delighted to welcome Liam Conlon MP to discuss the work we are doing to support local patients with diabetes."

Parkinson's disease patient plays clarinet during brain operation

Denise Bacon, a patient with Parkinson's disease, has played the clarinet while undergoing Deep Brain Stimulation to help manage her symptoms, enabling surgeons to see – and hear – immediate results. Professor Ashkan, said: "Deep Brain Stimulation, where stimulating electrodes are placed into the deep structures of the brain, is a long-established procedure to improve motor symptoms in patients with movement disorders.

"As a keen clarinettist, it was suggested Denise bring her clarinet into the operating theatre to see whether the procedure would improve her ability to play, which was one of Denise's main goals for the surgery. We were delighted to see an instant improvement in her hand movements, and therefore her ability to play, once stimulation was delivered to the brain."

King's treats first adult patients with 'incurable' T-cell leukaemia with new gene therapy

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

RoboDocs: King's surgeons perform 1,000 cases of robotic surgery in two years

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

Lambeth school children learn life-saving skills at King's

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

ECHO charity celebrates Heart Month at the PRUH

A team from ECHO, a charity supporting children and young people with heart conditions and their families, spent a day at PRUH in February 2026. Charity staff visited the paediatric cardiology service at PRUH, speaking to staff, parents and young patients about how their work makes a difference to families. Dr Ola Elmasry, Consultant Paediatrician at PRUH, said: "February is Heart Month, and so we felt it was perfect timing to open our doors to ECHO and show them how children and their families at PRUH have benefited through their generosity and kindness."

PERFORMANCE ANALYSIS

A Review of King's Strategic Objectives for 2025/26

As noted above, in 2021, King's published its five-year strategy, *Strong Roots, Global Reach*, setting out our BOLD vision across four ambitions Brilliant People, Outstanding Care, Leaders in Research, Innovation and Education and Diversity, Equality and Inclusion at the heart of everything we do.

As this strategy reaches its conclusion, 2025/26 has focused on delivering the final year of the BOLD strategy, consolidating progress made over the past five years and strengthening the foundations for the future.

Over the past year we have:

- Improved patient access and flow by delivering a 25% reduction in DNA rates, releasing over 20,000 additional appointments annually, alongside the rollout of patient self-scheduling and expansion of digital access through MyChart.
- Delivered 277 liver transplants, a record number and the highest number performed by any centre in the UK in a calendar year.
- Been selected by NHS Blood and Transplant as one of 15 national Assessment and Recovery Centres to trial an innovative organ preservation programme, helping to increase the number of life-saving transplants.
- Enhanced operational oversight and patient flow through the introduction of live bed state functionality across the Trust.
- Strengthened workforce pipelines through the delivery of over 400 apprenticeships, expanded work experience opportunities and supported employment programmes such as Project SEARCH.
- Invested in leadership capability, with 169 clinical managers completing clinical leadership programmes to support high-quality care and future leadership capacity.
- Introduced a new violence and aggression reduction plan to improve staff safety and experience.
- Continued delivery of the Harm Free Care Programme, supporting improvements across falls prevention, pressure ulcer prevention, medication safety, deteriorating patient care and infection prevention.
- Advanced research and innovation, including securing £4.9 million in external funding to support programmes improving pregnancy and neonatal outcomes.
- Delivered major digital and infrastructure improvements, including upgrades to patient monitoring systems, network capability and device integration, enhancing patient safety and organisational resilience. The Trust has also been recognised for outstanding digital maturity by Healthcare Information and Management Systems Society (HIMSS), placing it among a select group of leading hospitals in Europe.
- Increased estate capacity and capability through delivery of key infrastructure, alongside continued progress on major capital programmes such as our new endoscopy unit and upgraded electricity supply.
- Progressed sustainability ambitions, including achieving and retaining ISO 14001 certification and being recognised as one of the top 10 most sustainable health service organisations globally.
- Strengthened financial sustainability through the development of a clear financial strategy and enhanced governance framework.

Building on our achievements with BOLD, we have made strong progress in improving patient access, strengthening workforce foundations and advancing our digital and operational capability. Our new Trust Strategy for 2026-31 builds on these foundations and sets a clearer and more ambitious direction for King's, centred on the ethos *"the best at getting better"*. It will be underpinned by a refreshed set of values and strategic objectives which will guide how we continue to improve outcomes, experience and value for our patients and communities over the next five years.

Meeting our core constitutional operational performance targets

Providing high quality care when patients most need it

The 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% - 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 the target of 112%.

Referral to Treatment (18-week) performance

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.

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 just missed with 12 patients waiting over 65 weeks by the end of March.

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 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 targets

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, hepatopancreatobiliary (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 2025 to 96.7% in February, achieving the national standard of 96%.
The Trust was achieving the 75% national target for the 28-day 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 end of 2025/26, the Trust was in level two Tiering for cancer performance which resulted in additional scrutiny on the recovery plans and performance, and was subject to fortnightly review in Quarter 4 with NHSE.

Diagnostic waiting times
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 Care Standard (ECS)
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. At Denmark Hill, 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 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 has 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 has 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 over 60 minutes. The 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.

Achieving good clinical outcomes

Mortality and survival

The Summary Hospital-level Mortality Indicator (SHMI) remained 'as expected' across all Trust sites throughout the year. The latest SHMI published by NHS Digital (12/3/26) shows all tracked diagnostic groups as being 'as expected', with SHMI for pneumonia and secondary malignancies recorded as 'better than expected.' National clinical audit results report mortality as being within expected range or better than expected for primary and metastatic breast cancer, oesophago-gastric cancer, lung cancer, emergency laparotomy, paediatric and adult liver transplant, renal replacement therapy, hip fracture, bowel cancer, intensive care, hip and knee replacement surgery and neonatal care.

In-depth investigations have been completed in relation to deaths of patients with a learning disability and deaths of patients with severe mental illness. Whilst improvement actions are in place in relation to some aspects of the process of care, no evidence was found of systemic care quality issues.

Non-mortality outcomes

Performance against non-mortality outcomes indicators was recorded as better than expected or within expected range for intensive care, lung cancer, pre-gestational diabetes, stroke (some indicators), organ donation, fracture liaison service and cataract surgery.

Actions are in place to:

- Improve the rate of early diagnosis of oesophago-gastric cancer.
- Reduce unit-acquired infections in blood, delayed admissions and unplanned readmissions in intensive care.

- Reduce the time to operation following hip fracture.
- Improve the time to thrombolysis and admission to a ‘stroke bed’ following a stroke.
- Improve consent rate for organ donation.
- Reduce blood glucose levels in children and young people with diabetes.

Further detail on the Trust’s performance in relation to mortality monitoring and national clinical audits is provided in the 2025/26 Quality Account, published on our website.

Delivering our quality priorities

Each year the Trust sets a number of quality priorities aimed at enhancing the quality of care and patient safety. These priorities included measuring outcomes to drive improvement for acutely unwell patients, improving the experiences of patients with learning disabilities and autism receiving care, and the implementation of the revised national safety standards for invasive procedures (NatSSIPs 2).

Measuring outcomes to drive improvement for acutely unwell patients was chosen because 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. 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. A Trust-wide dashboard has been rolled out and embedded in ward and governance meetings to monitor deterioration, with clinical validation of data to improve accuracy and confidence. There has also been improvement work to strengthen observation practices and participation in national work to support escalation of deteriorating patients.

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.

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. 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. building the infrastructure needed to support improvement across the Trust. This has included development of guidance, piloting a reasonable adjustment flag within the patient record system and developing hospital passport materials and easy read resources.

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 **NatSSIPs2** across the Trust. This work supports safer care, clearer standards for staff and stronger governance oversight. Significant progress has been made in establishing the foundations needed to support safer procedures across the Trust, including establishing governance arrangements, developing a Trust procedural safety policy, establishing and improving compliance with the NatSSIPs 2 standards, and beginning work to improve consent processes, site marking, reconciliation and team briefing.

Infection Prevention and Control

The Trust continues to monitor healthcare-associated infections as a matter of priority. For April 2025 to March 2026, the Trust was over trajectory for MRSA bloodstream infections, E. coli bloodstream infections and C. difficile, while remaining on trajectory for klebsiella and pseudomonas bloodstream infections. There were nine Trust-apportioned MRSA bloodstream infections against a target of zero avoidable cases, compared to 3 cases in 2024/25. Issues identified included inconsistent MRSA screening practice and delays in prescribing MRSA protocol, with actions taken including reinstated screening compliance reports, Epic prompts for doctors, and a Trust-wide MRSA campaign.

The Trust was also over trajectory for C. difficile year to date. Improvement work has continued through the C. difficile quality improvement group, focusing on stool sampling, antimicrobial prescribing, documentation of stool charts in Epic and cleaning. This has included ward-based teaching, daily diarrhoea rounds by Infection Prevention and Control Nurses, and evaluation of enhanced disinfectant products for use on high-risk wards.

From April 2025 to March 2026, the Trust recorded 40 line-related bloodstream infections, representing a reduction of nine cases compared with the previous financial year. The intravenous devices quality improvement group has focused on reducing harm from intravenous lines through measures such as daily chlorhexidine washing for patients with central lines, ANTT audits, and Epic prompts to support timely review and removal of peripheral cannulae.

The Trust is over trajectory for E. coli bloodstream infections, although klebsiella and pseudomonas bloodstream infections remain on trajectory. The majority of the gram-negative blood stream infections occur from an unavoidable source (e.g. gastrointestinal/hepatobiliary infections), however, 8% of the cases are attributable to urinary catheters, and are potentially avoidable. . Actions to reduce risk have included electronic prompts in Epic for post-operative catheter review and extension of the ‘Tic Twoc’ study to additional wards to encourage earlier catheter removal. Across all priority areas, the IPC PSIRF Improvement Group is using the King’s Improvement Method to coordinate quality improvement work on intravenous line infection, C. difficile, cleaning and safer clinical practice.

Freedom to speak up

Over the past year, the Trust has continued to strengthen its Freedom to Speak Up (FTSU) arrangements, embedding the Board-approved Vision and Plan with a clear focus on leadership accountability, psychological safety and organisational learning. Governance and

oversight have been significantly enhanced through clearer expectations for leaders, strengthened divisional engagement and improved Board level reflection on compassionate and visible leadership.

Psychological safety is now embedded across all FTSU training, supported by closer collaboration with Organisational Development, Equality, Diversity and Inclusion and Staff Networks. The Trust has also made substantial progress in preventing and monitoring detriment, with strengthened governance processes, enhanced use of the InPhase case management system and the introduction of structured oversight arrangements. Improvements in the quality and use of data, including alignment with national culture indicators and the development of a triangulated risk dashboard, are supporting earlier identification of cultural risk and more targeted intervention. While progress remains on track, the Trust recognises the need to sustain momentum, with continued focus on leadership visibility, confidence in confidentiality, embedding learning from concerns and demonstrating measurable improvements in staff confidence to speak up. More detail on numbers will be available in the Freedom to Speak Up Guardian's annual report, available later in 2026.

Patient Experience and Volunteering

Patient experience, involvement and improvement are essential to ensure care is shaped around what matters most to patients, families and carers. When people are involved, services are more likely to be safe, effective and responsive to real needs. Listening to patient experience helps organisations identify what is working well and where things need to change. Continuous improvement, informed by lived experience, leads to better outcomes, greater trust and more compassionate care.

Waiting Well

NHS England's Elective Recovery Programme aimed to reduce long waits for planned care and restore the standard that patients start treatment within 18 weeks. To support this, the Trust collected survey feedback and ran four engagement workshops with 363 people taking part. Key findings showed that:

- 55% of patients rated their experience of waiting as good or very good
- Only 16% were told by their GP how long they were likely to wait at the point of referral
- 58% knew who to contact if they were worried about their health while waiting
- Disabled people, older adults, and people from Black ethnic backgrounds consistently reported poorer experiences of waiting, particularly in relation to communication, understanding wait times, and knowing who to contact when concerned about their health.

Through the engagement workshops, participants proposed practical solutions focused on clearer and more regular communication, improved expectation-setting, simpler and more accessible digital tools, and additional support for people who experience the least good outcomes. The report recommended co-designing care-group-specific Waiting Well solutions, piloting new resources with the Surgery Admissions Team, and developing more proactive support through Care Navigators.

Volunteer Care Navigators have supported over 300 people waiting for surgery, offering additional support and flagging vulnerable patients to the relevant services. This should lead to fewer complications, faster recovery, shorter hospital stays, and fewer last-minute

cancellations. It should also improve patient experience and can deliver lasting health benefits beyond surgery, making it valuable for both outcomes and NHS efficiency.

Volunteering for Health
This programme has brought together NHS Trusts, Volunteer Centres and system partners to create a more connected, inclusive and impactful volunteering model across southeast London. Since its launch, a clear shared vision has been established through a theory of change event, volunteer-led priorities, and the successful appointment of Volunteering for Health officers to drive delivery.

Significant achievements include strengthened partnerships, early movement of volunteers between organisations, and improved collaboration between NHS and community partners. The programme has also opened real pathways into employment and education, with 30 job opportunities shared through the DWP and strong interest from volunteers in further qualifications with local colleges.

Engagement events have been well attended and continue to shape the programme, ensuring it is grounded in lived experience. With governance arrangements nearly finalised and benchmarking underway, the foundations are firmly in place to deliver a volunteer passport, expand opportunities, widen participation and reduce health inequalities. The programme is already demonstrating the power of partnership and innovation to improve volunteer and patient experience at scale.

King's Volunteer Programme
King's Volunteer Programme has continued to excel as one of the largest hospital-based volunteering services in the NHS. The service is hugely beneficial to the Trust and our patients. Between April 2025 and January 2026, 1,766 volunteers contributed over 70,500 hours of support across 169 clinical and non-clinical areas, marking a significant year-on-year increase in activity and reach.

The programme has gone from strength to strength by introducing new, high-impact roles and strengthening existing ones. Innovations such as DNA Caller and Care Navigator volunteers are already delivering measurable benefits, reducing non-attendance, supporting elective recovery, easing patient anxiety, and improving discharge experiences. Volunteer-led support has reached at least 18,000 patients, with 89% of volunteers reporting a positive shift experience.

Alongside operational delivery, the programme has led the way nationally in developing an Outcomes Framework and observational study methodology, creating a robust, credible approach to demonstrating volunteer impact. With record participation, strong volunteer satisfaction, and clear links to Trust priorities on patient experience, flow and quality, the Volunteer Programme is delivering outstanding value for patients, staff and the wider system.

Digital Patient Panel
The Digital Patient Panel is a joint initiative between King's College Hospital NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust, established in October

2025 to ensure that digital transformation is shaped by patient and carer experience. Since its launch, the panel has brought together a core group of over 50 patients, carers and parents who meet regularly with NHS colleagues to provide insight and feedback on digital tools and services.

Panel sessions typically involve between 20 and 25 patient participants, alongside project and clinical teams. Membership reflects a range of lived experience, including people with differing levels of digital confidence, people with learning disabilities, and those living with long-term conditions or sensory impairments. Across panel meetings, surveys and breakout discussions, participants have consistently highlighted a number of key themes. These include the usability of MyChart, particularly issues relating to login, verification codes, multiple accounts and notifications, as well as wider concerns about digital confidence and inclusion. Panel members have also provided detailed feedback on the clarity of pre-appointment information, accessibility of language and formats, and the importance of trust and reassurance as new digital processes are introduced.

Patient input has led to improvements in the clarity and accessibility of patient messaging. Issues raised by panel members, such as MyChart verification delays and account confusion, have been formally escalated to digital and IT teams for investigation and resolution. The panel has also informed the development and testing of learning-disability-friendly materials and worked with young people and carers to provide more effective materials to encourage people to sign up. Overall, the Digital Patient Panel has played a central role in embedding lived experience into digital change, ensuring that digital tools are more accessible, inclusive and responsive to patient needs.

AccessAble Launch
The AccessAble Launch brought together teams from across the Trust to celebrate our ongoing commitment to improving accessibility for patients, visitors, and staff. The launch highlighted the new AccessAble guides, showcased practical improvements already underway, and reinforced our shared responsibility to create environments that are welcoming and inclusive for everyone who uses our services.

Reducing Health inequalities
King's College Hospital NHS Foundation Trust has adopted a structured, organisation-wide approach to healthcare equity/ addressing inequalities, embedding consideration of unequal access, experience and outcomes into core clinical, operational and governance processes. This includes Alignment with national and system priorities, including NHS England frameworks, CORE20PLUS5 and Southeast London ICB priorities, to ensure consistency and Trust-wide coherence.

The Trust demonstrates due regard to the 3 aims of the Public Sector Equality Duty by:

- Eliminating discrimination and reducing unwarranted variation in access and outcomes through targeted programmes addressing the Vital 5 risk factors and CORE20PLUS5 clinical priorities.
- Advancing equality of opportunity by focusing on groups experiencing the greatest disadvantage, informed by deprivation, protected characteristics and other vulnerabilities, and prioritising areas where need is greatest.

- Fostering good relations through strengthened patient, community and staff involvement in service design, research and improvement activity.

These principles are embedded within programme design, governance papers, and decision-making processes, rather than being treated as a separate compliance exercise.

The Trust uses a growing range of clinical, outcomes and population health data (including EPIC-enabled datasets and outcomes reporting) to identify inequities in service delivery and prioritise action, particularly across Vital 5 and CORE20PLUS5 priorities. Current work has highlighted that, while there are strong examples of equity-focused practice across Care Groups, activity has historically been fragmented and inconsistently reported, prompting a move to a more systematic and assured approach. Where available, demographic and deprivation data are used to understand service utilisation and outcomes; further work is underway to strengthen routine, consistent disaggregation by protected characteristics.

Activities to promote equality of service delivery

The Trust is undertaking a range of actions to actively promote equality of service delivery, including:

- Targeted programmes addressing known drivers of inequality through Vital 5 and CORE20PLUS5, with named clinical leadership and defined improvement trajectories.
- Strengthened governance, including proposals to establish a single committee covering healthcare inequalities and population health, supported by clear terms of reference, action tracking and reporting routes.
- Embedding equity into service design and improvement, supported by the development of a Healthcare Equity Framework, equity lens and practical toolkit to guide teams.
- Inclusive research and innovation, including work to improve participation of under-represented groups in research and ensure learning is translated into frontline care.
- Partnership working with system partners (including King's Health Partners and SEL ICB) to align delivery, share learning and maximise impact at scale.

Achievements in 2025/26

- Advanced delivery of the Vital 5 priorities, with demonstrable progress across smoking cessation, alcohol harm reduction, healthy weight, mental health integration and blood pressure management, supported by Epic-enabled data capture and outcomes work.
- Improved outcomes intelligence and insight, including use of linked data, outcomes projects (e.g. obesity, tobacco dependence, alcohol harm), and early work to disaggregate outcomes by deprivation and ethnicity to identify unwarranted variation.
- Strengthened system partnership working, including hosting the South East London Vital 5 Workshop, collaboration with SEL ICS partners,
- Strengthened inclusive and preventative care for staff, including installation of the Staff Vital 5 health machine, improving access to preventive health checks and positioning staff as part of the Trust's population health approach.
- Embedded equity within quality and improvement activity, with Care Group-led exemplars recognised through the CQC Well-Led framework.

- Developed the foundations of a Healthcare Equity Framework, including agreement to introduce an Equity Lens and practical Toolkit to support divisions to routinely consider equity in service design, business cases and improvement activity.
- Establishing a clear Population Health and Healthcare Equity direction under the CMO, aligning prevention, equity and PHM with national policy (Health and Care Act 2022, Core20PLUS5, NHS Long Term Plan) and SEL system priorities.

Overall, the Trust is moving from a position of strong but dispersed activity to a more mature, systematic and assured approach to healthcare equity. This includes clearer governance, better alignment of data and metrics, and a sustained focus on reducing unwarranted variation in access, experience and outcomes for different population groups. Continued development of disaggregated performance and experience data will further strengthen assurance and transparency.

2025/26 R&D Summary

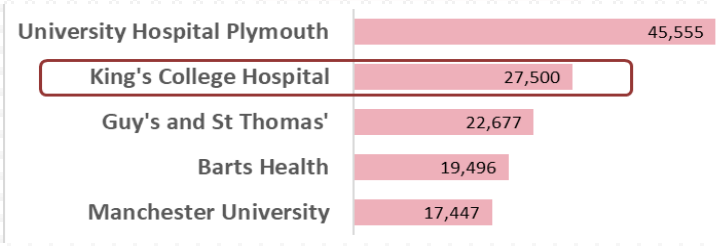
R&D Performance Metrics

33,619
Patients recruited

143
Non Comm Studies Approved

113
Commercial Studies Opened

UK Recruitment Rankings



1,260
Active Research Studies

£12,321,017
Commercial Research Income via KHP CTO

£4,849,592
NIHR RDN Funding

162 WTE
Workforce

25% met
150 Day Target

228
Non Comm contracts Executed

Future Focus

- Streamline study setup & recruitment workflows to meet 150-day target
- Embed research across the Clinical Divisions as part of NHS "BAU"
- Implement digital tools to automate key processes and inform quality improvement
- Actively pursue and secure studies that reflect strategic research priorities

Environmental sustainability
In January 2026, we published our Trust's Green Plan to 2028. This sets out how we will protect the environment across 10 focus areas over the next 3 years, while continuing to provide the best possible care for our patients.

We undertook extensive engagement while developing the Green Plan with our staff, patients, visitors and partners via workshops, drop-in sessions and surveys.

As part of the Green Plan we have committed to incorporating sustainability into everything we do, which means treating our patients in the most environmentally friendly way. It also means transforming our green spaces, improving the air we all breathe, minimising waste and championing cleaner, greener ways of getting around. As well as creating a healthier local environment, these measures will improve the health and wellbeing of our patients, staff and visitors.

The carbon footprint is reviewed and calculated annually, and in 2025/26, it was equivalent to an NHS Carbon Footprint (emissions controlled directly) of 36,455 tonnes CO2e and NHS Carbon Footprint Plus (including emissions that can be influenced) of 223,957 tonnes CO2e. Compared to the previous year, this represents an 8% decrease in the NHS Carbon Footprint and no change in the NHS Carbon Footprint Plus.

Key Performance Updates for 2025/26 include:
During 2025-26, the Trust made good progress in delivering energy and decarbonisation projects across our estate. From generating more renewable electricity on site to improving how we heat, monitor and manage our buildings, these schemes focus on cutting carbon, reducing costs and strengthening resilience, while continuing to support safe, high-quality patient care.

The Trust has reduced the amount of energy used to power and heat its buildings, leading to an 8% reduction in carbon emissions. This reduction is mainly temporary and reflects planned maintenance work on our energy infrastructure. During the year, one of the Trust's two gas-powered Combined Heat and Power (CHP) engines was taken out of service for a major overhaul.

The second CHP engine is scheduled for similar maintenance in 2026-2027. While this essential work supports the long-term reliability of our energy systems, it means that carbon emissions are expected to rise slightly in 2027-2028 before longer-term decarbonisation measures take effect.

Orpington Hospital solar PV project - The scheme was completed in March 2026 and saw 322 roof-mounted solar panels installed across two arrays. This is the largest of the six solar PV arrays across the Trust estate and is expected to generate around 146,000 kWh of clean electricity each year, reducing carbon emissions by around 34 tonnes and delivering electricity cost savings of approximately £28,000 a year.

Sustainable Heat and Energy Infrastructure – Denmark Hill - During 2025-26, the Trust completed a major heat decarbonisation study for the Denmark Hill site, supported by £216,000 from the Greater London Authority's Zero Carbon Accelerator programme.

Connection to the South East London Combined Heat and Power (SELCHP) district heat network was identified as the preferred option and is expected to reduce heat-related carbon emissions by around 93% compared to the current system. The Trust is now progressing discussions with the SELCHP district heat network team and the London Borough of Southwark to explore next steps.

Site-Wide Energy Monitoring to Support Net Zero – The Trust has implemented a Site Wide Monitoring System (SWMS) across the Denmark Hill campus to monitor critical electrical infrastructure and strengthen oversight of a complex, high-risk estate. The system improves resilience and safety, enabling faster fault detection and response, and provides high-quality energy data to support energy management, carbon reporting and informed investment decisions.

LED Lighting and BMS optimisation improvements - During 2025-26, the Trust completed a number of projects to reduce energy use and improve efficiency, supported by £480,000 of grant funding. This included installing new LED lighting at the Dental Building at Denmark Hill and the Day Surgery Unit at the Princess Royal University Hospital (PRUH), replacing older, less efficient lighting. These upgrades have reduced electricity use and ongoing maintenance needs.

The funding also supported optimisation of the Trust's Building Management System (BMS), which controls heating, ventilation and air-conditioning in our buildings. These changes have helped systems run more efficiently, cutting energy waste while keeping patients, staff and visitors comfortable.

Medical gases and inhalers: The focus on reducing nitrous oxide waste continues, as this anaesthetic gas has a global warming potential 300 times greater than carbon dioxide. Following significant progress at the Denmark Hill site in previous years, theatres at the Princess Royal and Orpington Hospitals are switching over to portable cylinders supplying nitrous oxide where required, allowing for the decommissioning of manifolds and a significant reduction in nitrous oxide wastage. Building on the success of reducing emissions from pure nitrous oxide, we are also increasingly focused on the lean supply of Entonox (nitrous oxide and oxygen mixed), further reducing our emissions and looking after the health and wellbeing of our staff. Compared to 2024-25, emissions from anaesthetic gases reduced by 4%.
The carbon footprint from the prescription of inhalers reduced by 19% compared to 2024-25. 24,000 inhalers were recycled as part of the South East London Inhaler Recycling pilot with an impressive return rate of 16%. The review of the pilot is ongoing with the recommendation for inhaler recycling to be included in Trust waste management contracts as standard.

Travel and Transport: The proportion of Zero-Emission Vehicles (ZEVs) in the Trust's Salary Sacrifice Scheme saw an uplift in 2025/26, climbing from 68% to 74% of the total fleet. The Trust proudly operates the NHS's first dedicated A&E electric vehicle charger. In 2025/26, this unique asset supported London Ambulance Service (LAS) with almost 600 charging sessions, delivering more than 9000 kWh of energy to power their electric ambulance fleet. The Trust has continued to grow its core electric vehicle fleet, increasing to 27% of the fleet being EVs.

Air quality has been formally integrated into the King's Green Plan as its own focus area, going above and beyond NHS England's Green Plan guidance. Alerts of 'high' and 'very high'

air pollution continue to be shared with all staff on the intranet, allowing clinical staff to share information about actions that can be taken with vulnerable patients. Air pollution also continues to be flagged as a health risk on the electronic patient records system EPIC for patients living in areas of elevated air pollution.

Greenspace and nature: We have received funding from the Centre for Sustainable Healthcare for the Healthy by Nature programme to boost both wellbeing for patients and staff and local biodiversity through landscaping and nature-based activities, led by a dedicated Nature Recovery Ranger. Meanwhile, work is progressing on a Critical Care Unit patient rooftop garden which will launch in 2026.

Sustainable food: Food waste collection increased by 44% compared to the previous year, partially driven by the implementation of the Simpler Recycling legislation and a roll-out of food waste caddies in the appropriate areas. A review will be undertaken to assess this trend with an aim of achieving reductions over the next year following the new patient menu and Trust Food and Drink Strategy.

Climate Change Adaptation Plan: The Trust's Climate Change Adaptation Plan Working Group started work on an action plan to mitigate the impacts of climate change on the Trust's operations. The group has identified a need to review the Trust risk register to more accurately reflect the climate risks and opportunities impacting or expected to impact the Trust in the future.

Environmental management: The Capital Estates and Facilities Team maintained BSI certification to the ISO14001:2015 environmental management standard, demonstrating international best practice.

Waste and recycling: The amount of waste generated and disposed of by the Trust has remained stable over the past year but associated carbon emissions decreased by 32%. This reduction was largely due to the roll-out of the lower-carbon offensive waste stream for clinical waste, where appropriate. We have installed bright blue collection bins at King's College Hospital so patients can easily drop off the crutches and metal walking sticks they've finished using. So far, more than 787 sets of walking aids returned for reuse, giving 7,421kg carbon emissions reduction and over £4,800 cost savings. We will be extending the scheme to PRUH and Orpington this year.

Procurement: In procurement practices, NHS England's 10% Net Zero and Social Value weighting criteria, as well as Carbon Reduction Plan (CRP) requirements, are consistently applied, and work is ongoing to ensure consistent application in contract management. The analysis of carbon emissions from procurement remains spend-based and shows an annual increase of 3%.

Workforce and Leadership: We educate and empower our staff to make sustainable choices in their everyday lives at work and home. This year we launched a new Green Champions Network – with 35 members so far – who have ring-fenced time to lead on sustainability activities. Several colleagues have enrolled on the Sustainable Healthcare Academy, run by NHS approved supplier LDN Apprenticeships, which provides staff with the opportunity to learn practical sustainability skills that can be put into practice in their roles. We have driven

behaviour change through the Trust's Gloves Off campaign which aims to reduce unnecessary use of non-sterile gloves. Since implementing the Gloves Off campaign across the pilot wards, glove usage has reduced by around 370,000 gloves. This has also delivered an estimated annual cost saving of £40,000, alongside a reduction of approximately 9.6 tonnes of carbon emissions and associated plastic waste.

Governance
The Trust Board, through the Trust Executive, has responsibility for oversight, management, and delivery of commitments relating to environmental sustainability and climate-related issues and receives an annual sustainability report outlining progress.

Delivery of the Trust Green Plan is overseen at an executive level by the Green Plan Delivery Board (GPDB), which has representation from all clinical divisions and corporate delivery groups. The GPDB meets every two months and reports biannually to King's Executive. The GPDB is responsible for collating good practice from across the Trust.

The GPDB is chaired by Liz Shutler, Director of Strategy (deputised by Julie Lowe, the nominated Board-level Net Zero lead), whose role is to drive forwards the sustainability agenda and promote environmental considerations through the GPDB and its members. The Trust is set to appoint its first Net Zero Clinical Lead in 2026 – a member of the GPDB - who will shape and drive the integration of sustainability into our clinical pathways, ensuring we deliver high-quality, preventative, low-carbon care across the Trust.

The GPDB will identify operational support for each of our 10 focus areas. A number of sustainability working groups will lead on the implementation of Trust-wide initiatives in their areas - as well as group or departmental specific pieces of work.

The Sustainability team continues to partner across King's College Hospital NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust. The team carries out cross-functional collaboration to integrate sustainability into all aspects of the organisations.

Task Force on Climate-related Financial Disclosures (TCFD) NHS England's NHS foundation Trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

TCFD recommended disclosures, as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year.

Local NHS bodies are not required to disclose scope 1, 2, and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance, risk management, and metrics and targets pillars for 2025/26. These disclosures are provided below with appropriate cross-referencing to relevant information elsewhere in the annual

report and in the King's Green Plan. Delivery of the Trust Green Plan is overseen by a board-level Net Zero lead and the Green Plan Delivery Board.

Strategy While we have not yet met the TCFD recommended disclosures around 'Strategy', 'Risk Management' or Metrics', the Trust is actively developing its approach and has identified opportunities to enhance compliance. The 'Strategy' pillar is complex for the organisation due to the level of analysis required.

The Trust is developing a climate change adaptation working group action plan which will set out the key risks to the organisation and how these could impact our Trust strategy, operations and finances. The plan will also highlight the actions we must prioritise for implementation.
Risk management We are also working on an approach to meet the TCFD 'Risk Management' recommended disclosures. Similarly, this pillar is complex due to the level of risk assessment required to adequately score the risk.

The Trust is developing a climate change risk assessment and further work is required to integrate this into the corporate risk register. Once this action is completed the organisation will be in a position to confirm whether climate risk is deemed a 'principal risk'.
The Trust recognises both the 'transitional' risk associated with meeting the mandatory Net Zero carbon targets and the 'physical' risk associated with the impacts of climate change on our operations.

Physical risks are managed by our Emergency Preparedness Resilience and Response (EPRR) team and associated governance processes.

Metrics and targets The Trust is actively developing its approach to meet the TCFD 'Metrics and Targets' recommended disclosures. This pillar requires the organisation to first complete the 'Strategy' and 'Risk Management' TCFD pillars to enable the most appropriate metrics and targets to be selected based on a full review of climate-related risks and opportunities.

The organisation currently uses a range of metrics and targets to assess and manage climate related issues. The environmental impact performance indicators for 2025/26 were used to track our progress to Net Zero as well as other sustainability programme targets. Our Green Plan to 2028 sets out the targets and objectives for each of our 10 focus areas. A review of our metrics and targets will be conducted next year once we have reviewed the corporate risk register climate risk in further detail.

Summary of Performance

The performance report was approved by the Board of Directors on 18th June 2026 and signed on its behalf by:

Professor Clive Kay Date: 18 June 2026
Chief Executive

Significant issues and events since the end of 2025/26

There have been no significant issues or events since the end of the reporting period.

The performance report was approved by the Board of Directors on 18 June 2026 and signed on its behalf by:

Professor Clive Kay Date: 18 June 2026
Chief Executive

ACCOUNTABLITY REPORT

2.1 Directors' Report

Governance Framework

Our Trust's governance framework comprises its membership body, the Council of Governors and the Board of Directors.

The Trust's membership plays an important role in supporting and shaping the services provided to local communities. The Trust's membership is drawn from patients, staff and individuals from the local constituencies it serves. Membership is open to people aged 16 and over who live locally, have used the Trust's services within the past six years, care for a patient, or work for the Trust. Members contribute through feedback, engagement activities, fundraising, and participation in Governor elections, helping to ensure that the views of patients, staff, and the wider community are represented in the Trust's governance and development. Members also receive regular updates on Trust developments and opportunities to participate in meetings, health talks, and community events. More information about recruiting and involving members in the life of King's starts on page 67.

The Council of Governors is elected by the membership or appointed in accordance with the Trust's Constitution. The Council of Governors is responsible for representing the interests of members and stakeholders in the governance of King's. The Council of Governors exercises statutory powers such as the appointment or removal of non-executive directors; appointing the external auditor; approving mergers, acquisitions and significant transactions; holding the non-executive directors individually and collectively to account; and representing the interests of members and the public. The Council of Governors met formally six times during the year to discharge its duties. Four of these were standard meetings held in accordance with the normal schedule, while two were extraordinary meetings convened to address urgent matters: one to approve the Annual Report and Accounts, and the other to approve the appointment of the new Chief Executive Officer. The matters specifically reserved for the Council's decision are set out in the Trust's Constitution. Governor elections were held in February 2026. More information about the Council of Governors, including its composition and terms of office, can be found on page 62.

Led by the Chair, the Board of Directors sets King's strategy, determines objectives, monitors performance and ensures that adequate systems are maintained to measure and monitor effectiveness, efficiency and economy. The Board has spent a considerable amount of time in the year developing its new 2026-31 strategy which is scheduled to be launched in June 2026. This has included updating the Trust values which set the culture of the organisation. The Board decides on matters of risk and assurance and is responsible for ensuring high quality and safe services. It provides leadership and effective oversight of King's operations to ensure the Trust is operating in the best interests of patients within a framework of prudent and effective controls that enables risk to be assessed and managed. Further information about King's internal controls and approach to clinical and quality governance can be found in the Annual Governance Statement starting on page 109.

The Board of Directors, comprising the Chair, independent non-executive directors and executive directors, is collectively responsible for the success of King's. The responsibilities of the Senior Independent Director (SID) are undertaken by one of the non-executive directors.

One of the non-executive directors is appointed by King's College London (KCL). All Board members have been assessed against the requirements of the 'fit and proper' person test. The terms of office and voting rights of each director are recorded later in this section of the annual report. Non-executive directors bring a breadth of expertise to the Board and provide objective and balanced opinions on matters relating to Trust business.

The Board met six times in the year and has a formal schedule of matters specifically reserved for its decision. The Board delegates other matters to its committees and the executive directors. This is outlined in the Trust's Constitution, board Committee terms of references and standing financial instructions. The Board also has a number of development sessions throughout the year. Details of the work of the board sub committees and the development sessions held are included in this report.

The Trust's Constitution sets out the roles and responsibilities of the membership body, Council of Governors and the Board. It also details the procedures for resolving any disputes between the Council of Governors and the Board of Directors. To develop an understanding of the views of members and governors, Board members attend meetings of the Council of Governors and its Committees, the Annual Members' Meeting, and community events. Both board members, and lately governors, also visit wards and other clinical areas across all sites on a regular basis.

Board of Directors

Executive directors are full-time King's employees. Non-Executive Directors (NEDs) are appointed by the Council of Governors on a four-year fixed term (due to the size and complexity of the Trust). The Council of Governors has the power to remove non-executive directors. Executive Directors manage the day-to-day running of King's whilst the Chair and the non-executive directors provide strategic and board-level guidance, support and challenge. The Board benefits from the wide range of skills and experience of its members, gained from NHS organisations, other public bodies and private sector organisations. The skills portfolio of the directors, both executive and non-executive, includes accountancy, audit, education, management consultancy, clinical research, commercial, communications, transformation, governance and medicine. This broad coverage of knowledge and skills strengthens the effectiveness of the Board, giving assurance that it is balanced, complete and appropriate to supporting King's in meeting its objectives.

During 2025/26, the Board of Directors comprised:

Chair	Sir David Behan
Deputy Chair	Jane Bailey (Until 31 December 2025)

Non-Executive Directors	Dame Christine Beasley (Senior Independent Director) Nicholas Campbell-Watts Professor Yvonne Doyle (Until 31 September 2025) Dr. Jane Fryer (from 26 January 2026) Professor Graham Lord Sheena Mackay (from 19 January 2026) Akhter Mateen Gerry Murphy (from 9 April 2025) Dr. Angela Spatharou (from 9 April 2025) Professor Anthony Schapira (from 19 January 2026)
Chief Executive Officer	Professor Clive Kay
Deputy Chief Executive Officer	Julie Lowe
Chief Financial Officer	Roy Clarke
Chief Nurse and Executive Director of Midwifery	Professor Tracey Carter, MBE
Chief Delivery Officer	Angela Helleur (from 1st July, previously Site CEO PRUH)
Chief People Officer	Mark Preston (until 31 August 2025) Damian McGuinness (from 1 September 2025)
Chief Medical Officer	Dr Mamta Shetty Vaidya

Non-Executive Directors

Sir David Behan

Sir David Behan began his career as a social worker and over a twenty-five-year period worked in five local authorities, leading three as director of social services. He was President of the Association of Directors of Social Services in 2002.

In 2003, he became the first Chief Inspector of the Commission for Social Care Inspection. In 2006, he became the first Director General for Social Care in the Department of Health in England, advising ministers of both the Labour and coalition governments. During this period, he was responsible for a range of policy areas, including social care reform and the development of the first dementia strategy for England. As CEO of the Care Quality Commission (CQC) from 2012 to 2018, he led a fundamental reform of the way health and care services were regulated.

From 2018 he has held several non-executive director and adviser roles with a number of public and private organisations across the health and social care system, which currently include: Cera Care, HC-One limited, the London School of Economics Care Policy Evaluation

Centre, the Catholic Safeguarding Standards Board and the international Sciana Leadership Programme.

Between 2018 and 2023 he chaired the Board of Health Education England and until August 2024, was a Non-Executive Director of NHS England chairing the Workforce, Training and Education Committee. He was appointed as the new chair of King's College Hospital NHS Foundation Trust in April 2024 and formally began his duties as Chair in June 2024.

He was the Interim Chair of the Office for Students between July 2024 and July 2025 taking up the role following the completion of his Independent Public Bodies Review of the Office for Students.

Voting Board Member. Term in office: June 2024 to Current (four-year term)

Dame Christine Beasley
Dame Christine Beasley has held senior roles across the NHS in a career spanning 50 years. This includes being appointed Chief Nursing Officer at the Department of Health, a position she held from 2004 to 2012. She has extensive experience of driving positive changes in clinical practice, as well as overseeing major organisational change and development.

Voting Board Member. Term in office: October 2021 to Current (Reappointed in October 2025 for a second four-year term)

Nicholas Campbell-Watts
Nicholas Campbell-Watts has spent much of his career working with people and communities experiencing multiple and complex health and social care challenges linked to mental health, learning disabilities, homelessness, or offending. He has predominantly worked at a senior level in the voluntary sector. He currently works for Certitude, a charity that supports people across London who have learning disabilities, autism, and mental health needs.

Nicholas has a track record of involvement in system and organisational change and transformation and has previous experience as a NED at Lambeth NHS Primary Care Trust. He has lived and worked in south London for over 30 years and currently lives in Lewisham. He is married with three children.

Voting Board Member. Term in office: January 2020 to Current (Reappointed in late 2023 for a second four-year term)

Dr Jane Fryer
Dr Fryer has worked as a GP in south east London for over 30 years, and has also held a number of senior leadership positions within the NHS, most recently as Deputy Medical Director for NHS England (London region). She is also currently regional Medical Director for Systems Improvement and Professional Standards.

Voting Board Member. Term in office: January 2026 to Current (four-year term)

Professor Graham Lord
BA MB BChir MA PhD FRCP FRSB FMedSci, NIHR Senior Investigator (Emeritus)

Professor Graham Lord is the Senior Vice-President, Health & Life Sciences, King's College London (KCL), Executive Director, King's Health Partners and Chief Academic Officer & Board Director, Guy's & St. Thomas' and King's College Hospital NHS Foundation Trusts. He was previously Vice-President at the University of Manchester and Dean of the Faculty of Biology, Medicine and Health, a Consultant Transplant Nephrologist at Manchester NHS Foundation Trust and Executive Director of the Manchester Academic Health Science Centre (2019-2024).

Graham qualified in Medicine from Cambridge. Following clinical posts at the Hammersmith Hospital and Imperial College, he was appointed as Senior Lecturer and Honorary Consultant specialising in renal and transplantation medicine. As an MRC Clinician Scientist, he undertook postdoctoral research in fundamental immune cell biology including a five-year appointment as a Visiting Fellow at Harvard University. On his return to the UK, he established a Department of Experimental Immunology at KCL and was the Director of the NIHR Biomedical Research Centre from 2012-2019. His clinical academic interests include multi-organ transplantation and the immunogenetics of transplant survival. Graham has significant commercial expertise, having founded companies in the US that focus on immuno-oncology, infectious diseases and autoimmunity. He has a long-term interest in academic healthcare systems and how they can drive improvements to human health in an equitable and sustainable manner and recently graduated from the Advanced Management Program at Harvard Business School.

Voting Board Member. Term in office: September 2024 to current (four-year term).

Sheena Mackay
Sheena Mackay has led global HR functions for over 20 years across a range of FTSE 100 and 250 companies, most recently for Smiths Group plc and previously for Aggreko plc, BBA Aviation plc and SSL International plc (Reckitt Benckiser plc). She is now a Non-Executive Director on the Boards of Porvair plc, Lords Group Trading plc and NESO.

Voting Board Member. Term in office: January 2026 to Current (four-year term)

Akhter Mateen
Akhter Mateen is a former Chief Auditor of Unilever. He retired from Unilever in December 2012. In his 29-year career he has held high-level finance roles in Pakistan, Bangladesh, the UK, Latin America, South-East Asia and Australasia. Since 2014, he has held non-executive roles in various public, private and not-for-profit organisations. He is currently; a non-executive director of the South London and Maudsley NHS Foundation Trust, where he is the chair of the Audit & Risk Committee, he is an Independent Member of the Governance, Risk and Audit Committee of the Bar Standards Board, a Trustee of Malala Fund UK, focusing on education for girls around the world, and the chair of the Joint Audit Committee of Kent Police & Crime Commissioner.

He has also served in the past as the Deputy Chair of Great Ormond Street Hospital NHS Foundation Trust. He has an MBA in Finance.

Voting Board Member. Term in office: July 2020 to Current (Reappointed in mid-2024 for a second four-year term)

Gerry Murphy
Gerry Murphy joined the Trust as a Non-Executive Director in April 2025. He was formerly a Non-Executive Board member of the Department of Health and Social Care (2014 to 2024), and also chaired its audit and risk committee.

Gerry's previous roles include being a Non-Executive Director of Currys PLC; Senior Independent Director of Capital & Counties Properties PLC; and a Non-Executive Director of Capital & Regional PLC. He is also a former Deloitte LLP Partner and member of the Deloitte Board, and was previously Chairman of the Audit and Assurance Faculty of the Institute of Chartered Accountants in England and Wales.

Voting Board Member. Term in office: April 2025 to Current (four-year term)

Dr Angela Spatharou
Dr Spatharou is a Senior Partner, UKI and EMEA Leader for Healthcare and Life Sciences for IBM Consulting, and a member of IBM's global Healthcare leadership. She is a member of the Council of The London School of Economics and Political Science (LSE), as well as a member of the LSE Finance and Estates Committee, the LSE Data Science Institute (DSI) Advisory Board, and an LSE Governor Emeritus.

Dr Spatharou has spent over two decades working with the NHS and international health systems, health providers, insurers, and digital innovators on value-based care, productivity, digital health and advanced analytics, in senior leadership roles with IBM and formerly with McKinsey & Company. She was awarded the UK Management Consultancies Association (MCA) "Thought Leader Consultant of the Year" Award in 2022 for her work driving "new thinking globally around AI, Digital and Analytics, and also on inclusiveness in Healthcare and Higher Education".

Dr Spatharou has previously served as a Supervisory Board member of the EU agency European Institute of Innovation and Technology (EIT) Health; Board member of Action on Addiction UK; Chair of the Board of Kids' City Foundation in South London; and Advisory Board Member of Healthcare Business International (HBI).

Voting Board Member. Term in office: April 2025 to Current (four-year term)

Professor Anthony Schapira
Professor Schapira is Head of Clinical and Movement Neurosciences at University College London, and Professor of Neurology at the National Hospital, Queen Square and the Royal Free Hospital. He is also a Non-Executive Director and Vice-Chair of the Board at the Royal National Orthopaedic Hospital NHS Trust. He has held Non-Executive Director roles on the Boards of the Royal Free (2009 to 2020) and Oxford University Hospitals (2019 to 2025).

Voting Board Member. Term in office: January 2026 to Current (four-year term)

Executive Directors

Professor Clive Kay, Chief Executive Officer
Professor Kay joined King's as Chief Executive in April 2019. Clive has extensive clinical and leadership experience and, prior to taking up his position at King's, he was Chief Executive at Bradford Teaching Hospitals NHS Foundation Trust from January 2015. Previously he was Clinical Director of Radiology (2001-2006) and subsequently the Medical Director (2006-2014) at Bradford.

Prior to working at Bradford, Clive was a Visiting Associate Professor of Radiology at the Medical University of South Carolina. He was a Member of Council of the Royal College of Radiologists, and former Chairman of both the Royal College of Radiologist's Scientific Programme Committee and the British Society of Gastrointestinal and Abdominal Radiology. He is currently a Fellow of the Royal College of Radiologists and a Fellow of the Royal College of Physicians of Edinburgh.

From April 2025 until the end of March 2026, Clive was Chair of the Shelford Group, a collaboration between ten of the largest teaching and research NHS hospital Trusts in England. He currently serves as the Acute Partner Member of the South East London Integrated Care Board.

Voting Board Member. Term in office: April 2019 to Current (permanent contract, six-month notice period)

Julie Lowe, Deputy Chief Executive Officer
Julie took up the Deputy Chief Executive role at King's in July 2024. She joined the Trust in 2020 and was previously Site Chief Executive for the Denmark Hill site. Julie joined the NHS in 1992 as a national NHS management trainee. She has worked in hospitals in London, Yorkshire and Hertfordshire in a variety of positions, including nine years in Chief Executive roles. Prior to joining King's, Julie spent three years as Programme Director for the South East London Integrated Care System (ICS).

Voting Board Member. Term in office: March 2020 to Current (permanent contract, six-month notice period)

Professor Tracey Carter MBE, Chief Nurse and Executive Director of Midwifery
Professor Carter joined the Trust in June 2023. Prior to this she worked at West Hertfordshire Teaching Hospitals NHS Trust, where she was Chief Nurse and Director of Infection Prevention and Control from 2014 until her departure. Tracey has over 35 years' experience as a nurse, and has held several other senior nursing positions, including Deputy Chief Nurse at Barts Health. In May 2019, Tracey received a prestigious Chief Nursing Officer award, and in 2020 she was appointed a Member of the Order of the British Empire (MBE) for her nursing leadership and services to the NHS.

Voting Board Member. Term in office: June 2023 to Current (permanent contract, six-month notice period)

Roy Clarke, Chief Financial Officer
Roy joined the Trust in March 2024 on secondment and was appointed substantively in November 2024. Prior to joining the Trust, Roy held a number of Board positions within the NHS, including as Chief Financial Officer at Norfolk and Norwich University Hospitals NHS Foundation Trust and, before that, at Royal Papworth Hospital NHS Foundation Trust. Roy is a Chartered Management Accountant. He is a Trustee of both King's College Hospital Charity and the Royal College of Obstetricians and Gynaecologists. He also holds senior positions across the Trust's group companies, as a director of King's Commercial (KCH Management Ltd) and KCH Commercial Services Ltd, and one of the Trust's representatives on the management board of KFM (KCH Interventional Facilities Management LLP). He has also worked as an Executive Reviewer for the Care Quality Commission.*)*

Voting Board Member. Term in office: March 2024 to Current (permanent contract, six-month notice period)

Angela Helleur, Chief Delivery Officer
Angela joined the Trust in September 2023 as Interim Site Chief Executive for Princess Royal University Hospital and South Sites (PRUH & SS) and was made substantive in the role in November 2023. She joined the Trust from the South East London Integrated Care Board (ICB), where she was Chief Nursing Officer. Angela has 42 years' experience in the NHS having trained as a nurse in Exeter and as a midwife at King's. She was previously chief nurse and chief operating officer for Lewisham and Greenwich NHS Trust and also held senior leadership roles in acute provider organisations, at a Strategic Health Authority and at NHS Improvement.

Following the Trust's transition to a Divisional structure in July 2025, Angela moved from her role as Princess Royal University Hospital and South Sites CEO to become the Chief Delivery Officer.

Voting Board Member. Term in office: September 2023 to Current (permanent contract, six-month notice period)

Dr Mamta Shetty Vaidya
Dr Shetty Vaidya joined the Trust in January 2025. Before joining King's, Mamta was Chief Medical Officer and a Consultant Paediatric Intensivist at Barking, Havering and Redbridge University Hospitals NHS Trust. Prior to this she was Deputy Medical Director at The Royal London Hospital, part of Barts Health NHS Trust, where she worked for more than 15 years.

Voting Board Member. Term in office: January 2025 to Current (permanent contract, six-month notice period)

To contact an Executive, send an email to the Foundation Trust Office at kchtr.FTO@nhs.net

Board Meetings and Committees
The Board of Directors meets regularly throughout the year. It also holds a series of strategy discussions and workshops. Patient and staff stories are a regular item on the Board agenda. During the year, the Board had six Committees. Each Committee is chaired by a non-executive director. The Board approves the terms of reference for the Board Committees, which set out the remit and delegated authority of each Committee. All Committees report regularly to the Board.

Audit Committee
The Audit Committee is responsible for providing independent assurance to the Board of Directors in a range of areas including internal control, governance, risk management, fraud, corruption, impropriety and externally reported financial performance.

The Committee receives assurance from the executive team and other areas of the Trust through reports, both regular and bespoke. It validates the information it receives through the work of internal audit, external audit and counter-fraud. Assurance is also brought to the Committee through the knowledge that non-executive directors gain from other areas of their work, not least their own specialist areas of expertise as well as their roles on other Board Committees.

The Audit Committee is chaired by Non-Executive Director Akhter Mateen and its membership is composed entirely of non-executive directors. During 2025/26, membership comprised of Akhter Mateen, Prof. Yvonne Doyle (until 30 September 2025), Jane Bailey (until 31 December 2025), Gerry Murphy and Sheen Mackay (joined 19 January 2026). The internal and external auditors regularly attend Committee meetings, as do the Chief Financial Officer, Chief Executive Officer, Deputy Chief Executive Officer and Chief Nurse and Executive Director of Midwifery, although they are not members of the Committee. The Counter Fraud Specialist is a regular attendee of committee meetings. The Trust Chair, and other members of the executive team attend meetings of the Committee by invitation. The broad knowledge and skills of the members and attendees strengthen the effectiveness of the Committee. The Committee chair provides the Board of Directors with a highlight report at each meeting, escalating any issues as necessary. The Committee met five times in 2025/26

The Committee effectively fulfilled its core responsibilities during 2025/26, providing strong oversight of financial reporting, governance, risk management and assurance processes. The Committee maintained a structured programme of work, enabling the Board to receive robust assurance on the effectiveness of internal controls, governance arrangements and financial reporting. It undertook detailed scrutiny of the Annual Accounts, Annual Governance Statement, audit findings and Value for Money conclusions, alongside ongoing oversight of financial governance matters, waivers, losses and special payments throughout the year.

The Committee also maintained regular oversight of risk management, internal control, internal and external audit, counter fraud, cyber security and information governance arrangements. Routine review of the Corporate Risk Register, Board Assurance Framework, audit progress reports and management actions provided assurance on the effectiveness of assurance and control processes across the Trust. Broader governance oversight included reports on clinical audit, insurance arrangements and Standing Financial Instructions, supporting a comprehensive view of organisational assurance.

Whilst the Committee provided strong assurance across its core responsibilities, some opportunities to strengthen oversight were identified, including more explicit reporting on conflicts of interest, whistleblowing arrangements and sustainability matters. Feedback from the Committee effectiveness review was very positive overall, with members recognising the Committee's clear purpose, effective leadership, constructive challenge and high-quality discussions, while identifying some opportunities to improve administrative support, paper circulation and timely implementation of actions.

Finance and Commercial Committee

The Committee oversees the Trust's financial management, financial planning and commercial activities, including budgets, capital investment, efficiency programmes and major business cases. It also provides oversight of estates, digital strategy, sustainability and major programmes, while monitoring risks relating to commercial entities, contracts and procurement. The Committee maintains a forward workplan to support delivery of its responsibilities and provide assurance to the Board.

The committee is chaired by Non-executive Director Gerry Murphy. Until 31 December 2025, the Committee comprised at least three Non-Executive Directors at any one time, in line with its terms of reference. From 1 January to 31 March 2026, the Committee comprised two Non-Executive Directors, with a third attending as an observer ahead of formally joining the Committee in July 2026. Other members include the Chief Financial Officer, the Deputy Chief Executive Officer, the Chief Delivery Officer, and the Chief People Officer. During the year, the membership of Board subcommittees was reviewed to ensure the effective use of executive time while maintaining broad oversight. As a result, the Chief Medical Officer stepped down from this Committee and was replaced by the Chief People Officer. The Chair of the Board and the Chief Executive Officer serve as ex officio members.

The Committee effectively fulfilled its responsibilities during 2025/26, maintaining regular oversight of the Trust's financial performance, operational planning, capital investment, commercial activities and maintaining a relentless focus on financial sustainability, delivery of the Cost Improvement Programme (CIP) and financial recovery. Monthly finance reporting, routine review of Investment Board outcomes, operational planning updates and capital allocation decisions enabled ongoing scrutiny of financial risks, financial recovery and strategic planning. The Committee also maintained oversight of estates, sustainability and major programmes, including the Epic/Apollo programme, digital strategy and pathology services performance. Governance and risk oversight was supported through regular review of the Board Assurance Framework, forward plans and Board highlight reports, ensuring that key risks and issues within the Committee's remit were appropriately monitored and escalated.

The Committee's effectiveness review was highly positive overall, with members recognising its clear purpose, effective leadership, constructive challenge and high-quality discussions and papers. Some opportunities for further improvement were identified, including reducing duplication with other committees, improving the accessibility and length of papers, and strengthening administrative support, minutes and the timely implementation of actions. Overall, the Committee provided strong assurance to the Board across its core financial, commercial and strategic responsibilities throughout the year

Quality and Research Committee

During 2025/26, the Committee changed its name from the Quality Committee to the Quality and Research Committee following the transfer of responsibility for research oversight into its remit. The Committee provides assurance to the Board on the quality, safety and effectiveness of Trust services across the domains of patient safety, clinical effectiveness and patient experience, while overseeing the Trust's quality governance arrangements and compliance with regulatory requirements. Its responsibilities include oversight of patient safety incidents, safeguarding, infection prevention and control, clinical audit, quality improvement, patient and carer experience, complaints management and quality risks. The expanded remit also includes oversight of the Trust's Research and Innovation Strategy, research governance arrangements and research performance, supporting the development of a strong Trust-wide research culture and increased research activity across the organisation.

The Quality Committee was partly chaired by Prof Yvonne Doyle (until 30 September 2025) and then by Prof Anthony Schapira (from January 2026) following Prof Doyle's departure. The membership is a combination of Non-Executive Directors (Nicholas Campbell Watts, Dame Christine Beasley and Dr Jane Fryer) and Executive Directors (Dr Mamta Shetty Vaidya (Chief Medical Officer), Julie Lowe (Deputy Chief Executive Officer), Prof Tracey Carter (Chief Nurse and Executive Director of Midwifery) and Angela Helleur (Chief Delivery Officer). The Director of Equality, Diversity and Inclusion (EDI) regularly attended meetings until May 2025. The Chair and Chief Executive are ex-officio members and have attended all of the meetings through the year. There was Governor observer attendance at all the meetings. The breadth of knowledge and experience of the membership of the Committee supports its effectiveness. The Quality Committee met six times through the year.

The Committee maintained strong oversight of quality, safety and patient experience throughout 2025/26, receiving regular reports on quality performance, patient outcomes, quality risks and governance arrangements. Integrated Quality Reports, Quality Account priorities, the Corporate Risk Register and Board Assurance Framework were reviewed routinely throughout the year, supporting continued scrutiny of quality performance, improvement priorities and mitigating actions. The Committee also reviewed the Clinical Strategy and wider strategy delivery plans, ensuring oversight of the Trust's broader quality governance arrangements.

In relation to patient safety, the Committee maintained oversight of a wide range of safety and assurance processes, including medicines safety, infection prevention and control, safeguarding, maternity safety, Freedom to Speak Up, PSIRF implementation, health and safety, inquests and pathology risks. The Committee also reviewed quality impact assessments, patient outcomes and improvement initiatives throughout the year to ensure that service transformation and cost improvement programmes did not adversely impact patient care or clinical effectiveness. Patient and carer experience remained a key area of focus, with reports received on complaints and PALS, PLACE assessments, children and young people's feedback, inpatient surveys and end-of-life care.

During the year, the Committee's remit expanded to include research oversight following the transfer of responsibilities from the People Committee. While some strategy-level items relating to research and organisational development were considered, research governance and research performance reporting remained limited during 2025/26 due to the timing of the

transfer. The review identified some areas where reporting against the Committee's terms of reference could be strengthened further, including more explicit reporting relating to dementia strategy implementation and radiation protection standards.

Feedback from the Committee effectiveness review was positive overall, with respondents recognising clear leadership, constructive challenge and improving focus within meetings. However, feedback also identified opportunities to strengthen prioritisation of agenda items, reduce the breadth and length of papers, and improve the extent to which Committee discussions consistently translate into measurable improvements. Overall, the Committee demonstrated strong oversight of its core quality and safety responsibilities while continuing to evolve following changes to its remit and leadership arrangements.

People, Education and Inclusion Committee

The People, Education and Inclusion Committee met six times in 2025-26. During 2025/26, the Committee changed its name from the People, Inclusion, Education and Research Committee to the People, Education and Inclusion Committee following the transfer of research responsibilities to the Quality and Research Committee. The Committee provides assurance to the Board on the development and delivery of the Trust's workforce, education and equality, diversity and inclusion (EDI) strategies. Its responsibilities include oversight of workforce planning, recruitment, staff wellbeing, organisational development, leadership development and staff experience, including Freedom to Speak Up and staff survey outcomes. The Committee also oversees delivery of the Trust's EDI agenda, including WRES, WDES and Gender Pay Gap reporting, and receives assurance regarding education, training and professional development arrangements across clinical and non-clinical staff groups.

The Committee was chaired by non-executive director Jane Bailey until December 2025 and then by non-executive Sheena Mackay following Jane's departure. The membership was a combination of Non-Executive Directors (Nicholas Campbell Watts, Jane Bailey, Prof Yvonne Doyle, Sheena Mackay and Dame Christine Beasley) and Executive Directors (Dr Mamta Shetty Vaidya (Chief Medical Officer), Prof Tracey Carter (Chief Nurse and Executive Director of Midwifery), Damian McGuinness Chief People Officer) and Angela Helleur (Chief Delivery Officer). The Chair and Chief Executive are ex-officio members. The Chief Executive attended all the meetings while the Chair attended most of the meetings through the year. A Governor Observer attended some of the meetings. The breadth of knowledge and experience of the membership of the Committee supports its effectiveness.

The Committee maintained regular oversight of workforce performance, workforce planning and staff experience throughout 2025/26. Workforce performance reports were reviewed consistently across the year, alongside key workforce strategies and plans including the People and Culture Plan, Workforce Plan and Talent Management Strategy. Staff wellbeing and experience remained a key focus, with regular review of the National Staff Survey, sickness absence, safer staffing, violence and aggression, Guardians of Safe Working and workforce establishment reports. The Committee also maintained oversight of workforce risks through routine review of the Corporate Risk Register and Board Assurance Framework.

The Committee also maintained oversight of the Trust's equality, diversity and inclusion agenda through review of WDES actions, inclusion recruitment initiatives, Equality Quality Impact Assessments and workforce equality standards. Education and workforce

development remained an important area of focus, with reports received on medical engagement, non-clinical learning and development, resident doctor progress, resuscitation training and GMC survey outcomes, supporting assurance regarding training and regulatory requirements.

During the year, the Committee also received reports relating to research governance and strategy, including research roadmap updates, research governance arrangements and clinical trials delivery. However, responsibility for research transferred during the year to the Quality and Research Committee following changes to the Committee's remit and terms of reference.

The review identified some opportunities to strengthen coverage across aspects of the Committee's remit, including more systematic oversight of reward and recognition, career progression, formal EDI assurance reporting, and the Trust's wider education strategy and external partnership arrangements. Feedback from the Committee effectiveness review was positive overall, with members recognising improved focus, effective leadership and constructive challenge, while also identifying opportunities to improve administrative support, clarity of outputs and implementation of actions. Overall, the Committee demonstrated strengthened governance and consistent oversight across its core responsibilities throughout the year.

Performance, Transformation and Improvement Committee

In late 2025/26, the Improvement Committee changed its name to the Performance, Transformation and Improvement Committee to reflect its expanded remit for operational performance oversight. The Committee provides assurance to the Board on delivery of the Trust's transformation agenda, operational performance and associated strategic risks. Its responsibilities include oversight of the Trust's Improvement Programme, operational recovery and access standards, financial and workforce sustainability, governance and regulatory assurance, and the management of key strategic risks. The Committee also oversees implementation of the King's Improvement Method (KIM) and has delegated responsibility for oversight of Digital and ICT transformation, ensuring that digital programmes and investments support the Trust's wider improvement and operational objectives. The committee met 11 times in the year.

The Committee was partly chaired by the Trust Chair and then by Dr Jane Fryer. The membership was a mix of Non-Executive Directors (Sir David Behan, Chairman; Jane Bailey, Prof Yvonne Doyle, Gerry Murphy, Non-Executive Director and Chair of the Finance and Commercial Committee; Dr Angela Spatharou, Non- executive director); and Executive Directors (Prof Clive Kay, Chief Executive Officer; Julie Lowe, Deputy Chief Executive Officer; Roy Clarke, Chief Financial Officer; Dr Mamta Shetty Vaidya, Chief Medical Officer; Angela Helleur, Chief Delivery Officer and Prof Tracey Carter, Chief Nurse and Executive Director of Midwifery). The breadth of knowledge and experience of the membership of the Committee supports its effectiveness.

The Committee substantially discharged its responsibilities during 2025/26, maintaining oversight of the Trust's transformation agenda, improvement programme, operational recovery and governance assurance arrangements. Regular Improvement Programme updates, quarterly reviews, workstream deep dives and oversight of the King's Improvement

Method enabled ongoing scrutiny of delivery against the Trust's improvement objectives. The Committee also maintained oversight of exit criteria, transition arrangements, financial recovery and regulatory oversight matters, while routinely escalating significant risks and issues to the Board.

Operational performance oversight developed during the year following the expansion of the Committee's remit. The Committee considered reports relating to RTT recovery, operational planning, finance, workforce and high-risk schemes, alongside oversight of the development of the 2026/27 CIP programme and workplan. Governance and assurance arrangements were supported through review of Regional Oversight Meeting feedback, elements of the Board Assurance Framework and improvement-related risks.

Feedback from the Committee effectiveness review was positive overall, with members recognising clear leadership, constructive challenge and improving effectiveness, while acknowledging that the Committee remains in a period of transition following changes to its remit and responsibilities. A strengthened forward workplan has been developed for 2026/27 to support fuller coverage of the Committee's responsibilities going forward.

Remuneration Committee
The Remuneration Committee is chaired by the Chair of the Board of Directors. On behalf of the Board of Directors, this Committee agrees executive directors' remuneration and terms of service. Together with the Chief Executive Officer, Committee members form a panel for the appointment of executive directors. The Committee met three times in the year. More information can be found in the Remuneration Report on page xx.

Acute Providers Collaborative
The Trust works closely with Guy's and St Thomas' NHS Foundation Trust and Lewisham and Greenwich NHS Trust, and the Acute Provider Collaborative was established in 2020 to formalise these arrangements. The purpose of the Committee-in-Common is to align decision-making between the three Trusts and to provide oversight of joint working. At a high level, the Committee is responsible for driving and overseeing alignment activities between the Trusts in the context elective recovery plans for the South East London Integrated Care System and building relationships between the three Trusts.

Joint Academic Committee in Common
King's College Hospital, with Guy's and St Thomas' NHS Foundation Trust and King's College London, have established a Joint Academic Committee in Common. The Committee met four times in the year. The Committee is aimed at improving health and care through collaborative research, education, and clinical practice. Its focus during the year has been to gain assurance that the two Trusts will be in a position to meet the new clinical trials performance indicator, and to agree a memorandum of understanding for clinical academic appointments.

Evaluation and Development of the Board
Collectively, the Board holds development sessions periodically throughout the year to allow for deeper discussion and investigation of key topics. Board members also undertake personal development on an ongoing basis. All Executive and Non-Executive Directors have an annual performance appraisal that includes an assessment of progress against agreed objectives as well as individual development. The performance of executive directors is

reviewed by the Chief Executive Officer and considered by the Remuneration and Appointments Committee. The Chair of the Board of Directors undertakes NED appraisals and reports them to the Governor Nominations Committee. The Senior Independent Director leads the Chair's appraisal and reports to the Governor Nominations Committee.

During 2025/26, the Board held several formal Board development sessions and strategy awaydays to support Board effectiveness, strategic development and organisational leadership. These sessions focused on the Trust's long-term strategic direction, organisational improvement, regulatory preparedness, digital transformation and Board development, helping to strengthen collective leadership, governance and strategic oversight across the organisation.

In April and June 2025, the Board participated in strategic development sessions focused on the development of the Trust's 2026-2031 strategy and Strategic Deployment Framework (SDF). These sessions considered the future strategic direction of the Trust, including financial sustainability, quality improvement, partnerships, workforce transformation, research and innovation, population health and digital transformation. The Board also reviewed the future vision, values and strategic objectives of the organisation, including continued engagement with staff, patients and partners in shaping the emerging strategy.

Board development activity also included a dedicated programme focused on Board effectiveness, leadership behaviours and organisational culture. In June 2025, the Board undertook a facilitated development session exploring how the Board works together to achieve greater success, with a focus on trust, psychological safety, constructive challenge, leadership behaviours and strengthening relationships between executive and non-executive members.

Additional development sessions during the year focused on operational improvement, regulatory preparedness and digital transformation. In October 2025, the Board considered the Trust's ambition, risk appetite and recovery from NOF5/RSP oversight arrangements. In December 2025, the Board received a dedicated development session on the King's Improvement Method (KIM), supporting the Board's understanding of the Trust's improvement methodology and transformation approach. In February 2026, the Board held a further strategy and development session covering neighbourhood services, digital transformation, artificial intelligence and the future digital direction of the Trust. The Board also received detailed briefings on CQC activity and preparation for the Well-Led inspection framework, including governance, leadership, workforce, improvement and sustainability requirements.

Board of Directors – Meetings, Attendance, Committee Memberships

Board of Directors (Current Members)	Board of Directors (Public)	Audit & Risk Committee	Finance & Commercial Committee	Performance, Transformation and Improvement Committee	People, Education and Inclusion Committee	Quality and Research Committee	Remuneration Committee
Total number of meetings held	**6**	**5**	**12**	**11**	**6**	**6**	3
Non-Executive Directors							
Sir David Behan** Trust Chairman	6/6	2/5**	10/12**	10/11**	4/6**	6/6**	2/3
Dame Christine Beasley	6/6	n/a	n/a	n/a	6/6	6/6	3/3
Nicholas Campbell - Watts	6/6	n/a	n/a	n/a	5/6	5/6	3/3
Dr Jane Fryer	1/1		n/a	1/2*	n/a	0/1	n/a
Professor Graham Lord	3/6	n/a	n/a	n/a	n/a	n/a	
Sheena Mackay	2/2*	1/1*	n/a	2/2*	1/1	n/a	n/a
Akhter Mateen	5/6	5/5	12/12	n/a	n/a	n/a	
Gerry Murphy	6/6	5/5	12/12	9/10	n/a	n/a	3/3
Prof Anthony Schapira*	1/1*	n/a	n/a	n/a	1/1*	2/2	n/a
Dr Angela Spatharou*	3/6	n/a	n/a	4/7	n/a	n/a	
Executive Directors							
Professor Clive Kay** Chief Executive Officer	6/6	3/5**	12/12	9/11	6/6	6/6**	n/a
Julie Lowe Deputy Chief Executive Officer	6/6	n/a	12/12	10/11	3/4	5/5	n/a
Prof Tracey Carter MBE Chief Nurse and Executive Director of Midwifery	6/6	4/5	9/12	0/2*	6/6	6/6	n/a
Roy Clarke Chief Financial Officer	6/6	5/5	12/12	11/11	n/a	n/a	n/a
Angela Helleur Chief Delivery Officer	6/6	n/a	11/12	1/2*	5/6	6/6	n/a
Damian McGuinness* Chief People Officer	4/4*	n/a	1/1	n/a	4/5	n/a	n/a
Dr. Mamta Shetty Vaidya Chief Medical Officer	6/6	n/a	9/11	1/2*	5/6	6/6	n/a

Board Members no longer in post	Board of Directors (Public)	Audit & Risk Committee	Finance & Commercial Committee	Performance, Transformation and Improvement Committee	People, Education and Inclusion Committee	Quality and Research Committee	Remuneration Committee	
Professor Yvonne Doyle Non-Executive Director (*Left 31 September 2025)*	3/3	3/3	4/8	5/5	2/3	3/3	n/a	
Jane Bailey Non-Executive Director *(Left 31 December 2025)*	3/4	0/4	6/9	4/8	4/5	n/a	n/a	
Anna Clough Deputy Chief Delivery Officer (*Left 31 July 2025*)	1/1	n/a	4/4	n/a	n/a	n/a	n/a	
Mark Preston Chief People Officer (*Left 31 December 2025)*	2/2	n/a	n/a	n/a	2/2	n/a	n/a	

*Board Members who joined/left the Trust at a point during 2025/26; therefore, would not have been able to attend all meetings within the reporting year. The total number of meetings each person attended are indicated for the reporting period.

** The Chair is an ex-officio member of all Committees except Audit Committee. The Chief Executive is an ex-officio member of all Committees except Audit Committee and Remuneration Committee.

Council of Governors
The Council of Governors is made up of elected and appointed stakeholders. Elected governors make up the majority of the Council; appointed stakeholder governors include representatives from regional Integrated Care Boards, partner health provider organisations, and local councils, which play an important part in stakeholder relations. Governors are elected by the members of the Trust. The membership constituencies include patients, staff and residents from Bromley, Lambeth, and Southwark, as well as the wider London area.

The composition of the Council, names of individual governors and their terms of office can be found in the tables on page 66.

To contact a Governor, send an email to the Foundation Trust Office at kch-tr.FTO@nhs.net

Function and Meetings of the Council of Governors
The Council of Governors met six times during the reporting period. Four of these were planned formal meetings, the remainder were extraordinary for specific business. The attendance of individual governors at these meetings, is detailed in a table on page 66.

All directors are invited to attend Council meetings. Individual directors, executive and non-executive, regularly present items at Council meetings, in accordance with the planned agenda.

The Council of Governors has two key functions, which are to hold non-executive directors to account for the performance of the Board and to represent the interests of members and the public. The Council of Governors also has specific responsibilities, which include the appointment, remuneration and removal of the Chair and other non-executive directors. During 2025/26, the Council of Governors continued to support the governance of the Trust by representing the interests of members, patients, staff and the wider community, while holding the Non-Executive Directors collectively to account for the performance of the Board. The Council received regular updates on operational performance, financial performance, workforce matters, quality priorities and strategic developments, enabling governors to maintain oversight of the Trust's key risks, challenges and priorities throughout the year.

Throughout the year, the Council considered a range of significant matters including the Trust's Operational Plan, financial sustainability, operational performance, quality priorities, workforce and staff survey responses, winter pressures, maternity and neonatal reporting, Epic and MyChart developments, and the Trust's strategic direction. Governors also received regular updates on governor engagement activities, Board committee observations, governance matters, the Trust Constitution review and reports from Board sub-committee Chairs.

The Council also undertook its statutory responsibilities in relation to the Trust's Annual Report and Accounts. In October 2025, governors met with the Trust's external auditor to review the Annual Report and Accounts for 2024/25, including audit findings, financial sustainability, governance and Value for Money conclusions. Governors noted the significant improvement in the Trust's financial governance and recovery position during the year.

An additional meeting of the Council of Governors was held in March 2026 to consider the appointment of the Trust's new Chief Executive Officer following the retirement announcement of Professor Clive Kay. Governors participated in the recruitment and stakeholder process and formally approved the appointment of Matthew Trainer as Chief Executive Officer, following recommendation from the Remuneration Committee.

The Council elects one of its members to be the Lead Governor. The Lead Governor during the year was Prof Daniel Kelly (until August 2025) and then Jane Lyons MBE (from August 2025). The Lead Governor acts as a communication link between governors and the Board of Directors. In very rare circumstances the Lead Governor will act as a direct communication link between regulators such as NHS England and the Council of Governors where it is inappropriate for regulators to communicate directly with the Trust Chair or Director of Corporate Affairs.

Governors in the Community

Governors are active within the community, helping to facilitate communication between the Trust, members and the local communities of Southwark, Lambeth, Bromley and south-east London more widely. Governors are pivotal to sharing the Trust's vision and performance with key stakeholders.

As guardians of the community interest, the Council of Governors ensures that the needs of members are considered in the planning of future services.

Governor Committees

The Council of Governors has Committees which provide the opportunity to delve deeper into issues that are of interest to members, patients and the local community. All governors are eligible to serve on governor Committees, except for the Nominations Committee, where members are elected following a nomination process.

Patient Experience and Safety Committee

The Committee acts as a reference group for the Trust's planned activity relating to patient experience and safety. Committee members are involved with a range of initiatives to improve patient experience and safety and to monitor progress against King's quality priorities. The committee continued to support the Council of Governors during 2025/26 by providing a forum for governors to receive assurance and engage with the Trust on matters relating to its responsibilities. The committee reviewed regular Integrated Quality Reports throughout the year, alongside reports on end-of-life care, chaplaincy services, complaints and compliments, national patient survey outcomes, Quality Account priorities and learning arising from claims and incidents. Governors also received updates on learning disability and autism services, patient communications and leaflets, and Care Quality Commission (CQC) activity and action plans.

The Committee also supported governor involvement and assurance activity through regular feedback from governors on engagement activities and observation of the Trust's Quality Committee. Throughout the year, the Committee maintained oversight of its forward workplan, terms of reference and future agenda planning to support delivery of its responsibilities. Overall, the committee provided an important mechanism for governors to gain assurance on patient experience, safety and quality matters while supporting engagement between governors, patients and the Trust.

Strategy Committee
The Committee reviews the Trust's strategy and annual forward plan, and feeds back to the Council of Governors. The committee supported the Council of Governors during 2025/26 by providing a forum for governors to engage with the Trust's strategic direction, organisational improvement and long-term planning. A key focus throughout the year was development of the Trust's emerging 2026–2031 strategy, including review of the Trust Strategy refresh, King's BOLD programme and Improvement Plan, enabling governors to contribute to discussions regarding the organisation's future priorities and transformation agenda.

The Committee also considered broader strategic and system matters, including the National Ten-Year Plan, system partnerships and organisational improvement activity, alongside updates from Non-Executive Directors on Board committee activity. Governors also received reports on staff morale and staff survey results, supporting wider understanding of organisational culture and workforce challenges.

Throughout the year, the Committee maintained oversight of its terms of reference, leadership arrangements, forward workplan and future agenda planning to support effective governance and delivery of its responsibilities. Overall, the Committee provided an important mechanism for governor involvement in the Trust's strategic planning, transformation and improvement agenda.

Nominations Committee
This Committee is responsible for determining and administering the selection process for the appointment and remuneration of the Chair and Non-Executive Directors and recommending the preferred candidates to the Council of Governors for appointment. This includes consideration of the structure, size and composition of the Board. It also monitors the performance of Non-Executive Directors and makes recommendations to the Council of Governors for the reappointment or removal of individual Non-Executive Directors.

During the year the Committee met to support the Council with the appointment of Non-Executive Directors. An external recruitment firm was used to support the appointments.

Nominations Committee Members	**Status**	**Constituency**
Sir David Behan	Current	n/a – Chair of the Trust Board and Council of Governors
Prof Daniel Kelly (Lead Governor until August 2025)	Former	Public Governor Lambeth
Jane Lyons (Lead Governor)	Current	Public Governor Southwark
Hilary Entwistle	Current	Public Governor Southwark
Billie McPartlan	Current	Bromley Governor
Dr Akash Deep (until 2 February 2026)	Former	Staff Governor
Dr Devendar Singh Banker (until 2 February 2026)	Former	Public Governor Bromley
Jacqueline Vassell-Best (until December 2025)	Former	Public Governor SEL

Non-Executive Directors Review Sessions
The Council of Governors held review sessions during 2025-26, at which Non-Executive Directors discussed the ways in which they discharge their duties to provide constructive challenge and strategic expertise to the executive team and what level of assurances they receive.

Governor Development and Engagement
King's is committed to providing support and training for governors and opportunities to engage with staff, directors, members and one another. The Council of Governors held a development session during the year to strengthen their effectiveness and explore key areas of Trust activity. Topics included an introduction to the Chair, reflections on the role of Governors at King's, and ways of working together more effectively. Governors also took part in a facilitated discussion to identify what is working well, what could be improved, and to shape future priorities and workplans

A key area of focus for the governors has been End of Life Care and Chaplaincy, where Governors considered how the Trust provides compassionate, person-centred support to patients and families, including spiritual and emotional care. They have also been involved in working groups in support of the delivery of the Trust's quality priorities.

All governors are invited to attend meetings of the Public Board of Directors. Governors also observe several of the Board's Committee meetings including Audit Committee, People Committee, Quality Committee and the Trust's Finance and Commercial Committee. Governors have also been invited to participate in Board walkarounds, partnering with Board Members to visit Trust areas. These visits provide opportunities to engage directly with staff and patients and gain first-hand insight into how services operate and are experienced.

Council of Governors – Meetings and Attendance (Four formal meetings of the Council and 2 extra ordinary meetings for specific business and an Away Day)

Council of Governors Tenures and Meeting Attendances, 01 April 2025 - 31 March 2026				
	Governor	**Constituency**	**Tenure**	**Attendance**
	Deborah Johnston	Patient	15/06/2021 – 15/06/2027	5/6
	Pauline Manning	Patient	26/07/2024 – 26/07/2027	4/6
	Devon Masarati	Patient	15/06/2021 - 15/06/2027	5/6
	Billie McPartlan	Patient	01/12/2019 – 25/01/2026	4/5
	Chris Symonds	Patient	01/02/2023 - 31/01/2026	3/6
	David Tyler	Patient	14/06/2024 – 14/06/2027	3/6
	Fr Grant Ciccone	Patient	26/01/2026 – 26/01/2029	1/1
	Prof Koku Admodza	Patient	26/01/2026 – 26/01/2029	0/1
Public Governors	Ibtisam Adem	Lambeth	10/02/2023 – 10/02/2026	0/6
	Rashmi Agrawal	Lambeth	15/06/2021 – 15/06/2027	3/6
	Devendra Singh Banker	Bromley	01/02/2020 – 01/02/2026	1/5
	Tony Benfield	Bromley	01/02/2023 - 31/01/2026	1/5
	Angela Buckingham	Southwark	15/06/2021 – 15/06/2027	5/6
	Hilary Entwistle	Southwark	01/12/2019 – 01/12/2025	5/6
	Cllr Robert Evans	Bromley	20/11/2022 - 19/11/2025	2/4
	Emily George	Lambeth	15/06/2021 – 15/06/2027	4/6
	Renata Hamvas	Southwark	17/06/2026 – 17/06/2028	1/6
	Daniel Kelly	Lambeth	15/06/2021 – 15/06/2027	1/6
	Jane Lyons	Southwark	26/07/2024 – 26/07/2027	5/6
	Billie McPartlan	Bromley	26/01/2026 – 25/01/2028	0/1
	Marianna Masters	Lambeth	21/11/2024 – 07/05//2026	4/6
	Victoria O'Connor	Bromley	01/02/2023 - 31/01/2026	2/5
	Katie Smith	Bromley	01/02/2023 - 31/01/2026	5/5
	Lindsay Batty - Smith	Southwark	15/06/2021 – 15/06/2027	4/6
	Temitayo Taiwo	Lambeth	26/07/2024 – 26/07/2027	3/6
	Jacqueline Best-Vassell	SEL System	01/02/2023 - 31/12/2025	3/4
	Tony Darroch	Bromley	26/01/2026 – 26/01/2029	0/1
	Nihal Emmanuel	SEL System	26/01/2026 – 26/01/2029	0/1
	Bernie Butler	Lambeth	26/01/2026 – 26/01/2029	0/1
	Baroness Anne Marie Rafferty CBE.	King's College London	01/10/2026 – Retired January 2026	0/5
Staff Governors	Michael Bartley	Nurses and Midwives	26/07/2027 – 26/07/2027	6/6
	Aisling Considine	Allied Health Professionals	15/06/2021 – 26/01/2026	4/5
	Akash Deep	Medical and Dentistry	15/06/2021 – 26/01/2026	2/5
	Tunde Jokosenumi	Admin, Clerical and Management	15/06/2021 – 15/06/2027	5/6
	Christy Oziegbe	Nurses and Midwives	01/02/2023 - 31/01/2026	4/5
	Yogesh Tanna	Trust's Joint Staff Committee	23/10/2023 - 22/10/2026	5/6
	Gnananandan Janaka		26/01/2026 – 25/01/2028	1/1
	Melanie Dalby	Allied Health Professionals	05/02/2026 – 05/02/2029	1/1
	Christopher Akwagbe	Nurses and Midwives	26/01/2026 – 26/01/2029	0/1

Board Members attend the Public Council of Governor meetings.

Ensuring the Trust is Well-led

The Trust has a governance framework in place that aims to ensure it is well-led. Quality governance, the approach to risk management and internal control are outlined elsewhere in this report. The Board, through its quality committee, assures itself in relation to patient care. More detail on this can be found in the Annual Governance Statement (see page 109) and the 2025-26

Quality Account (found on the Trust website). Details of the development and evaluation of the Board can be found earlier in this section.

Stakeholder Engagement
The Trust continues to work with a wide range of stakeholders, including local Healthwatch groups, CCGs, local MPs and local authorities. It is actively engaged in developing integrated care systems in the relevant local authority areas (Bromley, Lambeth and Southwark) and is the Integrator for Bromley. The Trust has good relationships with a number of local charities and community groups.

King's membership
King's membership is split into four constituencies: public, patient, voluntary/community groups and staff.

Public membership – anyone who is 16 years old or over and lives within the London Boroughs of Lambeth, Southwark and Bromley. In order to reflect the role King's has within the wider south east London (SEL) health system, the Trust has established a SEL Constituency and a London Constituency.

Patient membership – anyone who is 16 years old or over that has been a patient of King's in the past six years, or has been the carer of a patient of King's in the past six years, is entitled to become a patient member.

Staff membership – All staff who have employment contracts lasting more than 12 months are automatically opted into membership. They have the option to opt out should they wish. King's Volunteers and full-time employees of King's contractors are also eligible to become members, though they have to opt in to become a member.

Associate membership – Any voluntary or community organisation working in our boroughs or serving our patients and communities can join King's as an Associate member. Associate membership provides an opportunity to increase partnership working and communication between King's and local voluntary and community groups for the benefit of our patients and their families.

Membership strategy
On 31st March 2026, our patient and public membership stood at 10,731. This remains within our target of between 9,800 and 11,100 members.

There are now around 60 voluntary and community organisations which have joined King's as Associate members.

Membership communication
We have distributed our membership leaflets for adults and a dedicated young person's leaflet across our sites and online.

Our e-bulletin reaches over 4,000 members. Associate members also received regular e-bulletins during the year.

Annual Members' Meeting 2025
The Trust's Annual Members Meeting was held at the end of September 2025. The meeting included a Trust update on finance and quality, presentations from clinical staff about use of AI in endoscopy and the CHIPS programme in Bromley. Our lead governor provided a governors' update and there was a question-and-answer session for members.

Member engagement in quality programmes
The Trust's ability to engage members in quality programmes including PLACE and nutrition audits and there is an ongoing programme of patient engagement.

Current membership numbers:

Membership size and movements	
Public constituency	**Last Year (2025/26)**
At year start (April 1)	7,731
New members	146
Members leaving	15
At year end (March 31)	7,862
Staff constituency	**Last Year (2025/26)**
At year start (April 1)	13,870
New members	1,237
Members leaving	1,464
At year end (March 31)	13,643
Patient Constituency	**Last Year (2025/26)**
At year start (April 1)	2,847
New members	29
Members leaving	7
At year end (March 31)	2,869

Management framework
The Board of Directors is the key decision-making body at the Trust. It is responsible for ensuring compliance with the Trust's provider licence, constitution, mandatory guidance issued by NHS England, and with relevant statutory requirements and contractual obligations.

Commercial opportunities and activities are subject to scrutiny by the Board of Directors, to ensure that benefits derived from non-NHS income are channelled into supporting King's core NHS activities without incurring significant financial or reputational risk. Information about King's services outside the UK can be found in the performance report on page 21.

Directors and governors are supplied with information to enable them to discharge their duties.

The performance of the Board of Directors, its committees and individual directors are subject to regular review. The Board is committed to the NHS/CQC Well-Led Framework and was inspected by the CQC during September 2025 in additional to other localised service reviews throughout the year. A report from this well-led review is still awaited.

Company directorships and other significant interests and commitments
King's maintains a register of interests for its directors and governors. Arrangements to view the register can be made by contacting the Foundation Trust Office at kch-tr.FTO@nhs.net. The register is also published on the Trust's website.

Board members and governors are asked to declare any interests and to self-certify that they meet the eligibility criteria set out in the Trust's Constitution. In addition, governors and directors are subject to a check by the Disclosure and Barring Service on appointment.

Political Donations
The Trust did not make any political donations during 2025-26.

Use of Consultants
On occasions the Trust brings in consultants from outside to provide advice and support that cannot be provided within the Trust.

	Group	
	2025-26	**2024-25**
	£000	**£000**
Consultancy costs	**3,058**	**3,341**

Better Payments Practice Code (BPPC)
King's has a responsibility to meet the Better Payments Practice Code (BPPC). This focuses on the speed at which the Trust pays its invoices to the private sector and to other NHS organisations. The BPPC requires the NHS Trusts to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The target is to pay 95% of invoices, in terms of value and volume, within 30 days.

The Foundation Trust's performance against this target was as follows:

	Group 2025-26	
	Number	**£000**
Non-NHS Trade Invoices:		
Paid in the year	169,633	995,269
Paid within target	157,913	976,868
Percentage paid within target	93.1%	98.2%
NHS trade invoices		
Paid in the year	3,532	77,360
Paid within target	3,529	77357
Percentage paid within target	99.9%	99.9%
Total trade invoices		
Paid in the year	173,165	1,072,629
Paid within target	161,442	1, 054,225
Percentage paid within target	93.2%	98.3%

Cost Allocation Requirements
King's has complied with the cost allocation and charging guidance issued by HM Treasury.

Summary of the Group's financial performance
The Group out-turn for the year was a surplus of £10.837m and this includes the asset impairment of £11.396m. This charge relates to impairments that arise from a clear consumption of economic benefits or service potential in the asset. The NHS Improvement financial performance control total measures the surplus (deficit) before impairments and after removing the income and expense impact of capital donations/grants. The control total surplus after adjusting for asset impairments and the impact of donated assets was £4.951m.

Because of the continuing service provider relationship that the Trust has with NHS England and ICSs, and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. The Trust has limited powers to borrow or invest surplus funds and financial assets. Liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Income Disclosures
King's is a public benefit corporation and its principal purpose is the provision of goods and services for the purposes of the health service in England. During the reporting period, income from the provision of goods and services for the purposes of the health service in England was greater than from the provision of goods and services for any other purpose. Income received from non-NHS services is directly invested in the provision of NHS services and does not impact the services provided to NHS patients. For the financial year 2025/26, no surplus was available for reinvestment.

Full details of financial performance in 2025/26, the responsibilities of the Accounting Officer and a statement from the auditors can be found in the Annual Accounts 2025/26 on pages later in this report.

Responsibility of Directors for Preparing the Annual Report and Accounts
Directors are responsible for preparing the Annual Report and Accounts. The Directors of King's College Hospital NHS Foundation Trust consider that the Annual Report and Accounts 2025/26, taken as a whole, are fair, balanced and understandable, and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

The Directors have taken all reasonable steps they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information. So far as the Directors are aware, there is no material audit information of which the Trust's auditors are unaware.

Going Concern
King's College Hospital NHS Foundation Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents

Accountability and Audit
Grant Thornton UK LLP was appointed as the Trust's external auditor in November 2020. The firm was appointed for a two-year term (to cover the audits of the 2020/21 and 2021/22 financial years). This was extended in 2022/23 to cover a further two years. This was extended for a further year in July 2024. In January 2025, the Council of Governors approved the appointment of Grant Thornton as External Auditors for financial years 2025-26 to 2027-28 following a tender exercise.

The Board of Directors maintained a system of evaluating and continually improving effectiveness of risk management and internal control processes. KPMG were reappointed as internal auditors during 2024/25 following a competitive process. KPMG provide a comprehensive internal audit function and they were also reappointed as the Trust's Counter-Fraud provider. The internal audit plan is discussed with Executive Directors, Non-Executive Directors and the Audit Committee.

The Board of Directors ensures effective scrutiny of financial and operational matters through its designated committees and by receiving reports from the executive which present a balanced and understandable assessment of King's performance and forward plans. Information about King's financial, quality and operational objectives and performance, including clinical outcome data, is published to allow members and governors to evaluate its performance.

Furthermore, all the Board Directors have made enquiries of fellow directors and the Trust's internal and external auditors through the Board of Directors' meeting and Audit Committee, and taken any steps required to give effect to their duties to the Trust to exercise reasonable care, skill and diligence.

Independence of the External Auditor
The Trust's external audit provider, Grant Thornton UK LLP, has confirmed to the Trust that there are no significant matters that impact on their independence as auditors that they are required or wish to draw to the Trust's attention. They have complied with, and implemented policies and procedures to meet the requirements of the Financial Reporting Council's Ethical Standard and confirm that as a firm, and each covered person, they are independent and are able to express an objective opinion on the financial statements.

The auditors have confirmed that they have complied with the requirements of the National Audit Office's Auditor Guidance Note 01 issued in December 2019 which sets out supplementary guidance on ethical requirements for auditors and local public bodies.

2.2 REMUNERATION REPORT

The information provided in this part of the remuneration report is not subject to audit.

Foreword

The Remuneration and Appointments Committee has worked with the Chief Executive Officer and Chief People Officer to ensure that the resilience of the leadership team has been maintained throughout the year. There have been no changes to the Trust's remuneration policies in the past year. Taking into consideration national pay agreements, and specifically the NHS Very Senior Managers pay framework the Board agreed a 3.25 % cost-of-living increase for very senior and executive staff with less than 2 years' service. As in accordance with the framework all other very senior and executive staff were not eligible for any cost of living increase due the NOF status of the Trust in this financial year. The paragraphs below outline the key activities of the Committee during the year.

Sir David Behan, Chair of the Remuneration Committee

The Annual Statement
The following King's Executive appointments were made in 2025/26

- Damian McGuinness, Chief People Officer
- Angela Helleur, Chief Delivery Officer
- Julie Lowe, Deputy Chief Executive

The Remuneration and Appointments Committee were provided with updates on appointments to other senior posts in the organisation along with confirmation on the outcomes of Executive Director appraisals.

Senior Manager Remuneration Policy
The Remuneration Committee reviewed the earn-back requirement that is included in executive director contracts and agreed to remove earn-back clauses from future executive contracts and it should no longer be a requirement for current executive directors that have it in their contract. All new appointments were made within standard NHS terms and conditions

The remuneration and terms of service of the Chair and Non-Executive Directors are determined by the Council of Governors, taking account of market and survey data from relevant benchmark sources which can include the Foundation Trust Network and the Trust's NHS peer group. More information about this process and the role of the Council of Governors' Nominations Committee can be found on pages 64.

Remuneration for King's most senior managers (Directors accountable to the Chief Executive) is determined by the Remuneration and Appointments Committee, which comprises the Chair and the Non-Executive Directors. See page 60-61 for Committee membership and meeting attendance.

The work of the Remuneration and Appointments Committee is informed by relevant benchmark data, periodic assessments conducted by independent remuneration consultants and by salary awards and terms and conditions applying to other NHS staff groups. The work of the Committee is supported by the Chief Executive Officer and the Chief People Officer, who are not members of

the Committee. The Committee engaged an external recruitment agency to support the appointment of the new Chief People Officer.

The Trust's strategy and annual planning processes set key business objectives which, in turn, inform individual and collective objectives for senior managers. Individual performance and that of King's as a whole is closely monitored, discussed throughout the year and forms part of the annual appraisal.

Details of senior employees' remuneration can be found on pages 77-81. Note 1.8.2 in the annual accounts sets out accounting policies for pensions and other retirement benefits.

The Trust has taken a number of steps to ensure that the salaries for Executive Directors are reasonable, especially where payment is more than £150,000. These steps include:

- Posts are evaluated using a recommended independent external agency. The Trust commissions Hays Executive to undertake this task in line with the Hays job evaluation scheme
- Hays considers a number of factors in the evaluation, comparing similar-sized Trusts and functions/complexity, factoring in the London market dimension and the relative remuneration amongst the Shelford Group, of which King's is a member. Hays provides the Trust with a salary range and recommendation
- The Remuneration and Appointments Committee agrees the salary range and benefits package before the post is advertised based on the advice from Hays Executive and market advice from the executive search organisation. The range of the salary must also comply with guidance set out in the NHS Very Senior Managers Pay Framework.
- Due cognisance is given to the VSM annual pay survey, which includes executive pay levels. The post is advertised and once appointed and remuneration agreed via the Remuneration and Appointments Committee, the Trust seeks guidance from NHSE to support the salary range
- The only non-cash element of the most senior managers' remuneration packages is pension-related benefits accrued during membership of the NHS Pension Scheme. Contributions into the scheme are made by both the employer and employee in accordance with the statutory regulations
- The Trust does not consult with staff on its senior staff remuneration. This is solely a matter for the Remuneration and Appointments Committee.

Service Contract Obligations
All senior managers have a standard King's service contract. Each individual Executive Director and Non-Executive Director has their appointment date, contract status and notice period (for Executive Directors only) listed in the Director's report.

Policy on Payment for Loss of Office
All senior managers are required to have a six-month notice period in their service contract. Policy for loss of office is in line with the NHSE VSM guidance and the Trust has a policy of not paying over contractual entitlement.

Compensation in the event of early termination for substantive directors is in accordance with contractual entitlements, as set out in the Agenda for Change (AfC) national terms and conditions of service. There were no exceptions to this policy during 2025/26.

Diversity and Inclusion
In line with the Trust policy on diversity and inclusion, the Remuneration Committee has considered the diversity at the most senior levels of the organisation as part of a wider review of talent management and succession.

Non-Executive Director Remuneration Framework
Remuneration for Non-Executive Directors and the Chair is at a spot rate and is not pensionable. It has not been reviewed during 2025/26.

Senior Manager Remuneration Framework

	Explanation
Salary	Senior manager pay is awarded on a spot rate and is not subject to incremental increase. Senior managers may, at the discretion of the Remuneration and Appointments Committee, be awarded a cost–of-living increase, in line with the rest of the Trust (in 2025/26 this was 3.25% but only staff with less than 2 years' service were eligible).
Pension benefits	Senior managers may opt to be members of the NHS Pension Scheme. Contributions to the scheme are made by the employee and the employer in line with statutory regulations.
Performance-related pay	Senior managers do not receive performance-related pay.
Other employee benefits	There were no other employee benefits made in 2025/26
Performance Management Framework	Performance is managed on an annual baseline in line with the financial year. Individual objectives are agreed with line managers, in line with the Trust Strategy and monitored throughout the year. The Trust has an online appraisal process which is used by all staff.

Annual Report of the Remuneration and Appointments Committee
The membership, meetings and attendance of the Remuneration Committee can be found on pages 60-61. The Chief Executive Officer and Chief People Officer attended the Committee for relevant agenda items but were not full members. During 2024/25, the Committee took advice no external advice, nor did it use any executive search agencies to fill key posts.

The Committee took reports during the year including:

- The appointments outlined on page 72.
- The resignations of executive directors.

There have been no other major decisions on senior managers' remuneration or substantial changes relating to senior managers' remuneration in 2025/26. The Committee agreed to award senior managers with less than two years' service a 3.25% pay increase, as per the NHS Very Senior Managers Pay Framework.

The information in this section of the remuneration report is subject to audit.

Fair Pay Disclosures

NHS foundation trusts are required to disclose the relationship between the total remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director in the organisation in the financial year 2025-26 was £337.5k (2024-25, £337.5k). This is a change between years of 0% (2024-25, 4.7%). The highest-paid director did not receive any performance pay or bonuses in either year.

The percentage change in average employee remuneration (based on total for all employees on an annualised basis, excluding the highest paid director, divided by full time equivalent number of employees, also excluding the highest paid director) between years is 5.5% (2024-25, 6.3%). The percentage increase is a weighted average by payroll category (substantive 4.84%, bank 0.04% and agency 0.58%). No performance pay or bonuses were paid by the Trust in either year.

No employees received remuneration in excess of the highest-paid director in 2025-26 (2024-25: 0).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2025-26 was from £24.5k to £337.5k (2024-25 £23.7k to £337.5k).

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

2025-26

	25th percentile	**Median**	**75th percentile**
Total Remuneration (£)	37,284	51,318	69,159
Salary component of total remuneration (£)	37,268	49,278	50,030
Pay ratio information	9.05 : 1	6.58 : 1	4.88 : 1

	2024-25		
	25th percentile	Median	75th percentile
Total pay and benefits excluding pension benefits (£)	35,719	47,490	63,723
Salary component of total pay (£)	35,473	45,873	63,723
Pay ratio information	9.45 : 1	7.11 : 1	5.30 : 1

Pay ratios have decreased from the previous year as a result of a pay freeze affecting the highest paid director.

The information in this section of the remuneration report is not subject to audit.

Director and Governor Expenses
There were no director or governor expenses during 2025/26.

The information in this section is subject to audit.

Salary and pension entitlements of senior managers

A) Remuneration

Name	Title	2025-26 Salary & Fees (bands of £5,000)	2025-26 Pension Related Benefits (bands of £2,500)	2025-26 Total (bands of £5,000)	2024-25 Salary & Fees (bands of £5,000)	2024-25 Pension Related Benefits (bands of £2,500)	2024-25 Total (bands of £5,000)
Chairman and Non-Executive Directors							
Sir David Behan	Chairman	65 - 70	-	65 - 70	50 - 55	-	50 - 55
Jane Bailey	Deputy Chair	10 - 15	-	10 - 15	30 - 35	-	30 - 35
Professor Yvonne Doyle	Non-Executive Director	5 - 10	-	5 - 10	10 - 15	-	10 - 15
Professor Richard Trembath	Non-Executive Director	-	-	-	5 - 10	-	5 - 10
Nicholas Campbell-Watts	Non-Executive Director	10 - 15	-	10 - 15	10 - 15	-	10 - 15
Akhter Mateen	Non-Executive Director	10 - 15	-	10 - 15	10 - 15	-	10 - 15
Dame Christine Beasley	Non-Executive Director	10 - 15	-	10 - 15	10 - 15	-	10 - 15
Simon Friend	Non-Executive Director	-	-	-	10 - 15	-	10 - 15
Professor Graham Lord *	Non-Executive Director	10 - 15	-	10 - 15	-	-	-
Gerry Murphy	Non-Executive Director	10 - 15	-	10 - 15	-	-	-
Dr Angela Spatharou	Non-Executive Director	10 - 15	-	10 - 15	-	-	-
Dr Jane Fryer	Non-Executive Director	0 - 5	-	0 - 5	-	-	-
Sheena Mackay	Non-Executive Director	0 - 5	-	0 - 5	-	-	-
Prof Anthony Schapira	Non-Executive Director	0 - 5	-	0 - 5	-	-	-
Executive Directors							
Professor Clive Kay	Chief Executive	335 - 340	-	335 - 340	335 - 340	-	335 - 340
Roy Clarke	Chief Financial Officer	240 - 245	-	240 - 245	265 - 270	-	265 - 270
Dr Leonie Penna	Chief Medical Officer	-	-	-	30 - 35	-	30 - 35
Professor Tracey Carter	Chief Nurse and Executive Director of Midwifery	195 - 200	20.0 - 22.5	215 - 220	195 - 200	460.0 - 462.5	655 - 660
Beverley Bryant	Chief Digital Information Officer	-	-	-	70 - 75	-	70 - 75
Angela Helleur	Chief Delivery Officer	220 - 225	-	220 - 225	195 - 200	-	195 - 200
Julie Lowe	Deputy Chief Executive	225 - 230	25.0 - 27.5	250 - 255	225 - 230	127.5 - 130.0	350 - 355
Mark Preston	Chief People Officer	75 - 80	-	75 - 80	180 - 185	25.0 - 27.5	205 - 210
Dr Mamta Shetty Vaidya	Chief Medical Officer	260 - 265	137.5 - 140.0	400 - 405	60 - 65	-	60 - 65
Ms Rantimi Ayodele	Acting Chief Medical Officer	-	-	-	15 - 20	117.5 - 120.0	135 - 140
Anna Clough	Site Chief Executive (DH)	35 - 40	115.0 - 117.5	155 - 160	120 - 125	25.0 - 27.5	155 - 160
Damian McGuinness	Chief People Officer	110 - 115	150.0 - 152.5	260 - 265	-	-	-

*** Salary Recharged**

Prof Graham Lord, Non-Executive Director

(King's College London salary includes the recharge cost to the Trust)

None of the Executive Director received a taxable benefit in kind in 2025/26

None of the Directors claimed non-taxable expenses in 2025/26

The Trust has not paid any of the Directors compensation on early retirement or for loss of office.

The Trust has not made any payments to past Directors.

Salary and pension entitlements of senior managers

Sir David Behan	Chair	1 April 2025 - 31 March 2026
Jane Bailey	Deputy Chair	1 April 2025 - 31 December 2025
Dame Christine Beasley	Non-Executive Director	1 April 2025 - 31 March 2026
Nicholas Campbell-Watts	Non-Executive Director	1 April 2025 - 31 March 2026
Professor Yvonne Doyle	Non-Executive Director	1 April 2025 - 03 October 2025
Akhter Mateen	Non-Executive Director	1 April 2025 - 31 March 2026
Prof Graham Lord	Non-Executive Director	1 April 2025 - 31 March 2026
Gerry Murphy	Non-Executive Director	10 April 2025 - 31 March 2026
Dr Angela Spatharou	Non-Executive Director	01 May 2025 - 31 March 2026
Dr Jane Fryer	Non-Executive Director	26 Jan 2026 - 31 March 2026
Sheena Mackay	Non-Executive Director	19 Jan 2026 - 31 March 2026
Prof Anthony Schapira	Non-Executive Director	19 Jan 2026 - 31 March 2026

Prof Clive Kay	Chief Executive	1 April 2025 - 31 March 2026
Julie Lowe	Deputy Chief Executive	1 April 2025 - 31 March 2026
Tracey Carter	Chief Nurse and Executive Director of Midwifery	1 April 2025 - 31 March 2026
Roy Clarke	Chief Financial Officer	1 April 2025 - 31 March 2026
Anna Clough	Acting Site Chief Executive (Kings College Hospital)	1 April 2025 - 30 June 2025
Angela Helleur	Chief Delivery Officer	1 April 2025 - 31 March 2026
Mark Preston	Chief People Officer	1 April 2025 -31 August 2025
DR Mamta Shetty Vaidya	Chief Medical Officer	1 April 2025 - 31 March 2026
Damian McGuinness	Chief People Officer	1 September 2025 - 31 March 2026

Salary and pension entitlements of senior managers
B) Pension Benefits

This pensions information is provided by the NHS Business Services Authority - Pensions Division on an annual basis.

Name	Title	Real Increase in pension at pension age (bands of £2,500)	Real Increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2026 (bands of £5,000)	Lump sum at pension age at 31 March 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2025	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2026
		£000			£000	£000	£000	£000
Executive Directors								
Julie Lowe	Deputy Chief Executive	2.5 - 5.0	(2.5) - (5.0)	100 - 105	250 - 255	2,236	41	2,305
Mark Preston	Chief People Officer	0	(72.5) - (75.0)	15 - 20	0	1,648	0	282
Tracey Carter	Chief Nurse & Executive Director of Midwifery	0 - 2.5	(2.5) - (5.0)	85 - 90	215 - 220	1,915	30	1,969
Damian McGuinness	Chief People Officer	2.5 - 5.0	5.0 - 7.5	40 - 45	90 - 95	621	68	762
Mamta Shetty Vaidya	Chief Medical Officer	7.5 - 10.0	7.5 - 10.0	65 - 70	150 - 155	1378	142	1553
Anna Clough	Site Chief Executive	0 - 2.5	0 - 2.5	55 - 60	130 - 135	1000	23	1111

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Roy Clarke chose not to be covered by the pension arrangements during the reporting year.

Angela Helleur chose not to be covered by the pension arrangements during the reporting year.

CETV as at 1st April 2025 has been inflated by 1.7% (Consumer Price Index)

Remuneration report

The disclosures in the remuneration report fulfil our obligations under the Health and Social Care Act 2012.

Signed:

Date: 18 June 2026

Professor Clive Kay
Chief Executive and Accounting Officer

2.3 Staff Report

The information in this section of the staff report is not subject to audit.

The following tables provide information on staff costs and numbers during 2025/26. The Trust is also required to make a number of disclosures in its staff report. These are also detailed below.

The information in this section of the staff report is subject to audit.

Workforce data

Average number of employees (WTE basis)

Group	Total 2025-26 No.	Permanent 2025-26 No.	Other 2025-26 No.	Total 2024-25 No.	Permanent 2024-25 No.	Other 2024-25 No.
Medical and dental	2,686	1,088	1,598	2,685	1,063	1,622
Ambulance staff	-	-	-	-		
Administration and estates	2,926	2,731	195	3,035	2,783	252
Healthcare assistants and other support staff	1,506	1,257	249	1,666	1,367	299
Nursing, midwifery and health visiting staff	5,373	4,772	601	5,405	4,788	617
Nursing, midwifery and health visiting learners	11	-	11	9		9
Scientific, therapeutic and technical staff	1,833	1,608	225	1,785	1,577	208
Healthcare science staff	317	269	48	333	261	72
Social care staff	23	21	2	21	20	1
Other	-	-	-	-		
Total average numbers	**14,676**	**11,747**	**2,929**	14,939	11,859	3,080

Staff Costs

Employee benefits

	Group					
	2025-26			2024-25		
	Total £000	Permanent £000	Other £000	Total £000	Permanent £000	Other £000
Salaries and wages	825,734	685,977	139,757	795,996	658,050	137,946
Social security costs	116,088	95,884	20,204	93,932	77,901	16,031
Apprenticeship levy	4,486	4,486	-	4,291	4,291	-
Employer contributions to NHS Pensions	94,688	78,208	16,480	88,935	73,756	15,179
Employer contributions to NHS Pensions paid by NHS England on behalf of the Trust	61,756	51,008	10,748	58,307	48,356	9,951
Termination benefits	742	742	-	1,674	1,674	-
Temporary staff (including bank and agency)	66,671	-	66,671	65,408	-	65,408
Total gross employee benefits	1,170,165	916,305	253,860	1,108,543	864,028	244,515
Recoveries from other bodies in respect of staff cost netted off expenditure	-	-	-	-	-	-
Total employee benefits	1,170,165	916,305	253,860	1,108,543	864,028	244,515
Of which						
Costs capitalised as part of assets	-	-	-	-	-	-
Total employee benefits excluding capitalised costs	1,170,165	916,305	253,860	1,108,543	864,028	244,515

The information in this section of the staff report is not subject to audit.

Sickness Absence data

NHS Sickness Absence Figures 2025-26

Figures Converted by DH to Best Estimates of Required Data Items		Statistics Produced by NHS Digital from ESR Data Warehouse		
Average FTE 2025	**Adjusted FTE days lost to Cabinet Office definitions**	**FTE-Days Available**	**FTE-Days Lost to Sickness Absence**	**Average Sick Days per FTE**
13,361	135,831	4,876,842	220,348	10.2

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the ESR Data Warehouse

Period covered: January to December 2025

Data items: ESR does not hold details of the planned working/non-working days for employees so days lost and days available are reported based upon a 365-day year. For the Annual Report and Accounts the following figures are used:

The number of FTE-days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.

The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.

The average number of sick days per FTE has been estimated by dividing the FTE Days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by Average FTE.

The information in this part of the staff report is not subject to audit.
Workforce Equality Analysis

	2025/2026	
	Headcount	%
Age		
(0-16)	0	0%
(17-21)	58	0.4%
22+	14379	99.6%
Ethnicity		
White	5386	37%
Black, Asian and Minority Ethnic	8417	58%
Not declared	528	4%
Unknown	106	1%
Gender (All staff)		
Male	3692	26%
Female	10744	74%
Gender (Senior Managers)		
Male	49	49%
Female	51	51%
Gender (Board)		
Male	9	53%
Female	8	47%
Recorded Disability		
Yes	569	4%
No	12736	88%
Not declared	932	6%
Unknown	200	1%
Sexual Orientation		
Bisexual	230	2%
Gay or Lesbian	412	3%
Heterosexual	11895	82%
Other	57	0.4%
I do not wish to disclose	1656	11%
Unknown	187	1%
Religion		
Atheism	1774	12%
Buddhism	313	2%
Christianity	7567	52%
Hinduism	757	5%
Islam	1187	8%
Jainism	24	0.2%
Judaism	42	0.3%
Sikhism	132	1%
Other	911	6%
I do not wish to disclose	1533	11%
Unknown	197	1%
Total Staff Numbers	**14437**	

The information in this section is subject to audit

Exit packages

Exit Packages agreed in 2025-26

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£	Number	£	Number	£	Number	£
Less than £10,000	3	17,698	407	594,140	410	611,838	-	-
£10,000 - £25,000	4	67,809	9	138,949	13	206,758	-	-
£25,001 - £50,000	1	40,228	7	276,838	8	317,066	-	-
£50,001 - £100,000	4	225,002	1	69,393	5	294,396	-	-
£100,001 - £150,000	1	100,903			1	100,903	-	-
£150,001 - £200,000					-	-	-	-
Greater than £200,000	-	-	-	-	-	-	-	-
Total	**13**	**451,641**	**424**	**1,079,321**	**437**	**1,530,962**	**-**	**-**

Exit Packages agreed in 2024-25

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£	Number	£	Number	£	Number	£
Less than £10,000	7	20,237	26	114,017	33	134,254	-	-
£10,000 - £25,000	6	102,340	4	65,766	10	168,106	-	-
£25,001 - £50,000	12	482,295	4	133,524	16	615,819	-	-
£50,001 - £100,000	18	1,181,847			18	1,181,847	-	-
£100,001 - £150,000	2	213,047			2	213,047	-	-
£150,001 - £200,000					-	-	-	-
Greater than £200,000	-	-	-	-	-	-	-	-
Total	**45**	**1,999,766**	**34**	**313,308**	**79**	**2,313,073**	**-**	**-**

Analysis of Other Departures

	Agreements Number 2025-26 No.	Total value of agreements 2025-26 £000	Agreements Number 2024-25 No.	Total value of agreements 2024-25 £000
Voluntary redundancies including early retirement contractual costs				
Mutually agreed resignations (MARS) contractual costs				
Early retirements in the efficiency of the service contractual costs				
Contractual payments in lieu of notice	**422**	**1040**	**31**	**282**
Exit payments following employment tribunals or court orders	**1**	**40**	**3**	**31.7**
Non-contractual payments requiring HMT approval (special severance payments)*				
Total	**423**	**1080**	34	313.7
of which:				
non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	**-**	**-**	-	-

The Remuneration Report includes disclosure of exit payments payable to individuals named in that report.

The information in this section of the staff report is not subject to audit

Off Payroll Arrangements

The Trust follows NHSE policy on off-payroll arrangements and any highly paid appointment is subject to NHSI approval and, where necessary, Trust Board approval.

During 2025/26, no Board members were off-payroll.

The Trade Union (Facility Time Publication Requirements) Regulations 2017

By law, organisations are required to publish Trade Union (TU) facility time information. The data below is for the financial year 1 April 2025 to 31 March 2026

Relevant union officials

Number of employees who were relevant union officials during the relevant period (full time equivalent)	*Full-time equivalent employee number*
26	26

Percentage of time spent on facility time

Percentage of time	*Number of employees*
0%	0
1-50%	26
51%-99%	0
100%	0

Percentage of pay bill spent on facility time

	Figures
Provide the total cost of facility time	£1,686,000
Provide the total pay bill	£1,103,494,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.015%

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: *(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100*	15%

Supporting our Staff

The Trust recognises that there is clear evidence supporting the link between staff health and wellbeing and safe patient care and is committed to continually working to improve the health and wellbeing of staff. The Trust's recruitment policy ensures that all applicants with a disability who meet the essential criteria are offered an interview. Successful candidates are asked what adaptations they may require, to carry out their role. Similarly, staff who become disabled after commencing employment with the Trust will be supported and individual packages of support and training will be offered depending on need.

The Trust has an in-house occupational health, wellbeing and staff psychology service with a wide ranging multi-disciplinary team which supports and advises both managers and staff on the full remit of occupational health services in line with our policies on sickness absence, preventative care and equality and diversity.

The King's Reasonable Adjustment Plan has been well received by staff in the Trust and has supported conversations between staff with a disability or long-term health condition and their line managers to discuss what support and changes can be put in place to enable them to thrive at work.

The Trust's Workforce team, EDI team, Health & Wellbeing team, Occupational Health and our line managers have been working collaboratively to ensure that we are being proactive and providing the support that our staff require to enable them to remain at work and their experience of this is positive and fulfilling.

The Trust recognises that the best outcomes often happen when concerns are dealt with at the earliest opportunity, quickly and informally. Our Early Resolution Policy provides guidance to managers and staff on this approach, and our Disciplinary Policy places an emphasis on 'just culture' principles and restorative justice.

The Trust has an approved counter-fraud and corruption policy and does not tolerate any form of fraud, bribery or corruption by its employees, partners or third parties acting on its behalf. We investigate allegations fully and apply sanctions to those found to have committed a fraud, bribery or corruption offence.

We have continued to work on streamlining our policies, benchmarking where possible with other NHS Trusts and professional bodies. We continue to aim to provide streamlined

processes which are less onerous for all staff and managers. We carry out this work in partnership with our staff side colleagues. Our policies are discussed and agreed at the Trust's Workforce Policy Review Group before final ratification at our Partnership Committee.

Supporting employee experience at King's

Our King's People and Culture Plan (2022-2026) is one of the supporting strategies of the Trust's '*Strong Roots, Global Reach*' overarching strategy, which places our Brilliant People at the centre of everything we do. The Plan is being reviewed in line with Trust's overall strategy refresh with objectives being updated for delivery post-2026.

Staff Wellbeing

The Trust continues to prioritise the health and wellbeing of its staff through a coordinated and accessible Health & Wellbeing Service. Wellbeing Hubs remain a valued resource, with permanent locations at Denmark Hill, Princess Royal University Hospital and Orpington Hospital, providing staff with a space to take breaks, rest and decompress. The hubs also offer opportunities for colleagues to seek additional support, advice and signposting from the Health & Wellbeing Team, who are trained Mental Health First Aiders.

To ensure equitable access for staff who are unable to attend the hubs regularly, the Health & Wellbeing team delivers regular in-reach and drop-in sessions across services and sites.

In addition, the Trust provides a wide range of wellbeing support, including access to Employee Assistance Programme, financial wellbeing support, digital wellbeing resources, initiatives promoting healthy eating, and a variety of staff-led wellbeing activities and clubs, such as running groups, journaling, book clubs and therapeutic art sessions.

Learning & Organisational Development

The Learning and Organisational Development team deliver a range of personal and professional development opportunities for staff across the Trust. This is managed under the King's Kaleidoscope banner. Examples include:

- King's Kaleidoscope hosts a suite of online learning catalogues and resources.
- The Organisational Development Team offer a business partner model to the Trust, enabling us to provide team-based interventions.
- The Trust currently has around 370 learners on Apprenticeship programmes covering over 35 different topics. This spans both clinical and non-clinical staff and our offer is open internal and external candidates.
- An internal coaching skills programme and coaching network is in development.
- A Talent Management Framework has been developed and is currently being piloted across six Care Groups, supporting mid-level leaders to develop and reach their full potential.
- The Trust continues to meet its target of 90% completion rate for our core skills compliance.
- We have a thriving Work Experience (WEX) programme and have hosted nearly 600 students which includes our core placement programme, focusing on widening participation from local communities. We have received the National Gold standard for Work Experience.

- We launched the King's Improvement Method Leadership, Improvement & Capability Framework, delivering Trust-wide KIM training for senior leaders and expanding our role-based improvement pathways to build sustainable leadership and improvement capability across the organisation.
- We delivered a nine-month development programme for our most senior leaders, equipping and enabling them to effectively undertake their leadership roles.
- The Trust exceeded its target, (90%) for appraisal completions for 2025 reaching a total of 93% at the end of the appraisal 'season'.
- We have integrated the NHS England Management and Leadership Framework into our talent management pilot and 2026/27 leadership development offer, with a focused provision for midlevel and senior leaders.

Following a successful launch in 2021, the Trust is now in its fourth year of DFN Project Search. This has supported 70 young people with autism and special education needs. One of our former interns, who successfully gained employment at the Trust spoke of his experience at King's at the Annual Shelford Group Conference.

Staff Feedback

We use the data and commentary from leavers' surveys, the national quarterly pulse survey and the annual National Staff Survey to inform us on how staff feel about working at King's.

We also receive regular feedback via the Trust's joint staff and management Committees, (i.e. the Partnership Committee and Local Negotiating Committee), and the FTSU Guardian and through our staff networks, trade union partners, cultural deep-dives and CQC feedback. These insights, alongside our ongoing staff engagement channels such as 'Ask the CEO' sessions, Trust bulletins, all-staff emails, management cascades and our intranet, enable us to understand the key concerns raised by our people and develop targeted interventions in response.

During 2025/26 we expanded these feedback routes further through an extensive engagement programme to support the development of the Trust's new Strategy, Vision and Values. Together, all these rich sources of feedback are informing the development of the Trust's new Strategy for 2026 – 2031 and our enabling People Strategy. Over the next year we will be co-designing a Trust-wide engagement programme to enable us to engage more consistently, listen more deeply and act more visibly by involving our people in shaping decisions that affect their working lives.

We have also developed a new cultural dashboard for Care Groups for formal launch in 2026/27. This provides an integrated view of staff experience and cultural indicators to help leaders identify areas of strong practice and emerging hotspots, supporting more proactive, evidence based cultural improvement.

2025 National Staff Survey

The 2025 Staff Survey took place between September–November 2025. 6373 staff (46%) completed the staff survey. This was slightly lower than 2024 response rate of 48%, 6783 responses. However, we have seen a significant increase in all 'People Promise' scores this year in the context of the benchmarking scores showing a general decrease, as illustrated in the table below.

Indicators	2025		2024		2023		2022	
People Promise Elements/ Themes	Trust Score	Benchmarking Score	Trust Score	Benchmarking Score	Trust Score	Benchmarking Score	Trust Score	Benchmarking Score
We are compassionate & inclusive	7.17	7.28	7.06	7.29	7.07	7.31	7.07	7.25
We are recognised & rewarded	5.79	5.87	5.64	5.92	5.63	5.94	5.55	5.73
We each have a voice that counts	6.51	6.60	6.43	6.67	6.43	6.70	6.50	6.65
We are safe & healthy	5.97	6.07	5.84	6.13	5.81	6.11	5.72	5.92
We are always learning	5.73	5.57	5.67	5.64	5.64	5.62	5.62	5.35
We work flexibly	5.86	6.22	5.69	6.24	5.63	6.20	5.60	6.00
We are a team	6.73	6.75	6.59	6.75	6.57	6.75	6.59	6.64
Staff engagement	6.68	6.74	6.58	6.84	6.64	6.91	6.70	6.80
Morale	5.72	5.84	5.54	5.93	5.56	5.90	5.52	5.68

People Priorities 2025/26

The national staff survey scores provide the Trust with opportunities to focus on improving staff experience. The 2024 and 2025 staff survey results are helping inform the priority areas for our new People Strategy for 2026-2031, helping us set out how we will create the conditions for our people to thrive.

Given our overall results, the Trust has also been progressing three key interventions during 2025/2026, designed to deliver longer lasting improvements to staff experience. These focus on strengthening mid-level leader development (including talent management), enhancing staff engagement, and supporting staff wellbeing (including recognition and reward). This approach enables us to deliver structured and focussed initiatives where all staff are involved and able to benefit.

Trust Recruitment

The Trust received circa 120,618 applications for substantive roles and conducted circa 10,782 interviews. Including Junior Doctors on rotation programmes, 2,134 new starters joined the Trust in 2025/26. International recruitment of nurses continues to be paused in 2025/26. The Trust substantive staff has increased from 13,341 to 13,412 and our overall establishment has reduced from 14,696 to 14,397. The overall Trust vacancy rate reduced from 8.59% on 1 April 2025 to 6.20% on 31 March 2026. The Trust voluntary turnover rate has been on a downward trend over the year and was recorded at 7.87% in March 2026 which is below the target of 13%.

Temporary Staffing
The temporary staffing provision saw a decrease in demand in 2025/26 compared to the previous year, with fill rates improving compared to 2024/2025.

- There was an overall fill of 199,884 bank shifts in 2025/26, compared to 186,071 bank shifts in 2024/25, (7.4% increase).
- There was a fill of 12,344 shifts by agency in 2025/26, compared to 13,827 agency shifts in 2024/25, (10.7% decrease).
- There was an overall average fill of 85.3% for requested shifts in 2025/26, which was higher than the fill rate of 83% of requested shifts in 2024/25.

Workforce Inclusion
The past 12 months have marked a significant period of growth, impact, and reflection for Equality, Equity, Diversity and Inclusion at King's. As we closed the chapter on the 2022–2024 Roadmap to Inclusion and 2021 - 2026 BOLD strategy we moved further with intention into a year of embedding learning, expanding innovation, and building structural resilience. Our recent 2025 workforce disability equality standard data (WDES) has seen improvement across seven of ten metrics, whilst our 2025 Workforce Race Equality Standard (WRES) saw five out of nine metrics improve. Whilst we saw an increase in median gender pay gap data of 7%, our mean pay gap has decreased by 2%. Our approach centred on ensuring EDI remained a lived reality across every care group, directorate, and team, not just a corporate function. To strengthen this commitment, we evolved our language and approach from 'Equality' to 'Equity', reflecting our focus on **real, meaningful outcomes**, rather than one-size-fits-all solutions. Through targeted training, active community engagement, and structural change, we have continued to place equity and inclusion at the heart of how we lead, work, and care.

Training and Development
Capacity-building and skills development remained central to our EDI agenda. We continued to embed the Cultural Intelligence (CQ) programme with full-day CPD-accredited sessions delivered by internal facilitators. Over 47 sessions have been facilitated since launch, supplemented with bespoke offers for smaller teams, equipping staff with the intercultural skills and self-awareness needed to lead compassionately and inclusively.

The Workplace Adjustments Programme grew in reach, with training delivered monthly and bespoke sessions arranged for high-need care groups. Combined with the Workplace Adjustment Policy and live WDES action plan, this approach continues to empower both managers and staff to embed disability inclusion into daily working practices.

We refreshed our Active Bystander training, introducing an accessible e-learning module to build empathy and real-world understanding of discrimination and allyship. Our Inclusive Recruitment training, jointly delivered by EDI and Recruitment Team members, was redesigned and reaffirms our commitment to achieving parity and representation in recruitment outcomes. Through Skill Boosters and a growing digital learning library, staff accessed over 247 completions of on-demand inclusive training, spanning topics from microaggressions to inclusive language.

Positive Action Initiatives
To address persistent disparities in career progression identified in WRES, WDES, and Gender Pay Gap data, the Trust's EDI team and staff networks offered a suite of targeted positive action initiatives throughout 2025-26. These included tailored development programmes for ethnic minority, women and disabled staff. Highlights include a bespoke coaching and career development series, which supporting ethnic minority colleagues in building confidence, communication, and career planning skills, and participating in a South East London regions NHS Calibre Disability Leadership Programme.

Recognition and Awards
The Trust continues to prioritise recognising and valuing staff through a range of formal and informal initiatives. Instant Recognition enables timely appreciation of positive behaviours and contributions, reinforcing our values across teams. Quarterly Awards celebrate individuals and teams who demonstrate outstanding commitment to patient care and service excellence. Thank You Week celebrations provided a Trust-wide opportunity for colleagues to recognise and thank one another for their dedication. In addition, Long Service Awards honour staff reaching 15, 25 and 40 years of service, recognising their loyalty and sustained contribution to the Trust.

We also introduced the Trust's first Inclusion Awards, celebrating the unsung champions of inclusion across the organisation. With 107 nominations across seven categories, the awards were a powerful affirmation of grassroots leadership and visible commitment from the Executive.

Nationally, the Trust and staff continued to receive recognition of contributions to EDI. Individual Staff were winners at the Black Healthcare Awards, Nursing Times Workforce Awards and finalists at SEL Inclusion Awards and BAME Health and Care Awards. These achievements reflect our collective efforts to embed inclusive values and practices across our systems and services.

Structural Improvements and Accountability
We made further progress embedding EDI into the heart of the organisation. Every Division and care group continues to be supported by an EDI Business Partner, with tailored support provided for improvement planning, complaint resolution, and inclusive policy implementation.

Our efforts in data governance also strengthened. We published our first Workforce Sexual Orientation Equality Standard (WSOES) report, one of few NHS Trusts to do so, setting a new standard in transparency and strategic action for LGBTQ+ equity.

We also renewed our disability confident employer level 2 status, complimented by an audit of our services to support our aspirations in becoming a disability confident level 3 leader.

Cultural Engagement and Awareness Campaigns
Engaging with national diversity awareness campaigns remained vital to our inclusion strategy. Across the year, cultural, faith, and inclusion-focused observances were marked with Trust-wide events, webinars, and campaigns.

Highlights included vibrant celebrations for Black History Month, National Inclusion Week, UK Disability History Month, Pride, Diwali, and International Women's Day, as well as powerful observances such as Trans Day of Remembrance and the International Day for the Elimination of Violence Against Women.

Staff Networks were instrumental in curating and delivering these experiences. Each event created space for connection, reflection, and learning—and also reinforced the message that inclusion is not an occasional effort, but an everyday practice.

Widening Participation
Our partnership with Project SEARCH reached a milestone with over 40 young adults with learning disabilities or autism supported across three years, and 11 gaining Trust employment. These internships exemplify how tailored support creates real pathways to sustainable work. Our next cohort will take place from September 2026.

Partnership working
Maintaining alignment to industry and other sector best practice has become central to our EDI agenda. We have established close working partnerships with several organisations including Business in the Community, Inclusive Employers, Stonewall, Working Families, and renewed memberships with the Business Disability Forum and Hidden Disabilities Sunflower Charity offering greater on demand avenues of support for staff, best practice support, consultation and guidance HR, EDI and cultural transformation practitioners which will support our ambitious strategic objectives in 2026 onwards.

Staff Networks
The Trust's five Staff Networks have continued to play a pivotal role in advancing inclusion, fostering community, and influencing strategy across King's. Each network has delivered impactful programmes tailored to their communities and grown in membership. King's & Queers expanded visibility and impact through LGBT History Month events, Pride and Trans Day of Remembrance ; the Women's Network focused on career growth, membership voice and education through events like International Women's Day; King's Able championed disability inclusion with a strong presence during Disability History Month; REACH led on race equity through its flagship conference; and the Interfaith and Belief Network delivered wide-ranging multi-faith events in partnership with Chaplaincy. Both our REACH and Interfaith and Belief Networks, successfully elected three co-chairs, providing critical leadership to their respective members and agenda. Each network is supported by two Executive Sponsors, who have access to dedicated EDI coaching to enhance their allyship and leadership. Aspiring to improve staff voice for more minority groups, we are actively supporting the growth and development of our crucial Armed Forces Network, with aspirations to formally embed a seventh Parent's and Carer's network within King's.

Occupational Health, Wellbeing and Staff Psychology
The multi-disciplinary team strives to meet the occupational health, wellbeing and staff psychological needs, supporting our values and strategic deliverable outcomes. The service is delivered by a close working, professionally diverse range of teams, including; accredited occupational medicine consultants, an occupational psychiatry consultant, staff psychologists, occupational health nurse practitioners, clinic nurses, occupational therapists and

physiotherapists, all aligned to functionally enabling employee health-focussed outcomes and supported by a long-standing administration and business development team.

The service has delivered another successful year-on-year staff flu vaccination delivery programme, with the close out rate at 45.9% of frontline workers vaccinated on 31.03.2026, with a peak of 47.6% vaccinated before the February national doctors' rotations.

Focussing on the trust's own occupational health activity, excluding the activity delivered as a service provider to several healthcare related organisations and local businesses, the service screened 4695 pre-employment questionnaires, assessed 2796 management referrals and delivered 13898 core service appointments. In pursuit of communicable disease management and the prevention of work-related ill-health, the service continued to deliver high-impact contact tracing support to staff, following a potential or confirmed occupational exposure to biological agents, as part of routine healthcare work risks, and delivered time sensitive trauma-focussed care to staff, following significant incidents.

As a driver for continuous organisational growth, focussing on staff retention, inclusion and equity, several members of the service provide educational and development support to managers, along with their attendance at several key committees and workstreams, such as the Health Inequality Working Group and Staff Flu Vaccination Operational Delivery Group.

Counter Fraud and Corruption

The Trust has policies in place to counter fraud and corruption and has a good track record in reporting suspected fraud. The work of the Local Counter Fraud Representative is outlined elsewhere in this report and is reported to the Audit Committee. During 2025/26, KPMG has provided the Trust with counter-fraud services, following a competitive tender process.

Disclosures set out in Code of Governance for NHS Provider Trusts

The Trust has applied the principles of the Code of Governance for NHS Provider Trusts (the Code) on a 'comply or explain' basis. The Code is founded on the principles of the UK Corporate Governance Code, and was most recently revised in October 2022. A summary of where detail can be found in relation to the matters we are required to disclose in the report is included in the table below:

Code of Governance reference	Requirement	Annual report reference
A.2.1 (Disclose)	The Board of Directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Accountability Report - Director's Report
A.2.3 (Disclose)	The Board of Directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the Board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	Accountability Report - Staff Report, Director's Report
A.2.8 (Disclose)	The Board of Directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The Board of Directors should keep engagement mechanisms under review so that they remain effective. The Board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	Accountability Report - Director's Report, AGS

Code of Governance reference	Requirement	Annual report reference
B.2.6 (Disclose)	The Board of Directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust Board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	Accountability Report – Directors' Report
B.2.13 (Disclose)	The annual report should give the number of times the Board and its committees met, and individual director attendance.	Accountability Report – Directors' Report

Code of Governance reference	Requirement	Annual report reference
B.2.17 (Disclose)	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the council of governors and the Board of Directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the Council of Governors operate, including a summary of the types of decisions to be taken by the Board, the Council of Governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.	Accountability Report – Directors' Report
C.2.5 (Disclose)	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	Accountability Report
C.2.8 (Disclose)	The annual report should describe the process followed by the Council of Governors to appoint the Chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	Accountability Report – Directors' Report
C.4.2 (Disclose)	The Board of Directors should include in the annual report a description of each director's skills, expertise and experience.	Accountability Report – Directors' Report
C4.7 (Disclose)	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	Accountability Report – Director's Report – not applicable for 2025/26

Code of Governance reference	Requirement	Annual report reference
C.4.13 (Disclose)	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the Board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.	Accountability Report – Directors' Report and Staff Report
C.5.15 (Disclose)	Foundation Trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Accountability Report – Director's Report

Code of Governance reference	Requirement	Annual report reference
D.2.4 (Disclose)	The annual report should include: the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	Accountability Report – Director's Report
D.2.6 (Disclose)	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Accountability Report – Director's Report
D.2.7 (Disclose)	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	Accountability Report - Annual Governance Statement

Code of Governance reference	Requirement	Annual report reference
D.2.8 (Disclose)	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	Accountability Report - Annual Governance Statement
D.2.9 (Disclose)	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	Performance Report and Annual Accounts.
E.2.3 (Disclose)	Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Not applicable for 2025/26
Appendix B para 2.3 (Disclose)	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Accountability Report – Director's Report.
Appendix B para 2.14 (Disclose)	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	Accountability Report – Director's Report.

Code of Governance reference	Requirement	Annual report reference
Appendix B para 2.15 (Disclose)	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, e.g. through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Accountability Report – Directors' Report
Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Accountability Report – Directors' Report Whilst Directors have attended all Governor meetings, this power has not been exercised.

NHS Oversight Framework
NHS England's "NHS Oversight Framework 2025/26" is the framework for assessing health systems including providers. It promotes transparency, improvement and helps identify potential support for or intervention needs. NHS organisations are allocated to one of five 'segments'.

Segmentation indicates performance and whether improvement is required, from high performing across all domains (segment 1) to low performance across a range of domain (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

a) its segment from scored metrics under five performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)
b) considering financial override which may limit a segment to be no better than 3
c) contextual metrics which are not scored (for example those under the sixth domain of improving health and reducing inequality) and
d) capability assessments which consider the organisation's leadership and governance.

Segmentation
The Trust is currently in segment 3, and cannot be rated higher than this due to its financial deficit position. The Trust was in segment 5 for Q1 and Q2 as it was included in the Recovery Support Programme (RSP) and has enforcement undertakings against its foundation trust licence. Confirmation was received on 10th April 2026, that the Trust has exited RSP, having met the criteria for strategy, leadership and governance, and financial stability and control. In the 2025/26 NHSE Provider Capability Assessment the Trust has been Trust as amber/red.

This segmentation information is the Trust's Q3 position published on 18 March 2026 (updated 1 April 2026). Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: NOF Acute Dashboard - NHS England public data gateway . The Trust is included on the acute hospital trust dashboard.

As noted above, the Trust has enforcement undertakings against its foundation trust licence. The Trust has made progress in demonstrating compliance and achieved a number of compliance certificates during the year.

- Section 1: Corporate Strategy: **Open with no compliance certificate received**.
- Section 2: Leadership and Governance: **Closed on 23rd February 2026 with a compliance certificate.**
- Section 3.1: Financial Governance and Controls: **Closed on 30th June 2025 with a compliance certificate**.
- Section 3.2- Financial Strategy: **Open with no compliance certificate received**.
- Section 4: Funding conditions and spending approvals: **Open with no compliance certificate received.**

- Section 5: Comprehensive Improvement Programme: **Closed on 23rd February 2026 with a compliance certificate.**
- Section 6 : Programme Management: **Open with no compliance certificate received.**
- Section 7: Meetings and Reports: **Open with no compliance certificate received**.

Discussions have been ongoing with NHSE London Region about closing the remaining undertakings, and a clear roadmap/timetable for the closure of any outstanding issue is being developed.

Statement of the Chief Executive's responsibilities as the Accounting Officer of King's College Hospital NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England has given Accounts Directions which require King's College Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of King's College Hospital NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

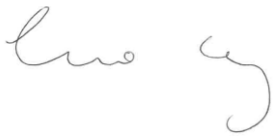
In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of

that information. To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.



Signed: Date: 18 June 2026

Professor Clive Kay, Chief Executive and Accounting Officer

Annual Governance Statement 2025/26

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust accounting officer memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of King's College Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in King's College Hospital NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Chief Executive and Accounting Officer, I have overall responsibility for risk management with the Chief Nurse and Executive Director of Midwifery providing operational leadership for risk within the Trust. Each Executive Director is responsible for managing the risks within their portfolio. All Executive Directors report to me and I have a range of forums in place to ensure that they are held to account for the performance and delivery of individual, team and Trust objectives.

The Trust's Risk Management Strategy was reviewed and updated in August 2025 and has resulted in:

- a combined Risk Management Policy and Strategy to reduce duplication and enhance clarity for staff.
- enhanced risk profile reporting through the Executive Risk and Governance Committee and the Audit & Risk Committee, particularly of longstanding high risks.
- further development of the risk module on the Local Risk Management System delivering more effective operational risk management and more effective reporting pathways, allowing focus on risk metrics, effectiveness of mitigating actions and timeliness of reviews.
- continued positive assurance through internal audits of the Trust's approach to managing risk.

The risk and control framework

The Trust's risk management policy and strategy outlines the risk principles, framework and process. It then focuses on the identification, recording, assessment and management of risk. The policy also includes a 5 x 5 matrix for the assessment and evaluation of risk. The risk

scoring is based on an assessment of the consequence/impact and the likelihood.

The policy identifies the duties of key individuals in the risk management process and the roles and responsibilities of relevant groups and Committees. The Trust's internal auditors have reviewed the design of the revised risk management framework (April 2021), assessed the operating effectiveness of the arrangements (March 2022) and reviewed the Corporate Risk Register (March 2023), operational functionality of the Care Group risk management processes (January 2024) and management of risk within cancer performance (March 2025). All the reviews have provided positive assurance.

Risk appetite

The Trust recognises that its long-term sustainability depends upon delivery of its strategic objectives and its relationships with its patients, staff, the local community and strategic partners. The risk management policy outlines the Board's approach to risk appetite with the lowest risk appetite relating to safety and compliance objectives, including employee health and safety, with a higher appetite associated with the strategic partnerships.

During 2025/26 the Board considered the risk appetite as part of the review and update of the Trust's risk management policy and strategy, published in August 2025. Risk appetite will be considered again by the Board in the first half of 2026/27. During 2025/26 risk appetite has been incorporated more fully into reporting of risk at committees and the consideration of target risk scores.

Board Assurance Framework

The Board Assurance Framework (BAF) connects the Trust's strategic objectives to risk management and assurance arrangements. It summarises the potential risks impacting the achievement of the Trust's strategic objectives and the key controls and processes in place to manage the key risks. The BAF supports the Board's understanding of the effectiveness of the key controls and mitigations in place to manage strategic risk and, as a result, supports oversight of the delivery of the Trust's strategic objectives. The BAF is reviewed regularly by the Board of Directors and by relevant Board committees and was subject to review by internal audit during 2025/26. The review provided partial assurance with improvements required. An action plan has been agreed to drive improvement.

Quality governance arrangements

'Outstanding care' forms part of King's BOLD vision, which was set out in Trust's strategy published in July 2021 and refreshed for its final year in 2025/26.

The corporate quality governance arrangements are led by the Chief Nurse and Executive Director of Midwifery and the Chief Medical Officer. The Trust's Quality and Research Committee scrutinises the clinical and quality risk management control arrangements and assurances that the arrangements are operating effectively. The Committee is chaired by a non-executive director.

The Committee receives an Integrated Quality Report at each meeting. This report provides information on key quality indicators, including infection control, patient safety, patient experience and clinical effectiveness. The report has been updated in 2025/26 to align with the principles of *Making Data Count* and this work will continue into 2026/27.

In addition to quarterly patient outcome reports the Committee receives updates on any specific quality and safety concerns the Trust is managing, for example: externally-led inspection findings and action plans; infection, prevention and control issues and learning from individual patient cases.

Risks to quality and safety are managed through the Trust's risk management processes. There are processes in place in relation to the identification and response to safety incidents, aligned to the Patient Safety Incident Response Framework (PSIRF). The Trust has maintained a positive level of incident reporting and has a framework for the identification and investigation of incidents meeting the nationally defined criteria for Patient Safety Incident Investigations (PSIIs). Over the course of 2025/26, the Trust declared eight Never Events. This was an increase on the previous year when three were recorded.

During 2025/26, the Trust commissioned 24 Patient Safety Incident Investigations (PSII), including 11 which met the criteria for referral to the Maternity and Newborn Safety Investigations programme. In September 2025 NHSE issued revised guidance following a consultation on the future of never events to state that never events require a proportionate response and no longer mandate a full PSII. As such only two of the never events declared were subject to a full PSII. Nevertheless, the Trust has sought an independent peer review of actions taken following the never events declared to ensure that all reasonable actions were being taken to avoid similar events occurring in the future. An internal audit review of the Trust's patient safety incident response framework during 2025/26 provided significant assurance with minor improvement opportunities.

The Trust has Quality Governance arrangements in place, including a Quality Assurance Framework, alongside a quality reporting structure through divisional level quality and governance meetings, which report into the Outstanding Care Board. The Quality Assurance Framework was subject to internal audit during 2024/25 and assessed as providing 'significant assurance with minor improvement opportunities'.

The Trust reviews care groups under the Quality Assurance Framework. This is an executive led quality visit supported by members of the quality governance team, medical equipment and pharmacy and which concludes with a mock 'Well Led' interview for the care group.

Care Quality Commission (CQC)

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.

Major risks

The Trust's principal risks are overseen by the Trust Board and its Committees through the board assurance framework. As outlined above the Trust's BAF was refreshed during the year

to reflect in-year and future risks to the achievement of our strategic objectives and BOLD vision.

The detail included in the BAF has been developed to:

- map the Trust's key controls, mitigations and sources of assurance to each strategic risk;
- identify the current risk scoring based on the Trust's likelihood/ consequence framework;
- identify any gaps in controls and/or assurances; and
- identify the actions required to address any significant gaps in controls and/or assurances (in line with the development of the Strong Roots, Global Reach Delivery Plan).

Each strategic risk has been assigned to a Board Committee for review and oversight. Review of all BAF risks is also considered at the Trust's Audit Committee. An overview of the BAF and a summary of any changes and key developments is presented to the Trust Board on a regular basis.

The BAF was used to inform the meeting agendas for the Board and its Committees in 2025/26.

The principal risks faced by the Trust in 2025/26 are set out below:

Risk	Summary	Board Oversight & Assurance Committee and summary of risk management and mitigation
Workforce	If the Trust is unable to transform the workforce and develop new ways of working in order to deliver the new Trust operating model, financially sustainable services will not be delivered, adversely impacting patient outcomes and staff engagement and patient experience	Overseen by People, Education and Inclusion Committee. Mitigations included: • workforce transformation through the improvement programme • development of a talent management strategy • strengthened workforce leadership team • Delivery of the People and Culture strategy.
King's Culture & Values	If the Trust is unable to transform the culture of the organisation to become more inclusive and positive, staff engagement and well-being may deteriorate, adversely impacting our ability to provide culturally intelligent, compassionate care to our patients and to each other.	Overseen by People, Education and Inclusion Committee. • Talent management strategy • Leadership development programme • Wellbeing strategy • Improved staff survey results achieved.
Financial Sustain-ability	If the Trust is unable to improve the financial sustainability of the service it provides, then we may not achieve	Overseen by Finance and Commercial Committee

	our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future	• Financial strategy agreed and delivered • Detailed monthly reporting of the Trust's revenue and capital position • Financial Governance Review action plan delivered and FG maturity improved. • Grip and Control measures maintained and developed. • Financial recovery plans in place.
Critical Infra-structure	If the Trust is unable to protect and maintain its critical infrastructure (estate, ICT and medical equipment) our ability to deliver safe and sustainable services will be adversely impacted	Overseen by Finance and Commercial Committee • Capital programme agreed and delivery oversight in place. • Capital repurposing where necessary. • Medical equipment programme in place. • ICT investment in place.
Research & Innovation	If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre	Quality and Research Committee • R&D strategy agreed and delivery overseen. • Research governance refreshed and improved. • Processes reviewed, with some investment secured to ensure Trust can meet the 150-day clinical target.
Safe and effective care	If the Trust does not have adequate arrangements to support the delivery and oversight of high-quality care, this may result in an adverse impact on patient outcomes and patient experience and lead to an increased risk of avoidable harm	Quality and Research Committee • Regular and detailed review of key safety and outcome metrics • Maternity assurance provided at each meeting including delivery of maternity incentive scheme • Positive internal audit reviews received. • Quality Assurance framework in place.
Partnership Working	If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely on our ability to achieve system transformation in line with the NHS 10-year plan ambition.	Board of Directors • Active engagement in key partnerships including the acute provider collaborative and SEL System Sustainability Group. • Leadership of the Bromley Health Integrator.

Demand and Capacity	If the Trust is unable to transform services, improve productivity and sustain sufficient capacity, patient waiting times may increase potentially resulting in an adverse impact on patient outcomes and an increased risk of avoidable harm.	Performance, Transformation and Improvement Committee • Detailed review of the IPR at Board and Committee • Oversight of Trust Improvement Programme • Deep dives • Quality Impact Assessment reporting in place.
IT Systems	If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data	Audit Committee • Action plan and mitigations in place. External assurance in place (DSPT, HIMSS)

Stakeholder involvement in managing risks that impact on them

The Trust's stakeholders are involved in the Trust's risk management arrangements in a number of different ways:

- The Trust's members are represented by the Trust's Council of Governors, which includes public, staff, patient and stakeholder governors. The Council of Governors receive updates on the delivery of the Trust's objectives and Governor representatives observe Board assurance Committees to seek assurance on the oversight and mitigation of risk.
- Governor engagement in Patient Experience and Safety Committee and Strategy Committee and other Trust patient groups.
- Feedback obtained through the Patient Advice and Liaison Services.
- ICS attendance at Serious Incident Panel and Quality Committee.
- Engagement with staff, governors, patient and community groups in the development of the Trust's five-year strategy.
- The Board receives patient or staff stories at each Board meeting
- Executive and Non-Executive Director clinical visits.

System for quality and clinical governance/audit

KCH prioritises two programmes of work in relation to clinical audit – the national clinical audit & confidential enquiry programme, and the Medical E-Governance (MEG) clinical quality assurance programme.

In 2025-26 there were 80 national clinical audits and confidential enquiries relevant to KCH, undertaken across all KCH sites and within most KCH specialties. KCH aims to submit data to 100% of these audits, undertake careful review of results and ensure that improvement actions are taken where needed. In 2025-26, KCH submitted data to 99% of the relevant national clinical audits and 100% of the national confidential enquiries – KCH did not manage to submit data to the National Diabetes Inpatient Safety Audit, and this is currently under review.

- Improvement actions have included: Interventions to reduce unit-acquired bacteraemias in critical care, including joining the national Infection in Critical Care Quality Improvement Programme, 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.
- Initiatives to improve care of people admitted with hip fracture, including transformation work to improve theatre utilisation and time to surgery, improved escalation processes, closer coordination between emergency care, orthopaedics and site management, and introduction of enhanced monitoring of transfer times.
- Work to reduce time to thrombolysis for stroke patients, including faster CT scan reporting, introduction of regular simulation training for the multidisciplinary team and an application to national funding for thrombolysis pathway improvement work.
- Ongoing participation in national and local initiatives to improve organ donation rates, including active participation in Organ Donation Week.
- Work to improve the rate of delayed cord clamping for newborn babies, including implementation of Life Start Trolleys which ensure that babies can be monitored, stabilised and given respiratory support whilst still attached to the umbilical cord, and a range of education and awareness interventions.
- Initiatives to improve glucose control in children with diabetes, including starting over 95% of our patients on continuous glucose monitoring and ensuring that all patients are assessed for hybrid closed loop(HCL) pump eligibility, with over 70% of patients going on to use HCL pumps.

MEG (Medical e-governance) is the platform used to undertake clinical quality audits across all inpatient, dental and outpatient departments.

In 2025/2026 to date, 124088 individual audits have been completed across the following areas:

- Hand Hygiene – 45920
- Infection Prevention and Control – 4009
- I.V Lines – 16244
- Uniform and Dress Code – 25541
- Medicines Managements – 2792
- Quality and Safety – 2885
- Documentation – 10604
- Mattresses – 11074
- Matron Audit – 2190
- Antimicrobial Stewardship (New) - 331
- Controlled Drugs (NEW) - 78
- Venous Thromboembolism (New)- 218

Results are reviewed and actioned locally with oversight at divisional and trust level through the IQR. Trust level actions have been identified to improve scores in documentation and matron audits to move compliance from amber to green (>90%). Common issues were identified around risk assessment completion and there is work in progress to improve this with re-designed Epic workflows for both falls and skin assessment. A systematic review of all

audits and content is in progress to remove or reduce number of questions/time to complete and align with Epic processes. Local clinical audit was subject to follow-up by internal audit during the year. This provided significant assurance with minor improvement opportunities.

Information Governance

The Trust is obligated to process information (both personal and corporate) in accordance with current standards set out in legislation, including the Data Protection Act 2018 and the UK General Data Protection Regulations 2021, as well as other government guidelines, such as the NHS IG Assurance Framework.

Information Governance (IG) at the Trust includes responsibilities, strategy, policy, and procedures for handling personal information. Oversight is provided by the Information Governance Steering Group (IGSG), reporting to the Risk and Governance Committee. The IGSG Chair is the Deputy Chief Executive, serving as the Senior Information Risk Owner (SIRO). Key members include the Caldicott Guardian, Data Protection Officer, IG Manager, Information Security personnel, Head of Patient Records, and representatives from across the Trust.

The Trust assesses its compliance with the IG Assurance Framework through the NHS England Data Security and Protection Toolkit (DSPT). Compliance with DSPT outcomes is verified by meeting the requirements outlined in the Cyber Assessment Framework. This compliance is audited annually by King's internal auditors to support the Trust's position. In June 2025, this was assessed to provide significant assurance, with minor improvement opportunities.

The Trust received an "Approaching Standards" rating with an action plan agreed with NHS England in June 2025. The Trust has completed two of the four actions and is expected to achieve "Standards met" status for version 7 DSPT 2024/25 once the final action is completed. Work on version 8 DSPT 2025/26 is ongoing, and the results will be included in the 2026/27 Annual Report.

Information governance risk is being managed through established arrangements for incident reporting, investigation, regulatory engagement, risk oversight and corrective action. Where serious incidents occur, these are reviewed through appropriate governance routes, with mitigation and lessons learned identified and implemented. The Trust is also strengthening its wider control environment through its 2026 Information Governance strategy, which is focused on improving workforce resilience, standardising and modernising core processes, enhancing governance and performance oversight, expanding audit and compliance activity, and increasing organisational capability in response to regulatory, cyber and technological change.

The ICT department have obtained ISO27001 certification, this provides assurance that the information security measures that the Trust's ICT department has in place to protect personal and sensitive data are robust, effective and comply with international standards.

During 2025/26, two incidents were deemed as serious and subsequently reported to the Information Commissioner's Office (ICO):

- In **December 2025**, the Trust reported an incident involving inappropriate access by a staff member to a patient record without legitimate clinical or operational justification. The incident was considered serious given the sensitivity of the information accessed and the absence of any authorised role-based reason for access.

- In **March 2026**, the Trust reported an incident involving repeated inappropriate access by a staff member to a patient record without legitimate clinical or operational justification. The incident was considered serious due to the scale and duration of the access and the wider concerns identified through the Trust's review.

During the year, the Trust received several communications from the ICO. The majority relate to failures to respond to data subject access requests (DSARs) within the statutory timescales and/or disputes regarding the accuracy or completeness of the information disclosed. Additional matters include an instance of a patient receiving information relating to a third party (disclosure in error), concerns that HR may have inappropriately processed staff data during a grievance process (inappropriate processing), and several cases associated with the 2024 Synnovis data breach (cyber incident response). The Data Protection Officer is overseeing a more robust and coordinated approach to the management of complaints and regulatory concerns.

Data Quality Governance

To effectively design, implement, and measure improvements in patient care and patient safety the Trust requires high quality data. The Trust has a series of processes and controls in place to support improvements in the completeness and accuracy of data, including elective waiting list data. Many of these processes continue to be revised following the implementation of our electronic health record (Epic) as we work with the system supplier to improve and enhance activity recording and clinical coding processes within Epic.

The Trust has developed multiple data quality dashboards both within the Epic system itself as well as part of its Business Intelligence report offering to support appropriate oversight and governance of activity and pathways. The Trust has also maintained its monthly Internal Activity Recording Panel governance meeting to review and approve any proposed changes to the recording of Trust data.

Following the implementation of Epic further work has been ongoing to understand the implication of the change on activity data recording. As an example, 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.

King's as well as Guy's & St Thomas' NHS Foundation Trust and commissioners have been able to understand recording issues and agree solutions that are in line with National Expectations and Data dictionary rules. A Joint Trust Activity Recording Panel and Counting & Coding workstream had previously been setup to oversee this work which has now been replaced with an Activity Capture and Assurance meeting group, with representation from both Trusts.

Data quality arrangements are also assessed as part of the Trust's annual internal audit plan supported by KPMG. In 2025/26, the review focused on RTT waiting time reporting. The audit found systems provided significant assurance with minor improvement opportunities.

Workforce Strategies

Our Strong Roots, Global Reach strategy places 'Brilliant People' as the centre of everything we do. During 2021/22 we developed our People and Culture Plan 2022-2026, underpinned by the Trust's refreshed values – We are a kind, respectful team – to support our BOLD vision. The Plan was formally launched in June 2022. In developing the People and Culture Plan we have prioritised five themes:

- Belonging to King's
- Being our best
- Looking after our people
- Inspiring leadership
- Ensuring our people thrive.

The Board Assurance Framework includes a specific risk in relation to the recruitment and retention of our people. Details regarding the mitigations and key sources of assurance are periodically reviewed by the Board and the Board's Committees.

The Trust's People, Education and Inclusion Committee received regular workforce performance reports to provide a consolidated overview of core workforce priorities and key performance indicators. The report also includes local and national benchmarking information. Metrics reported include: staff engagement, eRostering finalisation, job planning completion, vacancy rates, staff turnover rate, sickness absence, appraisal rates and training compliance. Key workforce metrics are also reported to the Trust Board within the Integrated Performance Report.

The People, Education and Inclusion Committee received other workforce reports including the results of the annual national NHS staff survey and plans to support improvements based on responses to the survey, exception reports from the Guardians of Safe Working and from the Trust's Freedom to Speak Up Guardian, as well as bi-annual nurse establishment reviews.

Workforce planning is undertaken as part of the Trust's business planning cycle. Business cases to address any emerging changes to the Trust's workforce profile and to reduce the reliance on temporary staffing arrangements are also considered by the Trust's Investment Board throughout the year.

Workforce data is reviewed along with operational, finance and quality performance metrics as part of care group and divisional performance reviews to support the identification and escalation of any emerging risks.

In line with NHS England's Developing Workforce Safeguards recommendations to support Trusts in making informed, safe and sustainable workforce decisions, there is regular reporting on nursing establishments to the People, Education Inclusion and Research Committee and to the Board to provide details of the staffing position including, care hours per patient day (CHPPD), vacancy rates and turnover rates, and to outline any trends. The number of staff required per shift is calculated using an evidence- based tool, the Safer Nursing Care Tool, which provides specific multipliers depending on the acuity and dependency levels of patients. The number is further informed by professional judgement, taking into consideration issues

such as ward size and layout, staff skill mix, incidence of harm and patient satisfaction.

On a monthly basis the Trust-wide Nursing and Midwifery Workforce Governance Group provides oversight and supports future nursing and midwifery workforce planning.

Processes to support business-as-usual dynamic staffing risk assessments, include regular review of staffing levels, for example, daily staffing huddles, and weekly e-rostering reviews.

Compliance Statements

The Foundation Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance. The Trust recognises the findings of internal audit that there is scope to improve the quality of declarations below Board level.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust's most recent CQC Well-Led inspection report (Feb 2023), assessed the Trust as good for Well-led. During 2025/26, the Trust refreshed its board committee and executive governance structures aimed at further improve the oversight of risk and the delivery of the Trust's strategic objectives and its improvement agenda.

The Trust has arrangements in place to identify and mitigate risks to compliance with the NHS Foundation Trust licence condition 4 (8) (Foundation Trust governance) including the Board and Board committee structure (details are outlined above and in the Accountability Report), the risk management framework and site governance and performance arrangements.

The Trust has a number of enforcement undertakings against its Foundation Trust Licence. Action plans are in place to ensure compliance can be demonstrated.

The Trust is able to assure itself by considering information from a range of sources including:

- the Head of Internal Audit annual report;
- external auditor reports; and
- other external assurance reports e.g. the CQC Inspections.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

The Board reviews the annual planning process. Delivery of the financial plan is subject to scrutiny and oversight by the Finance and Commercial Committee and the Trust Board at each meeting. A trust-wide process is in place to oversee the development and approval of revenue and capital business cases and significant programmes are monitored by the Finance and Commercial Committee.

The Trust uses a range of key performance indictors (KPIs) to monitor performance. The Trust's performance management framework is aligned to care group leadership structure and regular performance reviews are held at a division and group level. Presentation of data is based on the principles of 'Making Data Count' good practice developed by NHSE.

The Trust has a range of policies and procedures to support the financial control framework, and the Trust's Standing Financial Instructions were subject to review during 2025. The final document was agreed by the Trust's Board of Directors in September 2025. During 2025/26 the Trust's internal auditors reviewed the Trust's core financial controls (financial governance review follow-up) which provided 'significant assurance with minor improvement opportunities'.

In order to ensure that the Trust achieved its savings plan the Trust implemented enhanced governance to oversee the identification and delivery of its cost improvement programme (CIP). The King's Executive Improvement Board monitors overall progress of the cost improvement programme and major programme achievement against key KPIs, acts as primary decision maker to address key blockers and approve mitigating actions to support continuity of the work streams and programme's delivery objectives and provide assurance that decisions taken support and enhance the quality and safety agenda of the Trust. The Trust agreed a CIP of £82m, of which £66m was delivered (full year effect £72m). Assurance is provided to the Board of Directors through Finance and Commercial Committee and the Performance, Transformation and Improvement Committee monthly.

The Trust's external auditors are required to assess the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources in line with the National Audit Office's Code of Audit Practice. The external auditors report the findings of their review to the Audit Committee. The conclusion from the 2025/26 review can be found later in this report.

Equality, Diversity and Inclusion

King's is an incredibly diverse organisation, serving diverse communities and we are incredibly proud of the rich cultural heritage provided by our staff, patients and local communities. Putting diversity, equality and inclusion at the heart of everything we do forms part of King's BOLD vision, which is set out in the Trust's five-year strategy.

The Trust's work in this area is led by the Chief People Officer. The Trust reported progress regarding the gender pay gap, the workforce race equality standard (WRES) and the workforce disability equality standard (WDES) to the Trust's People, Education Inclusion and Research Committee along with plans to continue to make King's a better place to work. The Trust's gender pay gap data can be found here: Gender pay gap reports for King's College Hospital - Gender pay gap service (gender-pay-gap.service.gov.uk)

Control measures are in place to ensure that all obligations under equality, diversity and human rights legislation are complied with.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me.

My review is also informed by comments made by the external auditors in their annual audit report and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, and the Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board and its Committees continued to meet throughout the year to review and oversee the system of internal control and emerging risks. The Board has improving oversight of strategic risk. The Board and the Board's Committees continue to use the assurance framework to oversee the management and mitigation of strategic risks. The Audit Committee has received reports from the Trust's internal and external auditors and other external reviewers during the year to support the committee's review of the risk management arrangements and governance framework**.**

The King's Improvement Programme

King's has continued to make progress during the year in addressing the significant governance issues that resulted in the Trust entering NOF4 and the Recovery Support Programme. The Trust's finance governance arrangements have been subject to external review there has been good progress over the year in addressing the issues raised.

The purpose of the King's Improvement Programme is to transform the way the Trust uses the resources available to deliver high quality care to patients, in a financially sustainable way; to drive and embed effective distributed leadership in the large multi-sited organisation and embed a culture of continuous improvement for the benefit of our patient and local population. Key to this has been the development of the King's Improvement Method, a comprehensive methodology with tried and tested tools and techniques aimed at driving improvement consistently across the Trust.

Improvement Programme Workstreams have been mapped against the required Transition Criteria to ensure that once delivered, the Trust will meet the statutory required improvements set out both in the NHSE Operating Model Transition criteria and enforcement undertakings linked to its Foundation Trust Licence. The Trust was successful in demonstrating that a number of transition criteria were met during the year, and enforcement undertakings relating to financial governance and controls, establishing a comprehensive improvement programme and addressing leadership and governance were lifted.

The Trust continues to attend meet quarterly review meetings with NHSE London Region Leads, where progress against the Transition criteria and Enforcement undertakings is monitored with compliance certificates issued once sufficient assurance has been provided.

2025/26 Internal Audit Programme

The Trust's internal auditors, KPMG LLP, develop an annual audit plan based on the Trust's objectives, risk profile and an assessment of existing sources of assurance. The 2025/26 plan was presented to the Audit Committee in April 2025. In line with good practice the internal audit plan for the year was risk based and focused on some known areas of concern.

The reports, detailing the key findings and recommendations were reviewed by the Trust's Audit Committee. Plans are in place to address the recommendations made in the reviews. The high priority actions raised in their reports were implemented before the end of the 2025/26 year. The Risk and Governance Committee monitors progress with these actions and updates are provided to the Audit Committee.

The conclusions of each of the 2025/26 reviews are noted in the table below:

Internal Audit	Assurance Rating
Data Protection Toolkit	Significant assurance with minor improvement opportunities
Consultant Job Planning	Partial assurance with improvement required
Board Governance: Well-Led Self Assessment	Partial assurance with improvement required
Core Financial Controls: Financial Governance Review Follow-up	Significant assurance with minor improvement opportunities
Estates Backlog Maintenance	Partial assurance with improvement required
PSIRF Processes	Significant assurance with minor improvement opportunities
Academic Research Governance	Partial assurance with improvement required
Data Quality: EPIC RTT	Significant assurance with minor improvement opportunities
Risk Management: BAF	Partial assurance with improvement required
Quality Governance Local Clinical Audit Follow-Up	Significant assurance with minor improvement opportunities
Violence and Aggression	Significant assurance with minor improvement opportunities

Head of Internal Audit Annual Report

The overall Head of Internal Audit Annual Report for the period 1 April 2025 to 31 March 2026 reached the following conclusions:

Governance: Amber/Red – Overall findings on design showed the need to improve the design and implementation of controls.

Risk Management: Amber/Red – Overall findings on design showed the need to improve the design and implementation of controls.

Financial Reporting and Management: Green – Overall findings on design showed controls are effectively designed and testing showed controls are operating effectively.

Data captured and used by the organisation: Amber Green – overall findings on design show some controls to be effectively designed with some exceptions and our testing showed some controls to be operating effectively and others could be more consistently applied.

The basis for forming the opinion includes:

- An assessment of the range of individual assurances arising from contemporary core reviews of financial systems, governance, risk management and data quality;
- An assessment of the range of individual assurances arising from their risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of these areas; and
- An assessment of the implementation status of prior year actions raised from internal audit assignments. This assessment has taken account of the severity and nature of actions raised.

Conclusion

During the year, no significant control issues have been identified. The Trust has delivered significant improvements in financial governance and implemented detailed recovery plans aimed at addressing the enforcement undertakings issued against its licence. Compliance

certificates have been issued against a number of undertakings. Grip and control of key governance and management functions has been strengthened. The Trust has continued to strengthened risk management arrangements and has an internal control framework in place. A number of individual internal audit reviews provide significant assurance in many areas. I welcome the decision to release the Trust from the Recovery Support Programme, but recognise there is more to do, including addressing the concerns identified as a result of the Trust's 2025-26 internal audit programme.

As Accounting Officer, I have ensured action plans are in place and that there has been regular reporting to the Board of Directors on progress.

Professor Clive Kay **18 June 2026**
Chief Executive and Accounting Officer

ANNUAL ACCOUNTS 2025/26

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF KING'S COLLEGE HOSPITAL NHS FOUNDATIONTRUST

Report on the audit of the financial statements

Trust Accounts Consolidation (TAC) Summarisation Schedules for King's College Hospital NHS Foundation Trust

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2025/26 are attached.

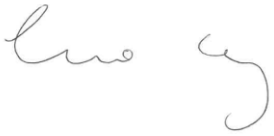
Finance Director Certificate

1. I certify that the attached TAC schedules have been compiled and are in accordance with:
   - the financial records maintained by the NHS Foundation Trust
   - accounting standards and policies which comply with the Group Accounting Manual issued by the Department of Health and Social Care and
   - the template accounting policies for NHS Foundation Trusts issued by NHS Improvement, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.
2. I certify that the TAC schedules are internally consistent and that there are no validation errors.
3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Foundation Trust.

Roy Clarke, Chief Financial Officer
Date 18 June 2026

Chief Executive Certificate

1. I acknowledge the attached TAC schedules, which have been prepared and certified by the Chief Finance Officer, as the TAC schedules which the Foundation Trust is required to submit to NHS Improvement.
2. I have reviewed the schedules and agree the statements made by the Chief Finance Officer above.



Professor Clive Kay Chief Executive Officer
Date: 18 June 2026

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

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of King's College Hospital NHS Foundation Trust (the 'Trust') and its subsidiaries (the 'group') for the year ended 31 March 2026, which comprise the consolidated statement of comprehensive income, the statement of financial position, the statement of changes in taxpayers' equity, the statement of cash flows, the notes to financial statements, the significant accounting policies and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2026 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

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

Conclusions relating to going concern

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

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2025-26 that the group's and the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the group and the Trust. In doing so we had regard to the guidance provided in Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the group and the Trust and the group's and the Trust's disclosures over the going concern period.

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

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

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

Other information

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

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

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2025/26 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2025/26; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

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

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

Responsibilities of the Accounting Officer

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS Foundation Trust Annual Reporting Manual 2025/26, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the group and the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26).
- We enquired of management and the Audit and Risk committee, concerning the group's and the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit and Risk committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the group's and the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and fraud in income and expenditure recognition. We determined that the principal risks were in relation to:
  - journal entries that improved the Trust's or group's financial performance for the year;
  - the occurrence and accuracy of income relating to the Trust, in particular income that varies based on activity;
  - the completeness of non-pay expenditure and payables for the Trust.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on high risk journals at the end of the financial year which could improve the Trust's or group's financial performance;
  - substantive testing of income for the Trust with a focus on income recognition;
  - substantive testing of completeness assertion of expenditure to search unrecorded liability and verify that all transactions related to the reporting period are accurately recorded in the financial statements to ensure expenses are recognised in the correct period, where we tested a sample of non-pay cash payments made and invoices received prevalent at year end and after the year end;
- assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including potential for fraud in revenue and expenditure recognition in the Trust accounts. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the group and Trust audit team members included consideration of their:

- understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
- knowledge of the health sector and economy in which the group and the Trust operates
- understanding of the legal and regulatory requirements specific to the group and the Trust including:
  - the provisions of the applicable legislation
  - NHS England's rules and related guidance
  - the applicable statutory provisions.

- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The group's and the Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, financial statement consolidation process, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The group's and the Trust's control environment, including the policies and procedures implemented by the group and the Trust to ensure compliance with the requirements of the financial reporting framework.
- For components at which audit procedures were performed, we requested component auditors to report to us instances of non-compliance with laws and regulations that gave rise to a risk of material misstatement of the group financial statements. No such matters were identified by the component auditors.

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

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

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

Responsibilities of the Accounting Officer

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

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

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

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

We cannot formally conclude the audit and issue an audit certificate for King's College Hospital NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of Chapter 10 of the National Health Service Act 2006 and the Code of Audit Practice until we have completed the work necessary in relation to the Trust's consolidation schedules and we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

Use of our report

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

Paul Dossett

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

London
18 June 2026

King's College Hospital NHS
NHS Foundation Trust

Final Annual Accounts
for the year ended 31 March 2026

FOREWORD TO THE ACCOUNTS

King's College Hospital NHS Foundation Trust

These accounts, for the year ending 31 March 2026, have been prepared by King's College Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 and comply with the guidance for NHS Foundation Trusts within the Department of Health Group Accounting Manual.

Signed: Date: 18 June 2026

Prof Clive Kay
Chief Executive

Consolidated Statement of Comprehensive Income for year ended 31 March 2026

	Note	Group 2025-26 £000	2024-25 £000
Operating income from patient care activities	2.1, 2.2	**1,932,872**	1,805,001
Other operating income	2.1	**133,081**	131,408
Total operating income from continuing operations		**2,065,953**	1,936,409
Operating expenses	3.1	**(2,034,476)**	(1,933,139)
Operating surplus from continuing operations		**31,477**	3,270
Finance income and costs			
Finance income		**4,718**	4,622
Finance expenses	5	**(38,162)**	(36,377)
Public Dividend Capital dividends payable		**(9,053)**	(9,712)
Net finance costs		**(42,497)**	(41,467)
Other (losses) / gains	7	701	849
Share of profit of associates and joint ventures	7.1	81	25
Corporation tax expense		(599)	(649)
Deficit from continuing operations		**(10,837)**	(37,972)
Deficit for the year		**(10,837)**	(37,972)
Other comprehensive expense, that will not be reclassified subsequently to income and expenditure			
Impairments	6	**(2,330)**	(2,337)
Revaluations	21	**7,525**	17,554
Fair value gains/(losses) on equity instruments designated at FV through OCI		**-**	-
Other reserve movements		**-**	44
Total other comprehensive income		**5,195**	15,261
Total comprehensive expense for the year		**(5,642)**	(22,711)
Allocation of losses for the year			
Deficit for the year attributable to:			
(i) non-controlling interest; and		-	-
(ii) Trust		**(10,837)**	(37,972)
Total		**(10,837)**	(37,972)
Total comprehensive expense for the year attributable to:			
(i) non-controlling interest; and		**-**	-
(ii) Trust		**(5,642)**	(22,711)
Total		**(5,642)**	(22,711)

Statements of Financial Position as at 31 March 2026

		Group		Trust	
		31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	Note	**£000**	£000	**£000**	£000
Non-current assets					
Intangible assets	8	**44,680**	49,578	**44,898**	49,294
Property, plant and equipment	9	**669,823**	672,360	**580,921**	591,190
Right of Use Assets	10	**103,804**	97,201	**161,876**	154,237
Investment in associates, joint ventures and subsidiaries	11.1,11.2	**6,425**	6,344	**250**	250
Other investments	11.4	**5,163**	4,983	**4,011**	4,011
Receivables	13	**10,806**	16,673	**33,159**	41,241
Total non-current assets		**840,701**	847,139	**825,115**	840,223
Current assets					
Inventories	12	**23,647**	23,043	**6,161**	7,171
Receivables	13	**70,230**	61,853	**66,133**	57,899
Cash and cash equivalents	14	**141,089**	84,864	**132,658**	73,758
Total current assets		**234,966**	169,760	**204,952**	138,828
Total assets		**1,075,667**	1,016,899	**1,030,067**	979,051
Current liabilities					
Trade and other payables	15	**(229,094)**	(211,734)	**(195,571)**	(176,780)
Borrowings	17	**(27,497)**	(26,452)	**(37,247)**	(36,140)
Provisions	18	**(3,882)**	(1,927)	**(3,763)**	(1,927)
Other liabilities	16	**(53,198)**	(24,567)	**(52,905)**	(24,470)
Total current liabilities		**(313,671)**	(264,680)	**(289,486)**	(239,317)
Net current (liabilities)		**(78,705)**	(94,920)	**(84,534)**	(100,490)
Total assets less current liabilities		**761,996**	752,219	**740,581**	739,734
Non-current liabilities					
Borrowings	17	**(357,204)**	(357,235)	**(404,334)**	(402,033)
Provisions	18	**(5,480)**	(3,496)	**(5,479)**	(3,496)
Total non-current liabilities		**(362,684)**	(360,731)	**(409,813)**	(405,529)
Total assets employed		**399,312**	391,488	**330,768**	334,205
Financed by:					
Taxpayers' equity					
Public Dividend Capital		**1,231,280**	1,217,814	**1,231,280**	1,217,814
Revaluation reserve	21	**185,631**	180,436	**185,631**	180,436
Financial assets at FV through Other Comprehensive Income reserve		**3,329**	3,329	**1,551**	1,551
Income and expenditure reserve		**(1,020,928)**	(1,010,091)	**(1,087,694)**	(1,065,597)
Total taxpayers' equity		**399,312**	391,488	**330,768**	334,205

The notes on pages 5 and 10 to 59 form part of these accounts.

The financial statements on pages 4 to 9 were approved by the Board on 18 June 2026 and signed on its behalf by

Signed: **Date:** **18 June 2026**

Prof Clive Kay
Chief Executive

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

Group	Note	Public Dividend Capital £000	Revaluation reserve £000	Financial assets at FV through Other Comprehensive Income reserve £000	Income and expenditure reserve £000	Total reserves £000
Taxpayers' and others' equity at 1 April 2025 - brought forward		1,217,814	180,436	3,329	(1,010,091)	**391,488**
Deficit for the year		-	-	-	(10,837)	**(10,837)**
Impairments	21	-	(2,330)	-	-	**(2,330)**
Revaluations - property, plant and equipment	21	-	7,525	-	-	**7,525**
Public Dividend Capital received		13,466	-	-	-	**13,466**
Other reserve movements		-	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2026		**1,231,280**	**185,631**	**3,329**	**(1,020,928)**	**399,312**
Taxpayers' and others' equity at 1 April 2024 - brought forward		1,200,314	165,219	3,329	(972,163)	396,699
Deficit for the year		-	-	-	(37,972)	(37,972)
Impairments	21	-	(2,337)	-	-	(2,337)
Revaluations - property, plant and equipment	21	-	17,554	-	-	17,554
Fair value gains on equity instruments designated at FV through OCI		-	-	-	-	-
Public Dividend Capital received		17,500	-	-	-	17,500
Other reserve movements		-	-	-	44	44
Taxpayers' and others' equity at 31 March 2025		1,217,814	180,436	3,329	(1,010,091)	391,488

Trust	Note	Public Dividend Capital £000	Revaluation reserve £000	Financial assets at FV through Other Comprehensive Income reserve £000	Income and expenditure reserve £000	Total reserves £000
Taxpayers' and others' equity at 1 April 2025 - brought forward		**1,217,814**	**180,436**	**1,551**	**(1,065,597)**	**334,204**
Deficit for the year		-	-	-	(22,097)	**(22,097)**
Impairments	21	-	(2,330)	-	-	**(2,330)**
Revaluations - property, plant and equipment	21	-	7,525	-	-	**7,525**
Public Dividend Capital received		13,466	-	-	-	**13,466**
Taxpayers' and others' equity at 31 March 2026		**1,231,280**	**185,631**	**1,551**	**(1,087,694)**	**330,768**
Taxpayers' and others' equity at 1 April 2024 - brought forward		1,200,314	165,220	1,551	(1,017,603)	349,482
Deficit for the year		-	-	-	(47,994)	(47,994)
Impairments	21	-	(2,337)	-	-	(2,337)
Revaluations - property, plant and equipment	21	-	17,554	-	-	17,554
Public Dividend Capital received		17,500	-	-	-	17,500
Taxpayers' and others' equity at 31 March 2025		1,217,814	180,436	1,551	(1,065,597)	334,204

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026 (continued)

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Financial assets at FV through Other Comprehensive Income reserve
This reserve holds the valuation gain in respect of the PIK note held by the group.
The Trust holds this PIK note as a result of a historic transaction in which it received a combination of cash and other benefits for the sale of a business. The instrument entitles the Trust to dividends and also the ability to cash out in two tranches in the future.
The PIK (payment in kind) note is a financial instrument which enables the issuer to defer dividend payments until the instrument matures. The dividend expense is not paid in cash but accrued onto the balance of the instrument.

Statement of Cash Flows for the year ended 31 March 2026

		Group		Trust	
		2025-26	2024-25	**2025-26**	2024-25
	Note	**£000**	£000	**£000**	£000
Cash flows from operating activities					
Operating surplus / (deficit) from continuing operations		**31,477**	3,270	**20,150**	(8,957)
Non-cash income and expense					
Depreciation and amortisation	3.1	**62,161**	63,599	**60,960**	61,024
Net Impairments	3.1	**11,650**	4,424	**7,315**	4,424
Income recognised in respect of capital donations		**(2,827)**	(1,116)	**(1,448)**	(745)
(Increase)/Decrease in trade and other receivables		**1,687**	12,151	**(152)**	29,821
(Increase)/Decrease in inventories		**(604)**	2,109	**1,010**	153
Increase/(Decrease) in trade and other payables		**18,292**	23,850	**23,376**	5,617
Increase/(Decrease) in other liabilities		**28,631**	(1,105)	**28,435**	(1,218)
Increase/(Decrease) in provisions		**3,832**	(3,003)	**3,819**	(3,002)
Corporation Tax Paid		**-**	(416)	**-**	-
Other movements in operating cash flows		**1,404**	720	**(1,679)**	1,072
Net cash used in operations		**155,703**	104,483	**141,786**	88,189
Cash flows used in investing activities					
Interest received		**4,718**	4,622	**5,561**	6,563
Purchase of financial assets		**(261)**	(836)	**-**	-
Purchase of intangible assets	8	**(1,312)**	(8,399)	**(1,404)**	(8,286)
Purchase of property, plant and equipment	9	**(51,824)**	(40,659)	**(34,417)**	(17,471)
Sales of property, plant and equipment		**326**	1,651	-	1,445
Receipt of cash donation to purchase asset		**2,827**	687	**447**	371
Net cash used in investing activities		**(45,526)**	(42,934)	**(29,813)**	(17,378)
Cash flows from financing activities					
Public Dividend Capital received		**13,466**	17,500	**13,466**	17,500
Movement in loans from the Department of Health and Social Care		**(3,418)**	(3,418)	**(3,418)**	(3,418)
Movement in other loans		**(640)**	(640)	**10,360**	(640)
Capital element of lease liability repayments		**(11,181)**	(12,145)	**(20,521)**	(22,139)
Capital element of PFI and other service concession	22.3	**(15,045)**	(13,126)	**(15,045)**	(13,126)
Interest on DHSC loans		**(827)**	(926)	**(827)**	(926)
Interest on other loans		**(24)**	(37)	**(24)**	(37)
Other Interest		**(3)**	(4)	**(3)**	(2)
Interest paid on lease liability repayments		**(1,063)**	(1,068)	**(1,640)**	(1,680)
Interest element of PFI and other service concession obligations		**(26,570)**	(26,911)	**(26,570)**	(26,911)
Public Dividend Capital dividend paid		**(8,851)**	(8,471)	**(8,851)**	(8,471)
Cash flows from (used in) other financing activities		**204**	-	**-**	-
Net cash from financing activities		**(53,952)**	(49,246)	**(53,073)**	(59,850)
Increase / (decrease) in cash and cash equivalents		**56,225**	12,303	**58,900**	10,961
Cash and cash equivalents at 1 April		**84,864**	72,561	**73,758**	62,797
Cash and cash equivalents at 31 March		**141,089**	84,864	**132,658**	73,758

Notes to the accounts

1. Accounting policies

Basis of preparation of the financial statements

NHS England, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going concern

The Trust has prepared its annual report and accounts on a going concern basis.

The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment and certain financial assets and financial liabilities.

Consolidated Accounts

1.3 Basis of Consolidation

Charitable funds
The King's College Hospital Charity and Friends of King's are independent charities and are not under the control of the Foundation Trust. Therefore, these charities have not been consolidated within these accounts.

1.3.1 Subsidiaries
Subsidiary entities are those over which the Foundation Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The amounts consolidated are drawn from the draft financial statements of the subsidiaries for the year. Where subsidiaries' accounting policies are not aligned with those of the Foundation Trust then the amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

The Foundation Trust has a wholly owned subsidiary company, King's Commercial Services Ltd, which wholly owns KCH Management Ltd. The accounts for these companies have been consolidated into the group accounts.

In 2016/17, the Foundation Trust formed King's Interventional Facilities Management LLP in partnership with King's Commercial Services Ltd. The accounts for this partnership have been consolidated into the Trust's annual accounts.

1. Accounting Policies (continued)

The primary statements and notes to the accounts have been presented with separate 'Group' and 'Trust' columns. Where the difference between the 'Group' and 'Trust' figures is considered immaterial, the 'Trust' version of the note has been omitted.

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's deficit for the period was (£22.1m) (2024/245 (£48.0)).

1.3.2 Associates
Associate entities are those over which the Foundation Trust has power to exercise a significant influence. Associate entities are recognised in the Foundation Trust's financial statements using the equity method of accounting. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Foundation Trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant or equipment) following acquisition. It is also reduced when any distribution (e.g. share dividends) are received by the Foundation Trust from the associate.

1.3.3 Joint ventures
Joint ventures are arrangements in which the Foundation Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

1.3.4 Joint operations
Joint operations are arrangements in which the Foundation Trust has joint control with one or more other parties, and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Foundation Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

In the application of the Foundation Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are reviewed on an on-going basis.
Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.4.1 Critical judgements in applying accounting policies

There are no critical judgements material to the accounts in year.

1. Accounting Policies (continued)

1.4.2 Sources of estimation uncertainty

The following are assumptions about sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Estimate - Revaluation of Land and Buildings

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

Non-specialised buildings and Land –market value for existing use

Land (Denmark Hill Site) –alternative site basis, based on patient postcode analysis
Specialised buildings –depreciated replacement cost on a modern equivalent asset basis.

The Trust seeks professional advice from its valuers' annually in determining the value of its land and buildings. The values in the valuer's report have been used to inform the measurement of property assets at valuation in these financial statements. The RICS qualified valuer exercised their professional judgement in providing the valuation and it remains the best information available to the Trust. However, the valuer uses informed assumptions regarding obsolescence, rebuild rates and the area of the sites required to accommodate modern equivalent assets with the same service potential which could change and have a material impact on the valuation. The valuation method assumes a smaller land area is required with a modern, efficient build, which reduces the value of land held.

Consequences of Change in Estimate

The net book value at 31 March 2026 of the Trust's Property, Plant & Equipment valued by professional valuers and reflected in these financial statements is £561.9m. A change in the estimated values would result in changes to the Revaluation Reserve and / or a loss or gain recorded as appropriate in the Statement of Comprehensive Income. If the value of land and buildings were to change by 5% this would result in a movement of around £28.1m.

It is also noted that land valuations, which are based on a notional appraisal are very sensitive to input parameters, with small variations in input leading to potentially large movements in value.

The Trust makes a number of other estimates in its financial accounts, which are not considered to be at risk of material uncertainty.

1. Accounting Policies (continued)

1.5 Operating segments

The Foundation Trust has a number of business divisions which are aggregated under one reportable segment being the provision of healthcare. The Foundation Trust provides Private Patient, Research and Development and Training and Education services within this healthcare sector, but as they do not have a material impact, they are aggregated under this one reportable segment. Note 2 entitled "Operating Income" includes the relevant income figures for these services.

The subsidiary figures have not been disclosed separately in this note as the SoCI has been prepared on a group only basis. Separate Group and Trust only SoFP information has been provided. The subsidiaries support the Trust in the overall provision of healthcare.

1.6 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability. The Trust typically applies standard payment terms of 30 days to all invoices raised.

Revenue from NHS contracts
The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under this scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as variable consideration under IFRS 15.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

1. Accounting Policies (continued)

Revenue from research contracts
Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme
The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.7 Other Forms of Income

1.7.1 Revenue grants and donations
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

1.7.2 Apprenticeship Service Income
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1. Accounting policies (continued)

1.8 Expenditure on employee benefits

1.8.1 Short-term employee benefits
Salaries, wages and employment-related payments, such as social security costs and the apprenticeship levy, are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.8.2 Pension Costs
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both Schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as a defined contribution scheme; the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to operating expenses at the time the foundation trust commits itself to the retirement, regardless of the method of payment.

1.9 Expenditure on other goods and services
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.9.1 Value added tax
Most of the activities of the Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.10 Corporation tax

The Finance Act 2004 amended S519A Income and Corporation Taxes Act 1988 provided power to the Treasury to make certain non-core activities of Foundation Trusts potentially subject to corporation tax. This legislation is effective from September 12 2005. Any outstanding payments of corporation tax as at the end of the financial year are provided for in the Statement of Comprehensive Income. The Foundation Trust did not incur Corporation Tax in 2024/25 as the Foundation Trust did not generate any taxable income. Corporation Tax is payable on profits made in the Trust's trading subsidiary companies.

1.11 Insurance Contracts (Trust as the insurer)

An insurance contract is a contract under which the Trust has accepted significant pre-existing insurance risk from the policyholder by agreeing to compensate the policyholder if a specified uncertain future event adversely affects the policyholder. IFRS 17 is effective from 2025/26 for the insurer accounting for such contracts. The standard is applied retrospectively with a transition date of 1 April 2024, restating prior periods.

1. Accounting policies (continued)

1.12 Property, plant and equipment

1.12.1 Recognition
Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the foundation trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.12.2 Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.12.3 Measurement and Valuation
All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

Current values in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

1. Accounting policies (continued)

A DRC model estimates current value in existing as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements. The Trust has previously used an external advisor to inform MEA assumptions.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation – Global Standards (effective from 31st January 2020).
Land and buildings are revalued by full site inspection every three years, with desktop valuations on interim years The last asset valuations were undertaken as at 31 March 2025 by a RICS Registered Valuer from Avison Young (Kerry Maguire) on a desktop basis.

Depreciated Replacement Cost (DRC) is recognised under IAS 16 as a method of valuation for financial reporting purposes. DRC assessments were undertaken for those assets considered to be specialised properties (e.g. NHS patient treatment facilities). The Department of Health and Social Care has adopted the Modern Equivalent Asset approach (MEA) in carrying out the DRC assessment method.

Depreciated Replacement Cost has been adopted because of the asset classification as specialist properties which are rarely sold in the open market. The MEA approach is based on valuing the cost of a modern equivalent asset that has the same service potential as the existing asset and then adjusted to take account of obsolescence.

Only that plant and machinery forming part of the building services installations has been included. Total external works for each site have been allocated to each building based upon a percentage of replacement build costs adopted.

The valuation included the Foundation Trust's PFI schemes.

The carrying values of property, plant and equipment are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. The costs arising from financing the construction of the property, plant and equipment are not capitalised but are charged to the Statement of Comprehensive Income in the year to which they relate. All impairments resulting from price changes are charged to the Statement of Comprehensive Income. If the balance on the revaluation reserve is less than the impairment the difference is taken to the Statement of Comprehensive Income.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

1.13 Intangible assets

1.13.1 Recognition
Intangible assets are non-monetary assets without physical substance controlled by the Trust, which are capable of being sold separately from the rest of the Foundation Trust's business or which arise from contractual or other legal rights. Intangible assets are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably.

1. Accounting policies (continued)

Software
Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset where it meets recognition criteria.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer, lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

1.13.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as ‘deemed cost’ and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve. Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

1.13.3 Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

1.14 Depreciation, amortisation and impairments

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the foundation trust, respectively.

Buildings, installations and fittings are depreciated on their current value on a straight line basis over the estimated remaining life of the asset as advised by the valuer.

Equipment is depreciated on current cost evenly over the useful economic life of the asset. Standard useful economic lives are estimated for each major category of equipment and individual lives will only be applied where it is clear that the standard lives are materially inappropriate.

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The major categories and their useful economic lives are:

Category	Useful Life
Furniture	7 - 10 years
Office and IT equipment	5 - 8 years
Soft furnishings	7 - 10 years
Medical and other equipment	5 - 15 years
Land	Infinite

Useful economic lives of building assets are provided through the annual independent valuation process and range from 5 - 61 years.
Leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

1. Accounting policies (continued)

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Useful economic lives reflect the total life of an asset and not the remaining life of an asset. Standard useful economic lives are estimated for each major category of equipment and individual lives will only be applied where it is clear that the standard lives are materially inappropriate. The Trust has one exception to the standard lives in respect of its Electronic Patient Records system and is amortising this asset over 15 years.

The Trust amortise intangibles over the following useful lives range:
software license, 3 - 10 years.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that had previously been recognised in operating expenses, in which case they are recognised as operating expenditure.
Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the DHSC GAM, impairments that arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (I) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as ‘Held for Sale’ once all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.
Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.15 Donated, government grant or other grant-funded assets

Donated and grant-funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor. In which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

1.16.1 The Foundation Trust as lessee
Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

1.16.2 The Foundation Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1. Accounting policies (continued)

1.17 Private finance initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as "on-Statement of Financial Position" by the trust. Annual contract payments (unitary payments) to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial Recognition

In accordance with HM Treasury's *FReM, t*he underlying assets are recognised as property, plant and equipment, together with an equivalent PFI liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent Measurement
Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income

1.17.1 Services received
The cost of services received in the year is recorded under the relevant expenditure headings within operating expenses.

1.17.2 PFI assets, liabilities and finance costs
The PFI assets are initially measured using the principles of IFRS 16. Subsequently, the assets are measured at current value in existing use per the policies applied under IAS 16.

A PFI liability equal to the capital value of the contract is recognised at the same time as the PFI assets are recognised. This does not include service elements and interest charges within the PFI contract which are expensed in accordance with IFRIC 12 as adapted and interpreted by the FReM and as detailed below.

An annual finance cost is calculated by applying the implicit interest rate in the contract to the opening PFI liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

An element of the annual unitary payment is therefore allocated as a financing cost when repaying the PFI liability over the life of the contract.

1. Accounting policies (continued)

1.17.3 Lifecycle Replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Foundation Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at cost.

The element of the annual unitary payment allocated to lifecycle replacement is predetermined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively. Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised, and is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.17.4 Assets contributed by the Trust to the operator for use in the scheme
Assets contributed by the Foundation Trust for use in the scheme continue to be recognised as items of property, plant and equipment in the foundation trust's Statement of Financial Position.

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out method. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks.

1.19 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. These balances exclude monies held in the Foundation Trust's bank account belonging to patients. Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within payables. Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, interest receivable and interest payable in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Foundation Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.20 Provisions

The Foundation Trust recognises a provision where it has a present legal or constructive obligation as a result of a past event for which it is probable that there will be a future outflow of cash or other resources to settle the obligation; and a reliable estimate can be made of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

1. Accounting policies (continued)

Early retirement provisions are discounted using HM Treasury's pension discount rate of 2.95% (2024-25: 2.40%) in real terms.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates.

	Inflation rate	Prior year rate
Year 1	2.5%	2.6%
Year 2	2.0%	2.3%
Into Perpetuity	2.0%	2.0%

1.20.1 Clinical negligence costs
NHS Resolution operates a risk-pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Foundation Trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the Foundation Trust is disclosed in note 18 but is not recognised in the Foundation Trust's accounts.

1.20.2 Non-clinical risk pooling
The Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk-pooling schemes under which the foundation trust pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses as and when the liability arises.

1.21 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 19 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 19.

Contingent liabilities are defined as:

possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.22 Financial assets and Financial Liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

1. Accounting policies (continued)

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income.

Financial liabilities classified as subsequently measured at amortised cost or fair value through income and expenditure.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

The Trust has irrevocably elected to measure the following equity instruments at fair value through other comprehensive income:

PIK Note held for investment in KCH Healthcare LLC

1. Accounting policies (continued)

Financial assets and financial liabilities at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Overseas visitor's debts less than one year are provided for based on historical recoverability. Private Patient debts and salary overpayments are provided for based on management estimation of the percentage of recoverability. The Foundation Trust applies the percentage provided by the Department of Health to gross debts for injury costs recovery (RTA).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate. Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-Recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.23 Public dividend capital

Public Dividend Capital (PDC) is a type of public sector equity finance, which represents the Department of Health and Social Care's investment in the trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

1. Accounting policies (continued)

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at

https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts

In accordance with the requirements laid down by the Department of Health and Social Care, the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts. The PDC dividend calculation is based upon the trust’s group accounts (i.e. including subsidiaries), but excluding consolidated charitable funds.

1.24 Foreign exchange

The functional and presentational currency of the Foundation Trust is sterling (£'000). A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. The Foundation Trust does not have material foreign currency transactions. Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise. Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

1.25 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. Details of third party assets are given in Note 24 to the accounts.

1.26 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis. The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1. Accounting policies (continued)

1.27 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.28 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

1.29 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2025-26 These Standards are still subject to HM Treasury FReM adoption.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

1. Accounting policies (continued)

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £561.9m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for some of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £16.7m at 31 March 2026.

1.30 Prior Period Adjustment Policy
The Trust applies IAS 8 when considering if prior period adjustments are required.

2. Operating income

2.1 Income from activities by classification

	Group 2025-26 £000	2024-25 £000
Income from patient care activities		
Income from commissioners under API contracts - fixed *	**1,534,736**	1,442,162 ^
Income from commissioners under API contracts - variable *	**57,618**	37,118
High cost drugs income from commissioners	**235,087**	223,406 ^
Other NHS clinical income*****	**14,722**	15,093
Additional income for delivery of healthcare services		
Private Patient income	**11,744**	9,197
Additional pension contribution central funding **	**61,756**	58,307
Pay award central funding	**-**	4,458
Other clinical income *****	**17,209**	15,260
Total income from patient care activities * **	**1,932,872**	1,805,001
Other operating income recognised in accordance with IFRS 15		
Research and development	**12,356**	8,764
Education and training	**55,179**	53,056
Non-patient care services to other bodies	**14,137**	13,013
Income in respect of employee benefits accounted on a gross basis	**998**	2,532
Trading Income ****	**11,928**	21,996
Other	**19,302**	13,689
Total other operating income (IFRS 15)	**113,900**	113,050
Other operating income recognised in accordance with other standards		
Research and development	**13,398**	15,014
Education and training - notional income from apprenticeship fund	**1,297**	644
Receipt of capital grants and donations	**2,827**	1,116
Charitable and other contributions to expenditure	**205**	28
Rental revenue from operating leases	**1,454**	1,556
Total other operating income (Non-IFRS 15)	**19,181**	18,358
Total operating Income	**2,065,953**	1,936,409

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.
https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

*** Income from patient care activity is recognised in accordance with IFRS 15.
**** Trading income relates to activities of the Trust's subsidiaries and includes revenus from consumables support services and international platforms work.

***** NHS Clinical Income is income from patient care activities funded by other NHS provider organisations, and other clinical income is patient care income external to the NHS

^Prior year figures restated to reflect consistent disclosure basis to current year, including homecare drugs

2.2 Income from activities by type

	Group 2025-26 £000	2024-25 £000
NHS Foundation Trusts	**407**	349
NHS Trusts	**8,612**	8,651
Integrated Care Boards and NHS England *	**1,889,197**	1,765,451
NHS Other (including Public Health England and Prop Co)	**5,703**	6,093
Non-NHS		
Local Authorities	**5,200**	5,248
Private patients	**11,744**	9,197
Overseas patients (non-reciprocal)	**7,860**	5,607
Injury costs recovery	**4,149**	4,405
Total income from activities	**1,932,872**	1,805,001

* Includes £61.756m (2024-25: £58.307m) notional income for pension contributions paid by NHS England on behalf of the Trust.

2.3 Overseas visitors

	Group 2025-26 £000	2024-25 £000
Income recognised this year	**7,860**	5,607
Cash payments received in-year	**1,850**	1,126
Additions to provision for impairment of receivables	**6,642**	4,290
Amounts written off in-year	**4,167**	2,646

2.4 Additional information on contract revenue (IFRS 15) recognised in the period

	2025-26 £000	2024-25 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	**16,869**	16,724
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

2.5 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2026 £000	31 March 2025 £000
within one year	**47,090**	18,278
after one year, not later than five years	-	-
after five years	-	-
Total revenue allocated to remaining performance obligations	**47,090**	18,278

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

2.6 Income from activities arising from commissioner requested and non-commissioner requested services

Under the terms of its Provider License, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Group 2025-26 £000	2024-25 £000
Commissioner requested services	**1,883,917**	1,762,784
Non-commissioner requested services	**182,036**	173,625
Total	**2,065,953**	1,936,409

2.7 Fees and charges - aggregate of all schemes that, individually, have a cost exceeding £1m

	Group 2025-26 £000	2024-25 £000
Income	**11,744**	9,197
Full cost	**(11,594)**	(7,537)
Surplus	**150**	1,660

2.8 Operating lease income

	Group 2025-26 £000	2024-25 £000
Rental revenue from operating leases	**1,454**	1,556

	31 March 2026 £000	31 March 2025 £000
Future minimum lease receipts due on leases of buildings expiring		
- not later than one year	**1,454**	1,555
- between one and five years	**5,804**	6,220
- later than five years	**9,084**	10,598
Total	**16,342**	18,373

The above note discloses income generated in operating lease agreements where King's College Hospital NHS Foundation Trust is the lessor. The operating leases relate to the lease of space and buildings owned by the Trust.

3. Operating expenses

3.1 Operating expenses by type

	Group 2025-26 £000	2024-25 £000
Purchase of healthcare from NHS and DHSC bodies	**13,677**	34,460
Purchase of healthcare from non-NHS and non-DHSC bodies	**114,200**	77,456
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	**265,948**	237,304
Supplies and services - clinical (excluding drugs costs)	**128,410**	140,910
Supplies and services - general	**4,411**	4,428
Inventories written down (net including drugs)	**468**	539
Staff and executive directors costs	**1,170,165**	1,108,543
Remuneration of non-executive directors	**193**	182
Establishment	**9,901**	11,193
Transport (including patient travel)	**15,344**	16,515
Premises	**61,257**	58,862
Rentals under operating leases - minimum lease payments	**51**	97
PFI service costs	**85,139**	81,117
Clinical negligence	**51,142**	49,905
Depreciation on property, plant and equipment and right of use assets	**56,174**	58,028
Amortisation on intangible assets	**5,987**	5,571
Net impairments	**11,650**	4,424
Movement in credit loss allowance: contract receivables / contract assets	**3,774**	8,529
Consultancy costs	**3,058**	3,341
Education and Training Costs	**5,173**	4,025
Audit fees payable to the external auditor		
Statutory audit	**494**	493
Internal audit costs	**298**	267
Other *	**27,562**	26,951
Total operating expenses	**2,034,476**	1,933,139

* Other operating expenses staff training, as well as legal fees, storage costs, work permits and infection control costs.

The external audit fee for the current year is £494k, including £82k of irrecoverable VAT. No other remuneration was paid to the Trust's external auditors in 2025-26 (2024-25 : Nil). This figure includes £215k inclusive of VAT for subsidiary audits.

Research and development expenditure is included in other operating expenditure, clinical and general supplies and services, premises and establishment expenses as well as in staff costs.

3.2 Late Payment of Commercial Debts (Interest) Act 1998	2025-26 £000	2024-25 £000
Compensation paid to cover debt recovery costs under this legislation	**3**	4

3.3 Limitation on Auditor's Liability

The limitation on auditor's liability in 2025/26 was £3m (2024/25: £5m).

4 Employee benefits

4.1 Employee benefits

	Group	
	2025-26 Total	2024-25 Total
	£000	£000
Salaries and wages	**825,734**	795,996
Social security costs	**116,088**	93,932
Apprenticeship levy	**4,486**	4,291
Employer contributions to NHS Pensions	**94,688**	88,935
Employer contributions to NHS Pensions paid by NHS England on behalf of the Trust	**61,756**	58,307
Temporary staff (including bank and agency)	**66,671**	65,408
Redundancy costs	**742**	1,674
Total employee benefits	**1,170,165**	1,108,543
Of which		
Costs capitalised as part of assets	**-**	-
Total employee benefits excluding capitalised costs	**1,170,165**	1,108,543

4.2 Early retirements due to ill health

During 2025/26 there were 9 early retirements from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £1,147k (£409k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

4.3 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

5 Finance expenses

	Group 2025-26 £000	2024-25 £000
Loans from the Department of Health and Social Care		
Capital loans	**799**	896
Finance leases	**1,063**	1,068
Other Loans	**24**	37
Finance costs on PFI and other service concession arrangements		
Main finance cost	**26,570**	26,990
Remeasurement of PFI liability resulting from change in index or rate	**9,596**	7,334
Interest on late payment	**3**	4
Total interest expense	**38,055**	36,329
Unwinding of discount on provisions	**107**	48
Other finance costs	**-**	-
Total finance costs	**38,162**	36,377

Finance expenditure represents interest and other charges involved in the borrowing of money.

6 Impairments

	Group 2025-26 £000	2024-25 £000
Changes in market price - charged to operating expenses	**11,398**	(1,027)
Changes in market price - charged to the revaluation reserve	**2,330**	2,337
Other impairments - charged to operating expenses	**252**	5,451
Total	**13,980**	6,761

Asset valuations were undertaken in 2026 as at the prospective valuation date of 31 March 2026. This was based on an alternative site assessed via an analysis of postcode information allocated between outpatients and inpatients.

The revaluation resulted in an overall decrease of £15.471m in the value of land and buildings owned by the Trust offset by revaluation increases to land and building values of £9.0m.

As a result of the land and buildings revaluation, a net impairment of £11.398m has been taken to the Statement of Comprehensive Income and an impairment of £2.330m has been charged to the revaluation reserve. A revaluation gain of £7.525m has been transferred to the revaluation reserve.

Other impairments relates to early termination of specific projects.

7 Other gains / (losses)

	Group 2025-26 £000	2024-25 £000
Gains on disposal of property, plant and equipment	**1,009**	1,258
Losses on disposal of assets	**(227)**	(212)
Fair value losses on investments	**(81)**	(197)
Total (losses) / gains on disposal of assets	**701**	849

7.1 Share of operating profit in associates and joint ventures

	Group 2025-26 £000	2024-25 £000
MedTech Innovations	**81**	25
	81	25

8 Intangible non-current assets

8.1 Intangible non-current assets - current year

Group	Software licences £000	Total £000
Cost*		
At 1 April 2025	**63,927**	**63,927**
Additions purchased	**1,312**	**1,312**
Additions donated	**-**	**-**
Reclassifications	**(223)**	**(223)**
Disposals	**(5,713)**	**(5,713)**
At 31 March 2026	**59,303**	**59,303**
Amortisation		
At 1 April 2025	**14,349**	**14,349**
Charged during the year	**5,987**	**5,987**
Reclassifications	**-**	
Disposals	**(5,713)**	**(5,713)**
At 31 March 2026	**14,623**	**14,623**
Net book value		
Purchased	**44,680**	**44,680**
Total at 31 March 2026	**44,680**	**44,680**

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

8.2 Intangible non-current assets - current year

Trust	Software licences £000	Total £000
Cost*		
At 1 April 2025	**62,089**	**62,089**
Additions purchased	**1,404**	**1,404**
Disposals	**(5,525)**	**(5,525)**
At 31 March 2026	**57,968**	**57,968**
Amortisation		
At 1 April 2025	**12,796**	**12,796**
Charged during the year	**5,800**	**5,800**
Disposals	**(5,526)**	**(5,526)**
At 31 March 2026	**13,070**	**13,070**
Net book value		
Purchased	**44,898**	**44,898**
Total at 31 March 2026	**44,898**	**44,898**

The range of useful economic lives over which intangible assets are amortised is included in note 1.13.

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

8 Intangible non-current assets

8.3 Intangible non-current assets - prior year

Group	Software licences £000	Total £000
Cost or valuation		
At 1 April 2024	**59,552**	**59,552**
Additions purchased	**8,399**	**8,399**
Disposals	**(4,024)**	**(4,024)**
At 31 March 2025	**63,927**	**63,927**
Amortisation		
At 1 April 2024	**12,802**	**12,802**
Charged during the year	**5,571**	**5,571**
Disposals	**(4,024)**	**(4,024)**
At 31 March 2025	**14,349**	**14,349**
Net book value		
Purchased	**49,578**	**49,578**
Total at 31 March 2025	**49,578**	**49,578**

8.4 Intangible non-current assets - prior year

Trust	Software licences £000	Total £000
Cost or valuation		
At 1 April 2024	**57,719**	**57,719**
Additions purchased	**8,286**	**8,286**
Disposals	**(3,916)**	**(3,916)**
At 31 March 2025	**62,089**	**62,089**
Amortisation		
At 1 April 2024	**11,706**	**11,706**
Charged during the year	**5,006**	**5,006**
Disposals	**(3,916)**	**(3,916)**
At 31 March 2025	**12,796**	**12,796**
Net book value		
Purchased	**49,293**	**49,293**
Total at 31 March 2025	**49,293**	**49,293**

The range of useful economic lives over which intangible assets are amortised is included

9 Property, plant and equipment

9.1 Property, plant and equipment - current year

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	Group							
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation								
At 1 April 2025	**38,434**	**519,973**	**1,455**	**26,677**	**141,357**	**48,733**	**916**	**777,546**
Additions purchased	-	897	-	27,365	11,151	4,869	3	**44,285**
Additions - IFRIC 12 scheme assets (excluding lifecycle)	-	584	-	370	1,065	-	-	**2,019**
Additions donations of physical assets	-	-	-	-	-	-	-	**-**
Additions - assets purchased from cash donations/grants	-	65	-	2,662	94	6	-	**2,827**
Impairments charged to operating expenses	-	(14,675)	-	(252)	-	-	-	**(14,927)**
Impairments charged to the revaluation reserve	-	(4,795)	(37)	-	-	-	-	**(4,832)**
Reversal of impairments credited to operating expenses	-	(2,246)	-	-	-	-	-	**(2,246)**
Revaluations	24	(7,491)	41	-	-	-	-	**(7,426)**
Reclassifications	-	40,696	-	(40,696)	223	-	-	**223**
Disposals	-	-	-	-	(14,746)	(12,291)	(378)	**(27,415)**
At 31 March 2026	**38,458**	**533,008**	**1,459**	**16,126**	**139,144**	**41,317**	**541**	**770,054**
Depreciation								
At 1 April 2025	**-**	**1,199**	**-**	**-**	**75,083**	**28,263**	**641**	**105,186**
Charged during the year	**-**	**23,259**	**88**	**-**	**13,431**	**7,983**	**122**	**44,883**
Impairments charged to operating expenses	**-**	**(1,786)**	**-**	**-**	**-**	**-**	**-**	**(1,786)**
Impairments charged to the revaluation reserve	**-**	**(2,470)**	**(32)**	**-**	**-**	**-**	**-**	**(2,502)**
Reversal of impairments credited to operating expenses	**-**	**(3,737)**	**-**	**-**	**-**	**-**	**-**	**(3,737)**
Revaluations	**-**	**(14,895)**	**(56)**	**-**	**-**	**-**	**-**	**(14,951)**
Disposals	**-**	**-**	**-**	**-**	**(14,193)**	**(12,291)**	**(378)**	**(26,862)**
At 31 March 2026	**-**	**1,570**	**-**	**-**	**74,321**	**23,955**	**385**	**100,231**
Net book value								
Owned - purchased	**19,369**	**303,093**	**1,274**	**16,108**	**57,031**	**17,168**	**116**	**414,160**
Owned - donated	**856**	**20,937**	**185**	**18**	**572**	**193**	**41**	**22,802**
On balance sheet PFI	**18,233**	**207,408**	**-**	**-**	**7,220**	**-**	**-**	**232,861**
Total at 31 March 2026	**38,458**	**531,438**	**1,459**	**16,126**	**64,823**	**17,361**	**157**	**669,823**
Revaluation reserve balance								
At 1 April 2025	**10,671**	**168,294**	**1,471**	**-**	**-**	**-**	**-**	**180,436**
Revaluation and indexation in year	**24**	**5,079**	**92**	**-**	**-**	**-**	**-**	**5,195**
At 31 March 2026	**10,695**	**173,373**	**1,563**	**-**	**-**	**-**	**-**	**185,631**

The effective date of land and building revaluation was 31 March 2026 and the valuation was carried out by Kerry Maguire of Avison Young, a RICS registered valuer.
The range of useful economic lives over which property plant and equipment are depreciated are included in note 1.13.
For all categories of non-property assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.
The total gross book value of assets held with a net nil carrying value is £3.9m.

9 Property, plant and equipment - continued

9.2 Property, plant and equipment - current year

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	Trust							
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation								
At 1 April 2025	**38,434**	**512,544**	**1,455**	**6,629**	**30,751**	**48,733**	**916**	**639,463**
Additions purchased	-	897	-	17,081	57	4,869	3	**22,907**
Additions - IFRIC 12 scheme assets (excluding lifecycle)	-	584	-	370	1,065	-	-	**2,019**
Additions - assets purchased from cash donations/grants	-	65	-	955	94	6	-	**1,120**
Impairments charged to operating expenses	-	(10,339)	-	(252)	-	-	-	**(10,591)**
Impairments charged to the revaluation reserve	-	(4,534)	(32)	-	-	-	-	**(4,566)**
Reversal of impairments credited to operating expenses	-	(2,246)	-	-	-	-	-	**(2,246)**
Revaluations	24	(7,492)	41	-	-	-	-	**(7,427)**
Reclassifications	-	10,040	-	(10,040)	-	-	-	**-**
Disposals	-	-	-	-	(12,742)	(12,291)	(378)	**(25,411)**
At 31 March 2026	**38,458**	**499,519**	**1,464**	**14,743**	**19,225**	**41,317**	**541**	**615,268**
Depreciation								
At 1 April 2025	**-**	**1,191**	**-**	**-**	**18,177**	**28,263**	**641**	**48,273**
Charged during the year	-	23,038	88	-	2,993	7,983	122	**34,224**
Impairments charged to operating expenses	-	(1,786)	-	-	-	-	-	**(1,786)**
Impairments charged to the revaluation reserve	-	(2,314)	(28)	-	-	-	-	**(2,342)**
Reversal of impairments credited to operating expenses	-	(3,737)	-	-	-	-	-	**(3,737)**
Revaluations	-	(14,833)	(56)	-	-	-	-	**(14,889)**
Disposals	-	-	-	-	(12,727)	(12,291)	(378)	**(25,396)**
At 31 March 2026	**-**	**1,559**	**4**	**-**	**8,443**	**23,955**	**385**	**34,347**
Net book value								
Owned - purchased	**19,369**	**271,669**	**1,275**	**14,725**	**2,990**	**17,168**	**116**	**327,312**
Owned - donated	**856**	**18,883**	**185**	**18**	**572**	**193**	**41**	**20,748**
On balance sheet PFI	**18,233**	**207,408**	**-**	**-**	**7,220**	**-**	**-**	**232,861**
Total at 31 March 2026	**38,458**	**497,960**	**1,460**	**14,743**	**10,782**	**17,361**	**157**	**580,921**
Revaluation reserve balance								
At 1 April 2025	**10,671**	**168,294**	**1,471**	**-**	**-**	**-**	**-**	**180,436**
Revaluation and indexation in year	**24**	**5,078**	**93**	**-**	**-**	**-**	**-**	**5,195**
At 31 March 2026	**10,695**	**173,372**	**1,564**	**-**	**-**	**-**	**-**	**185,631**

The effective date of land and building revaluation was 31 March 2026 and the valuation was carried out by Kerry Maguire of Avison Young, a RICS registered valuer.
The range of useful economic lives over which property plant and equipment are depreciated are included in note 1.13.

For all categories of non-property assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.
The total gross book value of assets held with a net nil carrying value is £3.9m.

9 Property, plant and equipment

9.3 Property, plant and equipment - prior year

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	Group							
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation								
At 1 April 2024	**38,434**	**505,610**	**1,465**	**27,236**	**136,825**	**61,253**	**1,757**	**772,581**
Additions purchased	-	1,806	-	22,260	9,052	5,976	-	**39,094**
Additions - donations of physical assets (non-cash)	-	-	-	-	55	-	-	**55**
Additions - IFRIC 12 scheme assets	-	-	-	-	1,716	-	-	**1,716**
Additions - assets purchased from cash donations/grants	-	-	-	382	93	212	-	**687**
Impairments charged to operating expenses	-	(4,727)	-	(5,450)		-	-	**(10,177)**
Impairments charged to the revaluation reserve	-	(6,585)	-	-	-	-	-	**(6,585)**
Reversal of impairments credited to operating expenses	-	709	-	-	-	-	-	**709**
Revaluations	-	5,409	(10)	-	-	-	-	**5,399**
Reclassifications	-	17,751	-	(17,751)	-	-	-	**-**
Disposals	-	-	-	-	(6,384)	(18,708)	(841)	**(25,933)**
At 31 March 2025	**38,434**	**519,973**	**1,455**	**26,677**	**141,357**	**48,733**	**916**	**777,546**
Depreciation								
At 1 April 2024	**-**	**816**	**-**	**-**	**66,277**	**38,416**	**1,344**	**106,853**
Charged during the year	-	21,745	85	-	14,585	8,555	138	**45,108**
Impairments charged to operating expenses	-	(747)	-	-	-	-	-	**(747)**
Impairments charged to the revaluation reserve	-	(4,248)	-	-	-	-	-	**(4,248)**
Reversal of impairments credited to operating expenses	-	(4,297)	-	-	-	-	-	**(4,297)**
Revaluations	-	(12,070)	(85)	-	-	-	-	**(12,155)**
Disposals	-	-	-	-	(5,779)	(18,708)	(841)	**(25,328)**
At 31 March 2025	**-**	**1,199**	**-**	**-**	**75,083**	**28,263**	**641**	**105,186**
Net book value								
Owned - purchased	**19,354**	**286,197**	**1,265**	**24,690**	**57,582**	**20,185**	**216**	**409,490**
Owned - donated	**847**	**18,793**	**190**	**606**	**942**	**284**	**60**	**21,722**
On balance sheet PFI	**18,233**	**213,784**	**-**	**1,381**	**7,750**	**-**	**-**	**241,148**
Total at 31 March 2025	**38,434**	**518,774**	**1,455**	**26,677**	**66,274**	**20,469**	**276**	**672,360**
Revaluation reserve balance								
At 1 April 2024	**10,671**	**153,152**	**1,396**	**-**	**-**	**-**	**-**	**165,219**
Revaluation and indexation in year	**-**	**15,142**	**75**	**-**	**-**	**-**	**-**	**15,217**
At 31 March 2025	**10,671**	**168,294**	**1,471**	**-**	**-**	**-**	**-**	**180,436**

The effective date of land and building revaluation was 31 March 2025 and the valuation was carried out by Kerry Maguire of Avison Young, a RICS registered valuer.
The range of useful economic lives over which property plant and equipment are depreciated are included in note 1.13.

For all categories of non-property assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

9 Property, plant and equipment - continued

9.4 Property, plant and equipment - prior year

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	Trust							
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation								
At 1 April 2024	**38,434**	**498,165**	**1,465**	**22,073**	**33,629**	**61,253**	**1,757**	**656,777**
Additions purchased	-	1,758	-	7,691	126	5,976	-	**15,551**
Additions - IFRIC 12 scheme assets (excluding lifecycle)	-	-	-	-	1,716	-	-	**1,716**
Additions - assets purchased from cash donations/grants	-	-	-	66	93	212	-	**371**
Impairments charged to operating expenses	-	(4,727)	-	(5,450)	-	-	-	**(10,177)**
Impairments charged to the revaluation reserve	-	(6,585)	-	-	-	-	-	**(6,585)**
Reversal of impairments credited to operating expenses	-	709	-	-	-	-	-	**709**
Revaluations	-	5,473	(10)	-	-	-	-	**5,463**
Reclassifications	-	17,751	-	(17,751)	-	-	-	**-**
Disposals	-	-	-	-	(4,813)	(18,708)	(841)	**(24,362)**
At 31 March 2025	**38,434**	**512,544**	**1,455**	**6,629**	**30,751**	**48,733**	**916**	**639,463**
Depreciation								
At 1 April 2024	-	814	-	-	19,143	38,416	1,344	**59,718**
Charged during the year	-	21,521	85	-	3,501	8,555	138	**33,800**
Impairments charged to operating expenses	-	(747)	-	-	-	-	-	**(747)**
Impairments charged to the revaluation reserve	-	(4,248)	-	-	-	-	-	**(4,248)**
Reversal of impairments credited to operating expenses	-	(4,297)	-	-	-	-	-	**(4,297)**
Revaluations	-	(11,852)	(85)	-	-	-	-	**(11,937)**
Disposals	-	-	-	-	(4,467)	(18,708)	(841)	**(24,016)**
At 31 March 2025	**-**	**1,191**	**-**	**-**	**18,177**	**28,263**	**641**	**48,273**
Net book value								
Owned - purchased	19,354	278,776	1,264	4,954	3,937	20,185	217	**328,687**
Owned - donated	847	18,793	191	290	887	284	59	**21,351**
On balance sheet PFI	18,233	213,784	-	1,381	7,750	-	-	**241,148**
Total at 31 March 2025	**38,434**	**511,353**	**1,455**	**6,625**	**12,574**	**20,469**	**276**	**591,186**
Revaluation reserve balance								
At 1 April 2024	10,671	153,152	1,396	-	-	-	-	**165,219**
Revaluation and indexation in year	-	15,142	75	-	-	-	-	**15,217**
At 31 March 2025	**10,671**	**168,294**	**1,471**	**-**	**-**	**-**	**-**	**180,436**

The effective date of land and building revaluation was 31 March 2025 and the valuation was carried out by Kerry Maguire of Avison Young, a RICS registered valuer.
The range of useful economic lives over which property plant and equipment are depreciated are included in note 1.13.

For all categories of non-property assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

10 Leases and Right of Use Assets

10.1.1 Right of use assets - current year

Group	Property (land and buildings)	Plant & machinery	Total	Of which: leased from DHSC group bodies
Cost or Valuation	**£000**	**£000**	**£000**	**£000**
Valuation / gross cost at 1 April 2025 - brought forward	126,366	8,126	134,492	55,893
Additions	9,315	-	9,315	-
Disposals / derecognition	-	-	-	-
Remeasurements of the lease liability	8,579	-	8,579	6,467
Valuation/gross cost at 31 March 2026	**144,260**	**8,126**	**152,386**	**62,360**
Depreciation				
Accumulated depreciation at 1 April 2025 - brought forward	31,004	6,287	37,291	18,149
Provided during the year	10,544	747	11,291	5,709
Disposals / derecognition	-	-	-	-
Accumulated depreciation at 31 March 2026	**41,548**	**7,034**	**48,582**	**23,858**
Net book value at 31 March 2026	**102,712**	**1,092**	**103,804**	**38,502**
Net book value of right of use assets leased from other NHS providers				**3,879**
Net book value of right of use assets leased from other DHSC group bodies				**34,623**

10.1.2 Right of use assets - prior year

Group	Property (land and buildings)	Plant & machinery	Total	Of which: leased from DHSC group bodies
Cost or Valuation	**£000**	**£000**	**£000**	**£000**
Valuation / gross cost at 1 April 2024 - brought forward	124,035	7,911	131,946	54,454
Additions	696	50	746	98
Disposals/derecognition	(749)	(66)	(815)	(749)
Remeasurement of the lease liability	2,384	231	2,615	2,090
Valuation/gross cost at 31 March 2025	**126,366**	**8,126**	**134,492**	**55,893**
Depreciation				
Accumulated depreciation at 1 April 2024- brought forward	20,168	4,613	24,781	12,343
Provided during the year	11,200	1,720	12,920	6,170
Disposals/derecognition	(364)	(46)	(410)	(364)
Accumulated depreciation at 31 March 2025	**31,004**	**6,287**	**37,291**	**18,149**
Net book value at 31 March 2025	**95,362**	**1,839**	**97,201**	**37,744**
Net book value of right of use assets leased from other NHS providers				**4,574**
Net book value of right of use assets leased from other DHSC group bodies				**33,170**

10 Leases and Right of Use Assets - Continued

10.2.1 Right of use assets - current year

Trust	Property (land and buildings)	Assets under construction	Plant & machinery	Intangibles	Total	Of which: leased from DHSC group bodies
Cost or Valuation	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Valuation / gross cost at 1 April 2025 - brought forward	133,777	-	92,432	-	**226,209**	55,893
Additions	9,044	-	11,094	-	**20,138**	-
Remeasurements of the lease liability	8,590	-	-	-	**8,590**	6,467
Reclassifications	-	-	223	-	**223**	-
Disposals / derecognition	-	-	(2,004)	-	**(2,004)**	-
Valuation/gross cost at 31 March 2026	**151,411**	**-**	**101,745**	**-**	**253,156**	**62,360**
Depreciation						
Accumulated depreciation at 1 April 2025 - brought forward	31,006	-	40,966	-	**71,972**	18,149
Provided during the year	10,766	-	10,227	-	**20,993**	5,709
Revaluations	(219)	-	-	-	**(219)**	-
Disposals / derecognition	-	-	(1,466)	-	**(1,466)**	-
Accumulated depreciation at 31 March 2026	**41,553**	**-**	**49,727**	**-**	**91,280**	**23,858**
Net book value at 31 March 2026	**109,858**	**-**	**52,018**	**-**	**161,876**	**38,502**
Net book value of right of use assets leased from other NHS providers						**3,879**
Net book value of right of use assets leased from other DHSC group bodies						**34,623**

10.2.2 Right of use assets - prior year

Trust	Property (land and buildings)	Assets under construction	Plant & machinery	Intangibles	Total	Of which: leased from DHSC group bodies
Cost or Valuation	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Valuation / gross cost at 1 April 2024 - brought forward	131,477	5,165	87,838	109	**224,589**	54,454
Additions	730	-	8,928	-	**9,658**	98
Remeasurements of the lease liability	2,319	-	-	-	**2,319**	2,090
Reclassifications	-	(5,165)	(2,751)	-	**(7,916)**	-
Disposals / derecognition	(749)	-	(1,583)	(109)	**(2,441)**	(749)
Valuation/gross cost at 31 March 2025	**133,777**	**-**	**92,432**	**-**	**226,209**	**55,893**
Depreciation						
Accumulated depreciation at 1 April 2024 - brought forward	20,165	-	31,373	99	**51,637**	12,343
Provided during the year	11,423	-	10,916	11	**22,350**	6,170
Revaluations	(218)	-	-	-	**(218)**	-
Disposals / derecognition	(364)	-	(1,323)	(109)	**(1,796)**	(364)
Accumulated depreciation at 31 March 2025	**31,006**	**-**	**40,966**	**1**	**71,973**	**18,149**
Net book value at 31 March 2025	**102,771**	**-**	**51,466**	**(1)**	**154,236**	**37,744**
Net book value of right of use assets leased from other NHS providers						4,574
Net book value of right of use assets leased from other DHSC group bodies						33,170

10 Leases and Right of Use Assets - Continued

10.3 Reconciliation of the carrying value of lease liabilities

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1st April 2025	**98,152**	**107,341**	**152,637**	**171,293**
Lease additions	**9,315**	746	**20,578**	**9,655**
Lease liability remeasurements	**8,579**	2,615	**8,580**	**2,388**
Interest charge arising in year	**1,063**	1,068	**1,640**	**1,683**
Early terminations/disposals	**(1,009)**	(405)	**(538)**	**(645)**
Reclassification	**-**	-	**-**	**(7,915)**
Lease payments (cash outflows)	**(12,244)**	(13,213)	**(22,161)**	**(23,822)**
Carrying value at 31 March 2026	**103,856**	98,152	**160,736**	**152,637**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

10.4.1 Maturity analysis of future lease payments at 31 March 2026

The Foundation Trust is not exposed to significant liquidity risks in relation to lease liabilities as the Foundation Trust is able to access funding through the Department of Health and Social Care in order to manage continuing operations.
The trust leases various buildings and medical equipment used in the provision of healthcare.
Buildings leases include renewal clauses and rental cost review dates and medical equipment leases include extension clauses or purchase options. Due to the uncertainty of these, potential future cash flows related to these are not included in the measurement of the lease liabilities.

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2026	31 March 2026	31 March 2026	31 March 2026
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	11,696	6,071	22,027	6,071
- later than one year and not later than five years;	40,605	19,472	71,066	19,472
- later than five years.	62,707	14,666	82,124	14,666
Total gross future lease payments	**115,008**	**40,209**	**175,217**	**40,209**
Finance charges allocated to future periods	(11,152)	(1,607)	(14,481)	(1,607)
Net lease liabilities at 31 March 2026	**103,856**	**38,602**	**160,736**	**38,602**
Of which:				
- Current	10,327	5,708	20,077	5,708
- Non-Current	93,529	32,894	140,659	32,894

At 31 March 2026, the Trust has not committed to any leases which had not commenced at that date.
There are no restrictions or covenants imposed by the Trust's lease arrangements.

10.4.2 Maturity analysis of future lease payments at 31 March 2025

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2025	31 March 2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	11,412	5,461	21,666	5,461
- later than one year and not later than five years;	38,261	18,658	70,625	18,658
- later than five years.	54,783	15,505	69,720	15,505
Total gross future lease payments	**104,456**	**39,624**	**162,011**	**39,624**
Finance charges allocated to future periods	(6,304)	(1,752)	(9,374)	(1,752)
Net lease liabilities at 31 March 2025	**98,152**	**37,872**	**152,637**	**37,872**
Of which:				
- Current	10,441	5,091	20,129	5,091
- Non-Current	87,711	32,781	132,508	32,781

At 31 March 2025, the Trust has not committed to any leases which had not commenced at that date.
There are no restrictions or covenants imposed by the Trust's lease arrangements.

11 Investments

11.1 Subsidiary undertakings, associates and joint ventures held

The Foundation Trust's principal subsidiary undertakings, associates and joint ventures as included in its consolidated accounts are set out below.
The accounting date of the financial statements for the subsidiaries is 31 March 2026, and for the associate (Synnovis), 31 December 2025.
The Trust holds a £250k investment in KCH Commercial Services Ltd.

	Country of Incorporation and Registered Office	Beneficial interest	Principal activity
Directly owned subsidiary undertakings			
KCH Commercial Services Ltd	UK	100%	Holding company
KCH Interventional Facilities Management LLP *	UK	100%	Interventional Facilities Management
Indirectly owned subsidiary undertakings			
KCH Management Ltd	UK	100%	Healthcare services
Associates			
Synnovis Group LLP (Synnovis)**	UK	24.5%	Healthcare services
MedTech Innovations Ltd ***	UK	30%	Healthcare technology
Joint operations			
NIHR/Wellcome Trust Clinical Research Facility (CRF) *****	UK		
Equity		35%	Research
Constructions		54%	Research
Other investments			
King's Fertility Limited	UK	10%	Healthcare services
Meridian Health Ventures I Limited Partnership ****	UK	6%	Healthcare technology

* KCH Interventional Facilities Management LLP (KIFM) is a limited liability partnership between King's College Hospital NHS Foundation Trust (90%) and KCH Commercial Services Ltd (10%). KIFM started trading on 1 July 2016 and was set up to provide an efficient transformation and procurement service to the Trust. The income, expenses, assets, liabilities, equity and reserves of KIFM have been consolidated in full into the appropriate financial statement lines.
** Synnovis Group LLP was formerly known as Viapath Group LLP
*** MedTech Innovations Ltd is a joint venture with GSTT NHS FT and King's College London. The Trust has a 30% ownership share in this company.
**** The Trust has invested as a limited partner in Meridian Health Ventures Limited Partnership (formerly known as KHP Ventures I Limited Partnership). This investment is held through its commercial subsidiary KCS. The current investment represents an 6% share of the partnership however this percentage will decrease as additional partners invest in line with fund plans.
***** The Foundation Trust entered into a joint operation with King's College London and South London and Maudsley NHS Foundation Trust for the construction and use of premises known as the NIHR/Wellcome Trust Clinical Research Facility, which opened in November 2012.
The Foundation Trust has capitalised 54% of the cost of the building, and equipment assets therein based on the construction proportion. The Foundation Trust recognises 35% of revenue and expenditure generated by the facility, based on the equity proportion as stipulated in the Collaboration Agreement.

11.2 Carrying value of associates

	2025-26	2024-25
Group		
	£000	£000
Balance at 1 April	**6,344**	6,319
Share of profit	**81**	25
Balance at 31 March	**6,425**	6,344

The balance includes investment of £1,163k in MedTech Innovations Ltd. The remainder of the balance relates to Synnovis, which provides critical pathology services to the Trust.
The share of profit relates to the investment in KHP MedTech Innovations Ltd.
Investments in Synnovis and MedTech Innovations are held by the Trust's subsidiary KCH Commercial Services Ltd.

11.3 Value of associates

	2025-26	2024-25
	£000	£000
Total gross assets of the entity as at 31 March	**215,859**	252,000
Total revenues for the year ending 31 March	**232,767**	215,300
Profit for the year ending 31 March	**(3,241)**	(30,100)

The above figures are estimates based on the Synnovis draft annual accounts for the year ended 31 December 2025 and Medtech accounts for year ended 31 March 2026
Figures from the Synnovis year end are used as there is not expected to be a material difference in position between the two year end dates.

11.4 Carrying value of other investments

	Group		**Trust**	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£000	£000	**£000**	£000
King's Fertility Limited	**335**	335	**335**	335
Meridian Health Ventures** I Limited Partnership	**1,152**	972	**-**	-
Other financial assets*	**3,676**	3,676	**3,676**	3,676
	5,163	4,983	**4,011**	4,011

*Other financial assets relates to a PIK note held by the Trust
**Previously called KHP Ventures
The Group invested £261k into Meridian Health Ventures Limited Partnership in year. This investment is held by KCH Commercial Services Ltd

12 Inventories

12.1 Inventories - current year

	Group		
	Drugs	**Consumables**	**Total**
	£000	**£000**	**£000**
At 1 April 2025	**8,558**	**14,485**	**23,043**
Additions	**265,429**	**122,613**	**388,042**
Inventories consumed and expensed	**(265,948)**	**(121,022)**	**(386,970)**
Write down of inventories	**(468)**	**-**	**(468)**
At 31 March 2026	**7,571**	**16,076**	**23,647**

Inventories - current year	Trust		
	Drugs	**Consumables**	**Total**
	£000	**£000**	**£000**
At 1 April 2025	**7,014**	**157**	**7,171**
Additions	**236,370**	**13,089**	**249,459**
Inventories consumed and expensed	**(236,920)**	**(13,081)**	**(250,001)**
Write down of inventories	**(468)**	**-**	**(468)**
At 31 March 2026	**5,996**	**165**	**6,161**

12.2 Inventories - prior year

	Group		
	Drugs	**Consumables**	**Total**
	£000	**£000**	**£000**
At 1 April 2024	10,329	14,823	25,152
Additions	236,072	130,002	366,074
Inventories consumed and expensed	(237,304)	(130,340)	(367,644)
Write down of inventories	(539)	-	(539)
At 31 March 2025	8,558	14,485	23,043

Inventories - prior year	Trust		
	Drugs	**Consumables**	**Total**
	£000	**£000**	**£000**
At 1 April 2024	7,156	168	7,324
Additions	214,018	13,036	227,054
Inventories consumed and expensed	(213,625)	(13,047)	(226,672)
Write down of inventories	(535)		(535)
At 31 March 2025	7,014	157	7,171

13 Trade and other receivables

13.1 Trade and other receivables

	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£000	£000	**£000**	£000
Current				
Contract receivables	**63,081**	56,163	**61,048**	53,353
Allowance for impaired contract receivables / assets	**(16,005)**	(16,898)	**(16,005)**	(16,898)
Deposits and advances	**168**	168	**168**	168
Prepayments (non-PFI)	**6,938**	6,946	**3,953**	4,644
PDC dividend receivable	**1,263**	1,465	**1,263**	1,494
VAT receivable	**14,306**	13,574	**14,462**	13,524
Other receivables due from subsidiaries	**-**	-	**769**	1,184
Clinician pension tax provision reimbursement funding from NHSE	**139**	124	**139**	124
Other receivables	**340**	311	**336**	306
Total current receivables	**70,230**	61,853	**66,133**	57,899
Non-current				
Contract receivables	**1,601**	11,004	**1,601**	2,220
Other receivables due from subsidiaries	**-**	-	**22,353**	33,353
Clinician pension tax provision reimbursement funding from NHSE	**2,028**	2,272	**2,028**	2,271
Other Receivables	**7,177**	3,397	**7,177**	3,397
Total non-current receivables	**10,806**	16,673	**33,159**	41,241
Total	**81,036**	78,526	**99,292**	99,140
Of which are receivable from NHS and DHSC group bodies:				
Current	**24,986**	22,620	**24,986**	22,620
Non-current	**2,028**	2,272	**2,028**	2,272

The majority of trade is with NHS England and other NHS bodies. As these bodies are funded by the UK Government to buy NHS patient care services, no credit scoring of them is considered necessary.
The largest outstanding debtor at 31 March 2026 was Guy's & St Thomas' Foundation Trust totalling £9.248m (2025: Guy's & St Thomas' Foundation Trust £7.858m).

13.2 Allowances for credit losses - 2025/2026

	Group		Trust	
	Contract receivables	**All other receivables**	**Contract receivables**	**All other receivables**
	£000	**£000**	**£000**	**£000**
Allowances as at 1 Apr 2025 - brought forward	**16,898**	**-**	**16,898**	**-**
New allowances arising	7,982	-	7,982	-
Reversals of allowances	(4,208)	-	(4,208)	-
Utilisation of allowances (write offs)	(4,667)	-	(4,667)	-
Allowances as at 31 Mar 2026	**16,005**	**-**	**16,005**	**-**

Allowances for credit losses - 2024/2025	Group		Trust	
	Contract receivables	**All other receivables**	**Contract receivables**	**All other receivables**
	£000	**£000**	**£000**	**£000**
Allowances as at 1 Apr 2024	**11,511**	**-**	**11,511**	-
New allowances arising	9,255	-	9,255	-
Reversals of allowances	(726)	-	(726)	-
Utilisation of allowances (write offs)	(3,142)	-	(3,142)	-
Allowances as at 31 Mar 2025	**16,898**	**-**	**16,898**	**-**

14 Cash and cash equivalents

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	**31 March 2026 £000**	31 March 2025 £000
Opening balance	**84,864**	72,561	**73,758**	62,797
Net change in year	**56,225**	12,303	**58,900**	10,961
Closing balance	**141,089**	84,864	**132,658**	73,758
Made up of				
Cash with Government Banking Service	**135,902**	79,412	**128,436**	70,329
Commercial banks and cash in hand	**5,187**	5,452	**4,222**	3,429
Cash and cash equivalents as in statement of financial position	**141,089**	84,864	**132,658**	73,758
Patients' money held by the Foundation Trust	**-**	-	**-**	-

15 Trade and other payables

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	**31 March 2026 £000**	31 March 2025 £000
Current				
Trade payables	**68,086**	60,504	**52,155**	41,495
Capital payables	**8,394**	9,326	**4,063**	8,655
Accruals	**104,735**	100,086	**95,215**	87,572
Receipts in advance	**1,584**	1,002	**1,584**	1,002
Social security costs	**13,473**	12,414	**13,455**	12,395
Other taxes payable	**12,804**	10,798	**12,788**	10,783
Other payables	**20,018**	17,604	**16,311**	14,878
Total	**229,094**	211,734	**195,571**	176,780
Of which are payable to NHS and DHSC group bodies:				
Current	**12,043**	28,876	**12,043**	28,876

All trade and other payables are current; there are no non-current balances.

16 Other liabilities

	Group and Trust	
	31 March 2026 £000	31 March 2025 £000
Current		
Deferred income	**46,709**	18,278
Other liabilities (pending clawback)	**6,489**	6,289
Total	**53,198**	24,567

All deferred income is current; there are no non-current balances.
£293k of the deferred income is held by subsidiaries, (£97k in 2024-25)
£32m is held by the Group as approved recovery support funding for future years

17 Borrowings

	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
Current	**£000**	£000	**£000**	£000
Loans from DHSC				
Capital loans	**3,630**	3,658	**3,630**	3,658
Other loans	**641**	641	**641**	641
Lease liabilities	**10,327**	10,441	**20,077**	20,129
Obligations under PFI contracts	**12,899**	11,712	**12,899**	11,712
Total current borrowings	**27,497**	26,452	**37,247**	36,140
Non-current				
Loans from DHSC				
Capital loans	**26,580**	29,998	**26,581**	29,998
Other loans	**-**	641	**-**	641
Lease liabilities	**93,529**	87,711	**140,659**	132,509
Obligations under PFI contracts	**237,095**	238,885	**237,094**	238,885
Total non-current borrowings	**357,204**	357,235	**404,334**	402,033
Total	**384,701**	383,687	**441,581**	438,173

17.1 Reconciliation of liabilities arising from financing activities

Group	**Loans from DHSC**	**Other loans**	**PFI and LIFT schemes**	**Lease Liabilities**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
Carrying value at 1 April 2025	**33,656**	**1,282**	**250,597**	**98,152**	**383,687**
Cash movements:					
Financing cash flows - payments and receipts of principal	(3,418)	(640)	(15,045)	(11,181)	**(30,284)**
Financing cash flows - payments of interest	(827)	(24)	(26,570)	(1,063)	**(28,484)**
Non-cash movements:					
Additions	-	-	4,846	9,315	**14,161**
Lease liability remeasurements	-	-	-	8,579	**8,579**
Remeasurement of PFI liability resulting from change in index or rate	-	-	9,596	-	**9,596**
Early termination	-	-	-	(1,009)	**(1,009)**
Interest charge arising in year	799	24	26,570	1,063	**28,456**
Carrying value at 31 March 2026	**30,210**	**641**	**249,994**	**103,856**	**384,701**

Group	**Loans from DHSC**	**Other loans**	**PFI and LIFT schemes**	**Lease Liabilities**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
Carrying value at 1 April 2024	**37,104**	**1,922**	**254,059**	107,341	**400,426**
Cash movements:					
Financing cash flows - payments and receipts of principal	(3,418)	(640)	(13,126)	(12,145)	**(29,329)**
Financing cash flows - payments of interest	(926)	(37)	(26,911)	(1,068)	**(28,942)**
Non-cash movements:					
Additions	-	-	2,251	746	**2,997**
Lease liability remeasurement	-	-	-	2,615	**2,615**
PFI liability remeasurement	-	-	7,334	-	**7,334**
Early termination	-	-	-	(405)	**(405)**
Interest charge arising in year	896	37	26,990	1,068	**28,991**
Carrying value at 31 March 2025	**33,656**	**1,282**	**250,597**	**98,152**	**383,687**

17 Borrowings - Continued

17.3 Reconciliation of liabilities arising from financing activities

Trust	Loans from DHSC	Other loans	PFI and LIFT schemes	Lease Liabilities	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2025	**33,656**	**1,282**	**250,597**	**152,637**	**438,172**
Cash movements:					
Financing cash flows - payments and receipts of principal	(3,418)	(640)	(15,045)	(20,521)	**(39,625)**
Financing cash flows - payments of interest	(827)	(24)	(26,570)	(1,640)	**(29,062)**
Non-cash movements:					
Additions	-	-	4,846	20,578	**25,424**
Lease liability remeasurement	-	-	-	8,580	**8,580**
PFI liability remeasurement	-	-	9,596	-	**9,596**
Early terminations	-	-	-	-	**-**
Reclassification	-	-	-	-	**-**
Interest charge arising in year	799	24	26,570	1,640	**29,033**
Disposals	-	-	-	(538)	**(538)**
Carrying value at 31 March 2026	**30,210**	**641**	**249,993**	**160,736**	**441,581**

Trust	Loans from DHSC	Other loans	PFI and LIFT schemes	Lease Liabilities	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2024	**37,104**	**1,922**	**254,059**	**171,293**	**464,378**
Cash movements:					
Financing cash flows - payments and receipts of principal	(3,418)	(640)	(13,126)	(22,139)	**(39,323)**
Financing cash flows - payments of interest	(926)	(37)	(26,911)	(1,683)	**(29,557)**
Non-cash movements:					
Additions			2,251	9,655	**11,906**
Lease liability remeasurement			-	2,388	**2,388**
PFI liability remeasurement	-	-	7,334	-	**7,334**
Reclassification				(7,915)	**(7,915)**
Interest charge arising in year	896	37	26,990	1,683	**29,606**
Early terminations/disposals	-	-	-	(645)	**(645)**
Carrying value at 31 March 2025	**33,656**	**1,282**	**250,597**	**152,637**	**438,172**

18 Provisions

18.1 Provisions - current year

Group	Pensions: Early Departure costs £000	Pensions: Injury benefits * £000	Legal claims £000	Other £000	Restructuring Provisions £000	Clinicians' Pension Provision £000	Total £000
At 1 April 2025	1,802	133	315	498	279	2,396	**5,423**
Arising during the year	2,739	363	-	2,350	120	-	**5,572**
Utilised during the year - cash	(616)	(73)	-	-	(125)	-	**(814)**
Utilised during the year - accruals	-	-	-	-	-	(139)	**(139)**
Reversed unused	(183)	-	-	(233)	(154)	(62)	**(632)**
Change in discount rate	(137)	10	-	-	-	(166)	**(293)**
Unwinding of discount	90	17	-	-	-	138	**245**
At 31 March 2026	**3,695**	**450**	**315**	**2,615**	**120**	**2,167**	**9,362**
Expected timing of cash flows:							
No later than one year	620	73	315	2,615	120	139	**3,882**
Later than one year and not later than five years	2,480	292	-	-	-	319	**3,091**
Later than five years	595	85	-	-	-	1,709	**2,389**
Total	**3,695**	**450**	**315**	**2,615**	**120**	**2,167**	**9,362**

All provisions relate to the Trust, except for restructuring provisions of £120k held by subsidiaries

The timing of the provisions cash flow represents our best estimate of future liabilities based on available input from NHS professionals in the respective areas.
"Other provisions" relates to provisions raised against the cost of defending and settling legal disputes

18.2 Provisions - prior year

Group	Pensions: Early Departure £000	Pensions: Injury benefits* £000	Legal claims £000	Other £000	Restructuring Provisions £000	Clinicians' Pension Provision £000	Total £000
At 1 April 2024	1,982	88	263	428	3,313	2,304	8,378
Arising during the year	527	111	177	126	-	49	990
Utilised during the year - accruals	(160)	(18)	-	-	-	-	(178)
Utilised during the year - cash	(508)	(54)	(14)	(56)	(756)	(52)	(1,440)
Reversed unused	(87)	-	(111)	-	(2,278)	-	(2,476)
Change in discount rate	5	1	-	-	-	(22)	(16)
Unwinding of discount	43	5	-	-	-	117	165
At 31 March 2025	1,802	133	315	498	279	2,396	5,423
Expected timing of cash flows:							
No later than one year	639	72	315	498	279	124	1,927
Later than one year and not later than five years	1,135	61	-	-	-	287	1,483
Later than five years	28	-	-	-	-	1,985	2,013
Total	1,802	133	315	498	279	2,396	5,423

All provisions relate to the Trust
The timing of the provisions cash flow represents our best estimate of future liabilities based on available input from NHS professionals in the respective areas.
"Other provisions" relates to provisions raised against the cost of defending and settling legal disputes

18.3 Provisions - further information

Clinical negligence

£735.568m (31 March 2025: £659.014m) is included in the provisions of NHS Resolution at 31 March 2026, in respect of the estimated clinical negligence liabilities and existing liabilities of the Foundation Trust. As such, no provision is included in the Trust's accounts. NHS Resolution took over responsibility for unsettled clinical negligence claims for 1 April 2000, financial responsibility for all other clinical negligence claims transferred on 1 April 2002.

Pensions

The measure of the Foundation Trust's pension liability for early retired staff was recalculated in 2012-13, using the Office for National Statistics life expectancy tables. Expected future cash flows have been discounted using the real discount rate of 2.95% (2024-25: 2.40%) (set by HM Treasury) to determine the full liability.

Legal claims

The provision is based upon information provided by the NHS Resolution and refers to non-clinical claims against the Foundation Trust (e.g. public and employer's liability cases).

Other

The Foundation Trust has provided £1.043m (31 March 2025: £0.498m) for outstanding Employment Tribunal cases and associated legal fees. A further provision has been provided for the costs of defending and settling legal claims.

19 Contingencies

	Group and Trust	
	31 March 2026	31 March 2025
	£000	£000
Contingent liabilities		
Non-clinical legal claims	**(90)**	(111)

The above contingencies refer to non-clinical legal claims, dealt with by the NHS Resolution on behalf of the Foundation Trust. This represents our best estimate of future liabilities based on available input from NHS professionals in the respective areas.

The Foundation Trust has no contingent assets.

20 Contracted capital commitments

	Group	
	31 March 2026	31 March 2025
	£000	£000
Property, plant and equipment	**12,733**	9,314

Capital commitments at 31st March 2026 include commitments of £10m to complete the fit out of the SARC facility.

21 Revaluation reserve

Group and Trust		**31 March 2026**	31 March 2025
	Property, plant and equipment	**Total**	Total
	£000	**£000**	£000
At 1 April	**180,436**	**180,436**	165,219
Net impairments	**(2,330)**	**(2,330)**	(2,337)
Revaluations	**7,525**	**7,525**	17,554
At 31 March	**185,631**	**185,631**	180,436

22 On-SoFP PFI arrangements

22.1 The following are obligations in respect of the finance lease element of on-Statement of Financial Position PFI schemes:

	Group and Trust	
	31 March 2026 £000	31 March 2025 £000
Gross PFI liabilities	**456,003**	472,748
Of which liabilities are due:		
- not later than one year	**40,216**	38,706
- later than one year and not later than five years	**157,066**	148,891
- later than five years	**258,721**	285,151
Total	**456,003**	472,748
Finance charges allocated to future periods	**(206,009)**	(222,151)
Net PFI liabilities	**249,994**	250,597
Of which liabilities are due:		
- not later than one year	**12,899**	11,712
- later than one year and not later than five years	**62,108**	51,054
- later than five years	**174,987**	187,831
Total	**249,994**	250,597

22.2 Total on-SoFP PFI commitments

Total future obligations under these on-SoFP schemes are as follows:

	Group and Trust	
	31 March 2026 £000	31 March 2025 £000
Total future payments committed of which will fall due:		
- not later than one year	**125,361**	120,103
- later than one year and not later than five years	**511,246**	495,715
- later than five years	**937,066**	1,037,135
Total	**1,573,673**	1,652,953

22.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Group and Trust	
	31 March 2026 £000	31 March 2025 £000
Unitary payment payable to service concession operator (total of all schemes)	**120,836**	116,896
Consisting of:		
- Interest charge	**26,570**	26,990
- Repayment of finance lease liability	**15,045**	13,126
- Service element	**75,123**	72,821
- Revenue lifecycle maintenance	**4,098**	3,959
	120,836	116,896
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	**5,918**	4,337
Total	**126,754**	121,233

22.4 PFI Schemes

King's College Hospital

The PFI consisted of two phases: phase 1 (construction of the new Golden Jubilee Clinical Wing) and phase 2 (refurbishment of the existing Ruskin Wing). The project enabled the centralisation of acute services on the Denmark Hill site following the transfer of services from Dulwich Hospital and Mapother House. As part of the scheme, HpC (King's College Hospital) plc also took responsibility for the provision of site-wide catering, domestic and portering services from April 2000. As a result recurrent revenue savings were achieved.

The project has been financed by a means of a wrapped, index linked bond guaranteed by MBIA-AMBAC and debt and equity capital provided by Costain, Skanska, Sodexo and Edison Capital. The contract period is 38 years. The annual payments by the Trust are dependent on availability and service quality standards being met.

22 On-SoFP PFI arrangements continued

Princess Royal Hospital - building PFI

Under the building PFI, United Healthcare (Bromley) Limited provided the land, building and site-wide hard and soft facilities management at the Princess Royal Hospital.

The capital funding is a combination of senior debt and equity finance. The senior debt financing was originally provided by way of loan from Commerzbank AG (and others). There was a refinancing process in 2004 which involved the issue of 3.018% index-linked guaranteed secure bonds, repayable in 66 six monthly instalments which commenced in 2004 and will end in 2036, and are subject to half yearly indexation in line with RPI.

Princess Royal Hospital - managed equipment services PFI

The MES PFI Scheme agreement dated 22 March 2002 is a 30 year PFI agreement and relates to the purchase of medical equipment, and the installation, maintenance and replacement of this and other clinical equipment. This agreement is between (1) The Trust, (2) United Healthcare (Bromley) Limited and (3) Healthsource (Bromley) Limited and commenced on the 1st of January 2003.

23 Financial instruments

23.1 Risk profile and management

Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Foundation Trust has with NHS England and integrated care boards, and the way those commissioners are financed, the Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Foundation Trust in undertaking its activities.

The Foundation Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Foundation Trust's standing financial instructions and policies agreed by the board of directors. This treasury activity is subject to review by the internal auditor.

Currency risk

The Foundation Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Foundation Trust itself has no overseas operations and therefore has low exposure to currency rate fluctuations. The Trust's subsidiary, KCH Management Ltd, is involved in some overseas activities and is exposed to exchange rate movements in some of its operations. This is an immaterial risk to the KCH group position.

Interest rate risk

28.5% of the Foundation Trust's financial assets and 99.9% of its financial liabilities carry nil or fixed rates of interest. The interest rate on cash held is 0.15%, so overall the Foundation Trust is not exposed to significant interest-rate risk. The two tables below show the interest rate profiles of the Foundation Trust's financial assets and liabilities.

Credit risk

Because the majority of the Foundation Trust's revenue comes from contracts with other public sector bodies, the Foundation Trust has low exposure to credit risk. The maximum exposures as at 31 March 2026 are in receivables from customers, as disclosed in the trade and other receivables note (note 13). Trade and other receivables outstanding but not past due date are considered recoverable and are not impaired. Factors determining the of impairment of trade and other receivables past due is included in note 1.22. Debts past their due date are covered by credit provisions or relate to intercompany loans where no requirement to impair has been identified.

Liquidity risk

The Foundation Trust’s operating costs are incurred under contracts with integrated care boards and NHS England, which are financed from resources voted annually by Parliament. The Foundation Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Foundation Trust is not, therefore, exposed to significant liquidity risks outside of the uncertainty in the funding regime. See note 1.1.

23.2 Financial assets

Group	Total £000	Floating rate £000	Fixed rate £000	Non-interest bearing £000
Gross financial assets				
at 31 March 2026	**197,436**	**141,089**	**-**	**56,347**
at 31 March 2025	142,823	84,864	-	57,959
Trust				
Gross financial assets				
at 31 March 2026	**208,937**	**132,658**	**-**	**76,279**
at 31 March 2025	153,683	73,758	-	79,925

The weighted average interest rate for total financial assets was 0.15% (2024-25: 0.33%).
The weighted average period for which fixed years was unlimited (2024-25: unlimited).
The non-interest bearing weighted average term years was nil (2024-25: nil).

23.3 Financial liabilities

Group	Total £000	Floating rate £000	Fixed rate £000	Non-interest bearing £000
Gross financial liabilities				
at 31 March 2026	**571,131**	**641**	**391,850**	**178,640**
at 31 March 2025	556,103	1,282	387,828	166,993
Trust				
Gross financial liabilities				
at 31 March 2026	**594,398**	**641**	**448,611**	**145,146**
at 31 March 2025	575,669	1,282	442,314	132,073

The weighted average interest rate for total financial liabilities was 7.40% (2024-25: 7.35%).
The weighted average period for which fixed years was unlimited (2024-25: unlimited).
The non-interest bearing weighted average term years was nil (2024-25: nil).

23.4 Carrying values of financial assets

	Group			
Carrying values of financial assets as at 31 March 2026	**Held at amortised cost £000**	**Held at fair value through I&E £000**	**Held at fair value through OCI £000**	**Total book value £000**
Trade and other receivables excluding non financial assets	51,183	-	-	**51,183**
Other investments / financial assets	335	1,153	3,676	**5,164**
Cash and cash equivalents	141,089	-	-	**141,089**
Total at 31 March 2026	**192,607**	**1,153**	**3,676**	**197,436**

Carrying values of financial assets as at 31 March 2025	**Held at amortised cost £000**	**Held at fair value through I&E £000**	**Held at fair value through OCI £000**	**Total book value £000**
Trade and other receivables excluding non financial assets	52,976	-	-	**52,976**
Other investments / financial assets	335	972	3,676	**4,983**
Cash and cash equivalents	84,864	-	-	**84,864**
Total at 31 March 2025	**138,175**	**972**	**3,676**	**142,823**

	Trust			
Carrying values of financial assets as at 31 March 2026	**Held at amortised cost £000**	**Held at fair value through I&E £000**	**Held at fair value through OCI £000**	**Total book value £000**
Trade and other receivables excluding non financial assets	72,268	-	-	**72,268**
Other investments / financial assets	335	-	3,676	**4,011**
Cash and cash equivalents	132,658	-	-	**132,658**
Total at 31 March 2026	**205,261**	**-**	**3,676**	**208,937**

Carrying values of financial assets as at 31 March 2025	**Held at amortised cost £000**	**Held at fair value through I&E £000**	**Held at fair value through OCI £000**	**Total book value £000**
Trade and other receivables excluding non financial assets	75,914	-	-	**75,914**
Other investments / financial assets	335	-	3,676	**4,011**
Cash and cash equivalents	73,758	-	-	**73,758**
Total at 31 March 2025	**150,007**	**-**	**3,676**	**153,683**

23.5 Carrying values of financial liabilities

Group

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	30,210	-	**30,210**
Obligations under PFI, LIFT and other service concessions	249,994	-	**249,994**
Obligations under leases	103,856	-	**103,856**
Other borrowings	641	-	**641**
Trade and other payables excluding non financial liabilities	178,640	-	**178,640**
Provisions under contract	7,790	-	**7,790**
Total at 31 March 2026	**571,131**	**-**	**571,131**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	33,656	-	**33,656**
Obligations under PFI, LIFT and other service concessions	250,597	-	**250,597**
Obligations under leases	98,152	-	**98,152**
Other borrowings	1,282	-	**1,282**
Trade and other payables excluding non financial liabilities	166,993	-	**166,993**
Provisions under contract	5,423	-	**5,423**
Total at 31 March 2025	**556,103**	**-**	**556,103**

Trust

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	30,210	-	**30,210**
Obligations under PFI, LIFT and other service concessions	249,994	-	**249,994**
Obligations under finance leases	160,737	-	**160,737**
Other borrowings	641	-	**641**
Trade and other payables excluding non financial liabilities	145,146	-	**145,146**
Provisions under contract	7,670	-	**7,670**
Total at 31 March 2026	**594,398**	**-**	**594,398**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	33,656	-	**33,656**
Obligations under PFI, LIFT and other service concessions	250,597	-	**250,597**
Obligations under finance leases	152,638	-	**152,638**
Other borrowings	1,282	-	**1,282**
Trade and other payables excluding non financial liabilities	132,073	-	**132,073**
Provisions under contract	5,423	-	**5,423**
Total at 31 March 2025	**575,669**	**-**	**575,669**

23.6 Fair values of financial assets and liabilities

The carrying value of financial assets and liabilities is considered a reasonable approximation of their fair values.

23.7 Maturity of financial liabilities

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
In one year or less	**237,759**	223,947	**214,473**	199,281
In more than one year but not more than five years	**215,052**	204,478	**245,513**	236,842
In more than five years	**339,056**	360,431	**358,473**	375,368
Total	**791,868**	788,856	**818,459**	811,491

This analysis is based on undiscounted future cash flows i.e. gross liabilities including finance charges. The amounts of both principal and interest payments which the Trust and group are committed to make under PFI and finance lease obligations are shown in Note 17.

24 Third party assets

At 31 March 2026, the Foundation Trust held £0 (31 March 2026: £0) cash at bank and in hand that related to monies held by the Foundation Trust on behalf of patients. This is excluded from the cash at bank and in hand figure reported in the accounts.

25 Events after the reporting period

No events after the balance sheet date have been identified.

26 Related parties

King's College Hospital NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health. The Department of Health and Social Care is the Trust's parent department and ultimate controlling party.

During the year, none of the Board members, the Foundation Trust's governors, members of the key management staff or parties related to them have undertaken any material transactions with the Foundation Trust.

The Department of Health and Social Care (DHSC) is the parent department and as such, is regarded as a related party. During the year, the Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is also regarded as the parent entity, including ICBs, NHS Trusts and NHS England, as well as NHS Resolution and NHS Business Services Authority . These organisations are listed below.

NHS South East London Integrated Care Board
London Commissioning Region
NHS England Central Commissioning Hub
NHS Kent and Medway Integrated Care Board
NHS South West London Integrated Care Board
NHS England
Guy's and St Thomas' NHS Foundation Trust
NHS Resolution
NHS Sussex Integrated Care Board
NHS Surrey Heartlands Integrated Care Board
Health And Social Care Board
NHS North Central London Integrated Care Board
Oxleas NHS Foundation Trust
NHS Blood And Transplant
Community Health Partnerships Ltd
NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board
NHS North West London Integrated Care Board
NHS North East London Integrated Care Board

Current year	Income £000	Expenditure £000	Receivables £000	Payables £000
Synnovis Group LLP	11,963	85,353	2,936	20,092
Medtech	-	-	-	-
Meridian Ventures (formerly KHP Ventures)*	-	-	-	-

*KCH Group invested £836k into Meridian Ventures in year. A dividend payment of £204k was received in year

Prior year	Income £000	Expenditure £000	Receivables £000	Payables £000
Synnovis Group LLP	10,904	62,120	2,933	15,220
Medtech	-	-	-	-
KHP Ventures	-	-	-	-

26.1 Related parties - Trust

In addition to the related party disclosures above, the Trust has the following transactions with its subsidiary companies:

Current year	Income £000	Expenditure £000	Receivables £000	Payables £000
King's Interventional Facilities Management*	10,725	215,044	19,363	58,273
King's Commercial Services Ltd	-	-	3,000	-
KCH Management Ltd	3,187	686	645	-

Prior year	Income £000	Expenditure £000	Receivables £000	Payables £000
King's Interventional Facilities Management*	10,560	206,767	21,353	59,853
King's Commercial Services Ltd	605	-	12,000	-
KCH Management Ltd	4,188	1,305	1,207	3

*The Payables figure with King's Interventional Facilities Management includes lease liabilities for equipment owned by the subsidiary

27 Losses and special payments

Group and Trust	2025-26 Number	2025-26 Value £000	2024-25 Number	2024-25 Value £000
Losses of cash due to:				
- overpayment of salaries	**215**	**280**	130	150
Bad debts and claims abandoned in relation to:				
- private patients	**-**	**-**	8	74
- overseas visitors	**738**	**4,167**	474	2,646
- other	**217**	**220**	37	272
Stores Losses	**24**	**468**	24	535
Damage to buildings, property etc. due to:				
- theft, fraud etc.	**5**	**12**	12	18
Total losses	**1,199**	**5,147**	685	3,695
Special payments due to:				
Ex-gratia payments due to:				
- loss of personal effects	**17**	**13**	8	8
Total special payments	**17**	**13**	8	8
Total losses and special payments	**1,216**	**5,160**	693	3,703

In 2025-26 there were nil cases where an individual loss or special payment exceeded £300,000 (2024-25 nil cases).

Losses and special payments are disclosed on an accruals, rather than a cash basis, but exclude provision for future losses.

28 Adjusted Financial Performance

	2025/26 £000	2024/25 £000
(Deficit) for the period per SOCI	**(10,837)**	(37,972)
Remove net impairments not scoring to the departmental expenditure limit	**11,398**	(1,027)
Remove I&E impact of capital grants and donations	**(1,213)**	397
Remove I&E impact of IFRIC 12 schemes on an IFRS 16 basis	**124,417**	120,693
Add back I&E impact of IFRIC 12 schemes on former UK GAAP basis	**(118,814)**	(115,757)
Adjusted financial performance surplus / (deficit)	**4,951**	**(33,666)**

The adjusted financial performance is the primary view which is used by the Board of Directors to monitor the Trust's financial performance and is in line with NHS England's financial performance measure.

The Group's deficit for the year was £10.837m and this figure includes allowable asset impairments of £11.4m. This charge relates to impairment reversals that arise from changes in market value of Land and Buildings assets and intangible assets. The NHSE financial performance measures the surplus/(deficit) before impairments and the impact of donated assets.

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The unconsolidated deficit relating to the Foundation Trust for the year ended 31 March 2026 is £22.1m (2025: £48.0m) and total operating income for the year is £2,067m (2025: £1,929m).