

AGENDA

Committee	Board of Directors – Public
Date	Wednesday 15 July 2026
Time	14:00 – 16:30
Location	The Education Center, Princess Royal University Hospital, Farnborough Common, Orpington BR6 8ND

No.	Agenda item	Lead	Format	Purpose	Time
STANDING ITEMS					
1.	Welcome and Apologies	Chair	Verbal	Information	14:00
2.	Declarations of Interest	Chair	Verbal	Information	
3.	Chair's Actions	Chair	Verbal	Approval	
4.	Minutes of the Meeting held on 14 May 2026	Chair	Enclosure	Approval	
5.	Action tracker	Chair	Enclosure	Discussion	
6.	Staff story	Chief Delivery Officer	Presentation	Information/ Discussion	14:05
7.	King's Charity	Chief Nurse and Executive Director of Midwifery	Presentation	Information	14:25
8.	Board Assurance Framework	Director of Corporate Affairs	Enclosure	Assurance	14:40
9.	Integrated Performance Report - Quality - Operational Performance - Finance - Workforce	Chief Executive Officer	Enclosure	Discussion/ Assurance	14:50
10.	Highlight Reports from Committee Chairs 10.1. Finance & Commercial Committee 10.2. Audit and Risk Committee 10.3. Quality and Research Committee 10.4. Performance, Transformation and Improvement Committee 10.5. People, Education and Inclusion Committee 10.6 Academic Committee in Common	Committee Chairs	Enclosure	Assurance	15:10
11.	Report from the Chief Executive Officer	Chief Executive Officer	Enclosure	Discussion /Assurance	15:20
12.	Report from the Chair of the Board	Chair	Verbal	Information	15:30
STRATEGY, PLANNING AND DELIVERY					
13.	Partnership Working	Deputy Chief Executive	Enclosure		15:40

14.	Maternity and Neonatal report	Chief Nurse and Executive Director of Midwifery	Enclosure	Discussion/ Assurance	15:50
GOVERNANCE AND ASSURANCE					
15.	Risk Register Report	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	16:00
COUNCIL OF GOVERNORS					
16.	Council of Governors' Update	Lead Governor	Verbal	Information	16:05
ANY OTHER BUSINESS					
17.					
FOR INFORMATION					
18.	Patient Experience Annual report	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	*
DATE OF THE NEXT MEETING					
	Date of the next meeting: The next meeting will be held on Wednesday 16 September 2026 at 1400 – 1630.				

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

Board of Directors - Public

DRAFT Minutes of the meeting held on 14 May 2026 at 14:00 – 16:30
Dulwich Room, Hambleden Wing, Denmark Hill, London SE5 8BQ

Members:		
Non-Executive Directors:		
	Sir David Behan	Non-Executive Director, (Chair)
	Dame Christine Beasley	Non-Executive Director
	Nicholas Campbell-Watts	Non-Executive Director
	Dr Jane Fryer	Non-Executive Director
	Sheena Mackay	Non-Executive Director
	Akhter Mateen	Non-Executive Director
	Gerry Murphy	Non-Executive Director
	Prof. Anthony Schapira	Non-Executive Director
	Dr Angela Spatharou	Non-Executive Director (via MS Teams)
Executive Directors:		
	Prof. Tracey Carter MBE	Chief Nurse & Executive Director of Midwifery
	Roy Clarke	Chief Financial Officer
	Angela Helleur	Chief Delivery Officer
	Prof Clive Kay	Chief Executive Officer
	Julie Lowe	Deputy Chief Executive Officer
	Damian McGuinness	Chief People Officer
	Mamta Shetty Vaidya	Chief Medical Officer
In attendance:		
	Jem Bautista	Matron for Quality, Safety & Governance (for item 26/49)
	Siobhan Coldwell	Director of Corporate Affairs
	Kat Hughes	Chief of Staff – CEO Office
	Jennifer Nabwogi	Deputy Trust Secretary
	Sarah O'Connor	Charge Nurse, Centralised Preassessment Unit
	Tosan Okubule	Head Of Nursing- Theatres and Anaesthetics (for item 26/49)
	Lloyd Page	King's Patient (for item 26/49)
	Chris Rolfe	Director of Corporate Communications
	Governors	
	Members of the public	
Apologies:		
	Prof Graham Lord	Non-Executive Director

Item	Subject
26/44	Welcome and Apologies The Chair welcomed everyone to the meeting and reflected that it was the Chief Executive's final public Board meeting before his retirement. On behalf of the Board, he paid tribute to the Chief Executive's seven years of leadership at the Trust and almost 40 years of NHS service, recognising his leadership during the COVID-19 pandemic, his commitment to King's, his contribution to the wider NHS, including through the Shelford Group, and his embodiment of public service values. The Chair also acknowledged the importance of their close working relationship and thanked him for his dedicated service.

	Apologies were received from Professor Graham Lord. Professor Anthony Schapira would be absent for part of the meeting and Dr Angela Spatharou joined virtually.
26/45	Declarations of Interest There were no declarations of interest over and above those already on record.
26/46	Chair's Actions There were no Chair's actions to report during this period.
26/47	Minutes of the meeting held on 12 March 2026 The minutes of the meeting on 12 March 2026 were approved as a correct record.
26/48	Action tracker The Board reviewed the action tracker and received the following updates: • Clarity of SPC Charts: It was noted that the issue was believed to relate to the Board portal and would be tested. • Action 2601 – Seminar on Flow: This item was on the agenda and the action was closed. • Action 2602 – Cancer Performance Deep Dive: Completed in April 2026; the action was closed. • Action 2603 – Vascular Lab Interventions: The Chief Delivery Officer had met with the team to agree the way forward; the action was closed. • Action 2604 – Linking Board Discussions to BAF Risk: This had been embedded into business as usual arrangements and the action was closed. • Action 2605 – Board Self-Assessment Against the CQC Insightful Board Framework: This was scheduled for a future date and remains open. The Board noted the updates.
26/49	Patient Story The Board heard from King's patient, Lloyd Page, who shared his experience of care at the Trust and the improvements made in response. Lloyd, who has learning disabilities (LD), described delays, poor communication, cancelled treatment, lack of support during admission, and insensitive staff interactions. He said he wanted clear, easy-to-read information and for his support needs to be recognised and respected. The Board noted the Care Group's apology and review, which identified failures in Lloyd's care. Board members received assurance that improvements had been implemented, including an LD Link Nurse, Easy Read information, mandatory learning disability training, enhanced communication, face-to-face assessment pathways for LD patients, stronger learning processes, and better support for families accompanying patients with learning disabilities. The Board emphasised the consistent use of LD Passports, sought assurance that learning was being shared Trust-wide, and noted the introduction of the Reasonable Adjustment Digital Flag in Epic to help identify and support vulnerable patients. Members also encouraged greater involvement of people with lived experience in training, a multidisciplinary approach, and clear distinction between local and systemic learning. The Board thanked Lloyd for sharing his experience and the Care Group for its commitment to learning and improving care.
26/50	Board Assurance Framework The Director of Corporate Affairs presented the Board Assurance Framework (BAF), noting that it comprised nine strategic risks, four of which remained rated red. The Board noted reductions in the risk scores for financial sustainability, demand and capacity, and cyber security, reflecting improved financial and operational performance and strengthened cyber assurance.

	The Director proposed increasing the research and innovation risk to reflect challenges in achieving the 150-day clinical trials target, while noting that some delays to the target were outside the Trust's control. She also advised that the wording of some workforce risks would be updated to better reflect current issues, without changing their scores. The Board welcomed the continued improvement in the BAF and the timely scrutiny by Board committees and suggested bringing Committee Chairs together for a session to discuss the BAF collectively. ACTION: To bring Board subcommittee Chairs together for a session to discuss the BAF collectively. SC
26/51	Integrated Performance Report Performance: The Chief Delivery Officer presented the March 2026 operational performance report, noting overall improvement. The Trust's 4-hour performance improved but remained below target. The Faster Diagnosis Standard exceeded the new national standard, while 62-day cancer performance remained below target. Referral to Treatment (RTT) performance remained above the national average and exceeded the Q4 Sprint target, with the Trust achieving its under-18-week target and making significant progress in reducing 65-week waits, although the 52-week target was not met. The Board congratulated the Trust on its year-end improvements and sought assurance that these would be sustained without additional improvement funding. Members were assured that improved understanding of demand and capacity would support sustainability, and they emphasised the need for continued oversight of diagnostic and treatment capacity, with early intervention where performance begins to deteriorate. Quality: The Chief Medical Officer reported on performance against the 150-day clinical trial set-up target. The Trust was performing well in non-commercial trials but not for commercial trials, although performance was generally improving. On complaints, the Trust had ended the year in a strong position, with no complaints outstanding for more than six weeks. Arrangements were in place to ensure learning from complaints was embedded. Workforce: The Chief People Officer reported that the principal workforce challenge remained the Agenda for Change time-to-hire metric, with recruitment to Bands 1–3 continuing to fall outside the target. As at 31 March 2026, there were 35 open formal disciplinary cases and 25 formal early resolution cases, both representing an increase of three cases compared with the previous month. Finance: The Chief Financial Officer reported that, as at March 2026, the Trust had delivered a year-to-date surplus of £5.0 million, ahead of plan. Total savings of £66.0 million had been achieved against a target of £82.4 million. The two principal areas of focus remained the underlying run rate and delivery of the CIP and transformation programmes. The Chair thanked the Executive Leadership Team, the Finance team and colleagues across the Trust for delivering a strong financial performance despite the challenging operating environment. Particular thanks were extended to the Chief Delivery Officer and her team for their contribution to the Trust's performance improvements.
26/52	Highlight Reports from Committee Chairs The Chair introduced the summary reports from the Board's sub-committees and invited each Committee Chair to present the key matters discussed at their respective meetings. Finance & Commercial Committee The Chair reported that the Committee had noted the improved performance of the Trust's subsidiaries following delivery of their improvement plans. It had also reviewed the Trust's

	2025/26 financial performance, cost improvement programme, workforce and risk, noting richer workforce discussions following the Chief People Officer joining the Committee membership, and approved its annual report, concluding that it had met its objectives for the year. The Committee also received updates on the strategic estates review, due to conclude in autumn 2026 and will inform the Estates Strategy; and on the Digital Strategy. People, Education and Inclusion Committee The Chair informed the Board that the Committee would meet the following day to consider workforce metrics, delivery of the 2025/26 workforce plan, the 2026/27 workforce plan, staff survey and staff engagement results, including a pharmacy case study on improving staff engagement. The Chief Medical Officer added that updates on the Resident Doctor 10-Point Plan and the Guardian of Safe Working were also on the agenda. Audit and Risk Committee The Chair reported that the April meeting had focused on governance, risk and the annual reports and accounts. He described the year-end accounts process as smooth, noting that the external audit was progressing well and approval remained on track ahead of the statutory submission deadline. The Committee also reviewed five internal audit reports covering RTT data quality, violence and aggression, local clinical audits, estates backlog maintenance and the Board Assurance Framework (BAF), together with the Head of Internal Audit's annual opinion. Three reports received Significant Assurance with Minor Improvement Opportunities, while the BAF and estates backlog maintenance received Partial Assurance with Improvements Required. Quality and Research Committee The Chair reported that the Committee had undertaken a detailed review of the Integrated Quality Report and maternity performance in April, noting significant progress across a number of areas. The Committee also received its first divisional presentation, with divisional updates now to become a standing feature of future meetings. Performance, Transformation and Improvement Committee The Chair reflected the CDO's earlier update on operational performance, noting that the Committee had received a detailed cancer performance deep dive in April, which prompted a constructive discussion. The Committee also reviewed the Trust's transformation programme, focusing on the pace, scale and scope of delivery. Academic Committee in Common The board noted that a meeting of the Academic Committee in Common had taken place on 23 April 2026.
26/53	Report from the Chief Executive Officer The Chief Executive Officer highlighted three key updates not included in his report: the Care Quality Commission (CQC) April 2025 inspections, the Trust's exit from the Recovery Support Programme (RSP), and his retirement. The Chief Nurse informed the Board that the CQC had advised that the outcome report from the April 2025 inspections contained insufficient evidence to support publication and the inspection would need to be repeated, confirming this was not due to any failing by the Trust. The Board expressed concern at the impact of repeating the inspection and agreed to seek an explanation and assurance from the CQC on the reasons for this, and the proposed next steps. The CEO confirmed that the Trust had formally exited the RSP on 12 May 2026 in recognition of the significant improvements made since entering the programme and thanked colleagues across the organisation for their contribution, while noting that further work remained. The CEO also reflected on his retirement after 40 years in the NHS, including 20 years as a Chief Executive. He spoke of his strong connection to King's, pride in the Trust's achievements and confidence in its future.

26/54	Report from the Chair of the Board The Chair reported on a number of recent visits and engagements. He had spent time with research teams, including principal investigators in Neurology, Haematology and Liver, and commended the outstanding research being undertaken across the Trust. He had also visited the new Endoscopy Unit at Princess Royal University Hospital, the pharmacy department, where he noted the significant improvements made; and the Mortuary. The Chair had also attended the KHP Policy Day and highlighted a recently published Policy Institute World Values survey, describing its findings as thought-provoking and encouraging Board members to read it. Finally, the Chair reported on a meeting with Ian Peters, the new London Chair. Their discussion covered the Health Bill currently before Parliament, including proposals relating to the abolition of NHS England and governors, and the wider implications for NHS trusts. It was noted that these developments would require careful consideration by trusts
26/55	Trust Strategy 2026-31 The Director of Strategy presented the draft 2026–31 Trust Strategy, seeking the Board's feedback ahead of publication, noting that further work was still underway on the Digital Strategy. The Deputy Chief Executive thanked colleagues and stakeholders for their contribution to developing the strategy, confirming that feedback from engagement had been incorporated. Supporting strategies would be presented to the Board in September 2026, with publication of the strategy and an accessible version planned for June 2026. The Board agreed that the strategy contained the right level of detail but recommended reviewing the order of priorities to better reflect the Trust's strategic ambitions, giving greater prominence to high-quality care, and correcting the financial year referenced under financial sustainability. The Board thanked the team for its work on the strategy and the extensive engagement undertaken.
26/56	Public Health & Inequalities The Chief Medical Officer (CMO) presented a report proposing the establishment of a Population Health Management (PHM) and Healthcare Equity function within the CMO directorate, together with a supporting PHM and Healthcare Equity Strategy aligned to the Trust's Organisational Strategy (2026–2031). The report outlined a three-year roadmap to consolidate and strengthen the Trust's use of population health data and insights. The Board welcomed the proposals and requested a Board development session on population health, aligned with King's Health Partners (KHP), to include input from the KHP Executive Director. DECISION: The Board noted the report and endorsed the proposed approach. ACTION: To arrange a Board development session on population health, aligned with King's Health Partners (KHP), to include input from the KHP Executive Director. SC
26/57	Patient Flow – Lessons learnt The Chief of Division B presented a report on the key lessons from the Trust's patient flow improvement programme during 2025/26, drawing on performance data, operational experience, and service delivery. He emphasised that patient flow is a longstanding NHS challenge requiring a whole-system approach rather than a hospital-only focus, reflecting the priorities set out in the NHS England plan. He outlined the four key stages of flow: pre-arrival, attendance, inpatient stay, and discharge. A criteria-led discharge process had been implemented to support timely discharge throughout the week. The Director of Operations for Division B reported sustained improvement against the UEC 4-hour and 12-hour standards throughout 2025/26, with positive performance continuing into April 2026. Governance arrangements had also been strengthened. While Type 1 UEC performance

	remained strong, Type 3 performance continued to present challenges. The increase in ambulatory care activity was noted, alongside the introduction of a Single Point of Contact (SPOC) service for patients aged over 65. The Trust had also reduced the number of patients being cared for outside designated clinical areas, although this remained a risk requiring ongoing mitigation. The Board discussed the importance of standardising patient placement according to clinical need and maintaining a whole-hospital approach to improving flow. Members highlighted the critical role of effective interfaces with mental health services and the need to continue strengthening relationships with mental health providers while developing a coordinated system-wide support plan for these patients. The Board requested that the July 2026 Board walkabouts include engagement with Division B teams involved in patient flow improvement, particularly the SPOC service and Endoscopy. ACTION: To include the Division B SPOC and Endoscopy unit as part of the July 2026 Board walkabouts. SC
26/58	Operational Plan The Chief Financial Officer presented the Trust's 2026/27 operational plan, noting that it had been submitted to NHS England in March 2026 and had received a <i>near compliant and accepted (subject to conditions)</i> rating. The Board noted the key delivery risks, particularly those relating to achieving improvements against constitutional standards. The Chair drew attention to the performance measures within the plan, noting that the 2026/27 trajectories demonstrated that the required performance standards were considered achievable. The Board received the update and thanked the team for securing a successful submission.
26/59	Risk Register Report The Chief Nurse and Executive Director of Midwifery presented the report, noting that the risks had been reviewed by the relevant committees and reflected within the Framework (BAF). The Board noted that the Risk Register had evolved into a more dynamic document and agreed that additional time should be allocated for its review at the next meeting.
26/60	Board and Subcommittee Forward Plans 2026-27 The Board noted the Board and sub committee forward plans which had also been reviewed at respective committees.
26/61	Council of Governors' Update The Director of Corporate Affairs presented the Lead Governor's report, welcoming newly elected governors and noting recent governor induction activity. She advised that changes to the Council's nominated governors would follow the outcome of the May 2026 local elections, resulting in the departure of the Bromley and Lambeth nominated governors. The Board thanked both governors for their contribution to the Trust. The Board noted the Governors' continued involvement in developing the Trust Strategy, reviewing the Quality Accounts and supporting Experience of Care Week. Members were also advised that the statutory requirement for NHS foundation trusts to have councils of governors was expected to be removed from April 2027, with the Trust to consider its future approach in due course. On behalf of the Council of Governors, the Governors thanked Professor Clive Kay for his leadership and service to the Trust and wished him well for the future.
26/62	Any other Business The Chair noted that one question had been received from the Council of Governors regarding arrangements for visitors seeking friends and relatives after 4pm, when PALS is closed and the main reception is often unmanned. The Chief Nurse explained the current arrangements and advised that options to improve access, including better use of technology and the switchboard,

	were being explored. In the meantime, patients were being encouraged to inform family and friends of their ward location. The Chief Nurse would respond directly to the governor who raised the question. In closing, the Chair drew attention to the reports received for information and congratulated the Trust's Staff Nurse of the Year.
26/63	For Information The following reports were noted: • Maternity and Neonatal Report • BOLD Refresh Q4 update and End of Year Report
	<u>Date of the next meeting:</u> Date of the next meeting: 15 July 2026 at 09:30 - 12:30 at the Princes Royal University Hospital.

Public Board Action Tracker - 15 July 2026

ACTION ID	Date & Ref	Action	Lead	Date Due	Status	Update
N/A	ACTIONS - PENDING					
BoDPB2605	12/03/2026 26/35	Board Self Assessment Against NHSE Insightful Board To arrange for the Trust Board to undertake a self-assessment against the six CQC domains using the Insightful Board framework	SC	14/05/2026	Open	This is scheduled for a future date (likely September) and remains open.
BoDPB2606		Board Committee3 Chairs BAF Session To bring Board subcommittee Chairs together for a session to discuss the BAF collectively.	SC	15/07/2026	closed	This is being scheduled for early August.
BoDPB2608		July 2026 Board Walkarounds To include the Division B SPOC and Endoscopy unit as part of the July 2026 Board walkabouts	SC	15/07/2026	closed	The two are scheduled as walkarounds in July.
	PENDING - ACTIONS					
	Date & Ref	Action	Lead for Action	Due	Status	Update
BoDPB2607		Board Development Session on Population Health To arrange a Board development session on population health, aligned with King's Health Partners (KHP), to include input from the KHP Executive Director	SC	16/09/2026	Open	this is being arranged for September

AGENDA ITEM:

Report to:	Board of Directors						
Date of meeting:	15 th July 2026						
Subject:	Board Assurance Framework (BAF)						
Author(s):	Siobhan Coldwell, Director of Corporate Affairs Experience						
Sponsor:	Matthew Trainer, Chief Executive Officer						
History:	Standing Agenda Item						
Status:							
Decision/Approval	✓	Discussion	✓	Assurance	✓	Information	✓

Purpose

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

Recommendations:

The Board of Directors is asked to :

- to review the BAF and note changes
- ratify the score changes as proposed by the relevant committee.

Strategy alignment

High Quality Patient Care	X	Strong Successful Partnerships	X
A Great Place to Work	X	Timely and Efficient Care	X
Pioneering Research, Innovation and Education	X	Financial Sustainability	X

Key implications

Strategic risk - Link to Board Assurance Framework	all
King's Improvement Impact (KIM):	The King's Improvement Method is one tool being used to deliver service improvements and mitigate risk

Quality Impact	Risks to safe and effective care are outlined in the document as well as the controls and assurance framework in place to address them.
Health Equity Impact	Not directly addressed by this paper.
Workforce Impact	Key strategic workforce risks are outlined in the document as well as the controls and assurance framework in place to address them.
Research/Innovation Impact	Key strategic research risks are outlined in the document as well as the controls and assurance framework in place to address them.
Digital Impact	Key strategic ICT and information security risks are outlined in the document as well as the controls and assurance framework in place to address them.
Financial Impact	Not applicable as far as this report is concerned, but there may be implications over time.
Legal/ regulatory compliance	Regulatory and Governance: all Trusts are required to have a system and framework to manage risk effectively. See NHS Code of Governance and the CQC Well-Led Framework.
Communications and Engagement	n/a
Use of Artificial Intelligence Tools	No AI tools have been used in the work reported in this paper
Committee that will provide relevant oversight Board of Directors	

Ref	Risk Summary	Executive Lead(s)	Assurance Committee	Current risk (LxC)	Change	Target Risk Score*	Update July 2026
1	Workforce If the Trust is unable to transform the workforce and develop new ways of working in order to deliver the new Trust operating model, financially sustainable services will not be delivered, adversely impacting patient outcomes and staff engagement and patient experience	Chief People Officer	People, Education and Inclusion	12 (4 x 3)	↔	6	Reviewed at P, E&I 1st July 2026 - The committee reviewed workforce KPIs in detail, including the delivery of the 2026/27 workforce plan. Q1 reductions have been achieved, but limited assurance can be provided that Q2 targets are achievable based on current trajectories. - Committee reviewed the Draft People Strategy which will provide the key delivery vehicle for addressing this risk.
2	King's Culture & Values If the Trust is unable to transform the culture of the organisation to become more inclusive and positive, staff engagement and well-being may deteriorate, adversely impacting our ability to provide culturally intelligent, compassionate care to our patients and to each other.	Chief People Officer	People, Education and Inclusion	12 (3 x 4)	↔	12	Reviewed at P, E&I 1st July 2026 The committee considered an update from the FSUG, outlining recent activity. The current model is being reviewed to understand whether it is fit for purpose.
3	Capability, Talent and Leadership: If the Trust is unable to build and sustain leadership and workforce capability (including a robust talent pipeline for critical clinical, operational and corporate roles), it will be unable to deliver the Trust Strategy and Operating Model at pace, leading to variable quality and safety, reduced productivity and financial performance, and poorer staff experience and retention	Chief People Officer	People, Education and Inclusion	TBC			Reviewed at P, E&I 1st July 2026 - Accepted as a new risk by the committee. Recommended to the Board of Directors for acceptance onto the BAF. Scoring will be completed thereafter. - Committee reviewed the Draft People Strategy which will provide the key delivery vehicle for addressing this risk. - The committee agenda also included an analysis of exit interviews. A further report will come back later in the year to provide more indepth analysis of drivers, and impact on talent pipelines.
4	Financial Sustainability If the Trust is unable to improve the financial sustainability of the service it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future	Chief Finance Officer	Finance and Commercial	25 (4 x 5)	↑	20	Reviewed at FCC 2nd July 2026 - The risk is well integrated into financial reporting. FCC agreed the risk should be increased reflecting the deterioration in the underlying financial position due to the partially identified CIP programme. Some assurance received as recovery plans are in place, but further high priority actions were requested. - Positive assurance received through the internal and external audit annual reports.
5	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	Deputy Chief Executive	Finance, Commercial & Sustainability	16 (4 x 4)	↔	15	Reviewed at FCC 2nd July 2026 The committee acknowledged improvements in the management of the capital programme and backlog maintenance, but that risks associated with an ageing estate and future capital affordability remain.
6	Research & Innovation If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre	Chief Medical Officer	Quality and Research	12 (3 x 4)	↔	6	Reviewed at QRC 8th July 2026 - The committee received a detailed report on progress to meeting the Government's nationally mandated 150-day research study set-up was discussed in detail. Whilst the Trust is not meeting the target, progress is being made. - A review of the Trust approach to R&D is underway. - Risk score remains under review. - Academic Committee in Common met on 8th July 2026.

Ref	Risk Summary	Executive Lead(s)	Assurance Committee	Current risk (LxC)	Change	Target Risk Score*	Update July 2026
7	Safe Effective Care If the Trust does not have adequate arrangements to support the delivery and oversight of high-quality care, this may result in an adverse impact on patient outcomes and patient experience and lead to an increased risk of avoidable harm	Chief Nurse & Executive Director of Midwifery and Chief Medical Officer	Quality and Research Committee	12 (4 x 3)	↔	8	Reviewed at Quality Committee 8th July 2026 - Risk has been comprehensively updated, although no change to the score. - Quality Assurance Framework has been reviewed and updated. - Focused discussions on safety, experience and outcomes including a review of corridor care, medicines safety, maternity services, patient experience and patient outcomes (including mortality).
8	System Sustainability If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely on our ability to achieve system transformation in line with the NHS 10-year plan ambition.	Deputy Chief Executive	Board of Directors	9 (3 x 3)	↔	9	Attached for review/discussion by the Board. Should be read in the context of the Partnerships Update on the agenda.
9	Demand and Capacity If the Trust is unable to transform services, improve productivity and sustain sufficient capacity, patient waiting times may increase potentially resulting in an adverse impact on patient outcomes and an increased risk of avoidable harm.	Chief Delivery Officer	Board of Directors	16 (4 x 4)	↔	20	Reviewed at Performance, Transformation and Improvement 9th July 2026 - Performance is off trajectory in a number of areas, linked in part to imbalances in demand and capacity. - There was detailed discussion at the committee about drivers, reviews are underway aimed at providing assurance that the risk can be mitigated. The committee will review at its next meeting, and consider whether the risk score should be raised.
10	Cyber If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data	Deputy Chief Executive	Audit	16 (4 x 4)	↔	16	Reviewed at Audit Committee 18th June 2026 - Positive assurance received from KMPG Cyber toolkit review - HIMMS digital maturity score high and penetration testing assurance received. - Board cyber training arranged for September.

Risk: If the Trust cannot transform the workforce and improve people cost control, it will be unable to deliver sustainable services, impacting quality and safety, staff engagement and patient experience. Strategic Objective: A great place to work Risk Owner: Chief People Officer																			
Committee		People, Education and Inclusion Committee																	
		Last review: Jun 2026																	
2026/27 Priorities (People Plan): - Continue to transform the Trust based on the 2026/27 workforce plan - Deliver safe staffing and productivity improvements through workforce redesign (rostering, skill mix and job planning) - Reduce bank and agency reliance and premium spend through improved bank fill, controls and SEL system working - Improve people services performance and workforce data quality (recruitment throughput, ESR and payroll assurance) - Strengthen partnership working and change capacity to deliver programmes at pace and manage workforce relations risk - Deliver a five year workforce strategy and plan that aligns with the objectives set out in the new Trust strategy (2026-2031) - Design, deliver and implement interventions for long lasting impact from staff survey feedback, with an initial focus on the three key priorities, (Band 7 Leadership Development, Reward and Recognition, Staff Engagement, including the Medical Engagement Scale) - Align people interventions with the King's Improvement Methodology to ensure there is a standard and consistent approach to enhancing staff experience Relevant significant risks on Corporate and Trust RR: - CRR 36 Bullying and Harassment - CRR 567 Harm from violence, abuse and challenging behaviour - To be updated with corporate risks being refreshed		Risk Scoring: <table border="1"> <thead> <tr> <th></th><th>consequence</th><th>Likelihood</th><th>Score</th></tr> </thead> <tbody> <tr> <td>Risk score Q1</td><td>4</td><td>4</td><td>16</td></tr> <tr> <td>Risk score Q2</td><td>4</td><td>4</td><td>16</td></tr> <tr> <td>Target (Mar 27)</td><td>4</td><td>3</td><td>12</td></tr> </tbody> </table> Appetite rating Averse: Safe staffing levels Cautious: Wellbeing / Rightsizing Open: Culture Eager: Learning and Development			consequence	Likelihood	Score	Risk score Q1	4	4	16	Risk score Q2	4	4	16	Target (Mar 27)	4	3	12
	consequence	Likelihood	Score																
Risk score Q1	4	4	16																
Risk score Q2	4	4	16																
Target (Mar 27)	4	3	12																
Controls: - Workforce plan governance (KE/Trust Board) including establishment control, vacancy control and CIP/workforce reduction oversight - Safe staffing and medical workforce oversight (e.g., safer staffing reporting, job planning/rota governance and Guardian of Safe Working) linked to escalation routes - Agency/bank management and system working (SEL ICS) including rate alignment and controls to reduce premium spend		Future Risks - Financial recovery/CIP under-delivery impacting ability to sustain safe staffing (including substantive, bank and agency) - Failure of establishment and vacancy controls leading to workforce growth above plan and reduced affordability - Temporary staffing spend increases due to inadequate controls (rate cards, caps, authorisation) and/or insufficient bank fill, creating financial and safe staffing risk - Roster / e-rostering non-compliance (including unplanned uplift, sub-optimal skill mix and weak roster governance) driving overspend and variable quality/safety - Workforce productivity / CIP benefits not delivered or not recurrent (including slippage in workforce redesign and job planning), leading to in-year and recurrent cost pressure - Cost control measures implemented without effective engagement and equality impact management, leading to industrial relations risk, morale impacts and reduced retention (with consequent cost and capacity effects) - Retention, wellbeing and sickness absence pressures (burnout/fatigue) reducing available workforce capacity - Industrial relations/collective disputes impacting delivery and staff engagement (including pay, job planning and local change) - Medical workforce sustainability risks (rota gaps, exception reporting and job planning capacity) impacting service delivery, training and staff experience - Workforce redesign and productivity programmes slowed by operational pressures and limited change capacity - Workforce compliance and governance gaps (mandatory training, appraisal, safer recruitment, professional revalidation and job planning) reducing assurance and increasing regulatory risk - Failure to meet safe staffing expectations and regulatory requirements, impacting quality and patient safety - Inadequate leadership and people-management capability leading to variation in experience, performance and turnover Future Opportunities: - Talent Management Strategy - Strengthened approach to EDI to deliver greater representation across King's - KIM - New senior people leadership team																	
		Assurance of Controls: Positive - Workforce plan, establishment and vacancy control reporting through KE/Trust Board and the People, Education, Inclusion and Research Committee - Safer staffing reports to Trust Board - Quarterly Guardian of Safe Working report (medical safe working assurance)																	
		Rationale for current score - Workforce plan, establishment and vacancy control is in place and reported through Trust governance. - There is established assurance on safe staffing and medical safe working (safer staffing reports and Guardian of Safe Working reporting). - However, performance indicators show continued pressure (vacancies/turnover in hard-to-fill areas, bank and agency above plan in some areas, and sickness absence impacting capacity).																	

• Workforce redesign programme governance via Trust Improvement Programme workstreams, with benefits tracking • Leadership and management capability programmes (senior leadership development, line manager development, talent management strategy) • Health and wellbeing plan, sickness absence management and wellbeing guardianship arrangements • Workforce compliance and governance framework (statutory & mandatory training, appraisal, safer recruitment, revalidation and job planning) with monitoring and escalation • Partnership and industrial relations structures (joint negotiating/consultative arrangements) to manage change, job planning and local agreements • People services improvement and workforce data oversight (ESR/payroll/recruitment), with performance monitoring and data quality checks • System workforce supply actions (SEL ICS/APC groups, KHP education partnerships) to strengthen pipeline, training and recruitment routes • Staff Experience Performance Committee and 'Focus on 3' interventions to improve engagement, retention and experience Gaps in Controls • Variable care group compliance with vacancy/establishment controls and workforce data timeliness/quality • Temporary staffing grip not yet consistent (authorisation, rate card compliance, bank fill and exception escalation) • Inconsistent roster/job planning and paybill controls (e-rostering compliance, planned vs actual, payroll/ESR exceptions) • Sustained delivery risk where financial recovery requirements constrain ability to invest in substantive workforce, retention and safe staffing mitigations • Limited leadership change capacity may slow workforce redesign/productivity programmes and benefits realisation • Workforce supply pipeline constraints (placements, specialist training routes and competition) may outstrip current mitigations • Industrial relations risk remains where pace/scale of change and job planning requirements exceed local partnership bandwidth • Leadership and people-management capability improvement is not yet consistent at scale across all divisions/care groups	• Bank and agency performance monitoring (spend and fill) through the Integrated Performance Report and workforce governance • Health and wellbeing governance (including NED Wellbeing Guardian) and sickness absence reporting • Workforce compliance reporting (statutory & mandatory training, appraisal and safer recruitment) through established governance routes • People services and workforce data assurance (recruitment/payroll/ESR performance measures) and Trust Improvement Programme benefits tracking Negative • Vacancy and turnover metrics (Integrated Performance Report) show continued pressure in hard-to-fill areas • Bank and agency spend/fill performance remains above plan in some areas (Integrated Performance Report) • Sickness absence levels remain a capacity risk (Integrated Performance Report and site performance reviews) • Workforce compliance and job planning/rota governance indicators show variable performance and incomplete assurance in some areas • Staff experience measures (National Staff Survey, pulse survey and medical engagement) indicate continuing improvement needs	• The score reflects gaps in consistent assurance (single people services performance dashboard, industrial relations early-warning indicators, workforce supply pipeline measures, and change capacity/benefits realisation). • Aligns with Finance BAF risk – Financial Stability
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Risk: If the Trust cannot transform the workforce and improve people cost control, it will be unable to deliver the Operating Model and sustainable services, impacting quality and safety, staff engagement and patient experience.

Strategic Objective: A great Place to Work

Risk Owner: Chief People Officer

Committee People, Education and Inclusion Committee

Last review: JUN 2026

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Maintain Workforce Plan governance and monthly establishment/vacancy control, with divisional variance recovery actions.	CPO/CFO	Q1–Q4 2026/27	Workforce stays within plan; improved affordability and reduced unplanned workforce growth.	In progress
Strengthen temporary staffing controls (authorisation, caps/rate cards, bank fill, exception escalation) and deliver divisional agency reduction plans.	CPO/CDO	End Q4 2026/27	Reduced agency spend and premium rates; increased bank fill; improved safe staffing at lower cost.	Ongoing
Align bank/agency rates (rate cards) to reduce premium spend and prevent market distortion.	CPO	Q1–Q4 2026/27	Lower premium rates and reduced agency price inflation across priority staff groups.	In progress
Improve vacancy management and recruitment throughput (end-to-end time-to-hire, controls, and workforce data quality) to reduce avoidable gaps and agency reliance.	CPO / CDO	Q1–Q4 2026/27	Reduced vacancy duration; improved fill; reduced temporary staffing requirement and safer staffing continuity.	In progress
Strengthen roster and job planning discipline (e-rostering compliance, planned vs actual, skill mix, escalation) with divisional review and benefits tracking.	CDO/CPO	Q2–Q4 2026/27	Reduced unplanned uplift and overspend; improved productivity and safe staffing assurance.	Planned
Deliver workforce productivity and CIP benefits (recurrent), with clear owners, milestones and benefits tracking through the Trust Improvement Programme.	CIP Programme Board	Q1–Q4 2026/27	Improved financial sustainability with maintained/ improved quality and safety; reduced recurrent cost pressure.	In progress
Strengthen paybill controls (ESR/payroll exceptions, leaver processing, enhancements/overtime validation) with routine reporting and recovery actions.	CPO	Q3 2026/27	Improved paybill accuracy; reduced avoidable loss/overpayments; stronger financial grip and assurance.	In progress

Risk: Staff Engagement: If the Trust is unable to create and sustain an inclusive and positive culture, staff engagement, wellbeing and retention may deteriorate, adversely impacting quality and safety, patient experience and our ability to provide culturally intelligent, compassionate care to patients and to each other.

Strategic Objective: A Great Place to Work

Risk Owner: Chief People Officer

Committee People, Education & Inclusion Committee

Last review: June 2026

2026/27 Priorities (People Plan): • Delivery of WRES and WDES action plans • Delivery of Gender Pay Gap actions • Recruitment and career pathways to improve representation in senior roles. • Embedding values and behaviours • Improve the people management capability of our line managers • Finalise and deliver our talent management strategy, including agreed aspirational targets for greater representation across the Trust • Deliver Trust-wide civility, respect and psychological safety improvements (including bullying/harassment reduction) • Reduce violence and aggression at work through hotspot action plans, prevention and reporting • Improve employee relations timeliness and confidence (case management standards, learning loops and 'just culture' approach) • Establish a composite culture dashboard that triangulates NSS/pulse, ER/FTSU, violence, turnover/absence and patient feedback for routine Board assurance • DEI Roadmap refresh and longer-term DEI strategy Relevant significant risks on Corporate and Trust RR: • CRR 36 Bullying and Harassment • CRR 567Harm from violence, abuse and challenging behaviour	Risk Scoring: <table><tr><th></th><th>Consequence</th><th>Likelihood</th><th>Score</th></tr><tr><td>Risk score Q1</td><td>4</td><td>3</td><td>12</td></tr><tr><td>Risk score Q2</td><td>4</td><td>3</td><td>12</td></tr><tr><td>Target (Mar 27)</td><td>4</td><td>3</td><td>12</td></tr></table> Appetite rating Averse: Safe staffing levels Cautious: Wellbeing / Rightsizing Open: Culture Eager: Learning and Development		Consequence	Likelihood	Score	Risk score Q1	4	3	12	Risk score Q2	4	3	12	Target (Mar 27)	4	3	12	Future Risks • Deterioration in staff experience, civility and wellbeing (including bullying/harassment and violence at work), impacting retention and patient experience • Staff health and safety risks (including stress, musculoskeletal injury and occupational health capacity) leading to increased absence, claims and regulatory scrutiny • Failure to improve representation and career progression for staff with protected characteristics (including senior leadership diversity) • Poor WRES/WDES, staff survey and medical engagement outcomes reducing confidence in culture and leadership • Inconsistent leadership behaviours and people-management capability across divisions, limiting sustainable culture change • Increased employee relations casework (grievance/disciplinary/whistleblowing) and slower resolution impacting trust, morale and management time • Inconsistent application of policies, procedures and 'just culture' principles across teams increasing perceived unfairness and undermining confidence in leadership • Change fatigue and competing operational pressures leading to limited engagement with culture/EDI programmes and reduced pace of improvement Future Opportunities: • WS2 Improvement Programme • King's improvement Model • Learning and development programmes • Pulse surveys
	Consequence	Likelihood	Score															
Risk score Q1	4	3	12															
Risk score Q2	4	3	12															
Target (Mar 27)	4	3	12															
Controls: • EDI annual plan/roadmap, including WRES/WDES and gender pay gap action plans, with dedicated resource for delivery • King's People and Culture Plan and Staff Experience Performance Committee oversight of staff survey priorities ('Focus on 3') and engagement interventions • Culture/DEI learning offer (e.g., inclusive recruitment, active bystander, cultural intelligence, workplace adjustments) • Staff networks and participation mechanisms to inform priorities and improve lived experience • Health and wellbeing programme, including targeted interventions for priority groups/themes • Health, safety and occupational health arrangements (including stress and musculoskeletal risk management) with monitoring and escalation • Freedom to Speak Up Guardian and routes for speaking up, with reporting to Trust Board • Equality impact/risk assessment framework embedded into change and policy development • Violence and aggression reduction programme • Employee relations case management framework and escalation routes (including grievance/disciplinary/whistleblowing), with learning loops into organisational development	Assurance of Controls: Positive • DEI quarterly progress reporting (including WRES/WDES and gender pay gap actions) • People & Culture Plan and Staff Experience Performance Committee reporting • Freedom to Speak Up reporting to Trust Board and triangulation with employee relations themes and learning actions • Staff health and safety/occupational health and wellbeing reporting (including absence and hotspots) through routine performance and governance routes • Workforce policy/procedure refresh programme and manager standards to support consistency and 'just culture' behaviours • Violence and aggression reduction programme monitoring and reporting (incidents and hotspots) Negative • National Staff Survey results (including engagement, civility and respect, and speaking up) show continued improvement needs	Rationale for current score • EDI delivery is supported by an annual plan/roadmap with dedicated resource, with quarterly progress reporting (including WRES/WDES and gender pay gap actions) to the People, Education, Inclusion and Research Committee. • The People & Culture Plan and Staff Experience Performance Committee provide Board-level oversight of National Staff Survey/pulse results and delivery of the priorities. • Freedom to Speak Up reporting and triangulation with employee relations themes, alongside monitoring of the violence and aggression reduction programme, provide additional assurance on 'speaking up' and safety culture. • However, negative assurance persists: National Staff Survey and pulse results show continuing improvement needs and variable experience/change fatigue across care groups. • WRES/WDES outcomes and ER/FTSU/violence indicators highlight persistent inequality and culture risks in some areas, despite values and behaviours being well established. • The score also reflects the current gap in assurance: a single composite culture dashboard (triangulating NSS/pulse, ER/FTSU, violence,																

- Policy and procedure refresh with clear manager standards to support consistent application and 'just culture' practice - Leadership behaviours and people-management capability development (values and behaviours, inclusive leadership and manager standards) Gaps in Controls - Consistency and pace of culture/DEI delivery varies by division/care group, with competing operational priorities contributing to change fatigue - Employee relations capacity and timeliness (case investigation and resolution) may not be sufficient to prevent deterioration in trust and morale at times of peak demand - Leadership behaviours and line-manager capability are not yet consistently embedded across all teams to sustain culture change - Composite culture measurement and triangulation (survey, ER, FTSU, turnover/absence, patient feedback) not yet fully developed as a single consistent view	- Trust pulse survey results indicate variable experience and risk of change fatigue across care groups - WRES and WDES outcomes show persistent inequality/experience gaps and representation challenges - Health and safety indicators (e.g., stress/MSK themes, absence) and local feedback indicate continued staff harm risk and variable policy application in some areas - Employee relations/FTSU indicators (case volumes, themes and resolution times) and violence at work reporting highlight ongoing culture risk in some areas Gaps in Assurance - A single, routinely reported composite culture dashboard is not yet in place (triangulating NSS/pulse, ER/FTSU, violence, turnover/absence and patient feedback), including consistent ER timeliness measures.	turnover/absence and patient feedback, including ER timeliness) is not yet routinely reported.
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Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Establish and run Staff Experience Performance Committee (SEPC), with a standard operating model for care group action plans and monthly progress reporting.	DOC	Q1–Q4 2026/27	Improved NSS/pulse and medical engagement metrics; consistent implementation and assurance of staff experience improvements across care groups.	In progress
Deliver Trust-wide civility, respect and psychological safety programme (including anti-bullying/harassment actions, active bystander training and local team charters), prioritising hotspot areas identified through NSS/FTSU/ER data.	DOC	Q2 2026/27 (launch); Q4 2026/27 (impact review)	Reduction in bullying/harassment indicators; improved speaking up and civility scores; fewer culture-related ER cases in hotspots.	Planned
Implement violence and aggression at work hotspot action plans (prevention, environmental controls, security response, reporting and post-incident support), with quarterly review of incident trends and learning.	DOC / CNO	Q1 2026/27 (hotspots agreed); Q3 2026/27 (mid-year review)	Reduced violence/aggression incidents and improved reporting/support; improved staff safety perceptions and retention in hotspot areas.	In progress
Refresh and deliver the EDI roadmap (including WRES/WDES and Gender Pay Gap actions), with clear executive sponsorship, milestones and care group delivery plans for representation, progression and experience gaps.	DOC	Q2 2026/27 (refresh agreed); Q4 2026/27 (delivery checkpoint)	Improved WRES/WDES domains and reduced experience gaps; improved senior representation and progression for under-represented groups.	In progress
Strengthen line manager capability and consistency through a core manager offer and standards (values & behaviours, inclusive leadership, ER fundamentals, sickness/attendance, difficult conversations), with uptake tracked and targeted support for hotspots.	DOC / DEPUTY CPO	Q3 2026/27 (standards/offer in place); Q4 2026/27 (uptake review)	Improved staff survey confidence in management; reduced ER case volumes and improved timeliness; improved retention and wellbeing.	Planned
Improve employee relations (ER) timeliness and confidence through case management standards, triage, investigation support and learning loops (including a 'just culture' approach), with routine reporting of volumes, ageing and outcomes.	DEPUTY CPO	Q2 2026/27 (standards live); Q4 2026/27 (improvement evidenced)	Reduced case ageing and improved timeliness; improved perceptions of fairness; reduced management time lost to protracted cases.	In progress
Implement a composite culture dashboard for Board assurance (triangulating NSS/pulse, ER/FTSU themes and timeliness, violence/aggression, turnover/absence and relevant patient feedback), with agreed thresholds and escalation.	DOC	Q3 2026/27	Single consistent view of culture risk and mitigations; earlier identification of hotspots and targeted intervention; improved assurance to PEIRC/Board.	Planned
Deliver targeted wellbeing and occupational health actions for priority staff groups/themes (stress and MSK hotspots), including proactive OH support, reasonable adjustments, and improved access to psychological support.	DOC	Q1 2026/27 (priorities agreed); Q4 2026/27 (impact review)	Reduced stress/MSK absence and improved wellbeing measures; improved retention and engagement in priority areas.	In progress

Risk: Capability, Talent and Leadership: If the Trust is unable to build and sustain leadership and workforce capability (including a robust talent pipeline for critical clinical, operational and corporate roles), it will be unable to deliver the Trust Strategy and Operating Model at pace, leading to variable quality and safety, reduced productivity and financial performance, and poorer staff experience and retention.

Strategic Objective: A great place to work

Risk Owner: Chief People Officer

Committee People, Education Inclusion and Research Committee

Last review: June 2026

2026/27 Priorities (People Plan): - Deliver the Trust’s talent management strategy (pilot and scale) with clear pathways for clinical, operational and corporate roles - Build leadership capability at scale (values-led, inclusive and improvement-focused) aligned to the new divisional model - Strengthen succession planning for critical posts and reduce reliance on interim and agency leadership cover - Improve line manager fundamentals (capability, confidence and consistency) to reduce variation in staff experience and performance - Develop workforce capability for transformation (change, improvement, productivity and digital) to deliver the Trust Operating Model Relevant significant risks on Corporate and Trust RR: - CRR (to confirm) – Leadership / workforce capability - CRR (to confirm) – Workforce supply / retention dependencies	Risk Scoring: <table><tr><td></td><td>Consequence</td><td>Likelihood</td><td>Score</td></tr><tr><td>Risk score</td><td>NEW</td><td>NEW</td><td>NEW</td></tr><tr><td>Target (Mar 27)</td><td>NEW</td><td>NEW</td><td>NEW</td></tr></table> Appetite rating Averse: Safe staffing levels Cautious: Wellbeing / Rightsizing Open: Culture Eager: Learning and Development		Consequence	Likelihood	Score	Risk score	NEW	NEW	NEW	Target (Mar 27)	NEW	NEW	NEW	Future Risks - Insufficient succession for critical leadership roles (clinical, operational and corporate) leading to instability, slower decision-making and variable performance - Capability gaps in line management (performance, wellbeing, ER, sickness, rostering/job planning) driving variation in staff experience, productivity and cost control - Talent pipeline and supply constraints in key professions (clinical specialists, diagnostics, theatres, digital, estates) impacting service delivery and transformation, including where educational development, placements and training routes are insufficient - Insufficient educational development and CPD (including clinical educator capacity, supervision, protected learning time and access to training) leading to slower time-to-competence, variable practice, reduced retention and greater reliance on short-term staffing solutions - High turnover in leadership and priority roles leading to increased interim reliance, loss of organisational memory and slower delivery of the strategy - Inadequate leadership development and support for the divisional model leading to inconsistent governance, improvement and patient experience, particularly where funding constraints limit backfill/protected time and investment in development Future Opportunities: - Talent Management Strategy (pilot and roll-out) and succession planning framework - Leadership development offer (senior leadership, divisional leadership and line manager core offer) - SEL/KHP education partnerships to expand pipeline, placements and recruitment routes - King’s Improvement Methodology and workforce transformation programmes to build improvement capability
	Consequence	Likelihood	Score											
Risk score	NEW	NEW	NEW											
Target (Mar 27)	NEW	NEW	NEW											
Controls: - Talent Management Strategy programme governance (pilot Q3 2026/27) with equality and representation targets - Leadership development offer (Senior Leadership Programme, divisional leadership development and core line manager programmes) - Succession planning and critical role review for executive, divisional and key operational posts - Education and workforce supply partnerships (SEL/KHP) including placement capacity, apprenticeships and recruitment pipelines - Appraisal, objectives and development planning expectations with compliance monitoring - Improvement capability building through King’s Improvement Methodology and improvement programme participation Gaps in Controls - Succession planning and talent identification not yet consistently embedded across all divisions/care groups - Limited consolidated view of critical roles, pipeline health and readiness (including time-to-competence and bench strength)	Assurance of Controls: Positive - Leadership programme participation and feedback (senior leadership, divisional and manager offers) - Talent pilot governance reporting (progress, diversity and pipeline metrics) through PEIRC - Appraisal and mandatory training compliance reporting through performance governance Negative - Vacancy and turnover in key leadership and specialist roles remains a risk in some areas - Staff survey/medical engagement feedback indicates variation in confidence in local leadership and management Gaps in Assurance - A single, routine capability and pipeline dashboard is not yet in place (succession readiness, bench strength, critical roles, time-to-fill/time-to-competence and leadership churn).	Rationale for current score - A leadership development offer is in place and the Talent Management Strategy is being piloted, but capability and pipeline strength are not yet consistent at scale across all divisions. - Vacancy/turnover in some key roles and variation in staff confidence in local leadership indicate an ongoing risk to delivery pace and performance. - Assurance is limited by the absence of a single pipeline dashboard and consistent succession readiness metrics.												

- Variation in line manager capability and access to development, with uneven uptake and protected time for learning, exacerbated where funding constraints limit backfill and programme capacity - Interim reliance and vacancy churn can disrupt continuity and reduce time available for development and improvement			
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Risk: Capability, Talent and Leadership: If the Trust is unable to build and sustain leadership and workforce capability (including a robust talent pipeline for critical clinical, operational and corporate roles), it will be unable to deliver the Trust Strategy and Operating Model at pace, leading to variable quality and safety, reduced productivity and financial performance, and poorer staff experience and retention.

Strategic Objective: A great place to work

Risk Owner: Chief People Officer

Committee

People, Education and Inclusion Committee

Last review: Jun 2026

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Deliver Talent Management Strategy pilot and scale (clear pathways, criteria and EDI targets for key roles).	DOC	Q3 2026/27 (pilot); Q1 2027/28 (scale plan)	Improved pipeline strength for critical roles; improved senior representation and progression.	In progress
Implement consistent succession planning for executive, divisional and critical operational/clinical posts (ready-now/ready-soon).	CEO/CPO	Q4 2026/27	Reduced leadership vacancies and instability; reduced interim reliance and churn.	Planned
Create a single critical roles and pipeline dashboard (bench strength, readiness, time-to-fill, time-to-competence, leadership churn).	CPO	Q3 2026/27	Improved assurance and early warning; targeted investment and interventions.	Planned
Implement core line manager offer/standards (performance, wellbeing, ER, sickness, rostering/job planning) with uptake tracked.	DOC/ CPO	Q3 2026/27	Improved management consistency; improved staff experience, productivity and cost control.	Planned
Deliver divisional leadership development aligned to the new operating model (governance, improvement, quality and people leadership).	DOC/ CPO	Q4 2026/27	Improved leadership capability and delivery pace; reduced variation in performance and patient experience.	Planned
Strengthen pipeline partnerships (SEL/KHP) for placements, apprenticeships and recruitment routes in priority professions.	DOC	Q2–Q4 2026/27	Improved supply for hard-to-fill roles; reduced vacancy duration and service fragility.	In progress
Reduce interim leadership reliance through planned conversions, handovers and recruitment/succession actions in priority areas.	CDO/CPO	Q4 2026/27	Improved leadership stability and continuity; reduced cost and delivery risk.	Planned
Increase uptake and protected time for development (leadership, line manager and improvement capability), prioritising hotspots.	CDO/CPO	Q2–Q4 2026/27	Improved capability at scale; reduced variation; improved retention and performance.	Planned

Strategy Objective: Financial Sustainability. Risk: If the Trust is unable to improve the financial sustainability of the service it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future Risk Owner: Chief Finance Officer																																				
Committee		Finance and Commercial Committee	Last review: June 2026																																	
2026/27 Priorities: - Grip and control - Delivery of the 2026/27 Operational plan - FGR – improvement on the maturity scale - Delivery of year 2 of the Financial Strategy (inc. component parts) - Refresh of Financial Strategy and agreement of Medium-Term Financial Plan Relevant significant risks on Corporate and Trust RR: 3608 Identification & delivery of efficiency requirements 3609 Expenditure Control 3610 Investment decisions 3611 Validity of activity assumptions 3612 Management of activity in line with contract arrangements 3613 Cost of Additional Capacity 3614 Capital programme 3617 Cost Inflation 3618 Strategic investments 3926 Withdrawal of Deficit Support Funding 3975 Changes to COS 45 VAT regulations 4108 Industrial action 4125 Impact of national review of band 5 nurses		Risk Scoring: <table><thead><tr><th></th><th>Impact</th><th>Likelihood</th><th>Score</th></tr></thead><tbody><tr><td>Gross Risk</td><td>5</td><td>5</td><td>25</td></tr><tr><td>Previous mitigated score</td><td>5</td><td>5</td><td>25</td></tr><tr><td>Previous mitigated score (April 2026)</td><td>5</td><td>4</td><td>20↓</td></tr><tr><td>Current mitigated Risk score – (June 2026)</td><td>5</td><td>5</td><td>25↑</td></tr><tr><td>Target (Mar 2027)</td><td>5</td><td>3</td><td>15</td></tr><tr><td>Target (Mar 2030)</td><td>5</td><td>2</td><td>10</td></tr></tbody></table> Appetite rating <table><tbody><tr><td>Control environment</td><td>Averse</td></tr><tr><td>Cost Improvement Programme</td><td>Open</td></tr></tbody></table> Risk Appetite:			Impact	Likelihood	Score	Gross Risk	5	5	25	Previous mitigated score	5	5	25	Previous mitigated score (April 2026)	5	4	20↓	Current mitigated Risk score – (June 2026)	5	5	25↑	Target (Mar 2027)	5	3	15	Target (Mar 2030)	5	2	10	Control environment	Averse	Cost Improvement Programme	Open	Future Risks - Shortfall in CIP identification and delivery compared with the pace of change set out in approved financial strategy - Additional efficiencies through 'frontier shift' are not planned and delivered at the pace required by financial strategy - Accelerated pace of change to address distance to 'fair shares' vs approved pace of change in financial strategy - Failure to control expenditure and activity in line with plan resulting in underlying financial performance deviating from the pace of change required by financial strategy. - Cash shortfall associated with under delivery of financial plan and associated risk of withdrawal of deficit support funding - Failure to deliver cost weighted activity in line with plan resulting in income shortfalls. Future Opportunities: - Alignment of efficiency development with the King's Improvement Method (KIM) with four key workstreams to support delivery of the 2026/27 CIP, each with assigned Executive Director and SRO - Evolution of the KIM approach and Step Change Projects to support development of plans for the lifetime of the financial strategy with successful delivery against them - Move from lower quartile to upper quartile Model Health System performance against peers by 29/20 - Delivery of 'frontier shift' across the life of the financial strategy to provide a further step change in productivity
	Impact	Likelihood	Score																																	
Gross Risk	5	5	25																																	
Previous mitigated score	5	5	25																																	
Previous mitigated score (April 2026)	5	4	20↓																																	
Current mitigated Risk score – (June 2026)	5	5	25↑																																	
Target (Mar 2027)	5	3	15																																	
Target (Mar 2030)	5	2	10																																	
Control environment	Averse																																			
Cost Improvement Programme	Open																																			
Controls: - Annual integrated activity and financial plan - Capital prioritisation process - Key financial system controls framework - Investment Board review and challenge of revenue and capital business cases. Board committee review of business cases >£5m - Strategic Development Review (SDR) / financial performance review meetings – at Care Group and Divisional level. - Vacancy/Pay controls process reviewed/updated incl. temporary staffing controls with 'break-glass' approvals from April 2026 - Non-Pay control panel - Monthly ESR and general ledger reconciliations - Transformation programmes in place to support improvements in efficiency and productivity - Budget holder training - Engagement with APC / ICS partners and finance leads to support SEL system financial planning - Long term energy contracts in place - Efficiency and Sub Efficiency Board governance in place - Scheme of Delegation and Standing Financial Instructions (SFIs) (Control) - Development of remedial plans where budget overspends identified in-year. - Fully signed contracts for 2025/26 Gaps in Controls - Fully signed contracts for 2026/27 - Multi-year improvement plan		Assurance of Controls: Positive - Monthly Financial performance reporting – KE, FCC & Board 2026/27 CIP delivery oversight embedded and reviewed fortnightly by executive and monthly by Board, with weekly flash reports to Executive leads. - Financial performance reporting – Improved reporting pack implemented including monthly forecasting, care group analysis, SPR and risk update. - Long-term financial strategy in place - Subsidiaries review complete and action plans implemented and embedded as BAU. - Continuation of SEL triple lock oversight of pay and non-pay expenditure (vacancy control and non-pay over £25k) - Financial Governance Review Follow Up 2024/25: 'Significant assurance with minor improvement opportunities'. Negative 2026/27 CIP not fully developed with £17.5m developed at Gateway 3 as 18 June 2026 . - Division recovery actions on overspends not fully identified. Gaps in Assurance - None identified		Rationale for current score - Trust is in National Oversight Framework Segment 3 and exited the Recovery Support Programme in April 2026. - Trust is in breach of its licence and is subject to enforcement undertakings. A compliance certificate was issued for Financial Governance undertakings on 30 June 2025, however remaining undertakings remain in place. - Trust 2026/27 Financial Plan is to deliver a break-even with an underlying deficit of £87.5m. - Financial Governance Review action plan has been delivered - Internal Audit Annual Conclusion 2025/26 – Financial reporting and management: <i>Green: Overall findings on design showed controls are effectively designed and our testing showed controls are operating effectively.</i> - External Audit value for money rating amber. No significant weakness in arrangements identified. Improvement recommendation raised to progress the earlier identification of recurrent CIP. £1.9m deterioration in the year to date underlying position against £16.1m plan in May 2026. £70.5m CIP planning gap and full year forecast risk against delivery of identified planned schemes at May 2026.																																

Strategy Objective: Financial Sustainability.

Risk: Financial Sustainability: If the Trust is unable to improve the financial sustainability of the service it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future

Risk Owner: Chief Finance Officer

Committee Finance and Commercial Committee

Last review date: June 2026

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Refresh the 2026/27 Trust's financial strategy for the 2025/26 outturn with approval by Trust Board.	CFO	By end June 2026	A refreshed financial strategy setting out route to financial stability and improved productivity with Trust Board approved pace of change.	~~Ongoing~~ -Complete
Workstream leads to accelerate development of mature efficiency schemes into Gateways 0-3, and / or identify additional schemes, to ensure the full planned CIP is identified.	CFO	By end July 2026	Full CIP in place, underpinned by operational plans, to deliver against 2026/27 efficiency requirement set out in financial strategy and 2026/27 operational plan. All schemes progressed to Gateway 3.	Ongoing
Divisions to implement updated Phase 1 and Phase 2 Financial Interventions actions to reduce budget overspends in line with agreed trajectories. I. Areas of focus include delivery of elective activity plans, grip and control of bank and agency spend and continued focus on PTS.	CFO	By end August 2026	Consolidated forecast developed with actions to mitigate identified 2025/26 financial risks to be reported in Month 5.	Ongoing
Annual Financial Governance internal audit.	CFO	By end October 2026	Re audit complete with minimum of 'integrated' maturity assessment (level 4 of 5) across all domains and action plan implementation underway.	Ongoing
Complete Operational and Financial Planning cycles 1 -4 for 2027/28	CFO	By end March 2027	An agreed operational and financial plan signed off at Trust, system and NHSE level. Timetable and framework for 2027/28 to be agreed.	Ongoing
Review PMO, transformation and improvement capacity and capability with recommendations for changes in Trust-wide approach	DCEO	tbc	Transformation and improvement capability more closely aligned to delivery of the strategic requirements of the Trust	Ongoing

Strategy Objective: Financial sustainability																																			
Risk: If the Trust is unable to protect and maintain its critical infrastructure (estate, ICT and medical equipment) our ability to deliver safe and sustainable services will be adversely impacted.																																			
Risk Owner: Deputy Chief Executive		Committee Finance and Commercial Committee	Last review: June 2026																																
2026/27 Priorities: • Delivery of the 2026/27 Operational plan • Delivery of year 2 of the Financial strategy (inc component parts) • Delivery of the capital programme and equipment replacement plans. Relevant significant risks on Corporate and Trust RR: 3614 Capital programme (20) 3617 Cost Inflation(8) 3682 PRUH (PFI) building - Estate issues (20) 213 IPC risks associated with estates (12)		Risk Scoring: <table><thead><tr><th></th><th>Impact</th><th>Likelihood</th><th>Score</th></tr></thead><tbody><tr><td>Gross risk</td><td>5</td><td>5</td><td>25</td></tr><tr><td>Previous mitigated risk (Q4 25/26)</td><td>4</td><td>4</td><td>16</td></tr><tr><td>Previous Risk Score (Q1)</td><td>4</td><td>4</td><td>16</td></tr><tr><td>Current Risk score (Q2)</td><td>4</td><td>4</td><td>16</td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td>Target (Mar 27)</td><td>4</td><td>3</td><td>12</td></tr></tbody></table> Appetite rating Risk Appetite: <table><tbody><tr><td>Compliance</td><td>Minimal</td></tr><tr><td>Experience</td><td>Open</td></tr></tbody></table>		Impact	Likelihood	Score	Gross risk	5	5	25	Previous mitigated risk (Q4 25/26)	4	4	16	Previous Risk Score (Q1)	4	4	16	Current Risk score (Q2)	4	4	16					Target (Mar 27)	4	3	12	Compliance	Minimal	Experience	Open	Future Risks • Aging medical equipment, particularly in radiology • Poor ventilation/air/water in parts of the aged estate particularly at DH. • Cooling systems for Pharmacy across PRUH and SS Future Opportunities: • Availability of capital • Soft FM tender at DH • Decant wards to facilitate estates work • Estates strategy
	Impact	Likelihood	Score																																
Gross risk	5	5	25																																
Previous mitigated risk (Q4 25/26)	4	4	16																																
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Current Risk score (Q2)	4	4	16																																
Target (Mar 27)	4	3	12																																
Compliance	Minimal																																		
Experience	Open																																		
Controls: Estates Maintenance • Estates/IPC ward-level risk assessment and prioritisation • Fire Risk Assessments • Water safety management service arrangements • IPC Committee – risk and governance arrangements • IPC audits and sampling • Bi-monthly Health & Safety Committee – review of estates H&S risks • Estates Compliance Programme • Duplicate • Water Safety, Ventilation, Medical gases, Electrical, Committees in place meeting regularly. • Fire Action group in place at PRUH • HTM control process management Development • Capital planning and prioritisation process 25/26. Capital Plan in Place • Backlog maintenance procedure • Scheme of Delegation and Standing Financial Instructions (SFIs) (Control) Gaps in Controls • Estates governance in review		Assurance of Controls: Positive • Annual Premises Assurance Model submission • Designated Persons and Authorising Engineers in place in line with HTM requirements providing audit reports • IPC BAF • Health and Safety and fire training compliance • Annual 6 facet (Condition) surveys Negative • LFB enforcement notice for DH. • LFB notice of deficiency received for PRUH • CAPITEC reviews • PFI Lippit Fire report, Trust Capita Fire reports. • Internal Audit Review of Estates Backlog maintenance found partial assurance with opportunities for improvement. Gaps in Assurance • None identified	Rationale for current score • Backlog Maintenance limitations due to budget and decant capacity • Off track on delivery of strategy priorities due to resourcing, supplier dependencies and co-ordination issues. • Improvement in PFI management, particularly at PRUH • Scope for improvement of estates governance.																																

BOLD Objective: Financial Sustainability.**Risk: Financial Sustainability: If the Trust is unable to improve the financial sustainability of the service it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future****Risk Owner: Chief Finance Officer****Committee Finance and Commercial Committee****Last review: April 2026****Action Plan**

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Completion of 2026 Premises Assurance Model	Deputy CEO	September 2026	Provision of assurance that robust systems are in place to ensure premises and associated services are safe, efficient, effective, and of high quality, and identification of any gaps.	No started
Strategic Estates Review	Deputy CEO	November 2026	Set of recommendations that will deliver clear and robust governance arrangements, eradication of any duplication or inefficient working practices; maximise alignment between the contractual arrangements held across estates and facility functions and enable the production of a long-term Estates Strategy that supports King's strategic ambitions	Ongoing
Work to review PFI performance across the PRUH and DH	Chief Delivery Officer	October 2026	Improved management of the Trust's PFI arrangements on both sites:	Provider in place and work is underway.
Delivery of the 2026/27 Capital Programme	Deputy CEO	March 2027	Backlog maintenance plan delivered and equipment replaced in line with prioritised plans.	The business case has been approved and work is underway

Strategy Objective: Pioneering Research, Innovation and Education

Risk: Values and Behaviours: If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre

Risk Owner: Chief Medical Officer

Committee Quality and Research Committee

Last review: June 2026

2026/27 Priorities (Research Roadmap): - strengthen research and innovation leadership and governance - Increase the number of studies set up and approved. - Implement a visible innovation route and co-ordinated innovation system - Expand education and training opportunities for staff, carers and volunteers - Strengthen the organisational support needed to enable innovation. Relevant significant risks on Corporate and Trust RR: TRR422 Reduction in R&D Funds due to CRN and RCF allocation reductions (20) TRR3836 Unable to complete mandatory paperwork required by regulators (15) TRR246 Lack of capacity for research scanning(9) TRR656 Wearing of safety glasses in the sample processing areas of the CRF (6)	Risk Scoring: <table><tr><th></th><th>Consequence</th><th>Likelihood</th><th>Score</th></tr><tr><td>Gross score</td><td>5</td><td>4</td><td>20</td></tr><tr><td>Risk score (Q1)</td><td>3</td><td>4</td><td>12</td></tr><tr><td>Risk score Q2</td><td>3</td><td>4</td><td>12</td></tr><tr><td>Target (Mar 27)</td><td>3</td><td>4</td><td>12</td></tr></table> Appetite rating The Trust has significant appetite to pursue innovation and challenge current working practices in pursuance of its commitment to clinical excellence, providing that patient safety and experience is not adversely affected.		Consequence	Likelihood	Score	Gross score	5	4	20	Risk score (Q1)	3	4	12	Risk score Q2	3	4	12	Target (Mar 27)	3	4	12	Future Risks - Access to funding and commercial research opportunities. - Ability to meet the 150-day target for commercial trials by end March 2027. - Loss of the ARC - Triple lock impact on recruitment Future Opportunities: - Strengthened relationships through KHP and new KHP strategy - ARC changes. - Agreement on single sponsorship with KCL - Increased collaboration through Academic Committee in Common - Innovation Strategy - R&D Strategy
	Consequence	Likelihood	Score																			
Gross score	5	4	20																			
Risk score (Q1)	3	4	12																			
Risk score Q2	3	4	12																			
Target (Mar 27)	3	4	12																			
Controls: - KCH Research & Innovation Strategy and annual plans - Engagement in King's Health Partners (KHP), Academic Health Science Network - Action plans to improve the diversity of research participants and increase awareness and engagement in research design and delivery within our local community - Research & Innovation governance and risk management structure in place, led by Chief Medical Officer - Quality Recovery Plan in place - Key policy framework including research misconduct policy - R&D handbook and mandatory induction for all new research staff. Gaps in Controls - Physical capacity to participate in drug trials and trials requiring clinical research facilities at PRUH - Longer-term research workforce model (linked to funding and investment planning)	Assurance of Controls: Positive - Annual strategy progress update reported to Board of Directors – progress aligned to key aims - Research progress metrics reported to Board – e.g. number of approved commercial studies and trends - KHP Ventures in place. - Joint Translational Research function agreed through KHP. - Academic Committee in Common Negative - Critical finding by MHRA in a routine inspection (related to KHP) - Loss of the ARC. - Internal Audit and LCFS Review of Academic Research Governance – partial assurance with improvements required - Critical MHRA triggered inspection (March 2026) Gaps in Assurance - R&D governance	Rationale for current score - Trust is the highest recruiter nationally to NHIR portfolio studies - Innovation portfolio has moved to the CQI team. QI and Innovation Strategies are being developed. - Challenging economic landscape for research with reduced commercial studies and reduced NIHR funding. - Trust unlikely to meet 150 target in 2026/27, although some limited additional funding has been secured and a review of approval processes is underway. 2026/27 performance to date showing some improvement - Negative assurance received from Internal Audit and MHRA reviews - Internal review of current processes identifies areas for development.																				

Strategy Objective: Pioneering Research, Innovation and Education.

Risk: Values and Behaviours: If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre

Risk Owner: Chief Medical Officer

Committee Quality and Research Committee

Last review: date June 2026

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	KEY UPDATES
Develop plans to increase the Trust's accredited research capacity at the PRUH	Chief Medical Officer	Q1-Q4 2024/2025	A culturally competent workforce that delivers compassionate care to patients.	A research nurse has been appointed, but space constraints continue to be a concern. A plan to free up space in 2023 did not come to fruition.
Develop an innovation strategy	Chief Medical Officer	On-going	Culturally competent workforce. Improved staff engagement.	COMPLETE
Development of the Research and Innovation roadmap	Director of Research	By June 2026	Detailed outcomes outlined in the Research Roadmap.	Refreshed R&D strategy being developed in line with Trust strategy.
Development of the KHPCTO and Joint Research Office	Chief Medical Officer	TBC	- Support growth in biomedical research - Enhance research career development and capacity building for staff - Strengthen opportunities for patients at KCH to benefit from research undertaken across the partnership - Align complementary strengths in translational activities across KHP - Provide support for the Governance of the TRC processes	Being developed through KHP.
Delivery of the MHRA remediation plan	Chief Medical Officer	End December 2026	Robust quality governance in place for all research and commercial trials	In implementation

Strategy Objective: High Quality Care

Risk: If the Trust does not have adequate arrangements in place to support the delivery of safe and effective care, this may have an adverse impact on patient outcomes and lead to an increased risk of avoidable harms.

Risk Owner: Chief Medical Officer and Chief Nursing Officer and Executive Director of Midwifery

Committee Quality and Research Committee

Last review: date June 2026

2026/27 Priorities:

- Experience of Care Improvement Framework and developing a quality culture
- Implement a ward quality dashboard.
- Delivery of the Trust Quality Priorities:
 - Implementing and embedding NATSSIPs2 across all areas carrying out invasive procedures
 - Improving the experience of patients with learning disabilities and autism
 - Improving outcomes of acutely unwell.

Relevant significant risks on CRR:

295 Mental Health patients waiting for admission in a non-MH environment (15)
 3986 Monitoring to prevent patient deterioration (12)
 3419 Corridor Care (20)
 3458 Delayed Diagnosis (12)
 3991 Delayed pathology results (15)
 387 Water Contamination (10)

Risk Scoring:

	Impact	Likelihood	Score
Gross	5	4	20
Previous quarter mitigated (Q1)	4	3	12
Current mitigated (Q2)	4	3	12
Target mitigated (Mar 27)	4	2	8

Risk Appetite:

Safety	Adverse
Outcomes	Minimal
Experience	Cautious

Future Risks

- Industrial action impacting delivery treatment pathways (including statutory performance standards)
- Clinical services transformation benefits not delivered impacting leading to corridor care (poor patient experience staff burnout/fatigue).
- Financial recovery and under delivery impacting ability to maintain safe staffing (safe care delivery, outcomes, experience)
- Failure to meet safe staffing expectations and regulatory requirements, impacting quality and patient safety.
- Cost improvement programmes implemented without effective engagement and quality and equality impact assessments, leading to reduced morale and cultural impact on multiprofessional teams (with impact consequently on quality and safety)
- Violence and aggression leading to retention, sickness absence (morale/burnout) impacting quality and patient safety
- Inadequate clinical leadership capability leading to variation in care delivery and impacting on quality and safety (patient outcomes, mortality)
- Medicines management non-compliance (antibiotic prescribing, time critical medicines, reconciliation, poly pharmacy) driving impact on quality and safety (reduced effectiveness of patient pathways and increased length of stay, corridor care)
- Estate management and regulatory compliance driving variability in the management of infection, prevention and control (Cleaning, hard FM i.e. macerator repairs, water, ventilation, decontamination) CQC Inspection non-compliance with statutory standards and frameworks (clinical safety standards, quality and cleanliness standards) leading to legal enforcement of quality and safety standards.
- Inadequate clinical leadership and failure to meet safe staffing controls leading to poor communication (increased complaints, upheld PHSO, PSII increase and moderate harm and above) impacting quality and safety.

Future Opportunities:

- King's Improvement Method implementation
- Clinical transformation as a result of the Improvement Programme (Clinical Services Reconfiguration)
- Review of patient safety across the health and care landscape (Penny Dash)
- 10 year plan and new 2026-31 Trust Strategy
- Experience of Care Improvement Framework

Controls: • Risk management policy and procedures • Incident management policy and procedures • Mortality Reviews and Learning from Deaths • Patient Reported Outcome Measures (PROM) • Quality governance and reporting structure and Strategy Deployment Reviews • Care group and divisional performance reviews to support oversight and escalation • Patient Safety Incident Framework (PSIRF) panels in place at care group, site and group to oversee review of incidents. • Trust wide PSIRF groups looking at themes and learning. • Patient safety committee with oversight of learning and PSII investigations • Care group quality governance development programme to support care groups progress governance and risk management arrangements • Corporate induction and programme of mandatory training for all staff • Appraisal, CPD and revalidation arrangements for registered professionals • Development of quality dashboards to provide real-time information to support decision-making • Inphase • Policy and clinical guidelines framework • MEG Audit Process – self assessment • Integrated Quality Report • Workforce establishment reviews in place • Sepsis lead clinical appointed. • PALS & complaints team fully resourced. • Worry & concerns implemented (Martha's Rule). • Staff vaccination programme Gaps in Controls • Quality Assurance Framework (QAF) being refreshed	Assurance of Controls: Positive: • CQC patient survey reports and friends and family test • Quality performance reporting to OCB, KE, QRC and Board • Safe Nurse & Midwifery staffing reports presented to Board of Directors • Quarterly patient outcome reporting to QRC • Internal Audit reports 2025/26 – PSIRF significant assurance with minor improvement opportunities • Complaints process embedded • PALS – improvement with no backlog • External service reviews (ad hoc) • CQC Well-Led (Feb 2023) – Good • MIS Incentive Scheme full compliance 2025/6. • Patient outcomes and national clinical audit results. Partial or Negative: • CQC Inpatient results 2024 require improvement • Never events numbers increasing • FSUG themes in relation to patient safety, confidence in speaking up and detriment • CQC inspections (CYP, Maternity and Adult Medicine DH) rated as requires improvement (March 2026) Gaps in Assurance • Awaiting outcome of CQC service inspections (Medical and Gerontology at PRUH and Orpington, ED and Surgery at Denmark Hill)	Rationale for current score • Good controls and assurance in place. • Improvement in key services such as Maternity as evidenced through MIS and exit from the Maternity Support Programme. • Patient outcomes as expected or better in most areas • Reduced score to risk 295 – improved controls in place to maintain safety of patients • Reduced score to risk 3458 • Positive assurance from KMPG internal audit review of PSIRF • Assurance received from harm reviews (pathology and Neuro MRI). • CQC inspections of Children and Young People (DH), Maternity (DH and PRUH) and Adult Medicine rated as requires improvement. • Recruitment of Patient Expert Partners underway • Duty of Candour improvement needed • Corridor Care metrics now reporting
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Strategy Objective: High Quality Patient Care

Risk: If the Trust does not have adequate arrangements in place to support the delivery of safe and effective care, this may have an adverse impact on patient outcomes and lead to an increased risk of avoidable harms.

Risk Owner: Chief Medical Officer and Chief Nurse

Committee Quality and Research Committee

Last review: date June 2026

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Implementation of the ward quality dashboard	Chief Nursing Officer and Executive Director of Midwifery.	Q4 2025/26	To improve oversight and correlation of safety and quality at ward level to enable local management, learning and focussed support.	Completed
Implementation of a Harm Free Care programme and Fundamentals of care (Productive work)	Chief Nursing Officer and Executive Director of Midwifery.	December 2025	Improve patient safety and outcomes by reducing preventable patient harm.	Piloted in 2025/26. Now rolling out in implementation
Implementation of 7-day clinical standards to ensure admitted patients receive consistent, high-quality care every day of the week.	Chief Medical Officer	March 2026	Improve patient care, safety and outcomes by ensuring care is not delayed.	Delayed pending CIP decisions
Implementation of the Trust Quality Priorities 2025/27	Chief Nursing Officer and Executive Director of Midwifery.	March 27	Improved patient safety, outcomes and experience.	Ongoing.
Implementation of the Experience of Care Framework Action Plan	Chief Nursing Officer and Executive Director of Midwifery.	April 2027	Improved safety, outcomes and experience	In implementation
Strategy Action Plans for High Quality Patient Care				

Strategy Objective: Strong Successful Partnerships

Risk: System Sustainability - If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely on our ability to achieve system transformation in line with the NHS 10-year plan ambition.

Risk Owner: Deputy Chief Executive

Committee

Board of Directors

Last review: date July 2026

2026/27 Priorities: 1. To complete the first year of our partnerships strategic objectives Strong Successful Partnerships What's our ambition for the next five years? - To transfer up to 30% of hospital care to an appropriate, alternative setting by 2031 What will this mean for our patients and communities? - People will get high-quality care closer to home, through virtual appointments and monitoring, meaning fewer hospital visits and less time as an inpatient 2. To develop our role as the integrator host in Bromley Relevant significant risks on TRR: - None	Risk Scoring: <table><thead><tr><th></th><th>Impact</th><th>Likelihood</th><th>Score</th></tr></thead><tbody><tr><td>Gross</td><td>4</td><td>4</td><td>16</td></tr><tr><td>Target (Mar 26)</td><td>3</td><td>3</td><td>9</td></tr><tr><td>Previous (Q1)</td><td>3</td><td>3</td><td>9</td></tr><tr><td>CURRENT Q2</td><td>3</td><td>3</td><td>9</td></tr><tr><td>Target March 2027</td><td>3</td><td>3</td><td>9</td></tr></tbody></table> Risk Appetite Open		Impact	Likelihood	Score	Gross	4	4	16	Target (Mar 26)	3	3	9	Previous (Q1)	3	3	9	CURRENT Q2	3	3	9	Target March 2027	3	3	9	Future Risks - ICS/ICB reform – transition leads to uncertainty and distraction. - Changes to Specialised commissioning (SLOSS) - Changes to NHS England especially changes to network arrangements Future Opportunities: 10 year plan and changes at local level (opportunities to transform service provision. - Host of the Bromley Integrator - Part of Southwark Integrator - Part of Lambeth Integrator - Lewisham and Greenwich joining EPIC - Population health work as part of KHP.
	Impact	Likelihood	Score																							
Gross	4	4	16																							
Target (Mar 26)	3	3	9																							
Previous (Q1)	3	3	9																							
CURRENT Q2	3	3	9																							
Target March 2027	3	3	9																							
Controls: - Trust relationship leads identified for key partnerships to ensure that the Trust is represented and engaged in relevant ICS and APC forums - Engagement and leadership of place-based partnerships e.g. One Bromley, Lambeth Together - KCH CEO is designated CEO lead on SEL ICB - Active role in existing APC and ICS clinical and operational forums e.g. Clinical, Strategy & Operations, APC Finance, and System Sustainability Group - Engagement in SEL ICS and APC elective recovery programmes - Trust's Anchor Programme - APC governance and decision-making arrangements operational - Partnership mapping (community & voluntary) completed Gaps in Controls - Oversight – improvements in equality of access, experience and outcomes	Assurance of Controls: - Updates to Trust Board regarding ICS and APC and the Trust's role as a partner - Workshop delivered on integrators - APC Committee-in-Common progress reports - SEL APC Elective recovery performance Gaps in Assurance - Well-Led Report to be published in July 2026	Rationale for current score - Trust well embedded in local partner arrangements. 10 year plan creates risk and opportunity - System sustainability remains a challenge																								

Bold Objective: cross cutting Team King's: working as 'one Trust' across our sites, and as a good partner in our local ICS and beyond

Risk: System Sustainability - If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely on our ability to achieve system transformation in line with the NHS 10 year plan ambition.

Risk Owner: Deputy Chief Executive

Committee

Board of Directors

Last review: July 2026

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Bromley Neighbourhood Integration	DCEO/CDO	tbc	KCH hosting the Integrator function for Bromley. An integrator at place (borough) based level is a key component in the development of Integrated Neighbourhood Teams (INTs)	

Strategy Objective: Timely and Efficient Care

Risk: Demand and Capacity: If the Trust is unable to transform services, improve productivity and sustain sufficient capacity, patient waiting times may increase potentially resulting in an adverse impact on patient outcomes and an increased risk of avoidable harm.

Risk Owner: Chief Delivery Officer

Committee Performance, Transformation and Improvement Committee

Last review: July2026

2026/27 Priorities: - To meet operational targets agreed in the 2026/27 operational plan - Deliver clinical services transformation and CIP Relevant significant risks on CRR: - Care of patients requiring therapeutic mental health intervention. - Delayed Diagnosis - Delivery of elective activity in line with financial plan - Corridor Care within PRUH 3915: Elective Recovery Achievement 3991: Delayed pathology results	Risk Scoring: <table><tr><th></th><th>Impact</th><th>Likelihood</th><th>Score</th></tr><tr><td>Gross</td><td>4</td><td>5</td><td>20</td></tr><tr><td>March 2026</td><td>4</td><td>5</td><td>20</td></tr><tr><td>April 2026</td><td>4</td><td>4</td><td>16</td></tr><tr><td>July 2026</td><td>4</td><td>4</td><td>16</td></tr><tr><td>Target (Mar 27)</td><td>4</td><td>4</td><td>16</td></tr></table> Risk Appetite <table><tr><td>Operational</td><td>Cautious</td></tr></table>		Impact	Likelihood	Score	Gross	4	5	20	March 2026	4	5	20	April 2026	4	4	16	July 2026	4	4	16	Target (Mar 27)	4	4	16	Operational	Cautious	Future Risks - Impact of cost improvement programme and potential workforce reductions. - Industrial action - Interdependences with the wider SEL system - Removal of waiting list initiatives Future Opportunities: - Trust transformation programmes to reduce length of stay and improve flow - Theatres and outpatient transformation - Operational and clinical service transformation - Endoscopy unit at the PRUH - Opportunity to optimise SDEC use - Review of stroke services - Increased support from NHSE for demand and capacity modelling - Participation in the NHSE ECHO demand project - Acute Services Review across SEL - External funding to support outpatient transformation and PTL reduction - Introduction of 'patient not present' tariff - Non-elective demand and capacity modelling
	Impact	Likelihood	Score																									
Gross	4	5	20																									
March 2026	4	5	20																									
April 2026	4	4	16																									
July 2026	4	4	16																									
Target (Mar 27)	4	4	16																									
Operational	Cautious																											
Controls: - Trust access policies in place - Clinical prioritisation and validation of waiting lists and patient engagement and status checks whilst on waiting list to minimise risk to patient safety - Use of virtual and telephone appointments/PIFU implementation - Team supporting the use of In/outsourcing arrangements for some clinical services - Engagement in SEL ICS and APC led programmes e.g. theatre productivity - Engagement and support from SELCA in relation to cancer targets - New governance structure in place to track cancer performance - Performance Board and associated governance within Divisions - Divisional SDRs and oversight by KE - Winter plan - Site management arrangements in place - Command and Control arrangements to support incident management response – arrangements can be activated as required - Data dashboard availability in PowerBI Gaps in Controls - Improvement plan to deliver RTT targets to be implemented - Demand and capacity modelling in progress - Non-elective demand and capacity modelling identified as a gap.	Assurance of Controls: Positive - Internal governance and escalation in place - Patient outcomes - IQPR report to Performance, Transformation and Improvement Committee and Board of Directors - SELCA Oversight and accountability - Internal Audit Review of Data Quality (RTT)– significant assurance with minor improvement opportunities - National Oversight Framework - - Tiering for cancer, elective care and DMO1 Gaps in Assurance - Local management of waiting lists	Rationale for current score - Trust operational performance in on an upward trajectory and there is confidence that most targets are achievable. - Cancer ITT referrals impacting on overall performance - LPRR Level 2 for elective and Cancer care and DMO1 - LPRR Level 3 for cancer delivery - LPRR Level 1 for UEC - Capacity issues in core diagnostic nodes, although significant improvements have been achieved. - Elective recovery funding no longer available, although some funding available to reduce PTL. - Transformation and GIRFT Opportunities - PRUH endoscopy and diagnostic centre to be operational in Q2. - UEC provider delivery failing below contracted performance levels at DH. - Removal of waiting list initiatives - NHSE Joint Improvement Programme - DMO1 performance off trajectory (although improving) - SPC assurance failures in key domains																										

Strategy Objective: Timely and efficient care

Risk: Demand and Capacity: If the Trust is unable to transform services, improve productivity and sustain sufficient capacity, patient waiting times may increase potentially resulting in an adverse impact on patient outcomes and an increased risk of avoidable harm.

Risk Owner: Chief Delivery Officer

Committee Performance, Transformation and Improvement

Last review: July 2026

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Demand and Capacity modelling underway for 2027/28 as part of planning for 27/28	OPOG	Q2 206/27	Clear assessment of demand and capacity to drive key planning decisions for 2027/28	Initiated
Delivering an elective Recovery plan – to eliminate 65ww by end March 2026	Chief Delivery Officer	By end January 2026	National target met and removal from tiering	At year end Trust reported 12 65ww breaches.
Flow Programme (Transformation)	Chief Delivery Officer	Ongoing	Reduction in corridor care and length of stay, closure of beds	Ongoing
Pathology Improvement Plan	Chief Delivery Officer	31 March 2027	Improved flow, reduced delays to diagnosis, reduced costs.	Ongoing.
Cancer Recovery Plan as agreed with NHSE England	Chief Delivery Officer	Ongoing	Achievement of key targets including 28-day FDS and 62-day treatment	Ongoing.
DMO1 Sustainability Plan	Chief Delivery Officer	End Q1	Plan that will ensure sustainable waiting times and performance in key DMO1 nodes	In train

BOLD Objective: greater use of digital solutions – including maximising the benefits of Epic, our electronic patient record system - to enhance patient access to care and to enable them to personalise their care through shared decision making Risk: If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data Risk Owner: Deputy Chief Executive Committee Audit Committee Last review: June 2026																																			
2026/27 Priorities: - Decommissioning of legacy systems - Delivery of the digital roadmap - Introduction of the Network Access Control software/hardware Relevant significant risks on Corporate and Trust RR: 391R03 Malware such as Ransomware Compromising Unpatched Servers	Risk Scoring: <table><thead><tr><th></th><th>Impact</th><th>Likelihood</th><th>Score</th></tr></thead><tbody><tr><td>Risk gross score (unmitigated)</td><td>5</td><td>5</td><td>25</td></tr><tr><td>Previous risk net score (2025/26 Q3)</td><td>4</td><td>5</td><td>20</td></tr><tr><td>Previous Risk net score (2026/27 Q1)</td><td>4</td><td>4</td><td>↓16</td></tr><tr><td>Current Risk net score (2026/27 Q2)</td><td>4</td><td>4</td><td>16</td></tr><tr><td>Target (Mar 26)</td><td>4</td><td>4</td><td>16</td></tr><tr><td>Target (Mar 27)</td><td>3</td><td>5</td><td>15</td></tr></tbody></table> Risk Appetite: <table><tr><td>Information Security</td><td>minimal</td></tr></table>				Impact	Likelihood	Score	Risk gross score (unmitigated)	5	5	25	Previous risk net score (2025/26 Q3)	4	5	20	Previous Risk net score (2026/27 Q1)	4	4	↓16	Current Risk net score (2026/27 Q2)	4	4	16	Target (Mar 26)	4	4	16	Target (Mar 27)	3	5	15	Information Security	minimal	Future Risks - External threat actors - Lack of Independent Recovery Environment for Epic - Below average spend on ICT security - Loss of key ICT Cyber Security staff Future Opportunities: - SEL Cyber-Security Steering Group: coordinated cybersecurity assessments - Bid to Frontline Productivity Programme for cyber funding (submitted March'26) - Improve BCP to reduce impact - Improve resilience of Atos connection. - Explore Independent Recovery Environment for Epic and dependant systems - Achieve Cyber Essentials Plus Accreditation - Achieve certification of PRUH data centre - Discussion with Synnovis about network segregation at KCH - Board training on cyber security	
		Impact	Likelihood	Score																															
	Risk gross score (unmitigated)	5	5	25																															
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Target (Mar 26)	4	4	16																																
Target (Mar 27)	3	5	15																																
Information Security	minimal																																		
Controls: 3rd Party firewall purchased and in place with a number of third parties behind the wall - Monthly contract meeting with senior staff to mandate the following of trust policies and procedures and compliance with SLA - Multi skilled staff to act on Cyber-attack. - Request are evaluated through ICT PMO to prevent unauthorized software and hardware being connected to the network/used. - Unsupported Systems Workstream in place to mitigate against use of out-of-date software and hardware. - Access rights not permitted to allow 3rd party installation onto the network. - Communication to staff via top tips published on Kingsweb including: - Do not connect unauthorised devices to the Trust Network AND Do not download any software to PCs/devices without explicit authorisation from the ICT Department. - ICT Systems Procurement -- Any proposed procurement MUST undergo the correct ICT checks and be officially authorised before purchase. - Password policy is technically applied - Password policy being brought in line with NCSC recommendations - Policy in place for the management of cyber-incidents - National Cyber-security Centre Information Sharing partnership registration and adherence to the National Cyber-security Centre (NCSC) "ten steps to cyber-security". - Information security and data protection policy in place. - Joining NHS England in a pilot monitoring medical devices via MDE Gaps in Controls - Integration of business continuity and cyber-security - Lack of automatic isolation of devices that generate a high risk alert out of hours	Assurance of Controls: Positive - HIMSS Digital maturity for infrastructure, Level 6 out of 7 achieved, March 2026, valid for 3 years. - Raised at Digital Board to promote PMO process. - Penetration Testing of 3rd party systems on Trust network carried out annually. From the latest (November 2025): - External Infrastructure: No critical findings noted - Internal infrastructure: Two critical findings, of which 1 related to a network vulnerability, which has been remediated 1 related to the existence of a number of unsupported systems; this is being managed by the Unsupported Systems Workstream - ISO 27001 Annex A controls are A9.1.1, A9.1.2, A9.4.1 and A15. - KPMG review of Cyber assessment framework aligned data security and protection toolkit provides significant assurance with minor improvement opportunities. Gaps in Assurance 3rd party assurance			Rationale for current score - Penetration testing assurance - Increasing external cyber risk (Middle East concerns) - Funding constraints - Extensive use of cloud-based or securely managed in KCH or Atos datacentres leading to significant enhancements in cyber-protection. - Need to integrate cyber security and business continuity approaches. - KPMG independent review of the Trust's submission of the cyber assessment framework and DSPT.																															

BOLD Objective: Greater use of digital solutions – including maximising the benefits of Epic, our electronic patient record system - to enhance patient access to care and to enable them to personalise their care through shared decision making

Risk: Financial Sustainability: If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data

Risk Owner: Deputy Chief Executive

Committee **Audit Committee**

Last review: date June 2026

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Programme to link together the operational impacts of downtime with the security arrangements of the different IT applications to give an aggregated profile of risk and resilience across the Trust	DCE	March 2027	Improved resilience	ongoing
Cyber-security investment programme (2026)	DCE	June 2026	Strengthened control environment	Funding allocated, currently implementing the purchased items.
Clear maintenance window agreed (monthly basis) with the organisation for servers to be rebooted	DCE	30/04/2026	Timely patch application to servers	Initiation
Move non-windows servers under Microsoft Defender	DCE	30/06/2026	Addition protection of non-windows devices on network	On-going
Explore Independent Recovery Environment risk assessment and options	DCE	31/06/2026	Digital board agreed to complete risk assessment, then generate options paper	On-going
2026 Frontline Productivity Programme (NHS England) – Year 1 of 4	DCE	March 2027	Improved resilience and cybersecurity in collaboration with SEL ICB partners	Bid submitted
Board training – Cyber security	DCE	By September 2026	Improved understand and awareness	Dates being sought from the external trainer.

AGENDA ITEM: 9**BOARD/COMMITTEE REPORT COVER PAPER**

Report to:	Trust Board						
Date of meeting:	15 July 2026						
Subject:	Integrated Performance Report Month 2 (May) 2026/27						
Author(s):	Steve Coakley, Director of Performance & Planning; Simon Lee, Assistant Director of Performance & Planning						
Sponsor:	Angela Helleur, Chief Delivery Officer						
History:							
Status:							
Decision/ Approval		Discussion	✓	Assurance	✓	Information	

Purpose

Brief The performance report to the Kings Board Committee outlines published monthly performance data for May 2026 achieved against key national operational performance targets (noting that latest submitted cancer performance and quality data is April 2026).

Recommendations:

The Committee is asked to note the latest position against the performance and quality metrics contained within the report.

Strategy alignment

High Quality Patient Care	✓	Strong Successful Partnerships	
A Great Place to Work		Timely and Efficient Care	✓
Pioneering Research, Innovation and Education		Financial Sustainability	✓

Key implications

Strategic risk - Link to Board Assurance Framework	<i>The summary report provides detailed performance against the core NHS constitutional operational standards.</i>
King's Improvement Impact (KIM):	<i>n/a</i>
Quality Impact	<i>There is no direct impact on clinical issues, albeit it is recognised that timely access to care is a key enabler of quality care.</i>
Health Equity Impact	<i>n/a</i>
Workforce Impact	<i>Describe the implications for staffing, workforce capacity, skills, wellbeing, engagement, recruitment, retention, training or organisational culture.</i>
Research/Innovation Impact	<i>n/a</i>
Digital Impact	<i>n/a</i>
Financial Impact	<i>Trust reported financial performance against published plan.</i>
Legal/ regulatory compliance	<i>Report relates to performance against statutory requirements of the Trust license in relation to waiting times.</i>
Communications and Engagement	<i>Trust's quarterly and monthly results will be published by NHSE.</i>
Use of Artificial Intelligence Tools	<i>n/a</i>
Committee that will provide relevant oversight Kings Board Committee	

Main Report

Performance:

Elective Activity @ M2:

At a Trust level, 100% of planned activity was delivered with activity levels operating close to or above plan in each week.

Emergency care:

- 4 hour All Types performance decreased to 71.39% for May, below the operating plan trajectory of 76.8%.

Actions Underway:

- Finalisation of care group improvement plans for the 2026-27 flow programme.
- Working with DH and PRUH UTC providers to optimise pathways.
- Re-focusing on ED assessment unit and SDEC pathway opportunities.
- Launch of specialty admission guidance as part of internal professional standards.
- Launch of revised long length of stay review SOP.

RTT:

- There has been a run of 7 months RTT Incomplete performance above the mean to May 2026, improving further to 67.48% in May, and achieving the target of 66.09% for the month.
- The total RTT PTL increased by over 2,100 pathways to 88,671 for May which is now above the Operating Plan target of 85,967. This PTL growth is mainly attributable to the increase in patients waiting under 18 weeks to May.

Actions Underway:

- NHSE are supporting pathway re-design work in Womens Health and Ophthalmology care groups.

Cancer performance:

- Cancer performance 62-day: Submitted April 2026 28-day FDS performance is 76.7%, below the higher 80% standard with impact from strikes and Bank Holidays.
- The Faster Diagnosis Standard (FDS) Latest submitted March 2026 28-day FDS performance is 78.9%, below the new 80% standard from 2026/27.
- **Cancer performance 31-day:** Submitted 31-day performance was 94.3% in April 2026 meeting the NHS operating plan standard and just below the 96% national standard.

Actions underway:

- Fast track breast reporting solution in place from 1 June
- Review meetings for lunch and prostate in June
- Balance of pathology reporting cross site (in place but can be further delineated) and recruitment to vacant posts.
- Endoscopy recovery plan from new unit opening
- Urology front end capacity/workforce plans to support enhanced diagnostic capacity
- Additional HPB and HCC OPA capacity from Q2 with additional workforce

- Review of DH colorectal cancer theatre utilisation (in comparison to GSTT) – longer term plan.
- Trust wide review of theatre demand and capacity underway including cancer pathway demand.

Diagnostics:

- There has been a run of 7 months DM01 performance below mean to May 2026.
- Whilst performance improved further by 1.47% to 18.32% in May, the Operating Plan target of 16.4% has not been achieved.

Actions underway:

- MRI/CT – mitigation actions identified and non-recurrent funding options submitted to NHSE for approval.
- Endoscopy performance was 31.7% and above the performance forecast of 28% for May – a revised recovery action plan and performance forecasts are being worked-up by the service.
- External validation team continues to focus on diagnostic DM01 and planned pathway validation.

Quality, Safety and Patient Experience:

Positive Progress

- Improvement in Duty of Candour performance reflects both compliance and a healthier safety culture.
- Progress on the incident backlog suggests stronger grip, better follow-up, and more effective operational response. These improvements have been driven through divisional accountability which has been key to progress in these areas
- Safer staffing picture: The staffing position appears more controlled, with better fill rates and fewer signs of unsafe shortfall.

Residual Concerns

- Several areas of poorer performance (e.g. Harms prevention and ED patient feedback) appear to be linked to flow and capacity issues, so some quality risks may persist even where indicators are improving. It is unclear whether the remaining risks are temporary consequences of pressure or more embedded problems that need longer-term action. A Trust-wide programme is in place to improve flow and reduce associated risks.

- The IQR does not yet present a fully settled assurance position; it points instead to partial reassurance with important caveats.
- There is a need to ensure that the improvements outlined lead to clear improvements for patients (in experience and/or outcomes). Whilst there are some early signs (e.g through the friends and family test) there is a need to develop and embed clear measures for this in the coming months

Workforce

- The sickness-absence rate is 4.05%, above the Trust's 3.50% target but improved from the March position of 4.40%. Benchmarking against other large London Trusts places the Trust within the middle quartile, indicating a relatively stable position in a challenging operating environment
- Trust vacancy rates increased slightly to 6.59%, however remains significantly below the 10% target, reflecting continued progress in workforce stabilisation and sustained alignment with Trust priorities

Core Skills compliance has been below the 90% target for three months and is currently at 89.28%.

- Agenda for Change time-to-hire performance remains within KPI for Bands 4–6 and 7–9. Although time to hire for Bands 1–3 is outside target, it is trending downwards and significantly improved on last month.
- Medical time-to-hire has further improved to 106.5 days, demonstrating continued movement towards national benchmarks and sustained progress in reducing delays in filling critical clinical roles

Finance

- As of May, the KCH Group (KCH, KFM and KCS) has reported a £1.8m deficit year to date. This represents a £1.5m favourable variance to the March 2026 NHSE accepted plan.
- The underlying position year to date is an £18.0m deficit after removal of non-recurrent items, £1.9m adverse to plan
- The Trust has confirmed plans to deliver £14.4m of Cost Improvement Programme (CIP), a planning gap of £70.5m against the £84.9m target.

- The Trust's WTE has reduced by 224 WTE year to date, with the main contributor being Nursing Bank, with a reduction in Medical Bank in May.

Key Actions:

- The Trust will minimise underspend against planned spend on DH NICU, then complete a variation to the capital programme to reallocate any excess capital to other Trust priorities.
- The Trust will prepare a capital variation to address the additional costs identified for the replacement MRI scanners for consideration by King's Executive and FCC, and in parallel will continue discussions with NHSE regarding funding the additional requirement.
- Remediation is required to be delivered by Divisions to address May 2026 adverse performance against the agreed Phase 1 and Phase 2 run rate intervention trajectories, to ensure full delivery.
- Enhanced controls are required on temporary staffing bookings, and this is being supported by the Workforce team focussing on approval levels particularly for short-term bookings, correct use of reason codes, retrospective bookings and annual leave management.
- The CIP programme has £14.4m schemes at Gateway 3+ against the £84.9m CIP programme. Rapid progress is required to develop and progress schemes through the Gateway process to mitigate risk to the financial plan.
- Nursing profile review programme to be established in response to a fairer deal for nursing, with a focus on band 5 nursing roles. Band 5 job evaluation delivery plan to be developed and submitted in line with national requirements.



King’s College Hospital
NHS Foundation Trust

Integrated Performance Report

Month 2 (May) 2026/27

Kings Board Committee

15 July 2026

King’s values ✓ Caring ✓ Collaborative ✓ Inclusive ✓ Innovative

Report to:	<i>Kings Board Committee</i>
Date of meeting:	<i>15 July 2026</i>
Subject:	<i>Integrated Performance Report 2026/27 Month 2 (May 2026)</i>
Author(s):	<i>Steve Coakley, Director of Performance & Planning;</i>
Presented by:	<i>Angela Helleur, Chief Delivery Officer</i>
Sponsor:	<i>Angela Helleur, Chief Delivery Officer</i>
History:	<i>None</i>
Status:	<i>For Discussion</i>

Summary of Report

This report provides the details of the latest performance achieved against key national performance, quality and patient waiting times targets for May 2026 returns.

Action required

- The Committee is asked to note the latest available 2026/27 M2 performance reported against key deliverables as set out in the national FY2026/27 Operating Plan guidance.*

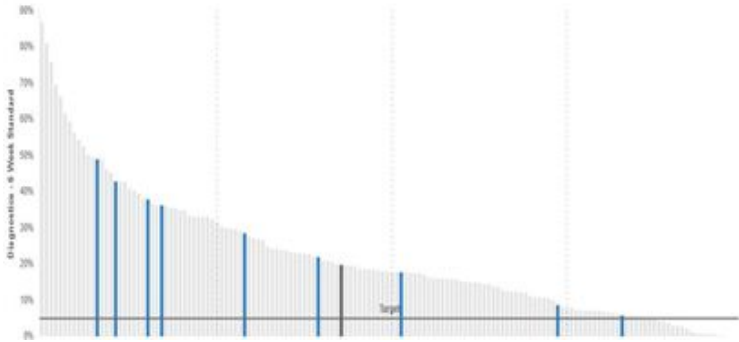
Key implications

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

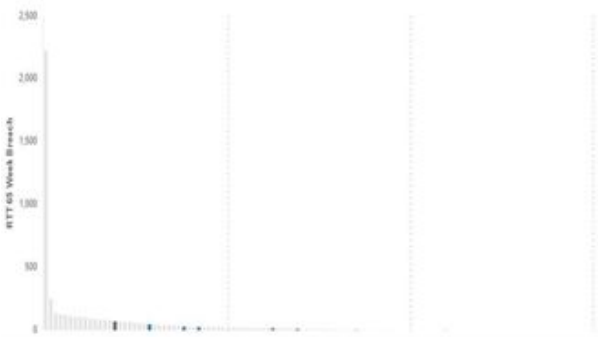
King's values  Caring  Collaborative  Inclusive  Innovative

Performance

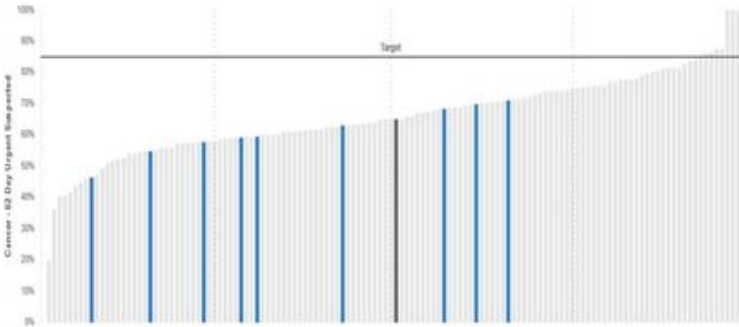
Benchmarked Trust performance
Based on latest national comparative data published



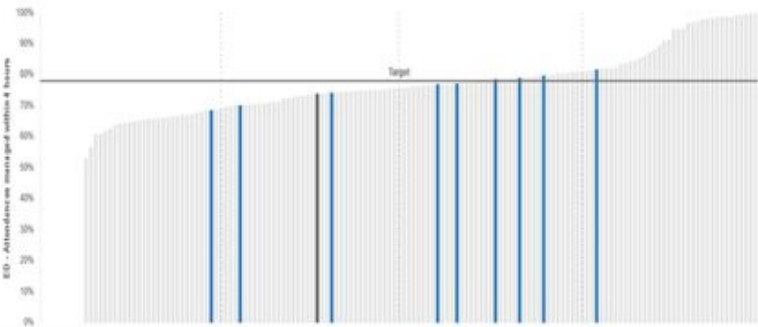
The chart above shows the national ranking against the DM01 diagnostic 6-week standard. Kings is ranked 87 out of 154 selected Trusts based on April 2026 data published.



The chart above shows the national ranking against the RTT 65-week waits. Kings is ranked 106 out of 163 selected Trusts based on latest April 2026 data published.



The chart above shows the national ranking against the cancer standard for patients receiving first definitive treatment within 62 days for all routes. Kings is ranked 65 out of 135 selected Trusts based on latest April 2026 data published.



The chart above shows the national ranking against the 4-hour Emergency Care Standard. Kings is ranked 92 out of 149 selected Trusts based on latest April 2026 data published.

King's values Caring Collaborative Inclusive Innovative

Domain 1: Performance Metric Assurance Summary

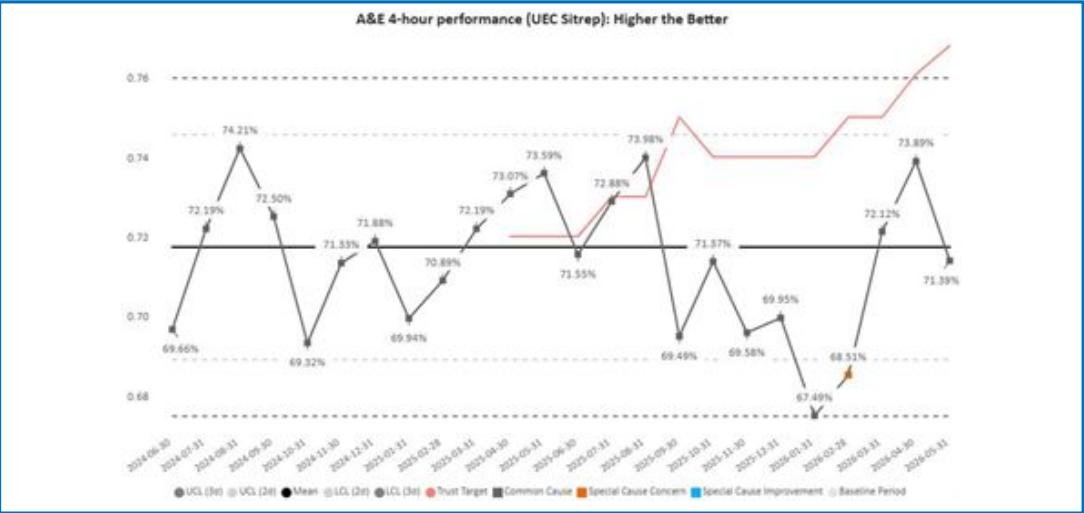
Metric Group / Metric Name	Reporting Month	Current Value (Month)	Previous Value (Month)	Assurance (Monthly)
Cancer				
Cancer 62 day PTL Backlog Size				
Diagnostics				
DM01 >6 week performance	2026-05	16.62%	18.75%	Fail
Emergency Care				
A&E 4-hour performance - Type 1	2026-05	49.01%	53.76%	Fail
A&E 4-hour performance (UEC Sitrep)	2026-05	70.73%	73.77%	Fail
A&E Attendances - Type 1	2026-05	6550	6332	No Target
A&E Attendances - Type 3 (Sitrep)	2026-05	5466	5277	No Target
A&E Breaches - Type 1	2026-05	3340	2928	No Target
A&E Breaches - Type 3 (Sitrep)	2026-05	142	133	No Target
Ambulance Handover Delays >60 minutes	2026-05	34	12	No Target
Ambulance Handover Delays 30-60 minutes	2026-05	572	573	No Target
Attendances in A&E over 12 hours %	2026-05	16.40%	15.28%	Fail
Rate of 4hr Breaches that are Non-Admitted/Referred	2026-05	53.94%	47.81%	No Target
Inpatients				
Average Length of Stay (Elective) - Model Hospital Definition	2026-05	7.7	6.8	No Target
Average Length of Stay (Non-Elective)	2026-05	8.8	8.9	No Target
Elective Inpatient Spells (Operational Planning) - SUS	2026-05	5749	5576	No Target
Operational Planning				
First Outpatient Attendances - SUS (+Operational Planning inc. logic)	2026-05	13112	13881	Fail
Outpatients				
New to Follow Up Ratio - all	2026-05	31.1%	30.8%	No Target
Outpatient DNA rate	2026-05	7.6%	7.6%	Pass
Outpatient PIFU Outcomes %	2026-05	3.7%	3.6%	Fail
RTT				
% 52-week Waiters	2026-05			
RTT 52 week waits	2026-05	570	473	Fail
RTT 65 week waits	2026-05	38	17	Fail
RTT 78 week waits	2026-05	1	0	Fail
RTT Incomplete Performance	2026-05	64.71%	64.14%	Fail
RTT Total PTL	2026-05	38374	37238	No Target

Executive Summary

- **Diagnostics:** There has been a run of 7 months DM01 performance below mean to May 2026.
- Whilst performance improved further by 1.47% to 18.32% in May, the Operating Plan target of 16.4% has not been achieved.
- **RTT incomplete performance:** There has been a run of 7 months RTT Incomplete performance above the mean to May 2026, improving further to 67.48% in May, and achieving the target of 66.09% for the month. The total RTT PTL increased to 88,671 for April which is below the Operating Plan target of 85,967.
- **Cancer performance 62-day:** Submitted April 2026 28-day FDS performance is 76.7%, below the higher 80% standard with impact from strikes and Bank Holidays.
- **The Faster Diagnosis Standard (FDS) Latest** submitted March 2026 28-day FDS performance is 78.9%, below the new 80% standard from 2026/27.
- **Cancer performance 31-day:** Submitted 31-day performance was 94.3% in April 2026 meeting the NHS operating plan standard and just below the 96% national standard.
- **Emergency care:** 4 hour All Types performance decreased to 71.39% for May, below the operating plan trajectory of 76.8%.

UEC 4-hour Emergency Care Standard – Trust Level

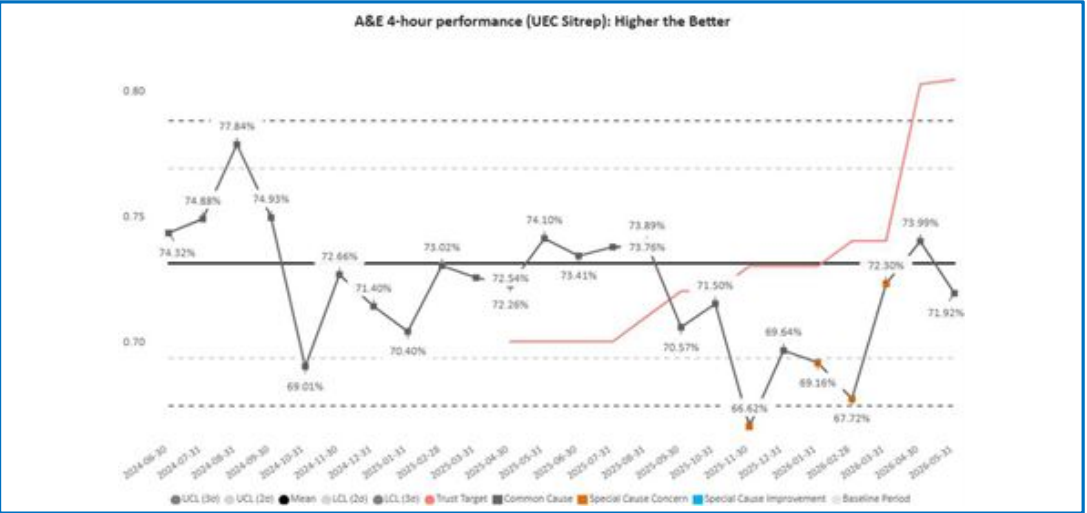
Background/national target description	
Ensure at least 78% of attendees to A&E are admitted, transferred or discharged within 4 hours of arrival.	
May 2026	Operating Plan May 2026
71.39%	76.8%
- Executive Owner: Angela Helleur, Chief Delivery Officer - Operational Leads : James Eales (DOO), Lesley Powls (DH Hospital Director), Paul Larrisey (PRUH Hospital Director)	



Update since previous month	Current Issues	Key Dependencies	Future Actions
4 hour All Types performance decreased to 71.39% for May, below the operating plan trajectory of 76.8%.	- DH Type 3 performance has reduced to 91.18%, however, there has been a sustained increase in attendances. - High Mental Health demand on both sites resulting in reduced physical and requiring significant staffing resource to maintain safety. - Reduced flow to G&A inpatient wards leading to congestion and extended waiting times.	- Utilisation of conveyance and admission avoidance pathways in the community. - Optimisation of referral pathways to SDECs to take lower risk presentations. - Flow into G&A inpatient wards.	- Finalisation of care group improvement plans for the 2026-27 flow programme. - Working with DH and PRUH UTC providers to optimise pathways. - Re-focusing on ED assessment unit and SDEC pathway opportunities. - Launch of specialty admission guidance as part of internal professional standards. - Launch of revised long length of stay review SOP.

UEC 4-hour Emergency Care Standard – Denmark Hill

Background/national target description	
Ensure at least 78% of attendees to A&E are admitted, transferred or discharged within 4 hours of arrival.	
May 2026	Operating Plan May 2026
71.9%	80.4%
- Executive Owner: Angela Helleur, Chief Delivery Officer - Operational Leads : James Eales (DOO), Lesley Powls (DH Hospital Director), Paul Larrisey (PRUH Hospital Director)	



Update since previous month	Current Issues	Key Dependencies	Future Actions
4 hour All Types performance remained below the operating plan at 71.9% in May.	- Type 1 attendances are 2.5% higher than May '25, with ambulance conveyances increasing by 2.1%. - DH Type 3 performance has reduced to 91.18%, however, there has been a sustained increase in attendances to 180 per day (May) compared to 163 (April). - Significant challenges with long Mental Health patient stays in ED, leading to cubicles being blocked for assessment.	- Utilisation of conveyance and admission avoidance pathways in the community. - Optimisation of referral pathways to SDECs to take lower risk presentations. - Flow into General & Acute (G&A) inpatient wards. - Flow into MH inpatient wards.	- Finalisation of care group improvement plans for the 2026-27 flow programme. - Working with UTC provider to optimise pathways and improve performance. - Re-focusing on ED assessment process and SDEC pathways opportunities. - Revising specialty admission guidance as part of internal professional standards.

Performance

UEC 12-hour stays – Denmark Hill

Background/national target description

To increase the proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26

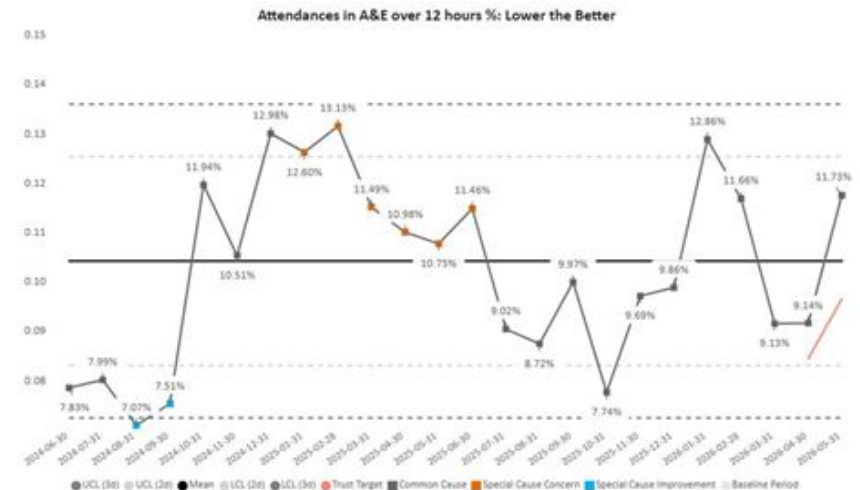
May 2026

11.73%

Operating Plan May 2026

9.6%

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



Update since previous month

- The percentage of patients waiting in ED over 12 hours increased to 11.73%, above the target of 9.6% for the month

Current Issues

- LAS ambulance attendances remain stable with an average of 96 per day with high conversion rate to ward admission.
- 12-hour length of stay breaches are mostly attributed to those awaiting inpatient admission to an acute or mental health hospital bed.

Key Dependencies

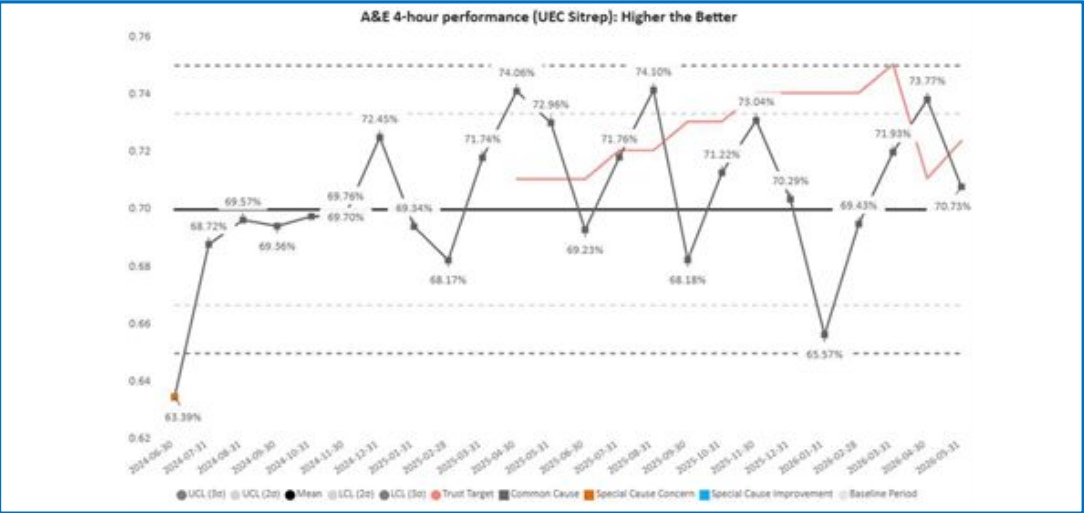
- Improved flow for patients with a mental health Decision To Admit (DTA) into partner organisations.
- Flow from ED into inpatient admission wards.
- Reduction in length of stay across inpatient wards through the site flow programme, particularly in view of predicted challenging winter virus presentations.

Future Actions

- Delivery of improved inpatient flow through the 26-27 flow programme and local care group initiatives.
- Ongoing engagement with SLAM to develop robust mental health pathways that are responsive to demand.

UEC 4-hour Emergency Care Standard – PRUH

Background/national target description	
Ensure at least 78% of attendees to A&E are admitted, transferred or discharged within 4 hours of arrival.	
May 2026	Operating Plan May 2026
70.73%	72.3%
- Executive Owner: Angela Helleur, Chief Delivery Officer - Operational Leads : James Eales (DOO), Lesley Powls (DH Hospital Director), Paul Larrisey (PRUH Hospital Director)	



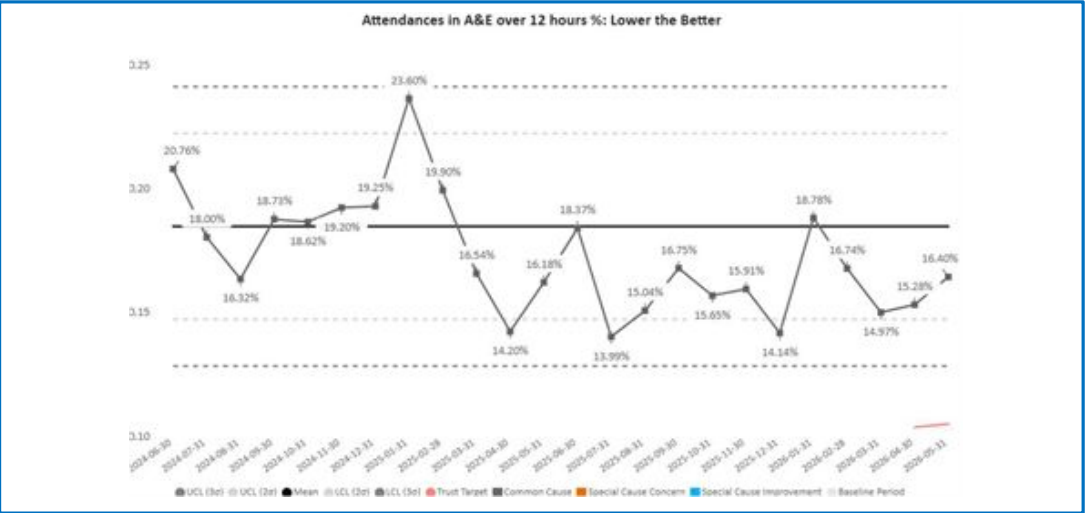
Update since previous month	Current Issues	Key Dependencies	Future Actions
- All type performance increased to 70.73% in May, below the Operating Plan target. - Launch of Frailty SPOA in April 2026.	- Corridor congestion due to admitted demand, but a significant reduction compared to 24-25. - Mental Health Decision To Admit delays remain a challenge, with limited escalation capacity.	- Attendance avoidance pathways in the community and the use of Universal Care Plans (UCP). - Re-direct pathways from ED into out-of-hospital providers. - Optimisation of referral pathways to SDECs to take lower risk presentations. - Flow into MH inpatient wards. - Flow into G&A inpatient wards.	- Finalisation of care group improvement plans for the FY2026-27 flow programme. - Revising specialty admission guidance as part of internal professional standards. - Focus on increasing pathways out of ED into SDEC and SAUU. - Launch of revised Long length of stay review SOP.

UEC 12-hour stays – PRUH

Background/national target description
To increase the proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26

May 2026	Operating Plan May 2026
16.4%	10.5%

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



Update since previous month
Increase in 12 hour stays in May to 16.4% and remained above the Operating Plan target of 10.5%.

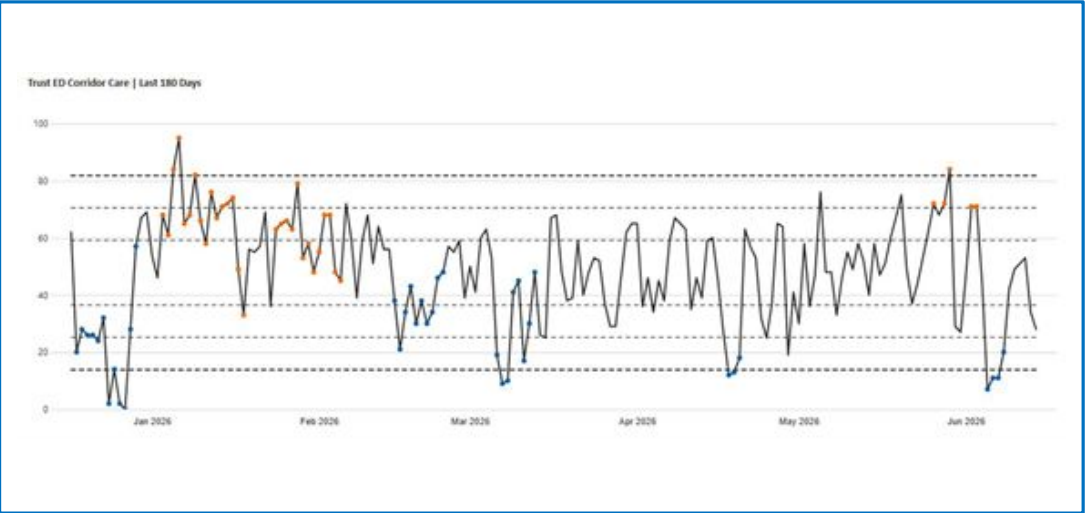
Current Issues
12 hour stays for patients requiring admission remain a significant challenge. - Patient requiring mental health input (and onward care) are a significant contributor to non-admitted and admitted breaches.

Key Dependencies
- Improved flow for patients with a mental health Decision To Admit into partner organisations. - Flow from ED into inpatient admission wards. - Reduction in length of stay across inpatient wards through the site flow programme.

Future Actions
Ongoing partnership meeting with Oxleas to support oversight of mental health patient management and pathway improvement.

ED Corridor Care – Trust Level

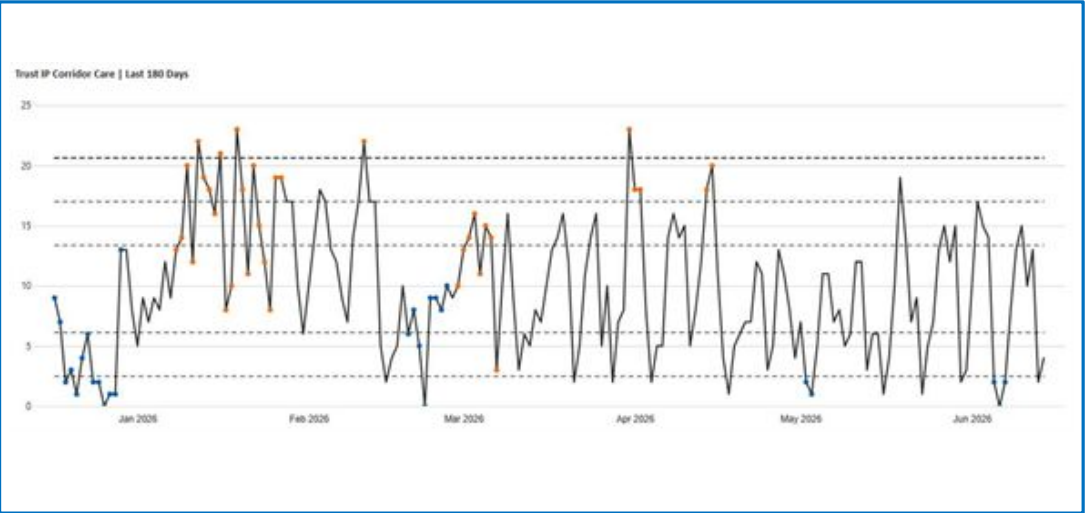
Background/national target description
- A count of the number of patients who received corridor care for more than 45 minutes within the previous 24-hour reporting period, from midnight to midnight - This metric counts patients recorded in a location marked as an escalation space in each department.
May 2026
1972
- Executive Owner: Angela Helleur, Chief Delivery Officer - Operational Leads : James Eales (DOO), Lesley Powls (DH Hospital Director), Paul Larrisey (PRUH Hospital Director)



Update since previous month	Current Issues	Key Dependencies	Future Actions
- Updated Corridor care policy has been approved and adopted. - Enhanced audit of corridor care patient appropriateness implemented.	Corridor care levels remains high, resulting from insufficient early and consistent flow and/or acute pressures from high conveyances.	- Increases conveyance avoidance to reduce pressure on ambulance offload. - Improved early flow into G&A beds to support continuous flow through the Trust. - Improved flow into MH beds to support increase assessment capacity	- Review of impact of Frailty SPOA (PRUH) and consideration of further opportunities for conveyance avoidance. - Implementation of revised focus of flow programme to support earlier site flow, including adoptions of LLOS review process. - Re-Audit of adherence to Criteria to admit in ED and AMU.

Inpatient Corridor Care – Trust Level

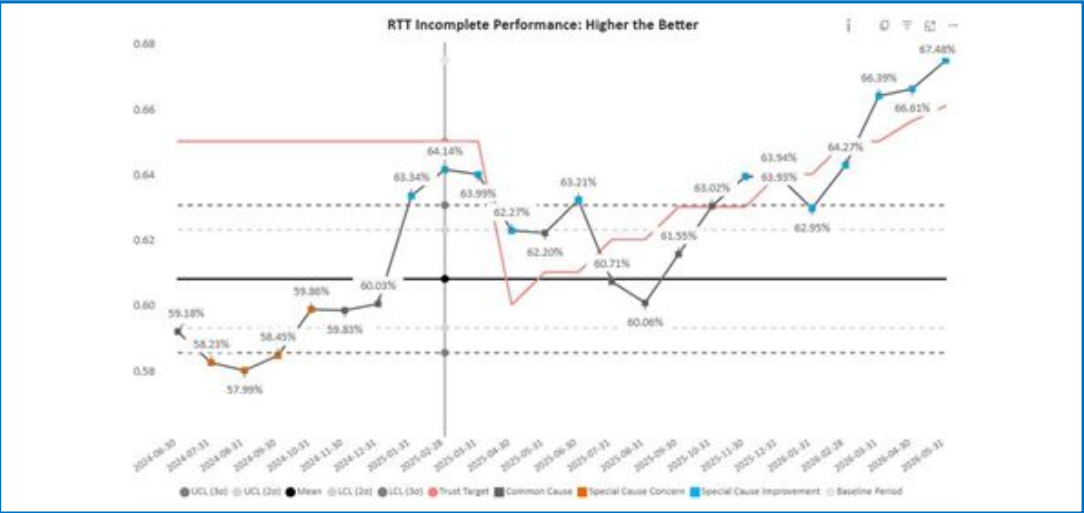
Background/national target description
- A count of the number of patients who are receiving care for more than 45 minutes on a ward outside of a bed space. This is limited to general and acute beds and excludes ED. - This metric counts patients recorded in surge beds on inpatient wards.
May 2026
654
- Executive Owner: Angela Helleur, Chief Delivery Officer - Operational Leads : James Eales (DOO), Lesley Powls (DH Hospital Director), Paul Larrisey (PRUH Hospital Director)



Update since previous month	Current Issues	Key Dependencies	Future Actions
	- Low discharges before 12 midday lead to implementation of flow policies to decompress ED resulting in corridor care. - Insufficient discharges compared to demand result in high bed occupancy.	- Improved discharges before 12 midday and utilisation of discharge lounge. - Increased discharges per day to lower bed occupancy. - Reduction in delays for patients who require support to enable discharge.	- Board round optimisation programme to support R2G and reduce delays that impact on patient LoS to be rolled out across all wards. - Criteria Led Discharge project being rolled out to support earlier in day discharges. - Long Length of Stay Reviews project to be rolled out to support reduction in LoS.

RTT Incomplete Performance

Background/national target description	
Ensure 78% of patients are treated within 18 weeks of referral.	
May 2026	Operating Plan May 2026
67.48%	66.1%
- Executive Owner: Anna Clough /Angela Helleur, Chief Delivery Officer - Management Owner: James Watts, DOO.	



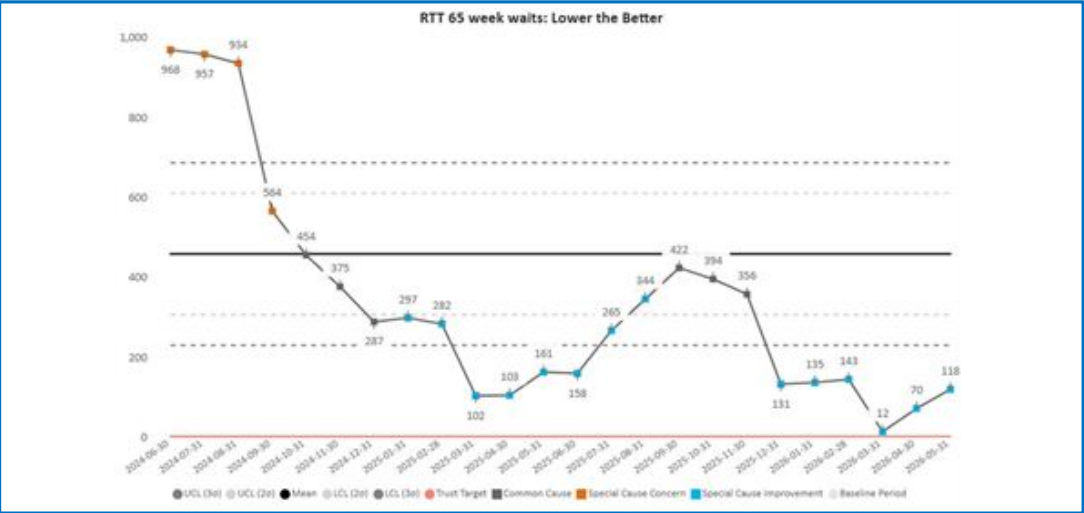
Update since previous month	Current Issues	Key Dependencies	Future Actions
- There has been a run of 7 months RTT Incomplete performance above the mean to May 2026, improving further to 67.48% in May, and achieving the target of 66.09% for the month. - The total RTT PTL increased by over 2,100 pathways to 88,671 for May which is now above the Operating Plan target of 85,967. This PTL growth is mainly attributable to the increase in patients waiting under 18 weeks to May.	- The Trust needs to reduce the number of SEL patients waiting on our PTL by 6,300 this year to contribute to SEL ICB reduction requirements. - SEL ICB has confirmed approval of our initial £1.6m Strategic Investment Fund (SIF) submission plus a further £1.6m ICB monies with activity schemes to further reduce the PTL. - A business case has been submitted to the Investment Board meeting in July to approve agreed activity schemes.	- Delivery of Trust activity plan in key areas of operational challenge within standard Trust capacity available. - Approval of SIF and extended SEL ICB business case to commence implementation of activity-driven PTL reduction plans.	NHSE are supporting pathway re-design work in Womens Health and Ophthalmology care groups.

RTT – 65 Weeks

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

May 2026	Operating Plan May 2026
118	0

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



Update since previous month
- The number of patients waiting over 65 weeks increased from 70 patients in April to 118 in May, and above the zero breach Operating Plan requirement. - Of the 65 week wait patients there are 32 patients in General Surgery, 30 in Ophthalmology, 19 in Bariatric Surgery, 10 in Colorectal Surgery and 8 in Vascular Surgery.

Current Issues
- The key challenge remains in Surgery care group at DH and Ophthalmology. - An admitted demand and capacity model has been developed in BIU with an initial focus on DH Surgery care group specialties. Initial mode outputs are being reviewed by the service. - There are emerging pressures in Vascular Surgery with a current loss in capacity due to the loss of surgical staff.

Key Dependencies
Delivery of Trust activity plan in key areas of operational challenge within standard Trust capacity available.

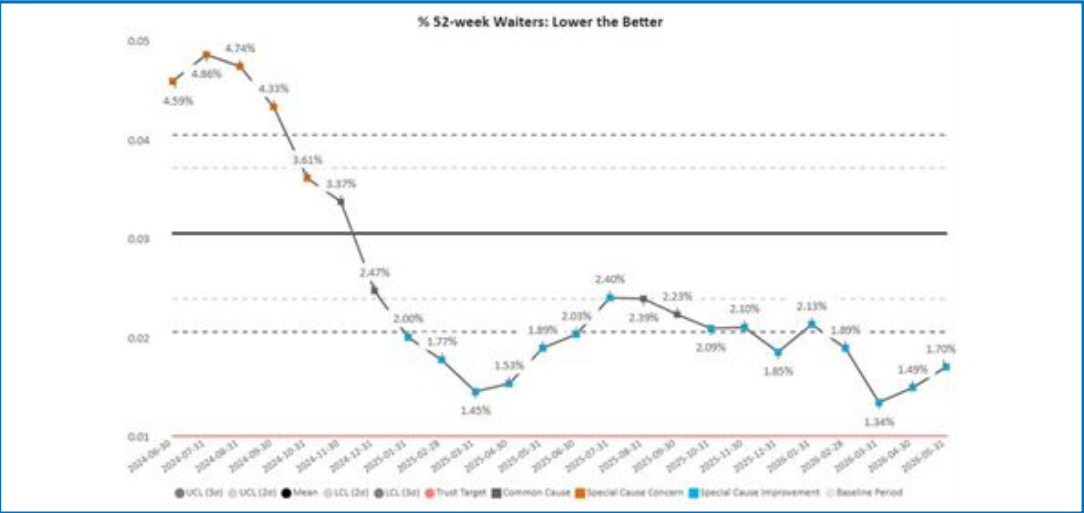
Future Actions
- Further develop admitted demand and capacity model for use in DH Surgery and other challenges specialty areas. - Model the impact on long wait position and performance in Vascular Surgery as a result of recent loss of surgical staff.

RTT – % 52 Week Waiters

Background/national target description
Reduce patients waiting over 52 weeks to represent at least 1% of the total RTT PTL.

May 2026	Operating Plan May 2026
118	0

- Executive Owner: Anna Clough /Angela Helleur, Chief Delivery Officer - Management Owner: James Watts, DOO.
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Update since previous month
- The number of patients waiting over 52 weeks increased further from 1,288 in April to 1,504 in May, above the target of 920. - This represents 1.70% of the total PTL and above the target of 1.07%. Over 1,000 patients are waiting on admitted and ca 460 on non-admitted pathways. - Over 400 patients waiting in Ophthalmology and nearly 390 waiting in DH Surgery care group.

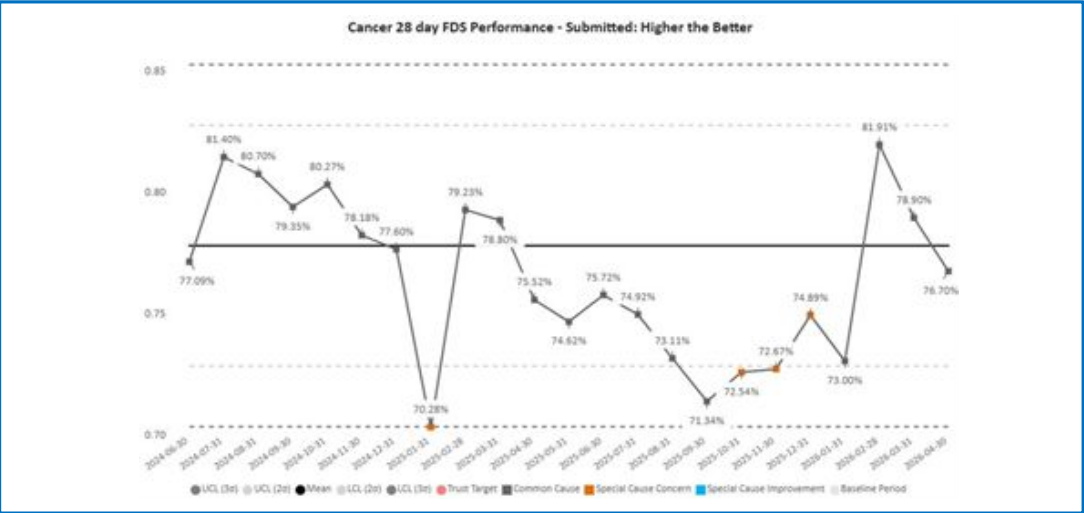
Current Issues
Demand and capacity modelling work referenced earlier in this report needs to assess impact on Surgery care group PTL following the cessation of ad-hoc funded capacity from Q4 last year.

Key Dependencies
Delivery of Trust activity plan in key areas of operational challenge within standard Trust capacity available.

Future Actions
- Enhanced senior clinical and operational oversight continues, with line-by-line review of long wait risks across both admitted and non-admitted cohorts. - Governance arrangements have been changed and the Deputy Chief Delivery Officer is also chairing line-by-line review meetings for Surgery, Ophthalmology and Cardiovascular care groups.

28-day Faster Diagnosis Standard

Background/national target description	
Improve Faster Diagnosis Standard target to 80% so that patients should not wait more than 28 days from referral to their cancer diagnosis.	
April 2026	Operating Plan April 2026
76.7%	80%



Update since previous month
- Submitted April 2026 28-day FDS performance is 76.7%, below the higher 80% standard with impact from strikes and Bank Holidays. - Provisional May 2026 performance is 79.5%. - The predominant breach reason for May was pathology reporting with the secondary reason relating to endoscopy capacity.

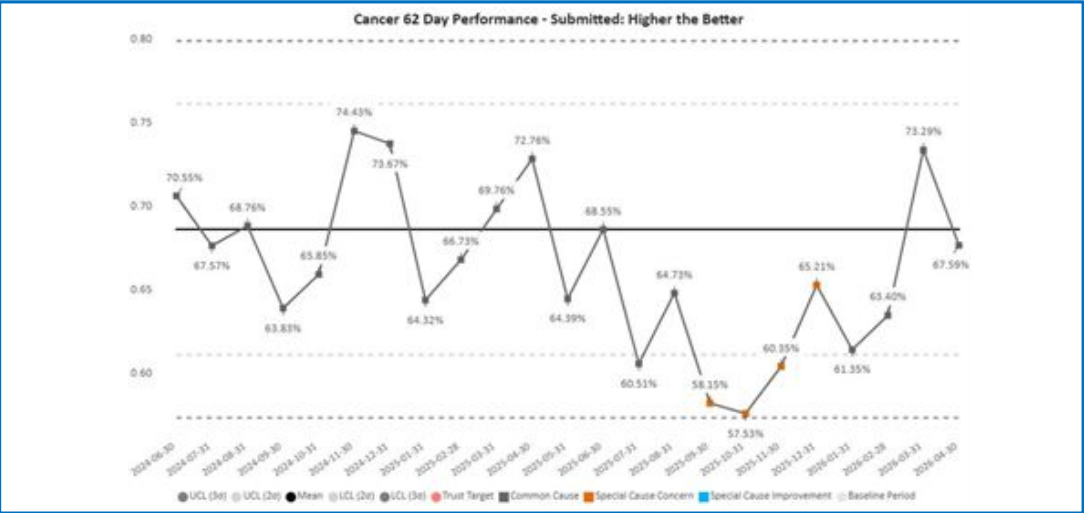
Current Issues
- Pathology reporting turnaround times - Opening of new PRUH endoscopy unit (planned reduced capacity during first few weeks of opening, but this will impact 28-day FDS performance throughout Q1 and possibly into early Q2) - Other challenges include HPB and urology CT reporting and PRUH head & neck OPA capacity impacting May performance.

Key Dependencies
- Radiology demand exceeds capacity overall (for both cancer pathways and all Trust standards). - Timeliness of processing pathology samples (Synnovis). - Balance of pathologist workload and demand at DH and PRUH. - Backlog from new endoscopy build.

Future Actions
- Fast track breast reporting solution in place from 1 June. Review meeting for lung in mid June has resulted in mid to long term actions. Review meeting for prostate cancer at the end of June. - Balance of pathology reporting cross site (in place but can be further delineated) and recruitment to vacant posts. - Endoscopy recovery plan from new unit opening (recovery expected within Q2).

Cancer 62-day standard

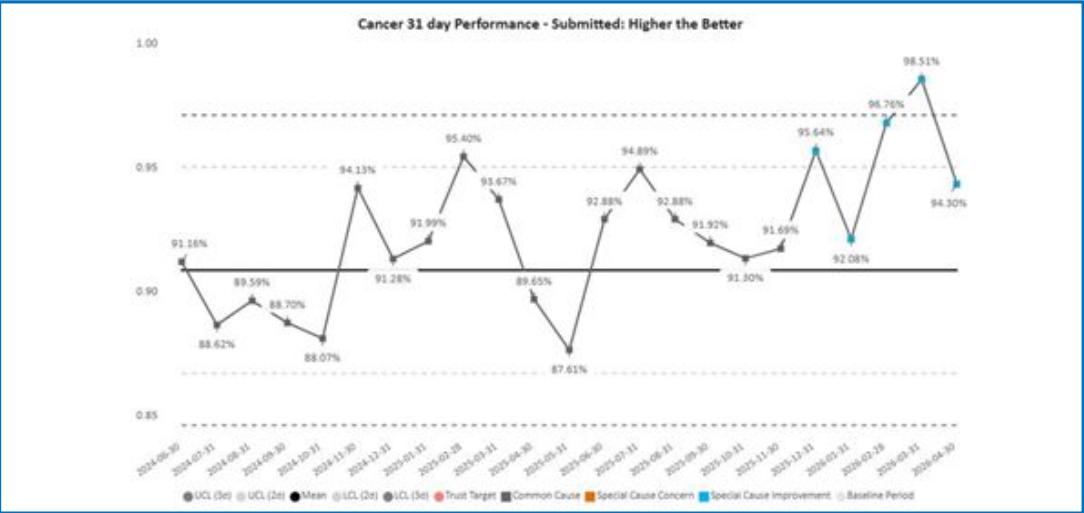
Background/national target description	
Improve performance so that 75% of patients receive their first definitive treatment for cancer within 62 days of an urgent GP (GDP or GMP) referral for suspected cancer.	
April 2026	Operating Plan April 2026
67.59%	76%



Update since previous month	Current Issues	Key Dependencies	Future Actions
- Submitted 62-day performance for April 2026 was 67.6%, below the 75.3% target operating plan target. - Provisional 62-day performance for May 2026 is 69.3% against the NHS operational plan target of 76.0% - Key themes include pathology reporting delays, clinical complexity of breast cancer pathways, liver treatment and OPA capacity and prostate diagnostic and OPA capacity.	- Pathology reporting delays (see previous slide for more info). For 62-day pathways delays add on average one week to each pathway due to needing discussion in a weekly cancer MDT meeting. - Complexities of breast pathways with additional imaging. - HPB surgical and radiology workforce. - Urology theatre diagnostic capacity.	- Synnovis pathology turnaround times. - Clinical review of breast diagnostic pathway (to be SELCA led).	- Pathology review meetings (see previous slide for more info). - Urology front end capacity/workforce plans to support enhanced diagnostic capacity—substantive CIF funding available to employ additional urology ANPs, job plans to be devised and business case being developed provisionally for July IB. - Additional HPB and HCC OPA capacity from Q2 with additional workforce. - Streamlining for prostate from patient being informed of diagnosis to PET scan and then surgery/oncology review.

Cancer 31-day standard

Background/national target description	
Improve performance so that 96% of patients with cancer should begin their treatment within 31 days of a decision to treat their cancer.	
April 2026	Operating Plan April 2026
94.3%	94%



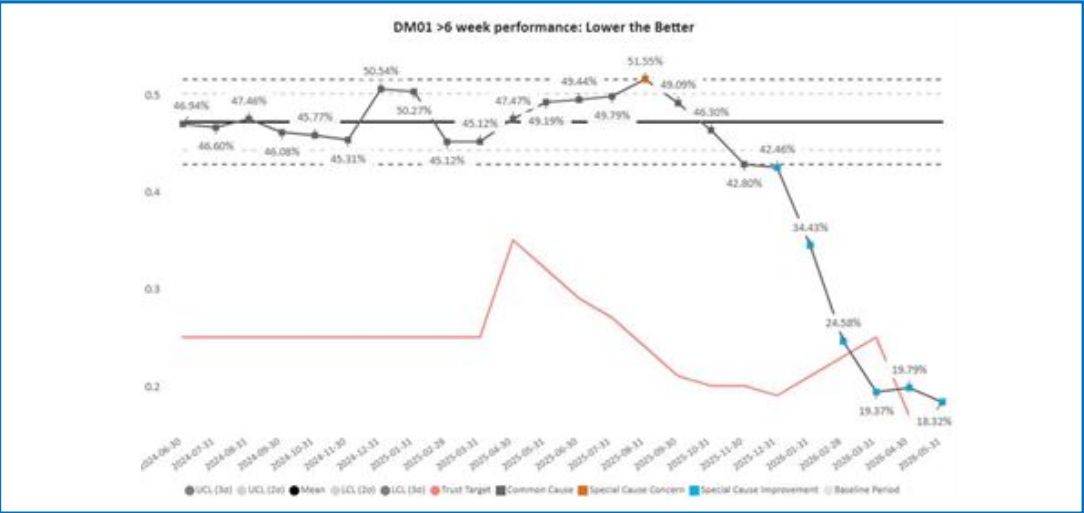
Update since previous month	Current Issues	Key Dependencies	Future Actions
- Submitted 31-day performance was 94.3% in April 2026 meeting the NHS operating plan standard and just below the 96% national standard. - Provisional May 2026 performance is 96.8%.	- HPB surgical capacity. - HPB liver interventional radiology treatment capacity.	- HPB surgical capacity; additional surgeon appointed, August 2026 start. - Two HPB radiology vacancies out to advert. One locum to commence covering one of the roles in September.	- Review of DH colorectal cancer theatre utilisation (in comparison to GSTT) – longer term plan. - Trust wide review of theatre demand and capacity underway including cancer pathway demand. - Liver interventional radiology scheduling process being streamlined.

Diagnostic Waiting Times – DM01

Background/national target description

- The percentage of patients not seen within six weeks for 15 tests reported in the DM01 diagnostic waiting times return improves to 5%.
- The target on the chart is incorrect and will be amended

May 2026	Operating Plan May 2026
18.32%	16.4%



Update since previous month

- There has been a run of 7 months DM01 performance below mean to May 2026.
- Whilst performance improved further by 1.47% to 18.32% in May, the Operating Plan target of 16.4% has not been achieved.

Current Issues

- MRI is the top modality with 766 breaches – a reduction of 45 breaches compared to April.
- Endoscopy service backlog has increased by a further 358 breaches for May with over 1,000 breaches which has prevented further DM01 performance improvement. Available PRUH capacity continues to be impacted in the short-term with the opening of the new endoscopy unit.

Key Dependencies

- The Acute Provider Collaborative (APC) is leading a sector-wide demand and capacity modelling exercise in Imaging for South East London although progress has stalled.
- Work is due to commence at end of June to re-develop the Trust’s demand and capacity and forecasting model.

Future Actions

- MRI/CT – mitigation actions identified and non-recurrent funding options submitted to NHSE for approval.
- Endoscopy performance was 31.7% and above the performance forecast of 28% for May – a revised recovery action plan and performance forecasts are being worked-up by the service.
- External validation team continues to be focused on diagnostic DM01 and planned pathway validation.

Domain 2 – Quality Summary (April 2026)

This month's report supports cautious assurance — there are credible signs of improvement in several core areas, but confidence remains qualified by further progress to measure the outcomes for patients and not just process related measures.

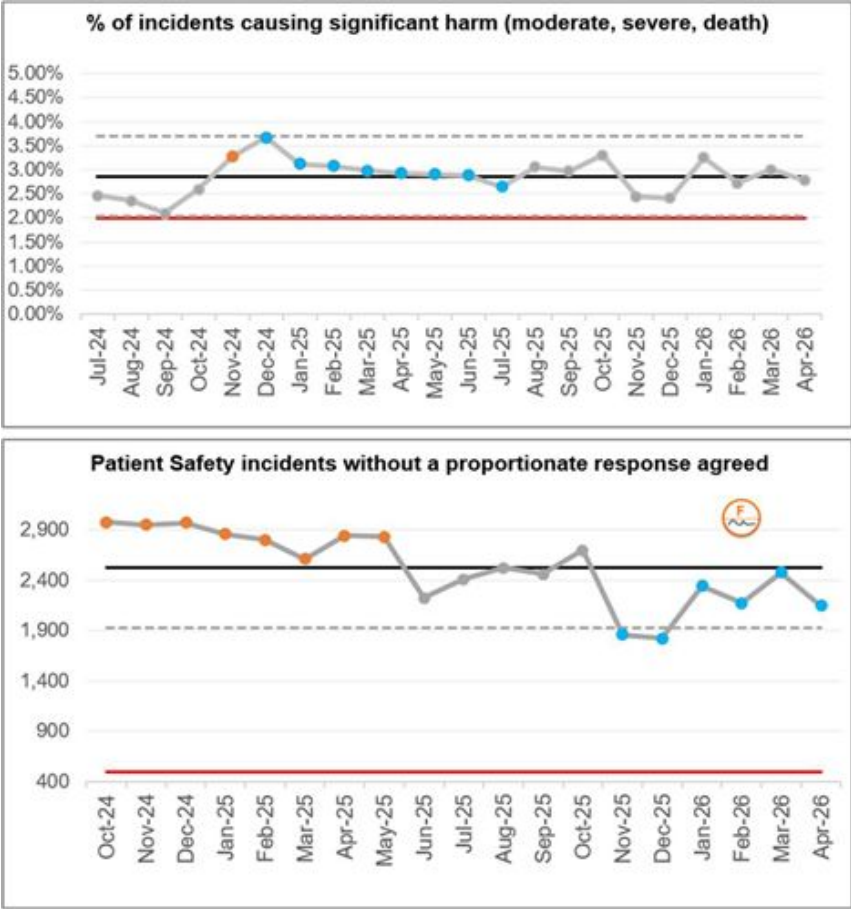
Positive Progress

- Improvement in **Duty of Candour** performance reflects both compliance and a healthier safety culture.
- Progress on the **incident backlog** suggests stronger grip, better follow-up, and more effective operational response. These improvements have been **driven through divisional accountability** which has been key to progress in these areas
- **Safer staffing picture:** The staffing position appears more controlled, with **better fill rates** and fewer signs of unsafe shortfall.

Residual Concerns

- Several areas of poorer performance (e.g. Harms prevention and ED patient feedback) appear to be linked to **flow and capacity issues**, so some quality risks may persist even where indicators are improving. It is unclear whether the remaining risks are temporary consequences of pressure or more embedded problems that need longer-term action. A Trustwide programme is in place to improve flow and reduce associated risks.
- The IQR does not yet present a fully settled assurance position; it points instead to **partial reassurance with important caveats**.
- There is a need to ensure that the improvements outlined lead to **clear improvements for patients** (in experience and/or outcomes). Whilst there are some early signs (e.g through the friends and family test) there is a need to develop and embed clear measures for this in the coming months
- It is important not to over-read single data points; the Board should continue to judge assurance through **triangulation across incidents, audits, patient experience, and harm data**. The IQR roadmap highlights plans to further enable such triangulation going forward

Safe – Incidents



The Trust did not commission any new PSIs in April 2026.

Incident reporting rates, levels of harm and PSIRF process are all as expected (or better) levels.

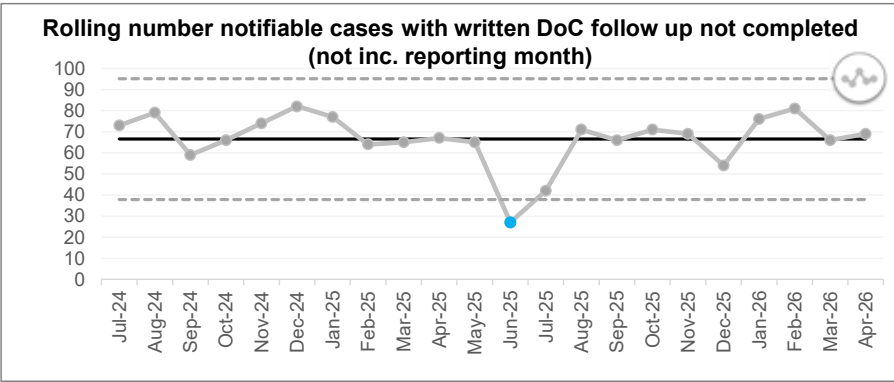
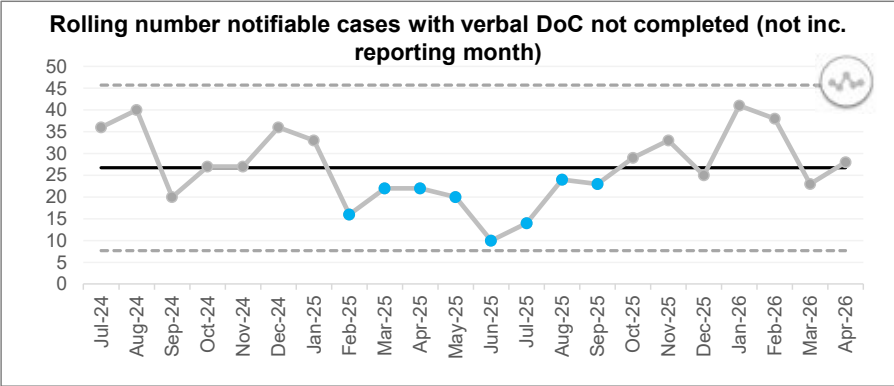
Patient Safety Incidents without a proportionate response agreed
Special cause improvement since late 2025

What does the data tell us?
Following a period of special cause concern in late 2024/early 2025 where the number of incidents with no response agreed stood at over 2500, improvement has been achieved and sustained in late 2025 and into 2026.

Actions being taken to improve
Divisional-level interventions made with care groups with highest backlogs. Incidents relating to Decontamination services are under consideration for a change in approach – for instruments these are managed via the contract but added to our InPhase system via an automated process. Responsibility for the review and closure of these being reviewed.

Impact on forecast
Aim for continued improvement for this figure to reach around 1000

Safe – Duty of Candour



What does the data tell us?
The rolling number of verbal and written DoC cases have both increased very slightly this month, but remain within common cause variation.

Actions being taken to improve
Planned interventions including improved notifications to care groups of cases where DoC has not been undertaken in 14 calendar days. This has now begun with new monitoring tools now available

What is the impact on our patients?
Expected improvements in average time taken to complete verbal DoC once interventions embed.

New metric introduced for % of cases of verbal DoC completed within 14 days. In April the Trust completed 47.5% of cases within this timescale. The target is to achieve 90% consistently by March 2027. A mechanism is in place to allow for approved exceptions to this timescale – Divisions are able to approve these exceptions and mark them as such on InPhase .

There are currently 32 cases where written DoC has not been completed 90 days after the incident was reported. Over half of these are in Division B.

In April, 27 duty of candour letters were sent. Of these, 8 (30%) were sent within 30 days and 18 (67%) were sent within 90 days. The target is to achieve 90% for 90 days consistently by March 2027, excluding PSIs. A mechanism is in place to allow for approved exceptions to this timescale.

Safe – Falls & Pressure Ulcers

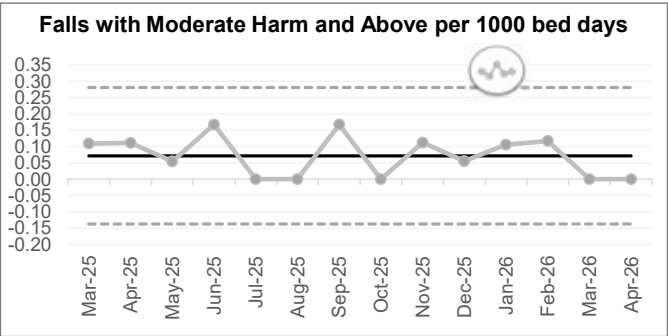
Improved Reporting: Ongoing work to improve data reporting from EPIC. Good progress with Falls data. Move to Purpose-T on Road Map for June 2026 but work in progress and plan to launch in August.

PSIRF Improvement Groups: Reduced membership with focus on one improvement at a time.

Falls: Development of a Trust wide Multidisciplinary falls strategy aligned with national guidelines, aimed at broader involvement in falls prevention and improvements in PSIRF/InPhase processes.

Pressure Ulcers: Exploring impact of long waits on ED trolleys on pressure damage development, and exploring potential options for short and long-term pressure relieving equipment in ED.

Falls & Pressure Damage associated with Corridor Care: In April, based on the limited data available, there have been no falls or pressure ulcers where boarding, corridor care or the use of surge beds was identified as a major contributing factor. Trolleys in ED have been flagged as a potential pressure ulcer risk and work is ongoing to explore mitigations.



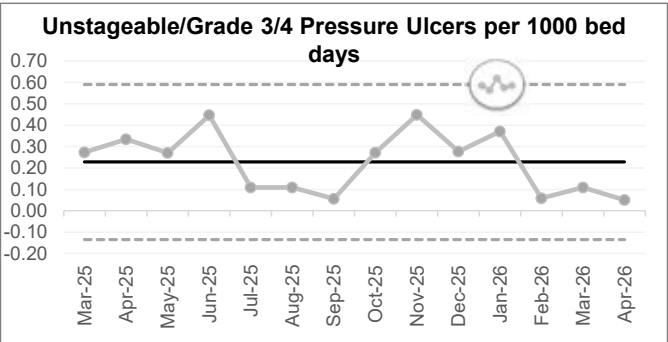
What is the data showing us?

Sustained common cause variation since July 2024. 181 falls in April. 3 Falls with injury graded moderate or above.

Actions being taken to improve:

Improvements in falls flowsheet in Epic signed off at Nursing WoT and went live on 2nd February. Ongoing review to ensure fit for purpose and make minor changes based on feedback. Issues ongoing with data outputs and reporting that are being explored.

Development of MDT falls strategy aligned to national guidance, aimed at broader falls prevention and management as well as improvements in PSIRF/InPhase processes. Preventing deconditioning project ongoing in AMU's at DH.



What is the data showing us?

Common cause variation identified for Trust-wide data; 148 pressure ulcers in April. 3 x unstageable and 1 category 3.

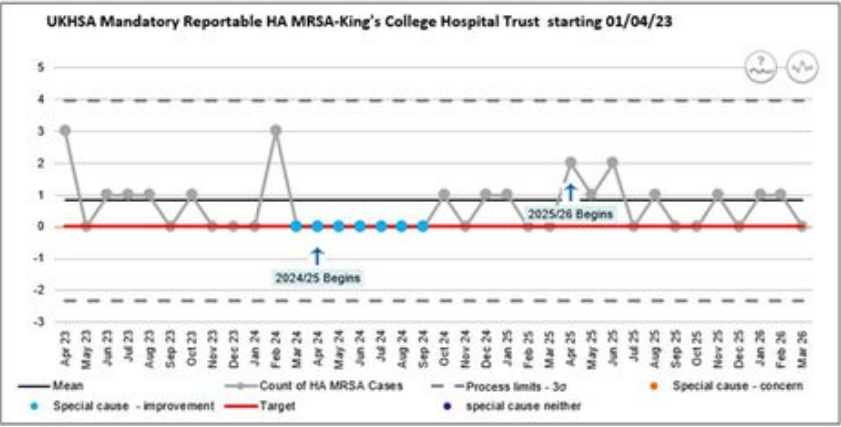
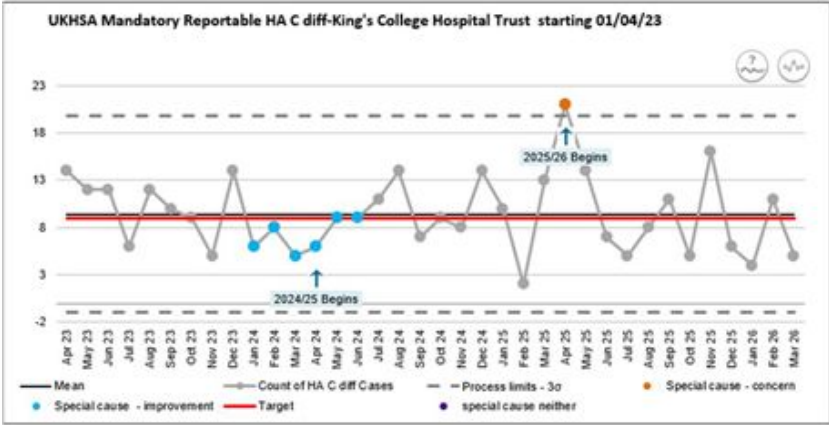
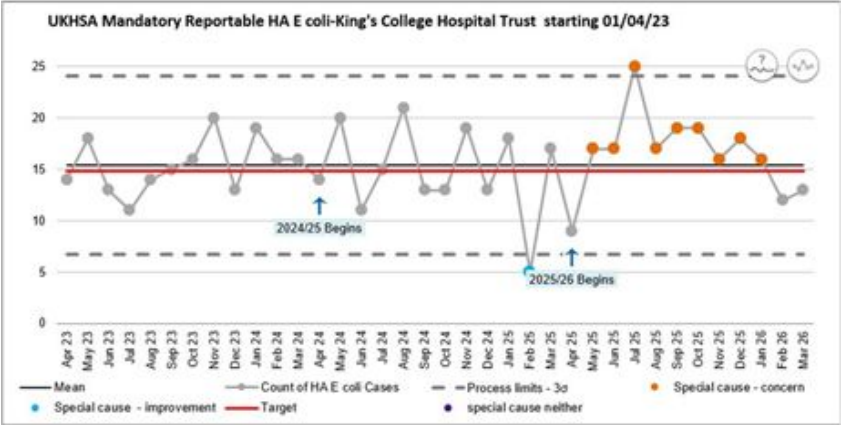
Actions being taken to improve:

Work ongoing to explore impact of long waits in ED on PU development. Exploring options for short- and longer-term pressure relieving equipment in ED.

Trust wide improvement work on skin assessments in Epic and reporting function at local, divisional and trust level. Await progress due to volume of Epic development work. On Road Map for June but work in progress and likely launch in August.

Quality

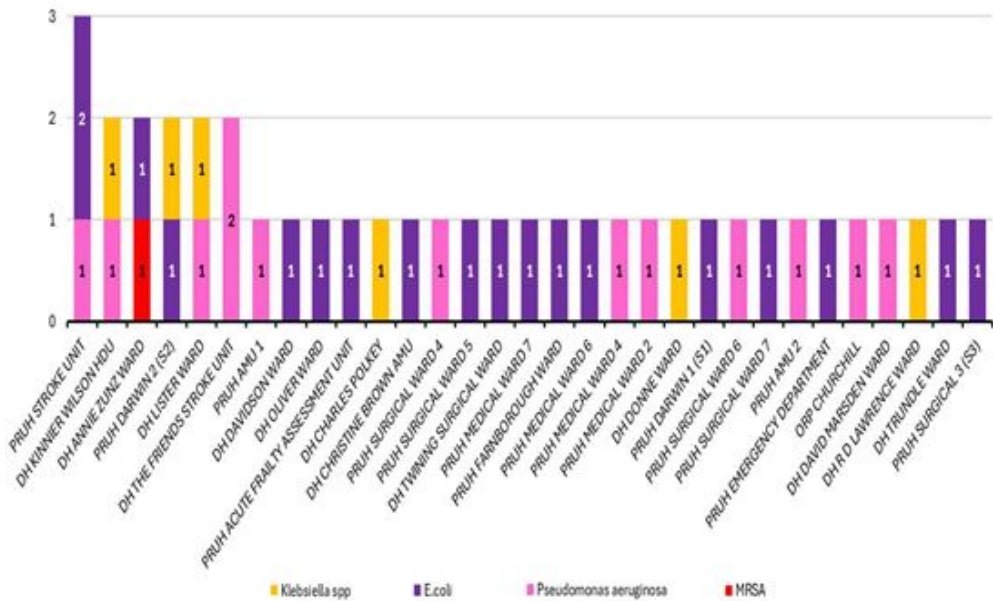
Safe – Infection Protection Control; MRSA, E.coli & C.diff



King's values Caring Collaborative Inclusive Innovative

Safe – Infection Protection Contro

Hospital attributed Mandatory Reporting Urinary Catheter Associated BSIs by Associated Ward (2025/26 FY)

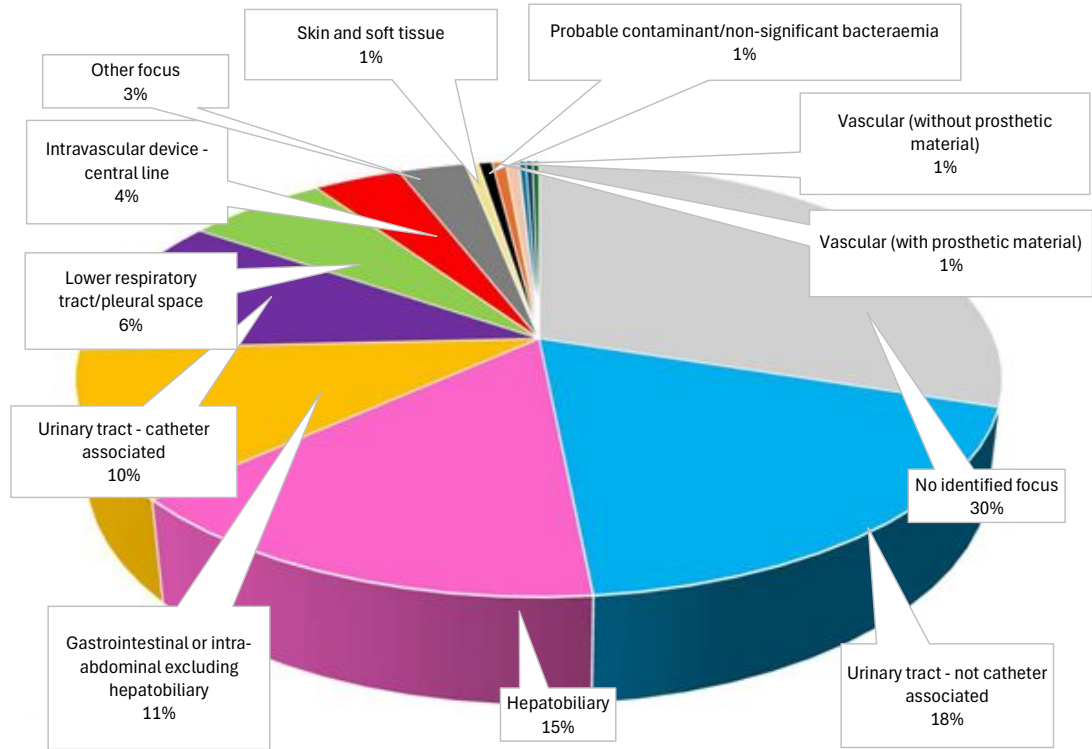


Actions being taken to address:

- A Trust-apportioned catheter-associated UTI (CAUTI) report has been built in Epic, and the IPC team will commence reporting on this measure from April 2026.
- An electronic prompt has been added to the Epic ward round note, as a visual reminder to prompt doctor review of urinary catheters post-op.
- Participation in the Lambeth and Southwark urinary catheter SEL meeting.
- IPC nurse urinary catheter reviews in high-risk wards.
- Collaboration with the Bladder & Bowel and Urology teams to undertake evaluation of innovative products – dependant on business cases.
- Working in partnership with Care Groups to ensure completion of after-action reviews for potentially avoidable bacteraemia, specifically related to urinary catheters.

Safe – Infection Protection Control

Trust Apportioned Gram negative Blood stream infection - probable Sources April 2025-February 2026 (n=357)



The ‘Tic Twoc’ study methodology was implemented on 4 wards during 2025-2026.

Kinnier Wilson and Mary Ray had zero catheter-related BSI during 2025-2026 (compared to 2 on each ward the previous year).

HASU at PRUH had zero catheter-related BSI cases 2025-2026, compared to 3 the previous year.

M4 at PRUH had one case during 2025-2026, compared to 2 the previous year.

Next Steps:

- Extend TIC TWOC sticker and poster campaign Trust-wide (depends on charity funding application).
- Trial of Bard Foley trays – dependent on financial implications.
- Further implementation of female Purewick device and trial of male version – dependent on financial implications

Quality

Caring – Friends & Family Test – Inpatient & Day Case



What is the data showing us?
Common cause variation for Friends and Family Test scores and number of responses remain steady overall. The overall Friends and Family Test score for Division B has statically improved since June 2025. Special cause of concerning nature for Division C, with score declining in January, March and April 2026 despite responses somewhat steady.

Actions & Impact:
Analytical deep dive within Renal & Urology and ASM care group is currently being undertaken to further understand patient experience and to determine why scores are significantly lower than the rest of the care group.

Observations by the Patient Expert Partners are being instigated to prepare areas for PLACE 2026. There is work underway to provide additional sensory spaces in the Day Surgery Unit at Denmark Hill for adult and paediatric patients.

Positive Feedback:
77% of the themes identified were positive in sentiment. Patients continue to praise the staff behaviour and the quality of patient care continue to be well received, and a substantial number of feedback provided.

Improvement Feedback:
The theme of facilities is becoming more prominent as a negative theme in patient comments for inpatient and day case areas. This includes cleanliness of the spaces, toilet and shower facilities, maintenance issues and being moved at nights. In April, facilities were the largest grouped theme and 58% were attributed to Division C.

Caring – Friends & Family Test – Emergency Department



Integrated Medicine



Special cause variation of concerning nature for Emergency Care experience rating; however this is as a result of a significantly increased response rate from August 2025 onwards. A recommendation rate of around 70% is not unusual for ED departments nationally. The Integrated Medicine Care experience rating is lower in month following low scores from the Emergency Departments across both sites.

Actions being taken to address

Following recent engagement work at PRUH, findings have been collated and recommendations provided to staff, focussing on reducing anxiety for patients on arrival to ED. Additional working groups planned to embed and develop these recommendations into effective departmental changes, with timelines.

- Provide a named staff member to act as a contact for patients; allowing them a specific person to ask questions about their care
- Waive parking fees for ED patients to alleviate patient anxiety while waiting for treatment
- Increased contact points with patients (through increased volunteer attendance) to manage expectations and deescalate when needed.

Within Denmark Hill, work continues to address communication issues, as a known primary cause of negative experiences.

- Improvement of Corridor Care communications; roll-out of NHSE posters; the trust understands their concerns around being treated in a corridor but assures that their care is not compromised.
- Health Innovation Network (HIN) report is imminent and will outline the success and challenges of the Digital Front Door programme which can further support our in-house feedback cycle.
- Patient Journey diagram to be designed and styled by Comms for better patient understanding of what to expect to at King's.

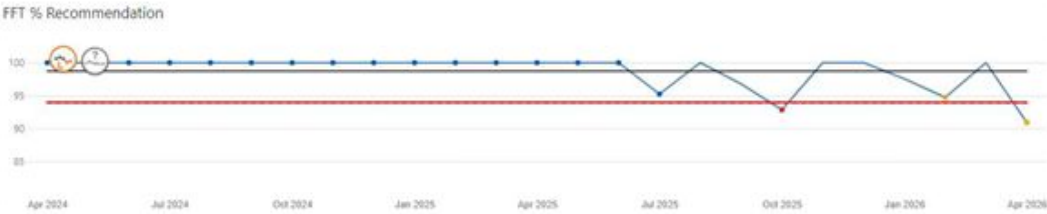
What is the impact for our patients?

From initiating these measures, we expect to see reduced stress, concern and anxiety for patients upon arrival and treatment at our EDs, therefore reducing the number of negative experiences reported. We also understand the importance of having human interaction and a visible presence for patients to talk to, and ask questions about their care or visit. This will lead to improved communication perception, and maintain a level of personalised care, whilst we roll-out and understand the benefits of the Digital Front Door programme and guide us on further improvements that can be made, with better understanding of concerns throughout the Patient Journey

Quality

Caring – Friends & Family Test – Outpatients

Therapies, Rehabilitation & Integrated Care Services



What is the data showing us?

Significant increase in responses over the last few months since support provided for outpatient areas with paper forms. Overall, Common cause variation for Friends and Family Test score, despite the small decline is experience scores.

Special cause of concerning nature for Therapies, Rehabilitation and Integrated Care Services. However, there was a dip in responses and a contributing factor, and more monitoring is required over the next few months.

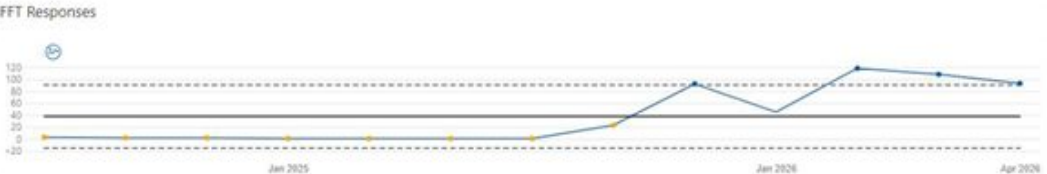
Women’s Health Outpatients



Special cause of improving nature for Women’s Health, consistently achieving a FFT rating of 100% since May 2025.

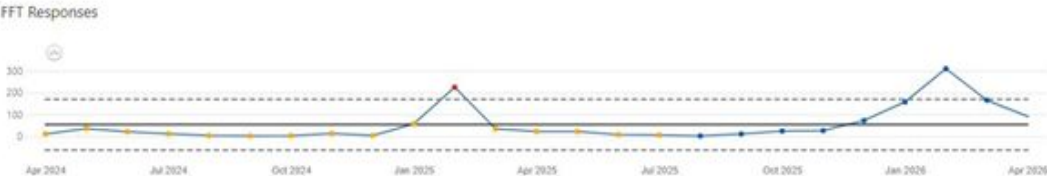
An increase in collecting responses for Liver, Gastroenterology and Endoscopy has led to an improvement highlighted although the lack of response prior to November 2025, skews the data.

Liver, Gastroenterology and Endoscopy Outpatients



A significant portion of outpatient feedback or Division C is from Ophthalmology, which has consistently performed under the trust benchmark since September 2025. Declined in scores is due to an increase in responses and reflect more accurately the experiences of patients within the area, in which long waits and appointments is reflective in their scores. Themes are similar to those seen in PALS.

Division C Outpatients



Positive Feedback:

Almost 80% of the themes identified were positive in sentiment. Staff were often described as kind, helpful and caring. Experience was improved when there was no delays in appointments.

Improvement Feedback:

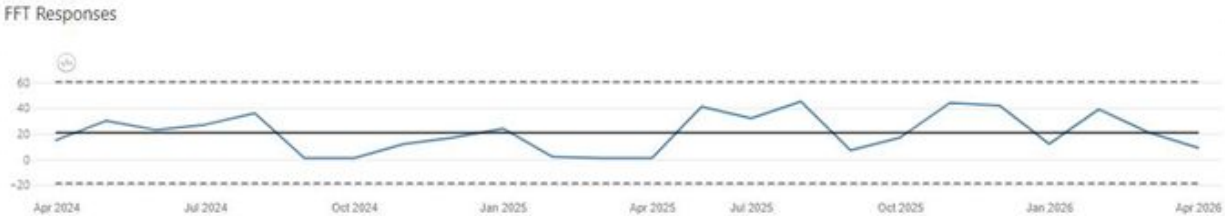
Waiting past the stated appointment time was noted from patients across all Divisions and noted wanting improved communication from staff when clinics are running late.

In response to the Trust Strategy publication, the Patient Experience Team are currently developing a 5-year plan to achieve 98% recommendation, including tackling key issues of communication

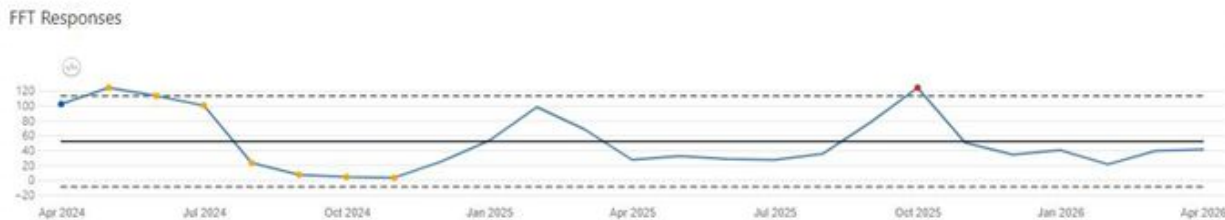
Quality

Caring – Friends & Family Test – Maternity

Denmark Hill Maternity Responses



Princess Royal University Hospital Maternity Responses



Denmark Hill Antenatal Responses



What is the data showing us?

Common cause variation for Friends and Family Test scores. Responses are primarily collected from Princess Royal University Hospital, particularly from labour touch point.

Antenatal at Denmark Hill touchpoint continue to perform lower than average, although numbers remain small. Lower scores were noted in Fetal Medicine specialty and Community Midwifery.

Meetings with the service are currently underway to discuss how we can improve the number of responses to ensure we are showing a more accurate picture of experience, based on number of patients seen.

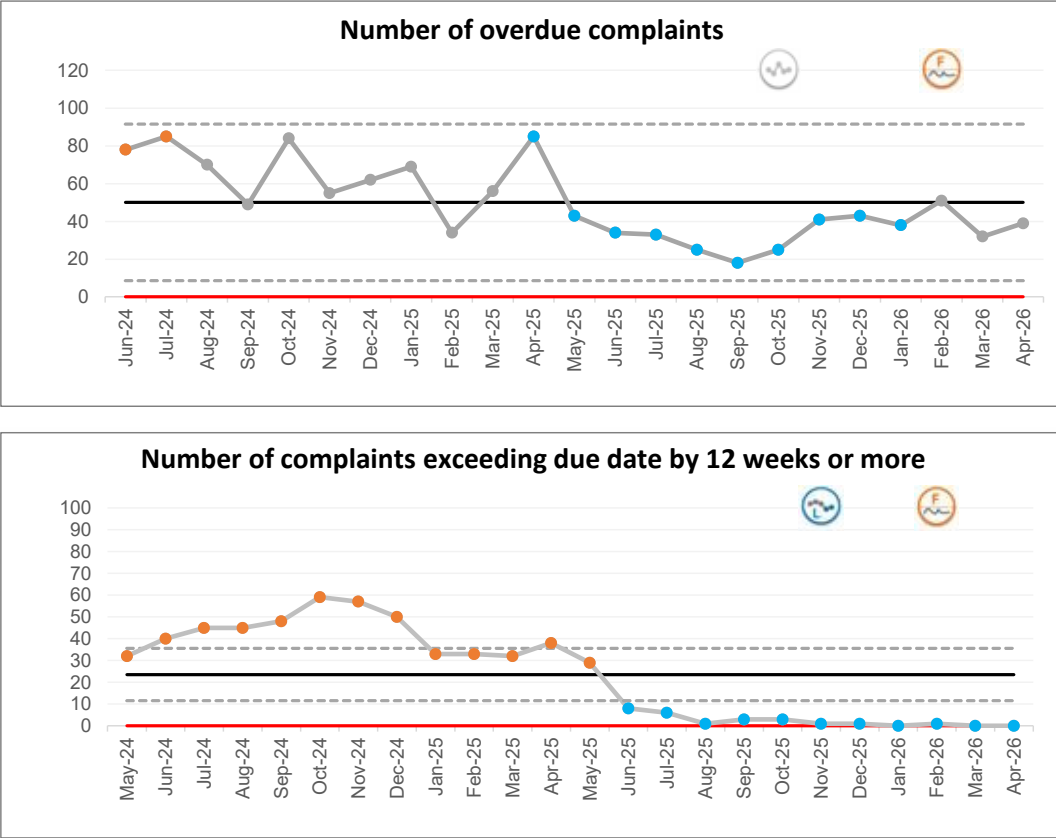
Positive Feedback:

Midwives and medical staff were praised on the kindness, support and quality of care provided.

Improvement Feedback:

A few patients suggested more private rooms and clearer communications of what to expect at different stages.

Responsive - Complaints



What is the data showing us?

Slight increase in number of overdue complaints following period of sustained special cause improvement; work has been ongoing to reduce this with backlogs from March and April since being closed.

50% of the overdue complaints are less complex/serious cases.

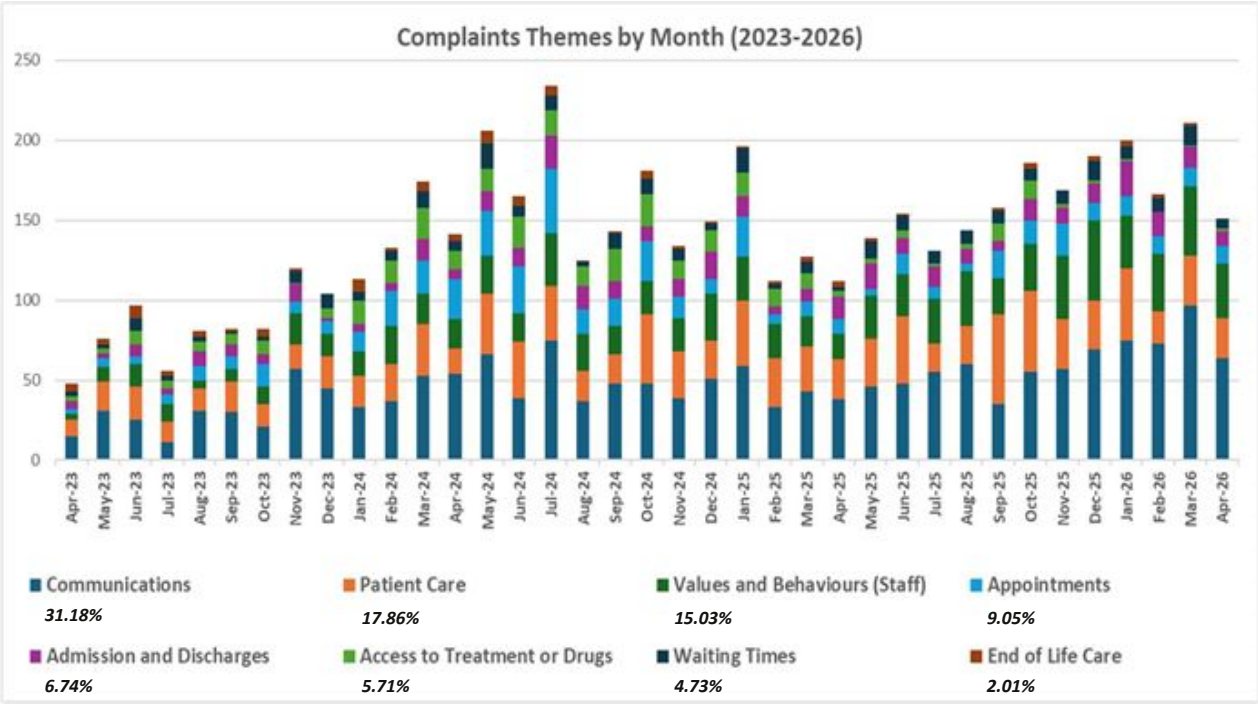
Actions being taken to improve:

Continuation of the regular Divisional complaint meetings to focus on those overdue, and support escalation/appropriate prioritisation.

What is the impact for our patients?

The sustained improvement in reducing overdue complaints with more timely responses restores trust and transparency for complainants of our organisation. Complainants feel heard and their concerns validated where we acknowledge care or service shortcomings – through the complaints process, they are informed of the improvements identified, and how appropriate changes will be made following investigation.

Responsive – Complaints (Spotlight on Themes)



What is the data showing us?
The 8 themes in the chart represent 90% of all complaints themes received across the past 3 years.

We can see that Communications, Patient Care, and Staff Values & Behaviours are key concerns. These themes are in keeping with top complaints themes for NHS Acute providers, in the year-on-year national dataset.

Actions being taken to improve:
The regular Divisional complaint meetings are continuing, to focus on those overdue, and support escalation/ appropriate prioritisation. Complaints is a standing agenda item for Care Group Specialty Clinical Governance meetings, with learning from complaints included alongside Ombudsman reviews.

Further work ongoing to drill down into sub-themes by Care Group, and Site, to enable exploration of appropriate improvements and actions.

What is the impact for our patients?
Understanding complaints by themes, and care group/site specifics, enables us to develop on focussed learning and actions plans to tackle known challenges. More timely and thorough responses evidence a balanced investigation, our commitment to be open and honest and a commitment to reflection and learning.

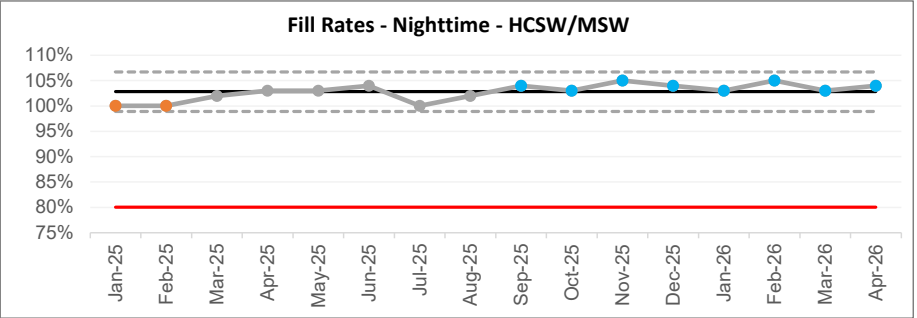
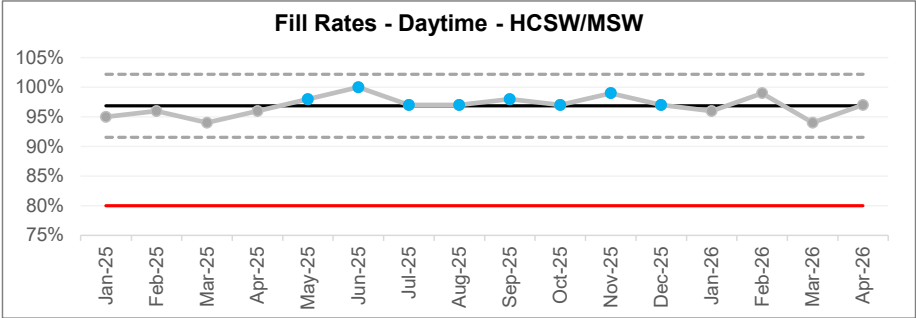
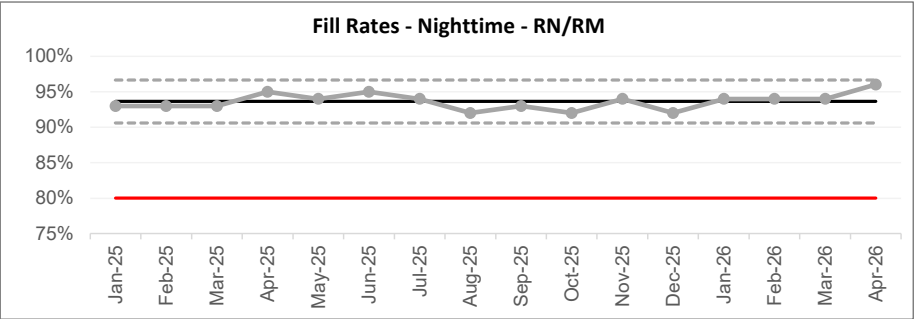
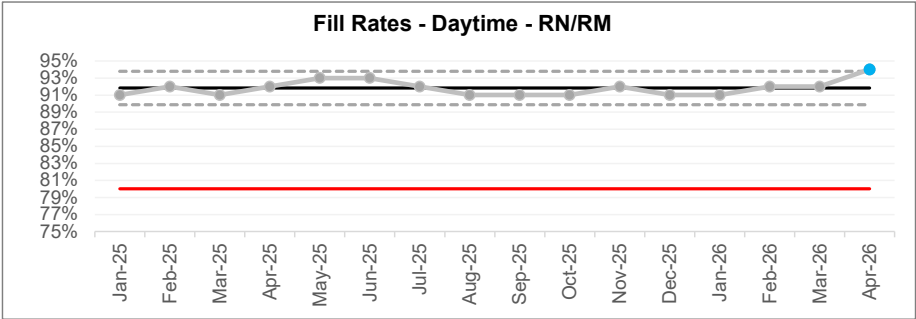
Quality

Well-led – Safer Staffing

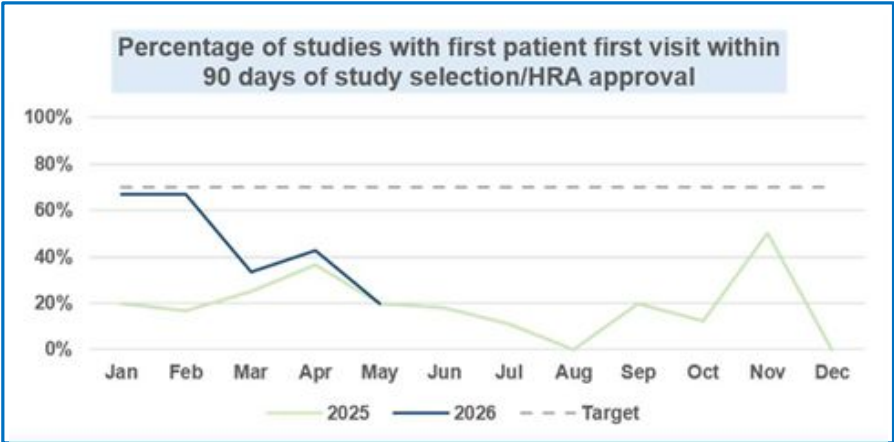
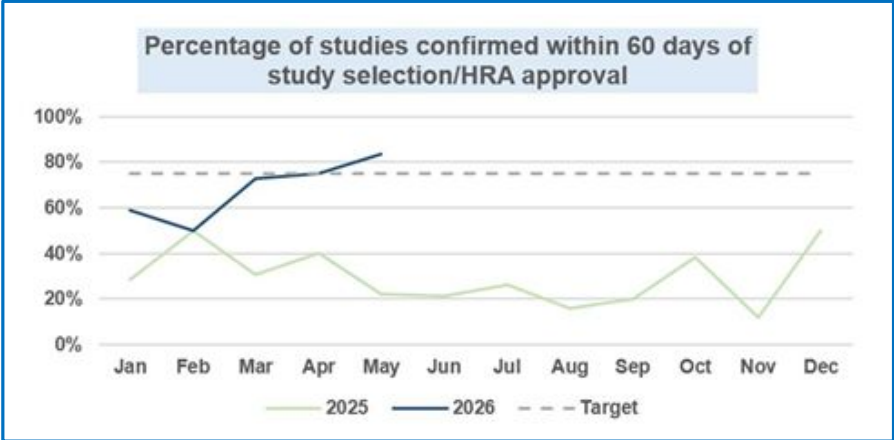
Fill Rates

Represent the proportion of planned care hours delivered against the hours scheduled by the clinical team.
Fill rate calculations do not include additional shifts needed for enhanced care, and are based on core template of staffing, producing inflated >100% figures.

Positive assurance and special cause improvement shown for fill rates for daytime and nighttime for both HCSW and RN/RM.
1 areas reported registered fill rates of <80% - Kinnier Wilson Ward (Day -69% Night – 74%)



150-day target Performance - R&D



What is the Data Telling Us

Studies confirmed within 60 days of selection or HRA approval: Performance improved from around the high-50% range in January to over 80% by May and is above the national average. This is a clear positive and suggests that internal processes and coordination at the early stages of study set-up are working well.

First patient first visit within 30 days of study start: performance declined from 65% in January to 20% in May. This process is reliant on having adequate clinical and supporting staff in post – there are significant delays in recruiting to new posts and filling vacancies that are adversely impacting this metric

90-day first patient first visit metric: Performance was close to the target in January and February but dropped from March onwards. KCH is clearly improving how quickly studies are set up and approved (60 days). The next step is to make sure this progress carries through to patient recruitment, with improvements to the research staff recruitment processes key to KCH meeting the overall 90-day target

Domain 3: Workforce Domain Metric Assurance Summary

Metric Group / Metric Name	Reporting Month	Current Value (Month)	Previous Value (Month)	Assurance (Monthly)	Reporting Week
Workforce					
Actual FTE	2026-05	13371.72	13403.45	No Target	
Advert Open to Conditional Offer (AfC)	2026-05	32.7	29.6	Fail	
Advert Open to Conditional Offer (Consultants)	2026-05	60.0	43.3	Fail	
Agency Cost	2026-05				
Appraisal %	2026-05	30.78%	19.82%	Fail	
Average days lost to sickness per FTE/employee	2026-05	7.1	7.1	No Target	
Bank Cost	2026-05				
Core Skills %	2026-05	89.29%	88.78%	Fail	
Disciplinary Cases(formal)	2026-05	29	35	No Target	
Dismissals	2026-05	1	1	No Target	
Early Resolution Cases (formal)	2026-05	42	25	No Target	
Establishment FTE	2026-05	14400.87	14408.30	No Target	
Flu Vaccination Uptake (%)					14/06/26
Gross Salary Bill	2026-05				
Headcount (Substantive)	2026-05	14397	14430	No Target	
Leavers < 12 Mths Service % (voluntary)	2026-05	22.08%	18.42%	No Target	
Leavers Headcount	2026-05	97	104	No Target	
Proportion of Apprenticeship levy spent	2026-05	0%	-1%	No Target	
Sickness %	2026-05	4.03%	4.05%	Fail	
Sickness Long Term %	2026-05	1.88%	2.04%	Pass	
Staff mix (substantive, honorary and volunteers)	2026-05				
Starters Headcount	2026-05	70	145	No Target	
Turnover Voluntary %	2026-05	7.87%	7.97%	Pass	
Vacancy %	2026-05	6.59%	6.42%	Pass	

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

Executive Summary

- The sickness absence rate is 4.05%, above the Trust's 3.50% target but improved from the March position of 4.40%. Benchmarking against other large London Trusts places the Trust within the middle quartile, indicating a relatively stable performance position in a challenging operating environment
- Reducing absence remains a strategic workforce priority, given its impact on service delivery, workforce productivity and staff wellbeing. To accelerate improvement and move towards the Trust target, focus will continue strengthening early intervention and prevention measures, delivering targeted support to high-absence divisions, and enhancing manager capability to proactively manage attendance.
- Core Skills compliance has been below the 90% target for three months and is currently at 89.28%. It is driven by underperformance in key areas, including resuscitation, infection control and manual handling. Targeted recovery actions are in place, with a focus on high risk modules and strengthened accountability to achieve compliance in the coming months.
- Targeted communications and focused escalation to line managers are in place, alongside strengthened reporting and monitoring, to drive improved compliance in these priority areas
- Trust vacancy rates increased slightly to 6.59%, however remains significantly below the 10% target, reflecting continued progress in workforce stabilisation and sustained alignment with Trust priorities
- Agenda for Change time-to-hire performance remains within KPI for Bands 4–6 and 7–9. Although time to hire for Bands 1–3 is outside target, it is trending downwards and significantly improved on last month. This indicates broadly effective recruitment processes, with a need for targeted optimisation in entry-level recruitment pathways and workforce supply pipelines
- Medical time-to-hire has further improved to 106.5 days, demonstrating continued movement towards national benchmarks and sustained progress in reducing delays in filling critical clinical roles
- Voluntary turnover has increased slightly to 7.97%; however,, it remains well below the 13% target. Importantly, turnover has consistently remained under target since October 2023, demonstrating sustained improvement in retention and relative workforce stability over time.

Appraisal Rate

Background / target description:

- The percentage of staff that have been appraised within the last 12 months (medical & non-medical combined)

May 2026	Target
30.78%	90%

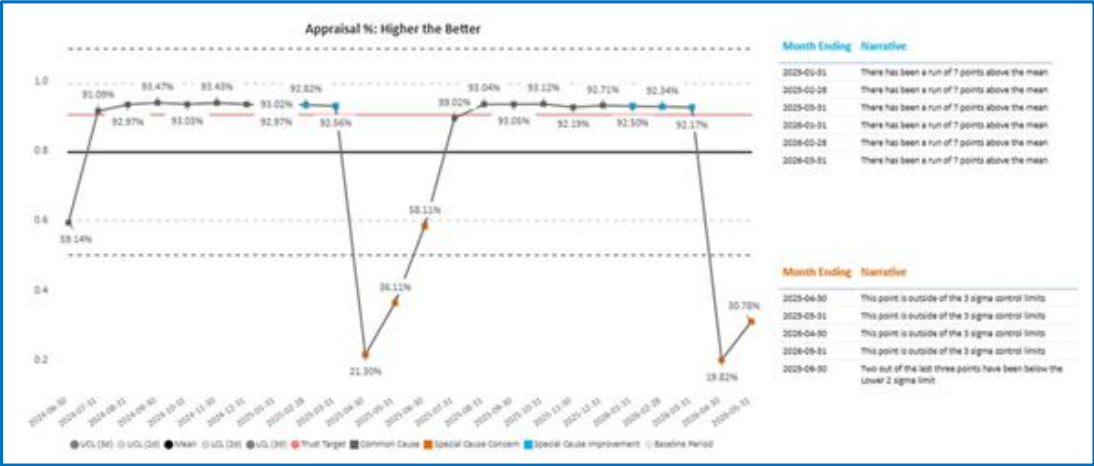
What is the Data Telling Us

Non-Medical:

- The FY2026/27 Appraisal ‘window’ for non-medical staff runs from 1 April to 31 July each year.
- The current return rate was 17.02% at the end of May 2026 – the second month of the appraisal window.
- Submissions historically increase significantly towards the latter part of the appraisal window.
- In comparison with the same period last year, the Trust is not performing as well as last year’s performance. At the end of May 2025, 22.46% had been submitted by this stage.
- Compliance resets to 0% on 1 April for AfC appraisals and historically it takes until at least late July before the 90% compliance is achieved. Last year it was 6 August 2026

Medical:

- Medical appraisal compliance has increased to 87.56%, reflecting continued incremental improvement. Work being done by the CMO/RO office, along with not having the winter clinical workload pressures has contributed to this.



Future Actions

Non-Medical:

- Regular reports to be circulated to Divisional and Care Groups as well as the wider Trust management for monitoring and following up as well as reminders being sent directly to appraisees and their line managers. The frequency of the reports increase nearer to the end of the appraisal window.
- People Business Partners to raise with the respective Care Groups / Departments to both monitor performance and to encourage completion in a timely fashion

Medical:

- A structured appraisal compliance framework is in place and actively supported. Monthly compliance reports are shared with Clinical Directors, People Business Partners, and General Managers, supported by automated SARD reminders
- For appraisals overdue by 3 months or more, escalation letters are issued by the Associate Medical Director (Responsible Officer) and followed up with Clinical Management. Also provide targeted support to ensure appraisees can access right appraisers.
- In addition, monthly oversight meetings between the Chief Medical Officer, Responsible Officer and Associate Medical Director for Professional Practice ensure ongoing monitoring and continued improvement in compliance.

Sickness Rate

Background / target description:

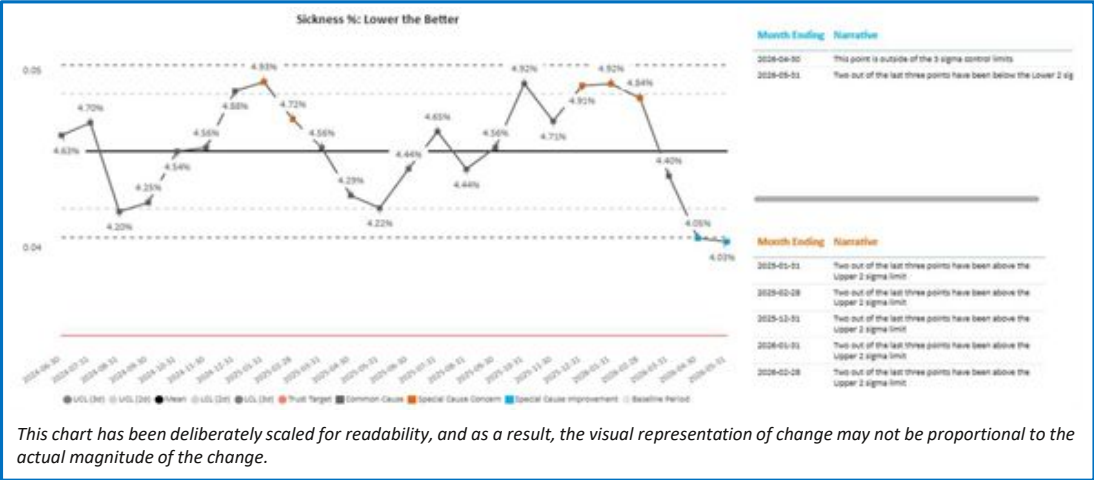
- The number of FTE calendar days lost during the month to sickness absence compared to the number of staff available FTE in the same period.

May 2026	Target
4.03%	3.5%

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

What is the Data Telling Us

- The sickness absence rate has improved, decreasing by 0.02% from 4.05% in April 2026 to 4.03% in May 2026, showing positive movement in overall absence performance of the Trust.
- In total, 2,450 staff were reported as absent due to sickness during May.
- The highest absence reasons based on the number of episodes were due to:
 - Cold/Cough/Flu (18.4%)
 - Gastrointestinal problems (16.4%)
 - Headache / migraine (8.8%)



Context

- Care groups with the highest sickness absence rates have been identified and are receiving targeted support, including case reviews and local training to strengthen management capability. The expected strategic outcome is a reduction in variation across care groups and improved consistency in absence management practice.
- The Sickness Absence Policy has been refreshed to provide clearer, more consistent guidance for managers and is aligned with the Trust's values and behaviours to support fair application across the organisation, with the expected outcome of improved decision-making and earlier intervention.
- Divisional People Teams are reviewing all cases over 12 months in duration, working closely with managers and Occupational Health to agree actions and support prompt resolution. This is expected to reduce long-term sickness caseloads and improve sustainable return-to-work outcomes.
- In addition, the ER team continues to deliver monthly and bespoke training to further strengthen manager confidence in managing and monitoring sickness absence, with the intended outcome of improved compliance with policy and reduced overall absence levels.

Statutory and Mandatory [Core Skills] Training

Background / target description:

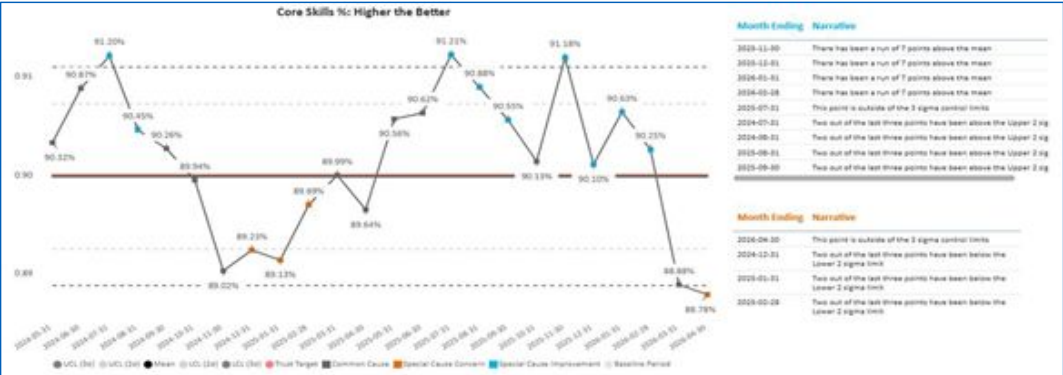
- The percentage of staff compliant with Statutory & Mandatory training.

May 2026	Target
89.28%	90%

What is the Data Telling Us

- The Trust's compliance rate improved last month to **89.28%**; however, it is the third consecutive month it has been below the 90% target.
- All three Divisions improved their compliance figures on last month with Division B now exceeding the 90% target.
Division A: **(88.20%)**,
Division B: **(90.04%)** and
Division C **(89.13%)**.
- With the exception of R&D (86.64%) and Chief Delivery Office (89.58%), the rest of the Trust shows over 90% compliance.
- The three Care Groups requiring the most intervention are: Haematology **(85.22%)** – *there has been a drop of 0.77% since last month* Child Health **(85.88%)** – *there has been an improvement of 0.6% since last month* and Pathology **(86.07%)**
- The 3 staff groups which have the lowest compliance score are: Medical and Dental with **(82.20%)**, Healthcare Scientists **(87.30%)**, and Additional Prof Med and Tech **(89.56%)**
- Topics below the 90% compliance rate are Resuscitation (all levels), Manual Handling (both levels), and Infection Protection Control (both levels).
- Resuscitation – Level 2 ABLS needs specific focus, despite a small increase on last month is still below target at **78.70%**. There are currently **130** staff listed who require this training but with no record of completion. This is being followed up through reporting being shared with the People Directors.
- Data Security Awareness compliance has improved from 85% in February, however, it dropped by 0.51% to **87.50%** last month

This chart has been deliberately scaled for readability, and as a result, the visual representation of change may not be proportional to the actual magnitude of the change.



Future Actions

- Communications and Reminders**
90-day advance training reminders are being reintroduced to prompt early bookings and maintain compliance. Targeted reminders are being sent to staff with expired training, with line managers notified. Direct emails copying line managers are being issued to staff with no LEAP certification recorded, including those requiring Level 2 ABLS Resuscitation. Appraisal communications are being updated to include core skills compliance as a requirement.
- Data and Reporting**
A revised monthly data product is being developed for People Business Partners and Care Group Leaders to actively target non-compliant staff. Monthly compliance figures are being shared with Divisional People Directors and Leaders, identifying staff with no training recorded.
- Targeted Improvement Work**
Exploratory work is underway with Medical and Dental leaders to improve compliance within this staff group. Work is ongoing with Subject Matter Experts in underperforming areas, such as Resuscitation, to identify systemic barriers to compliance.
- Systems and Processes**
Proactive rostering more than eight weeks in advance is being explored for certain Core Skills to maximise training places and prevent non-compliance. LEAP video tutorials are being developed to support staff with booking training and checking compliance scores
- Escalation**
An escalation report was submitted to the Executive Team outlining key areas of concern and risk as well as an improvement plan to bring compliance back on target. A deep dive into resus training and identified staff is underway as a result.

Vacancy Rate

Background / target description:

- The percentage of vacant posts compared to planned full establishment recorded on ESR.

Note: When the actual FTE is higher than the establishment FTE the vacancy % is displayed as zero.

May 2026	Target
6.59%	10%

What is the Data Telling Us

- The overall vacancy rate has increased slightly to 6.59% this month but remains well within the 10% target, reflecting continued workforce stability.
- Overall AfC time to hire remains within KPI for 2 band groupings and outside of KPI for one:
 - Band 1–3 at 70.9 days (outside 60-day target; trending downwards)
 - Band 4–6 at 67.6 days (within 70-day target),
 - Band 7–9 at 75.4 days (well within the 90-day target).
- Medical time to hire reduced to 106.5 days but still shows a continued opportunity for improvement in this cohort.
- Overall resourcing performance remains stable with strong controls on vacancy levels, while targeted focus on reducing medical recruitment timelines and further optimising Band 1–3 recruitment will support continued workforce efficiency.



Future Actions

- The vacancy controls in the Trac recruitment system have now been fully rolled out.
- The central redeployment Hub is being expanded to support the 26/27 CIP programme in redeploying displaced staff into vacant roles. This helps protect employment and ensure we can cover gaps without increasing headcount. The Trac system is being utilised to drive this and will work alongside the revised Trac vacancy control process.
- Continue to recruit in line with local and external ‘triple lock’ process.
- The new data quality team that is being setup within the People Directorate to address backlogs and bottlenecks within the recruitment team (funded from existing establishment) is still due to go live in Q1.
- Operational changes are planned in Q1 to streamline audit and checking processes which will free up resources to continue to improve metrics

Turnover Rate

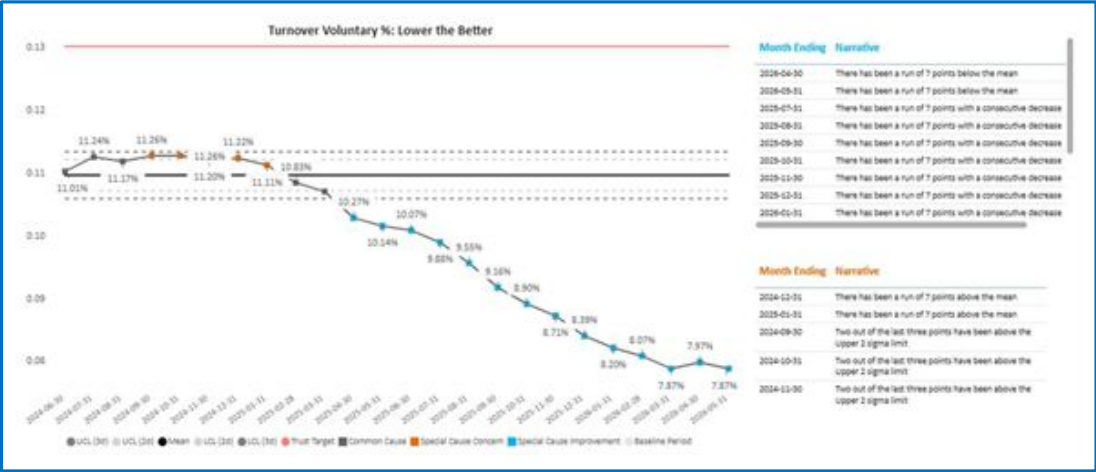
Background / target description:

- The percentage of vacant posts compared to planned full establishment recorded on ESR

May 2026	Target
6.59%	13%

What is the Data Telling Us

- Voluntary turnover has increased slightly to 7.97% in April 2026 and remains well below the 13% target. This continues a sustained positive trend, with turnover consistently remaining under the Trust target since October 2023.
- The three main voluntary reasons for leaving in April were:
 - Relocation (35.1%)
 - Promotion (22.1%)
 - Work Life Balance (20.8%)

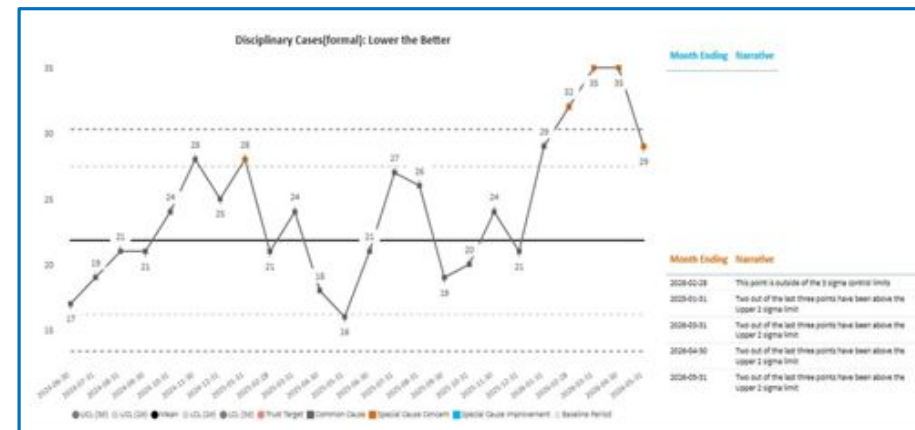
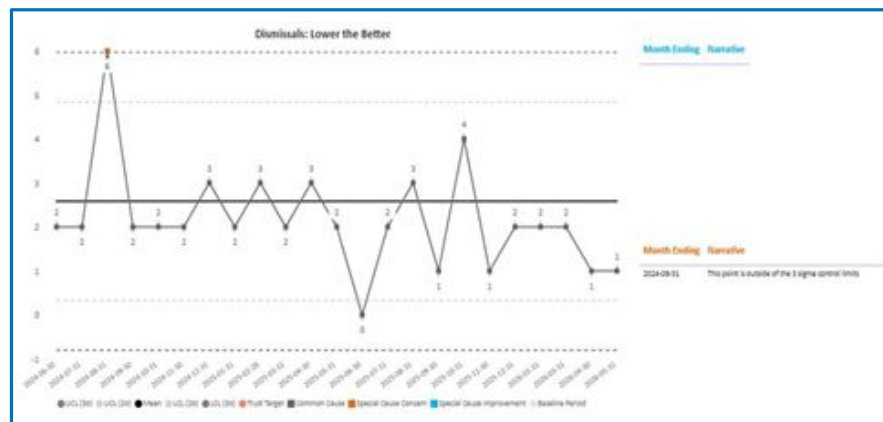


Future Actions

- Delivery on action plans from the 2025 National Staff Survey has taken place. Action planning sessions are in place to review feedback and agree targeted responses.
- Workforce priorities are progressing, including review of flexible working options, review of the reward and recognition offer, and strengthening of the exit interview and onboarding processes.
- Establishment of the Health & Wellbeing Steering Group to coordinate the implementation of Trust's Health and Wellbeing action plan under WS02.
- The Talent Management Strategy has been launched and is currently being piloted across four care groups and two corporate areas, supporting a more structured approach to workforce development and succession planning.

Workforce

Employee Relations



What is the Data Telling Us

As at 31 May 2026, there were 36 open formal disciplinary cases, an increase of one case from the previous month. There were also 27 formal Early Resolution cases, representing an increase of two cases compared to April.

The average investigation completion time remained at the 12-week target for the third consecutive month. During May, five formal disciplinary cases were closed, demonstrating continued progress in reducing case volumes and maintaining momentum in case resolution.

A number of the cases closed during the month had taken longer than anticipated to conclude due to factors including staff absence, which limited engagement with the process, and the complexity of individual cases. These factors have continued to impact overall completion times.

To support further improvement, we have strengthened our approach through earlier engagement with Commissioning Managers to expedite decision-making at the conclusion of investigations. We have also introduced monthly Divisional Strategic ER Exchange meetings to provide greater oversight and review of cases. In addition, panel members are now identified earlier in the process to support more timely scheduling of hearings.

All cases continue to be actively monitored against the 12-week KPI, with projected completion dates and clear decision-making plans in place to support timely progression and resolution.

EDI

What is the Data Telling Us

Sickness Category	Disabled	Non-Disabled	Sickness Category	Minority Ethnic	White	Not Stated
Sickness ST %	2.98%	2.11%	Sickness ST %	2.29%	1.93%	1.98%
Sickness LT %	4.41%	1.78%	Sickness LT %	2.03%	1.64%	1.86%
Sickness %	7.39%	3.90%	Sickness %	4.32%	3.57%	3.84%

ST – Short term sickness / LT – Long term sickness

- Sickness rates are calculated by looking at the number of FTE lost to sickness in the month against all FTE that was available in the same period.
- The splits by ST and LT show the proportion of the total rate that was lost for each category.
- The Non-Disabled group includes those with no disability and those who have not stated a disability.

- Since April, sickness absence rates have reduced for disability groups and marginally increased for minority ethnic staff (0.03%). Non-disabled staff sickness has decreased by 0.3%, and the not stated ethnicity category has decreased by 0.24%
- This disparity aligns with WDES indicators relating to pressure to work when unwell, access to reasonable adjustments, and capability processes. Disabled staff are over four times more likely to enter a capability process.
- These patterns indicate ongoing systemic inequities in the experience and support of disabled staff.
- Focus will now shift to strengthening data quality and analysis to identify key organisational hotspots, alongside delivery of a targeted disability equity programme aligned to the forthcoming People and Culture Strategy and embedded across People functions.

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

Ethnicity - Applications

Recruitment Stage	Minority Ethnic	White	Not Stated	Total
Shortlisted	777	268	47	1,092
At interview stage	598	185	22	805
Offered	179	83	25	287
Ready to Start	92	56	16	164

Disability - Applications

Recruitment Stage	Y	N	Not Stated	Total
Shortlisted	80	972	40	1,092
At interview stage	64	718	23	805
Offered	16	254	17	287
Ready to Start	8	145	11	164

- Data indicates improved progression rates for disabled candidates through the recruitment process.
- However, WRES Metric 2 remains a priority, with White applicants 1.84 times more likely to be appointed from shortlisting (Mar 2026).
- Inclusive recruitment training has been relaunched, with three sessions delivered in 2026 reaching approximately 50 staff.
- Focus will now shift to strengthening integrated reporting through development of an IPR dataset aligned to the culture dashboard (in development) and diversity metrics, alongside delivery of an inclusive recruitment and equity programme aligned to the People and Culture Strategy and anti-racism framework.

May 2026

Ethnicity - ER Cases

Cases	Minority Ethnic	White	Not Stated
Disciplinary	69%	14%	17%
Early Resolution	62%	25%	13%

Disability - ER Cases

Cases	Y	N	Not Stated
Disciplinary	6%	89%	6%
Early Resolution	4%	90%	6%

- Focus will now shift to strengthening integrated reporting through development of an IPR dataset aligned to the culture dashboard (in development) and diversity metrics, alongside delivery of a race equity programme aligned to the People and Culture Strategy, Lord Mann review and anti-racism principles.
- Race and ethnicity remain a key organisational priority for improvement.
- WRES Indicator 3 highlights a continued disparity in disciplinary processes, with minority ethnic staff overrepresented in formal cases (69%) relative to workforce demographics.
- This has decreased by 5% compared to white representation which has remained the same since April 26.
- These trends indicate persistent inequities in employee experience and outcomes.

Domain 4: Finance - Executive Summary

As of May, the KCH Group (KCH, KFM and KCS) has reported a £1.8m deficit year to date. This represents a £1.5m favourable variance to the March 2026 NHSE accepted plan.

The underlying position year to date is an £18.0m deficit after removal of non-recurrent items, £1.9m adverse to plan.

- The Trust is reporting a favourable variance of £3.8m on NHS patient care income with £2.1m underlying underperformance offset by £1.2m non-recurrent fixed contract protection.
- Excluded high cost drugs and devices income overperformed by £2.3m, offset by associated non-pay expenditure. There was also £0.7m over performance on Local Authority contracts and a further £1.1m on overseas visitors and the injury cost recovery scheme.
- Private patient income is £1.7m below plan, mainly due to the CAR-T cell CIP currently underperforming. However, as this is a low-volume, high-value and irregular activity, the CIP is still forecast to be fully achieved by the end of the financial year.
- £5.1m underperformance in Other Operating income relates to subsidiary income and is mitigated by reduced expenditure.

Pay £4.2m adverse variance:

- There was an adverse variance of £3.9m being undelivered CIP against plan.
- The Resident Doctors strike impact was £1.0m and £0.5m estimated cost for the National Band 5 Nursing review. These overspends are partly offset by underspends within Admin and Clerical.
- The Trust's WTE has reduced by 224 WTE year to date, with the main contributor being Nursing Bank, with a reduction in Medical Bank May due to the strike in April.

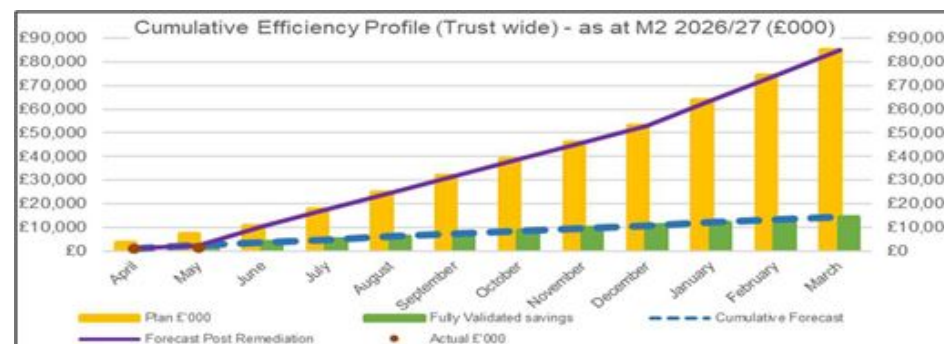
Non-pay £6.6m favourable variance:

- The favourable variance is largely due to £3.2m budgeted inflation expected to crystallise in future months. Additionally, Subsidiary Clinical Supplies & Healthcare are underspending by £5.1m which is offset with income underperformance. The favourable position offset pressures of £0.7m overspend in Patient Transport Services, and £0.5m within Estates costs.
- The favourable variance is further offset by under delivery of £0.8m Non-pay CIP.

CIP

- The Trust has confirmed plans to deliver £14.4m of Cost Improvement Programme (CIP), a planning gap of £70.5m against the £84.9m target. £6.5m (45% of forecast delivery) has moved into Gateway 3 since 1 January 2026. The Trust has delivered year-to-date recurrent savings of £2.4m (£0.3m pay and £2.1m non-pay), resulting in a year-to-date adverse planning variance of £4.7m. Plans to deliver additional CIP need to be rapidly delivered, with failure to do so a significant risk to delivery of the 2026/27 financial plan.

NHSE Category	Current Month			Year to Date		
	Budget £ M	Actual £ M	Variance £ M	Budget £ M	Actual £ M	Variance £ M
Operating Income From Patient Care Activities	155.7	160.1	4.4	311.4	315.2	3.8
Other Operating Income	11.9	8.8	(3.1)	23.7	18.6	(5.1)
Operating Income	167.6	168.9	1.3	335.1	333.8	(1.3)
Employee Operating Expenses	(93.8)	(96.1)	(2.3)	(187.5)	(191.7)	(4.2)
Operating Expenses Excluding Employee Expenses	(71.0)	(69.4)	1.6	(144.3)	(137.6)	6.6
Non Operating Expenses	(10.5)	(10.5)	0.1	(13.6)	(13.3)	0.3
Trust Surplus / (Deficit)	(7.7)	(7.1)	0.6	(10.3)	(8.8)	1.5
Less Control Total Adjustments	7.2	7.2	0.0	6.9	7.0	0.1
Adjusted Financial Performance (NHSEI Reporting)	(0.5)	0.1	0.7	(3.3)	(1.8)	1.5
Less: Non-recurrent Deficit Support Income (National)	(3.7)	(3.7)	0.0	(7.4)	(7.4)	0.0
Less: Non-recurrent deficit support income (Local)	(2.7)	(2.7)	0.0	(5.4)	(5.4)	0.0
Non-recurrent benefit and industrial action	0.0	(0.3)	(0.3)	0.0	(3.4)	(3.4)
Adjusted Financial Performance excluding NR Items	(6.9)	(6.6)	0.4	(16.1)	(18.0)	(1.9)
Other Metrics						
Cash and Cash Equivalent	84.7	123.3	38.6	84.7	123.3	38.6
Capital	6.7	1.8	(4.9)	8.6	2.2	(6.4)
CIP	3.6	1.3	(2.3)	7.1	2.4	(4.7)



Domain 4: Finance - Executive Summary (Continued)

As of May, the KCH Group (KCH, KFM and KCS) has reported a £1.8m deficit year to date. This represents a £1.5m favourable variance to the March 2026 NHSE accepted plan. Excluding non-recurrent support, this results in an underlying deficit of £18.0m.

Employee Operating Expense shows expected variation, driven by temporary staffing costs associated with Industrial Action, Enhanced Care, escalations and temporary cover. Grip and control actions continue to be required to reduce this. Special cause variations in March 2024, March 2025 and March 2026 relate to the annual NHSE pension contribution and are fully offset by income.

WTEs show special cause improvement from May 2024 to September 2025, however this changed to special cause concern in March 2026 following several months of increase. The May WTE position has reduced by 22 WTE, from 14,482 WTE to 14,460 WTE.

After adjusting for the temporary reduction in medical bank usage (45 WTE) associated with the April Resident Doctors' strike, underlying Trust WTE shows an increase of 23 WTE. The main area of focus should be nursing which has increased by 31 WTEs, driven by enhanced care requirements and escalation areas.

The 2026/27 plan includes a national NHS target to reduce temporary staffing by 4.3% for bank staff (£4.1m) and 0.4% for agency staff (£0.4m). Currently, the Trust is exceeding the cap by £2.6m year to date; wholly within Nursing bank staffing (£2.8m). This was exacerbated in April by additional backfill requirements during industrial action and May usage was to cover escalation, enhancement and sickness. Agency spend is however £0.2m below the target year to date, the improvement driven by Division A. Further action continues to be required to improve grip and control of temporary staffing to meet 2026/27 targets (see appendices 3 & 4).

Operating Expenses Excluding Employee Expenses (non-pay) shows no significant movement, with the special cause in March 2024, and to a lesser extend March 2025 and 2026 attributable to year end accruals.

The special cause variation in the Operating Income and Surplus/Deficit charts in October 2024 is because the Trust received non-recurrent deficit support income of £58m in that period.

The Surplus/Deficit chart shows an improvement in 2025/26, reflecting delivery of the financial plan. Otherwise, performance remains stable and within expected common cause variation, with no significant change.



SPC Chart note:

A Statistical Process Control (SPC) chart is a tool used to monitor process variation over time, helping identify trends, shifts, or unusual patterns to support data-driven decision-making and continuous improvement. See appendix 15 for SPC chart interpretation and key.

Domain 4: Finance - Executive Summary (Continued)

As of May, the KCH Group (KCH, KFM and KCS) has reported a £1.8m deficit year to date. This represents a £1.5m favourable variance to the March 2026 NHSE accepted plan

Cash: Month end cash balances have remained the same between April and May 26.

Cash Opex Days: In the current year the Cash Opex Days are running ahead of planned levels primarily due to the higher than planned opening cash balance throughout the year.

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

Capital: As at May 2026, Trust confirmed capital sources for 2026/27 core projects stands at £63.4m, an increase of £14.3m from April 2026. The movement relates to three further fully approved Return To Constitutional Standards schemes (£1.5m), confirmed Estates Safety Funding (£12.6m) and a charitable donation from Friends of Orpington (£0.2m).

May 2026 year-to-date expenditure is £2.2m, against the year-to-date planned spend of £8.6m, as submitted to NHS England in the Trust's plan for 2026/27. The year-to-date variance of £6.4m is driven primarily by timing differences for SARC, Neonatal ICU (DH NICU), rolling replacement programmes and backlog maintenance that are expected to resolve in 2026/27. The Trust now has outcomes for all its national funding bids, three of which (totalling £6.0m in 26/27) remain provisional until the Trust has submitted and received approval for Programmes of Works.

Key Actions
• The Trust will minimise underspend against planned spend on DH NICU, then complete a variation to the capital programme to reallocate any excess capital to other Trust priorities. Separately, project leadership must update KE on discussions with NHS England about potential delay to the project; and • The Trust will prepare a capital variation to address the additional costs identified for the replacement MRI scanners for consideration by King's Executive and FCC, and in parallel will continue discussions with NHSE regarding funding the additional requirement. The remaining two Programmes of Works for RtCS funding must be submitted by 31 July. • Remediation is required to be delivered by Divisions to address May 2026 adverse performance against the agreed Phase 1 and Phase 2 run rate intervention trajectories, to ensure full delivery. • Enhanced controls are required on temporary staffing bookings, and this is being supported by the Workforce team focussing on approval levels particularly for short-term bookings, correct use of reason codes, retrospective bookings and annual leave management. • The CIP programme has £14.4m schemes at Gateway 3+ against the £84.9m CIP programme. Rapid progress is required to develop and progress schemes through the Gateway process to mitigate risk to the financial plan. • Nursing profile review programme to be established in response to a fairer deal for nursing, with a focus on band 5 nursing roles. Band 5 job evaluation delivery plan to be developed and submitted in line with national requirements.



1.2 Executive Summary - Risk

The Trust identified the key strategic and operational financial risks during planning, and these are included on the corporate risk register and will continue to be monitored and reviewed throughout the year. The Trust also monitors regulatory risk against the indicators published in the National Oversight Framework (NOF).

The corporate risk register includes 12 key strategic and operational financial risks. The Finance Department continues to formally review the Financial Risk Register monthly, reviewing the risks and adding new risks which have been identified across the finance portfolio. Details of all risks can be found on page 14.

Corporate Risk

CIP Under Delivery (Risk A) is due to CIP under achievement against identified schemes. At May, CIP is £4.7m behind plan.

Expenditure variances to plan (Risk B) relate to continued overspends in PTS and other expenditure risks. Operational plans are in place to mitigate this risk and continue to be monitored and reported on to the Executive, however these have not delivered financial improvement to date.

Year to date contract performance was £2.1m adverse to plan (Risk E). There is mitigation in place from agreement of fixed contracts of £1.2m.

Risk I relates to the risk that Trust and the System's financial performance means national team withholds part of £44.5m deficit support funding in future quarters. If it was to materialise, it would worsen the Trust's deficit and negatively impact the Trust's cash position.

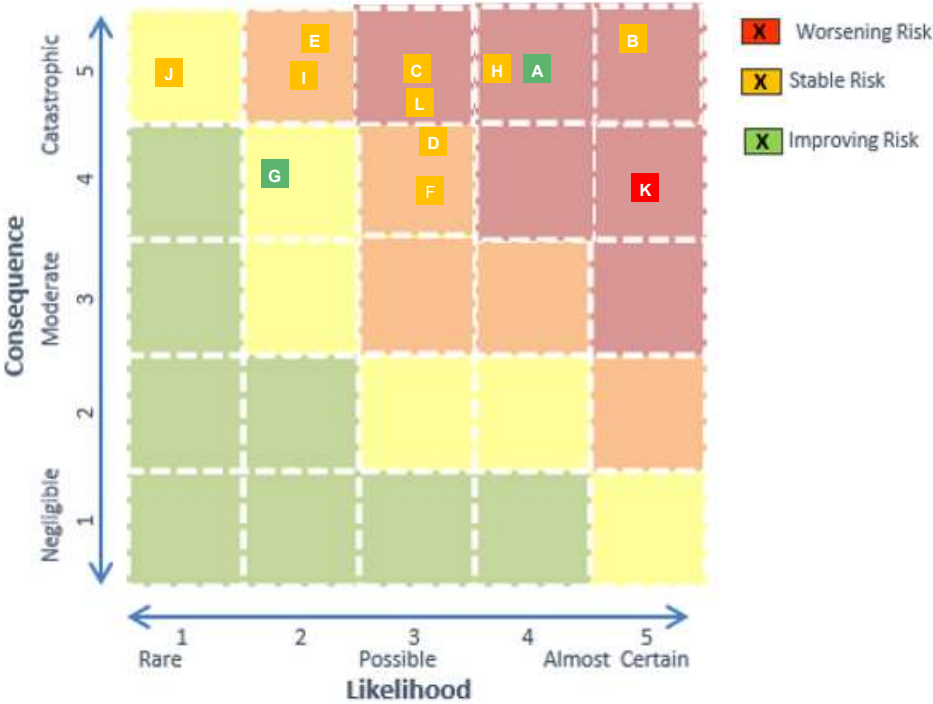
Risk J is related to the risk of changes to VAT regulations (COS 45) which could have a material impact on VAT recovery from April 2026 onwards.

Risk K relates to Resident Doctors' Industrial Action, which has crystallised at £1.0m net cost impact year to date. The risk has worsened due to the announcement of additional strike action.

Risk L is a new risk related to the financial impact of the implementation of the band 5 nursing review being in excess of available funding.

Regulatory Risk

The Trust is currently in NOF segment 3 based on the latest published data (Q3 2025/26). Finance and Productivity is the only domain in which KCH is currently scoring above average, due to a positive variance to plan year to date and improvements in implied productivity. This is despite the Trust's planned deficit score being in segment 4 due to deficit being higher than 2% of expenditure (excluding deficit support funding).



Metric Sub-Domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Median
Finance	Planned surplus/deficit	2025/26	-	%	4.00	101 out of 134	- 1.54
Finance	Variance year-to date to financial plan	Month 9 2025	0.16	%	1.00	9 out of 134	- 0.13
Finance	Combined finance	Q3 2025/26			2.00		
Productivity	Implied productivity level	Q2 2025/26 vs Q2 2024/25	0.38	%	1.65	30 out of 134	2.60

Appendix 1: Interpreting SPC charts

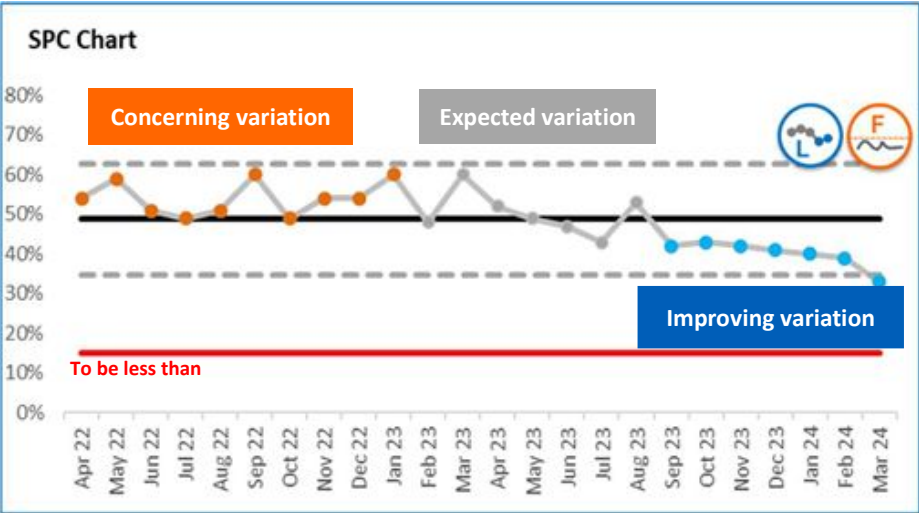
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

The following colour convention identifies important

Orange – there is a concerning pattern of data which needs to be investigated and improvement actions implemented

Blue – there is a pattern of improvement which should be learnt from

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable



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

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

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

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

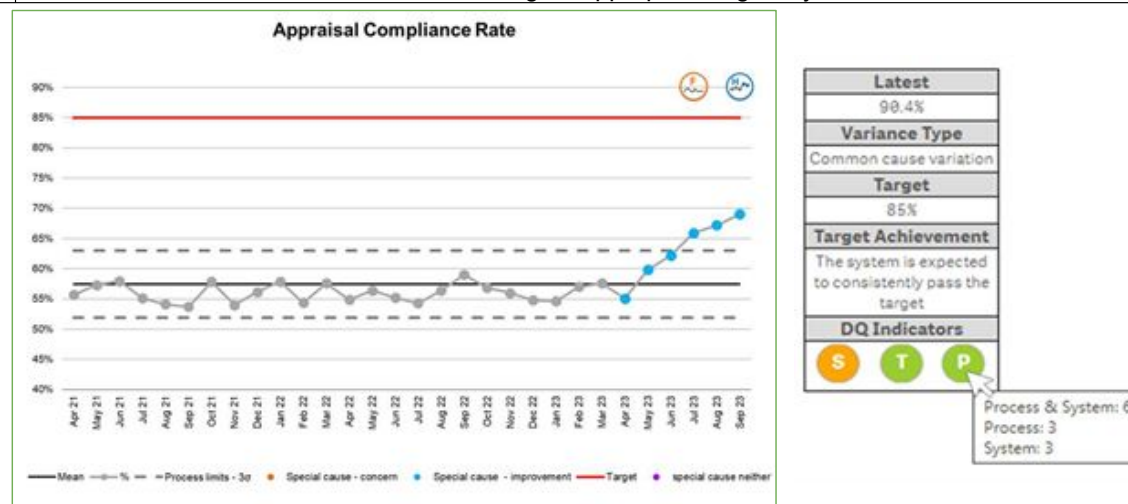
Interpreting summary icons

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

Interpreting the Data Quality Indicator

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

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



AGENDA ITEM:10**BOARD/COMMITTEE REPORT COVER PAPER**

Report to:	Trust Board meeting – Public						
Date of meeting:	15 July 2026						
Subject:	Highlight Reports from the Chairs of Board Sub committees						
Author(s):	Zowie Loizou, Corporate Governance Officer						
Sponsor:	Siobhan Coldwell, Director of Corporate Affairs						
History:	Items discussed at respective committee meetings						
Status:							
Decision/ Approval		Discussion		Assurance	✓	Information	

Purpose

This is a summary of the discussions held at the Board subcommittee meetings since 14 May 2026. The following reports are included:

1. Finance and Commercial Committee,
2. Audit and Risk Committee,
3. Quality and Research Committee
4. Performance, Transformation and Improvement Committee
5. People, Education and Inclusion Committee, and
6. Academic Committee in Common (external joint committee)

Recommendations:

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

Strategy alignment

High Quality Patient Care	✓	Strong Successful Partnerships	✓
A Great Place to Work	✓	Timely and Efficient Care	
Pioneering Research, Innovation and Education	✓	Financial Sustainability	✓

King's values ✓ Caring ✓ Collaborative ✓ Inclusive ✓ Innovative

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Key implications

Strategic risk - Link to Board Assurance Framework	The report links to all BAF risks in relation to the committees' oversight remit.
King's Improvement Impact (KIM):	N/A
Quality Impact	Links to improved quality of services and to patient safety.
Health Equity Impact	The Quality and Research Committee has oversight of health equity impact.
Workforce Impact	Improvements are being made in several workforce related areas, including skills, engagement, recruitment, training and organisational culture.
Research/Innovation Impact	Research and innovation discussions take place both at the Quality and Research committee, and at the Academic Committee in Common.
Digital Impact	The Performance and Finance committees discuss digital impact in detail.
Financial Impact	Links to Improvement Plan and financial strategy
Legal/ regulatory compliance	Meets the requirements of the Trust's constitution.
Communications and Engagement	N/A
Use of Artificial Intelligence Tools	N/A
Committee that will provide relevant oversight State name of committee	

Main Report

Guidance to report writers:

This report must be 10 pages maximum. It should be focused on the key issues and should be very clear about what is needed from the committee to which it is being presented – decisions, feedback etc.

You may use appendices, but you should not use them to circumvent the instruction above.



DRAFT AGENDA

Committee	Finance and Commercial Committee – Chair's Report to the Board
Date	Thursday 2 July, 2026
Time	09:30 – 11:30
Location	Dulwich Room, Hambleton Wing, King's College Hospital, Denmark Hill

No.	Item	Purpose	Format	Lead & Presenter
	PART 1			
1.	STANDING ITEMS			
	1.1. Welcome and Apologies Apologies were received from Sir David Behan. The Committee Vanisha Mistry, the new Corporate Governance Officer who will support committee meetings going forward.	FI	Verbal	Chair
	1.2. Declarations of Interest No new declarations were made.	FI	Verbal	
	1.3. Chair's Actions The Chair had visited both Queen Mary's Hospital and Orpington Hospital on the same day.	FI	Verbal	
	1.4. Minutes of Previous Meeting The minutes were approved subject to a minor amendment.	FA	Enc.	
	1.5. Action Tracker There was one outstanding action on the tracker relating to the Digital Strategy. Going forward, oversight of the Digital Strategy will transfer to the Performance, Transformation and Improvement Committee, while oversight of digital provision will remain with the Finance and Commercial Committee.	FA	Enc.	
	1.6. Matters Arising There were no matters arising.	FD	Enc.	
2.	FINANCIAL REPORTING 2025 / 26			
	2.1. Finance Performance Report – Month 2	FD/A	Enc.	Chief Financial Officer

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

	The Committee noted that, at Month 2, the Trust was reporting a year-to-date deficit of £1.8m, £1.5m favourable to plan, with an underlying deficit of £18m excluding non-recurrent funding. The year-end forecast remained breakeven, although significant financial risks, including the Agenda for Change Band 5 and 6 review, continued to be monitored. Workforce numbers had reduced by 224 WTE and capital expenditure remained below plan due to delays to the SARC and NICU projects. The Committee also discussed patient transport costs, noting opportunities to improve efficiency and mitigate expenditure, and reaffirmed that delivery of the Cost Improvement Programme remained the Trust's highest financial priority, with transformation central to achieving it.			
	2.2. Investment Board update In line with the Trust's Standing Financial Instructions, the Committee agreed to recommend for Trust Board approval, five business cases which exceed £5m and one case which was an extension of a previously approved >£5m case along with delegated authority for Executive contract sign off. The committee also noted the post implementation reviews.	FD/A	Enc.	Chief Financial Officer
	2.3. Capital Repurposing The Committee approved capital repurposing of up to £2.9m.	FD/A	Enc.	Chief Financial Officer
	2.4. National Cost Collection The committee received the 2025/26 National Cost Collection (NCC) pre-submission report, noting that the Trust had achieved full compliance with the national costing requirements. The committee approved the costing process and provided the CFO delegated authority relating to submission to NHS England.	FD	Enc.	Chief Financial Officer
	2.5. WTE Reduction Trajectory Plans The Committee noted that the Trust remained within its budgeted establishment at the end of May 2026 and received an update on the forthcoming WTE consultations. Discussion focused on staff turnover, safe staffing, delivery of the Cost Improvement Programme (CIP) and the operational factors affecting its achievement, including reliance on bank	FD/A	Enc.	Chief People Officer

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	staff and the impact of corridor care. Transformation was recognised as a key enabler of CIP delivery. The Committee also noted the relatively high attrition of newly registered nurses within their first 24 months and the work underway to better understand the underlying causes, including workforce modelling and measures to improve annual leave management and reduce reliance on bank staffing.			
3.	GOVERNANCE			
	3.1. Board Assurance Framework The Committee reviewed the two Board Assurance Framework risks within its remit: Financial Sustainability and Critical Infrastructure. The Financial Sustainability risk score increased from 20 to 25 to reflect the challenges in delivering the Trust's Cost Improvement Programme, with recovery work underway across the divisions. The Critical Infrastructure risk remained largely unchanged, although progress in addressing backlog maintenance was noted and further improvement was anticipated following the appointment of the Director of Capital, Estates and Facilities.	FD/A	Enc.	Director of Corporate Affairs
	3.2. Committee Terms of Reference The Committee reviewed and approved the revised terms of reference, noting amendments to clarify the respective oversight responsibilities of the Finance and Commercial Committee and the Performance, Transformation and Improvement Committee.	FD/A	Enc.	Director of Corporate Affairs
4.	CAPITAL AND ESTATES			
	4.1. Soft FM Contract The Committee received an update on the procurement for the new Denmark Hill soft FM contract, noting that the current contract expires in March 2027. The Committee was assured that robust governance arrangements were in place and that the procurement strategy reflected changes in the soft FM market since the current contract was let.	FD/A	Enc	Deputy Chief Executive Officer
5.	COMMERCIAL			
	There were no items.	FD	Enc.	

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

6.	DIGITAL			
	There were no items.			
7.	ANY OTHER BUSINESS			
	7.1. Draft agenda FCC meeting – 30 July 2026 The committee approve the draft agenda and advised that the agenda setting meeting in the diaries will not be required.	FD/A	Enc.	Chair
	7.2. Issues to be escalated to the Board (Board Highlight report) There were no issues to escalate to the board other than this summary report.	FD	Verbal	Chair
9.	Date of the next meeting: 30 July 2026 at 13:30 – 15:30 in the Dulwich Room, Hambleden Wing, KCH, & MS Teams Denmark Hill			

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Report from the Committee Chair

Committee	Finance and Commercial Committee
Date	Thursday 4 June, 2026
Time	13:00 – 15:00
Location	Dulwich Room, Hambleton Wing, King's College Hospital, Denmark Hill

No.	Item	Purpose	Format	Lead & Presenter	Time
	PART 1				
1.	STANDING ITEMS				
	1.1. Welcome and Apologies The Head of Intensive Support at NHS England joined the meeting as part of the new oversight arrangements following the Trust’s transition out of the Recovery Support Programme.	FI	Verbal	Chair	13:00
	1.2. Declarations of Interest None over and above those already registered.	FI	Verbal		
	1.3. Chair’s Actions None	FI	Verbal		
	1.4. Minutes of Previous Meeting The minutes were approved. It was noted provision had been made to fund the HCA Band 2-3 Transition.	FA	Enc.		
	1.5. Action Tracker The committee noted progress on the tracker.	FA	Enc.		
	1.6. Matters Arising There were no matters arising.	FD	Enc.		
2.	FINANCIAL REPORTING 2025 / 26				
2.1. Finance Performance Report – Month 1 The committee reviewed the M1 financial position, noting the Trust reported a £1.9 deficit, which was slightly ahead of plan despite a deterioration in the underlying position due to lower than anticipated income and a CIP gap. The committee was assured that the Trust’s cash position remained strong and that there had been some improvement in the pay run-rate as a result of improved grip and control. The committee received some assurance that divisional recovery plans were in place but the significant shortfall in CIP identification remains a significant risk to the overall delivery of the agreed 2026/27 financial plan. The committee recognised that the income position was likely to improve later in Q1 as coding was completed. Lower activity during industrial action was also a factor. The committee noted variations would be needed to the capital programme to ensure budget was fully utilised.					

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

2.2. Investment Board update The committee reviewed a report summarising outcomes from the May Investment Board, noting that several business cases had been approved following appropriate appraisal and pre-briefing. Although not requiring FCC or Board of Directors sign-off, a number of cases were highlighted in the context of the Trust's risk profile. The Committee welcomed the summary of post-implementation reviews, which provided assurance that the majority of schemes were delivering expected benefits. In line with the Trust's Standing Financial Instructions, the Committee agreed to recommend for Trust Board approval, two business cases which exceed £5m along with delegated authority for Executive contract sign off.	
2.3. M1 Workforce Plan vs Actual The committee reviewed the M1 workforce data and delivery against trajectory. The committee noted that whilst the Trust is carrying vacancies, pay expenditure is at 100% due to use of bank and agency. Agency use is compliant with NHSE policy, but bank use is above planned levels of 5%. Robust grip and control mechanisms are being put in place to ensure the Trust continues to meet monthly budget forecasts and the committee was assured that the Trust will meet the Q1 workforce reduction targets in the CIP programme. There is less confidence Q2 milestones are achievable without progress being with CIP approvals. The committee discussed in detail the reasons for high use of bank, as well as the need to transform workforce and service models.	
3.	ANY OTHER BUSINESS
3.1. Draft agenda FCC meeting – 2 July 2026 The draft agenda for the next meeting was noted.	
3.2. Issues to be escalated to the Board (Board Highlight report) Key issues to be escalated include financial sustainability risks, CIP delivery challenges and the need for transformational change. There being no other business the Chair formally closed the meeting.	

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

AGENDA

Committee	Audit and Risk Committee – Chair's report to the Board
Date	Thursday 18 June 2025
Time	Audit and Risk Committee (10.00 to 12.00)
Location	Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill, London SE5 9RS.

No.	Item	Purpose	Format	Lead & Presenter
Private session (Auditors and NEDs only): A private session between auditors and non-executive directors was held.				Chair
1.	STANDING ITEMS			
	1.1. Welcome and Apologies The Chair welcomed everyone to the meeting, reflecting that it had been a positive year overall for the Trust. He noted that the Annual Report and Accounts were in good shape and ready for submission, subject to the Committee's approval. There were no apologies for absence.	FI	Verbal	Chair
	1.2. Declarations of Interest There were none.			
	1.3. Chair's Actions There were none.			
	1.4. Minutes of the Previous Meeting The minutes of the meeting on 30 April 2026 were approved as a correct record.	FDA	Enc.	
	1.5. Action Tracker The Committee reviewed the action tracker. It discussed the respective roles of the Committee and the Risk and Governance Committee in the Trust-wide management of risk, agreeing that the Risk and Governance Committee provides retrospective assurance ("reverse gatekeeping"), while the Audit and Risk Committee provides prospective assurance ("forward gatekeeping"). The need to strengthen the Trust's declarations of interest process and register was also noted.	FD	Enc.	
	1.6. Matters Arising There were none.	FI	Verbal	
2				

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

No.	Item	Purpose	Format	Lead & Presenter
	2.1 Internal Audit Progress Report The Internal Auditor described a good start to the year. There were 4 overdue actions expected to close in next month or so. Ownership of the overdue actions was discussed.	FD	Enc.	
	2.2 Internal Audit Annual Report and Conclusion The Committee noted the revised report, previously reviewed, and the clarification that its ratings reflected the report's deliberate focus on areas of known weakness within the Trust.	FD	Enc.	
	2.3 Data Protection Security Toolkit Final Report (DSPT) The Committee noted the positive outcome of the Trust's annual Data Security and Protection Toolkit (DSPT) self-assessment, with the Internal Auditor expressing confidence in the Trust's assessment. The Committee emphasised the importance of completing DSPT actions earlier and receiving regular updates on progress.	FA	Enc.	
	2.4 Local Counter-Fraud Service Update The Committee received an update on delivery of the 2026/27 Counter Fraud work plan. Fraud referrals remained in line with the previous year, targeted staff awareness activity had been undertaken, and recent fraud cases were reviewed. The Committee also discussed fraud risks associated with the NHS Mutually Agreed Resignation Scheme (MARS) and the controls in place to mitigate potential misuse.	FI	Enc	
3 GOVERNANCE				
	3.1 Committee Annual Reports The Committee received the annual reports of the Board's sub-committees, summarising how each had discharged its responsibilities during the year. The reports had been approved by the respective Committee Chairs and reviewed by their committees, with the exception of the People Committee report, which was scheduled for review in July 2026.	FI	Enc.	Committee Chairs

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

No.	Item	Purpose	Format	Lead & Presenter
	3.2 Quality Account Data Assurance The Committee received a report outlining the process for assuring the accuracy and validity of the Trust's Quality Account in the absence of external audit. Members sought assurance on benchmarking with other trusts, and it was confirmed that external auditors do not provide assurance over Quality Accounts. The report was due for publication at the end of June 2026.	FA	Enc.	Chief Nurse & Executive Director of Midwifery
	3.3 Report from the Risk and Governance Committee The Committee received an update on discussions at the last Risk and Governance Committee meeting, which included review of the corporate risk report and assurance from divisions on risk management. The Chair of the People Committee reported plans for closer alignment between RGC and the People Committee on workforce risks. Members requested that relevant Risk and Governance Committee discussions be routinely fed back to respective board subcommittees.	FA	Enc.	Chief Executive Officer
	3.4 Cyber BAF The Committee reviewed the Board Assurance Framework risk relating to the resilience of the Trust's IT infrastructure, noting that the risk score remained unchanged and above the Board's risk appetite. Positive assurance was provided through recent internal audits of cyber security and the Data Security and Protection Toolkit. On a separate note, the Committee requested further assurance on the maturity of risk management generally across all divisions, including progress against previous maturity assessments and the embedding of agreed improvements.	FA	Enc	Director of Corporate Affairs
4 Annual Report and Accounts				
	4.1 2025/26 Annual Report Final Draft	FA	Enc.	Director of Corporate Affairs

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

No.	Item	Purpose	Format	Lead & Presenter
	The Committee reviewed the draft Annual Report, which had been prepared in accordance with the Annual Reporting Manual and reviewed by the external auditors. Members requested a simpler presentation with clear headlines supported by more detailed information where required. The Committee approved the Annual Report.			
	4.2 Annual Financial Accounts 2025/26 Incl. Commentary on Annual Accounts The Committee received the 2025/26 final Accounts following substantive completion of the external audit. Having received the external auditor's presentation, the committee approved the 2025/26 annual accounts for consideration at Board and supported the delegated authority to the Chair, Chief Executive and Chief Financial Officer to sign the final Accounts.	FA	Enc	Chief Financial Officer
EXTERNAL ASSURANCE				
5	External Audit Reports			
	5.1. Audit Findings Report The Committee received the External Auditor's Audit Findings Report, noting completion of the audit and the issuance of an unqualified opinion with no material misstatements identified. Low-level recommendations to strengthen income recognition and bank reconciliation processes were noted.	FI	Enc.	Grant Thornton
	5.2. Annual Report - Value for Money Arrangements The Committee received the External Auditor's Annual Value for Money Report, which highlighted significant improvements in financial sustainability and financial governance. The auditor confirmed that financial sustainability was no longer a significant weakness, noting delivery of planned savings and a break-even plan for the year ahead. Recommendations were made to address the underlying deficit and further strengthen governance.	FI	Enc.	
	5.3. Draft Audit Report to the Council of Governors The committee noted the report.	FI	Enc.	

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

No.	Item	Purpose	Format	Lead & Presenter
	5.4 Draft Letter of Representation The Committee reviewed the draft Letter of Representation, which the Chief Financial Officer confirmed was appropriate. The Committee thanked the external auditors for the timely completion of the audit, commended the finance team for the high-quality accounts process, and recognised the wider teams involved in producing the Annual Report. The letter or representation were approved and commended for approval to Board.	FA	Enc	
6.	Any Other Business			
	6.1 Trust Insurance Cover Overview The committee received an overview of the current insurance position of the Trust, including the subsidiaries. A benchmarking exercise had been carried out with the Shelford Group. Independently assessed assurance was given that the Trust is getting good value for money for its insurance arrangements. The committee noted the content of the report and endorsed the scope and level of cover.	FA	Enc.	Chief Financial Officer
	6.2 Issues to be Escalated to the Board The Committee noted that the Annual Report, Annual Accounts and associated documents would be recommended to the Board for approval.	FD	Verbal	Chair
	6.3 Any Other Business There was no other business.	FI	Verbal	Chair
7.	Date of Next Meeting			
	Date of the next meeting: Thursday 10 September 2026 at 12:30 – 15:00, Dulwich Room, Hambleton Wing, King's College Hospital, Denmark Hill			

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

Report from the Chair of the Quality Committee

Committee	Quality & Research Committee
Date	Wednesday 8 July 2026
Time	10:00 - 12:00
Location	Dulwich Meeting Room, Hambleden Wing, King's College Hospital, Denmark Hill

No.	Item	Purpose	Format	Lead & Presenter
1.	STANDING ITEMS (5 mins)			
	1.1. Welcome and Apologies There were no apologies.	FI	Verbal	Chair
	1.2. Declarations of Interest None over and above those already declared.	FI	Verbal	
	1.3. Chair's Actions None	FI	Verbal	
	1.4. Minutes of the previous meeting Approved.	FDA	Enc.	
	1.5. Action Tracker Noted.	FD	Enc.	
	1.6. Matters Arising The Committee received a verbal update from the Chief Medical Officer regarding a recent Human Tissue Authority inspection. The Committee noted the findings and the action being taken in response to the issues raised. It was agreed that a full report will be brought to the next meeting.			
	1.7. Immediate Items for Information There were not items for information.			
2.	SAFETY (35 mins)			
	2.1. Integrated Quality Report The Committee reviewed quality priorities including deteriorating patient care, antimicrobial resistance, and violence and aggression. Positive progress was noted in patient deterioration recognition, timely observations, and antimicrobial stewardship. Assurance was received, with a request for further review on PRUH cardiac arrest trends.			
	2.2. Legal Services Quarterly Report Q3 & Q4 Clinical negligence claims, inquests and legal developments were reviewed. The Committee noted continued organisational learning from claims and assurance that legal governance arrangements remained effective. Assurance was received. It was noted that incident reporting is a more reliable indicator of litigation risk than complaints.			
	2.3. Maternity & Neonatal Report The Committee reviewed maternity safety, quality indicators, workforce metrics and improvement programmes. Positive reductions in red flag incidents and sickness absence were noted, alongside continued focus on inequalities and learning from national reviews. The recent AMOS and Ockendon investigation and 10-point plan was discussed as it came post the submission of the report. Assurance was received on the report.			
	2.4. Review of Corridor Care Members reviewed corridor care performance following implementation of the national reporting definition. Corridor care remains a significant challenge, with ongoing work through			

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	urgent and emergency care programmes to reduce reliance on corridor spaces. Partial assurance was received and a further update requested later in the year.
	2.5. Medicine Safety Report The Committee received assurance regarding medicines governance, incident reporting, multidisciplinary learning and implementation of EPIC. Strong governance arrangements and a positive medicines safety culture were noted.
3.	ASSURANCE
	3.1. Patient-Led Assessment of the Care Environment (PLACE) PLACE improvement plans Sustained improvements across PLACE domains were reported. Members supported further work to strengthen care environments, particularly for patients living with dementia. Assurance was received. 3.2. Patient Experience Report 2025-2026 Improvements in Friends and Family Test responses, compliments and demographic analysis were noted. The Committee supported the increasing focus on health inequalities and demonstrating the impact of patient feedback. Assurance was received. 3.3. Quality Assurance Framework A refreshed Quality Assurance Framework was presented, providing a more structured, evidence-based and risk-focused approach aligned to regulatory requirements. The Committee noted the report, and further work was requested on measures of success and outcomes. 3.4. Synnovis Pathology Performance – Recovery, Turnaround Times and Workforce Update Continued improvement in pathology turnaround times and imaging reporting performance was noted. Recovery actions were progressing and governance arrangements remained in place to oversee performance. Partial assurance was received. 3.5. Neuro-imaging backlog harm review Significant progress had been made reducing the imaging reporting backlog, with improved oversight and mitigation of patient safety risks. The Committee recognised the improvements achieved and received assurance.
4.	OUTCOMES
	4.1. Patient Outcomes Quarterly Report – Stroke Outcome The Committee reviewed stroke performance against national standards and noted ongoing challenges around imaging timeliness and specialist bed access. Assurance was received that improvement actions were being implemented through the stroke improvement programme. 4.2. Mortality Monitoring Report Members reviewed mortality surveillance, learning reviews and governance arrangements. Continued focus on learning disability and severe mental illness mortality reviews was welcomed. Assurance was received.
5.	RESEARCH & INNOVATION
	5.1. Research 150-day performance and updates on action plans Improvements in performance against the national 150-day research target were noted, supported by process redesign and stronger oversight. Workforce and recruitment challenges remained, but assurance was received regarding ongoing improvement actions.
6.	DIVISIONAL DISCUSSION
	6.1. Divisional Discussion – Division C The Committee received an overview of Division C's quality, safety and governance arrangements. Positive progress was noted in strengthening governance and organisational learning. Assurance was received.
7.	GOVERNANCE (20 mins)
	7.1 Board Assurance Framework

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	The Committee reviewed quality risks within the Board Assurance Framework and noted further alignment with the Trust's strategic objectives. Assurance was received regarding continued framework development.
	7.2. Corporate Risk Register Quality-related corporate risks were reviewed. The Committee received assurance that risks continued to be actively monitored and managed through established governance processes. 7.3. Committee Annual Report The annual report was reviewed and approved. Members agreed it accurately reflected the Committee's work and the assurance provided during the year and recommended onward submission to the Board. 7.4. Draft Agenda September Meeting The Committee reviewed the draft agenda and work programme for the September 2026 meeting. Members noted that the agenda will remain flexible to accommodate emerging quality, safety, regulatory and strategic priorities. An agenda-setting meeting will take place in August 2026 to finalise items for Committee consideration.
8.	FOR INFORMATION
	8.1 Quality Account Final Document – Annual Report The final Quality Account was reviewed and approved for onward submission and publication. Members were assured that it accurately reflected quality, safety and patient experience performance during the year. 8.2. Patient Outcomes Quarterly Report Q4 The Committee noted improvements in several clinical outcome areas and welcomed the continued use of outcome and benchmarking data to support quality improvement. Assurance was received.
9.	ANY OTHER BUSINESS (5 mins)
	Issues to be escalated to the Board ▪ The Human Tissue Authority inspection, with an improvement plan in place and a further update requested by the Committee. ▪ Corridor care remained a key operational and quality risk requiring continued oversight. ▪ Continued monitoring of stroke performance, research delivery performance, and quality outcome measures through future Committee reporting ▪ Approval of the Committee Annual Report
	Any Other Business There were no items of any other business

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AGENDA

Committee	Performance, Transformation and Improvement Committee
Date	Thursday 9 July
Time	10:00 – 12:00
Location	Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill

No	Item	Purpose	Format	Lead & Presenter	Time
1.	STANDING ITEMS				
	1.1. Welcome and Apologies	FI	Verbal	Chair	
	1.2. Declarations of Interest				
	1.3. Minutes of the previous meeting and action tracker	FA	Enc.	Chair	
OPERATIONAL PERFORMANCE					
2.	Integrated Performance Report The Committee reviewed the Integrated Performance Report and noted continued challenges in Urgent and Emergency Care performance, including ongoing corridor care pressures and increasing 12-hour waits. Whilst RTT incomplete performance remained above the monthly Operating Plan trajectory, concerns were raised regarding growth in 52- and 65-week waiters, particularly within ophthalmology and general surgery. Cancer performance remains below national standards, with diagnostic capacity, pathology delays and workforce pressures continuing to impact delivery. The Committee was updated on plans to ensure recovery plans were in place across all challenged performance areas and that progress will be monitored closely.				
3.	RTT Actions Update Members reviewed targeted actions to address long-waiting patients and received assurance that detailed demand and capacity modelling was underway, supported by NHS England. The Committee noted that sustainable RTT recovery will require further pathway redesign as well as improvements in theatre capacity and utilisation.				
4.	Theatre Productivity The Committee welcomed significant improvements in theatre utilisation, which had increased from approximately 67% to consistently above 80%, approaching the Trust target of 85%. Improvements had supported increased elective activity and productivity gains without additional cost. Further work was planned to reduce avoidable cancellations and strengthen demand and capacity planning.				
5.	PTIC Cancer Deep Dive Report A deep dive review of cancer services highlighted ongoing challenges in meeting Faster Diagnosis Standard and 62-day targets. The Committee noted recovery actions underway, progress in several tumour pathways and increasing collaboration across the South East London Cancer Alliance. Workforce, diagnostic capacity and pathology performance remained key risks requiring continued oversight, although it was noted that pathology turnaround times were showing improvement				
6.	National Oversight Framework and Regional Performance Management Update The Committee received an update on the evolving NHS England National Oversight Framework and discussed the importance of considering both oversight ratings and underlying performance trajectories when assessing organisational performance. Assurance was received regarding the Trust's approach to monitoring and responding to the framework.				

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No	Item	Purpose	Format	Lead & Presenter	Time
TRANSFORMATION AND IMPROVEMENT					
7.	7.1. Transformation Programme Update The Committee reviewed progress across the Trust's Transformation Programme. Whilst improvement work continued to deliver positive benefits, including significant expansion of Quality Improvement capability and theatre productivity gains, Members highlighted the need to accelerate delivery of financial transformation initiatives and ensure benefits were translated into sustainable operational and financial improvements.				
	7.2. Digital Strategy The Committee considered the draft Digital Strategy and supported its progression to the Board. Members welcomed its focus on digital innovation, artificial intelligence, optimisation of existing digital systems and workforce capability. Feedback was provided to strengthen implementation priorities and delivery arrangements prior to Board consideration.				
GOVERNANCE					
8.	Board Assurance Framework (BAF) – Demand and Capacity The Committee reviewed the Demand and Capacity risk within the Board Assurance Framework. Members agreed that the current risk rating should remain unchanged at this stage but noted the importance of ongoing monitoring against operational performance trajectories and recovery plans				
9.	ANY OTHER BUSINESS				
	10.1 Issues for Escalation to the Board of Directors The Committee requested continued Board oversight of: ▪ RTT recovery and demand and capacity management. ▪ Cancer performance recovery. ▪ Delivery of the Transformation Programme, particularly financial benefits realisation. ▪ Implementation of the Digital Strategy. ▪ Long-term capacity planning and flow improvement, including reduction and elimination of corridor care. 10.2 Any Other Business There were no items of any other business				
	Date of the next meeting: Thursday 6 August 2026 at 10.00 – 12:00, Dulwich Room, Hambleton Wing, KCH, Denmark Hill.				

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

AGENDA

Committee	People, Inclusion & Education Committee
Date	Wednesday 1 July
Time	12:00 – 14:00
Location	Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill

No.	Item	Purpose	Format	Lead & Presenter	Time
1.	STANDING ITEMS				
1.1	Welcome and Apologies Apologies received from Sir David Behan.	FI	Verbal	Chair	
1.2	Declarations of Interest There were no declarations of interest over and above those on record.	FI	Verbal	Chair	
1.3	Chair’s Actions There were no Chair’s actions to report.	FI	Verbal	Chair	
1.4	Minutes of the previous meeting The minutes of the meeting held on 15 May 2026 were approved as an accurate record, subject to a missing attendance update.	FA	Enc.	Chair	
1.5	Action Tracker The action tracker was discussed.	FD	Enc.	Chair	
2.	PART ONE – Highlight Report				
2.1 Workforce Performance Report Workforce indicators remained positive, with significant improvement in sickness absence performance and strong comparative performance compared to other London Trusts. Workforce savings targets for Q1 were achieved, but there has been a reliance on short term grip and control measures rather than wider transformation. Delivery of the full-year workforce reduction target remains a key risk requiring ongoing monitoring.					
2.2 Month 2 Workforce Plan Update Q1 workforce plan targets were achieved across all divisions. The Committee noted continuing risks relating to delivery of the full-year workforce reduction programme and the need to maintain focus on vacancy controls and recruitment management whilst service transformation plans are developed.					

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2.3 Exit Interviews and Pulse Survey Insights	
Themes from staff feedback remained consistent, highlighting career development, wellbeing and workload as key factors influencing retention. The Committee supported increased focus on early engagement and retention initiatives, including stay conversations.	
2.4 Flu Lessons Learnt	
The 2025/26 flu campaign achieved significantly improved uptake, with King's the second highest-performing Trusts in London. Success was attributed to enhanced staff engagement, peer vaccination and partnership working with staff networks. The committee was assured that the learning from the 2025/26 campaign will be reflected in the 2026/27 plan.	
3.	DEEP DIVES – Discussion Papers
3.1 Freedom to Speak Up Report	
The Committee reviewed themes arising from speaking-up cases, including staff wellbeing, bullying and workplace behaviour. A review of Freedom to Speak Up reporting and governance arrangements with the NGO changes and options for the model will be undertaken and presented to Quality & Research Committee.	
3.2 Staff Network Presentation – Faith Network	
The Faith and Belief Network highlighted its role in promoting inclusion, belonging and staff wellbeing. The Committee welcomed proposals to strengthen collaboration across staff networks through an Inclusion Council.	
3.3 Violence & Aggression Plan and Update	
The committee reviewed progress in implementing plans aimed at reducing violence and aggression. The number of incidents continues to increase, and it remains a significant organisational concern. The Committee welcomed ongoing preventative measures and agreed that enhanced six-monthly reporting should be considered to strengthen oversight and assurance at the committee.	
4	EDUCATION
4.1 Higher Level Responsible Officer Quality Review (annual)	
The Committee received assurance that appropriate arrangements were in place to support medical appraisal, revalidation and professional standards processes, with continued focus on compliance improvement.	
4.2 Annual NMC Revalidation	
High levels of compliance with Nursing and Midwifery Council revalidation requirements were maintained. The Committee received assurance regarding the effectiveness of support and monitoring arrangements.	
4.3 Guardian of Safe Working	
The Guardians of Safe Working attended the meeting, and provided assurance regarding monitoring of safe working hours and exception reporting for resident doctors. Workload and staffing pressures remain key themes, with continued focus on wellbeing and training experience.	
5.	GOVERNANCE
5.1 Board Assurance Framework – Workforce Risks	
The Committee reviewed refreshed workforce risks and highlighted workforce transformation, organisational culture and leadership development as priority areas requiring ongoing oversight. The committee is recommending a third workforce risk is accepted by the Board of Directors.	
5.2 Draft agenda for next meeting	

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The Committee noted the draft agenda for the 24 September 2026 meeting

5.3 Committee Annual Report (incl. Committee effectiveness review outcome)

The Committee was satisfied that it had effectively discharged its responsibilities during 2025/26 and agreed further development work, including greater focus on education-related matters.

5.4 Draft people strategies (Workforce and Culture & OD)

Draft Workforce and Culture & Organisational Development Strategies were reviewed. The Committee supported the overall direction and noted that further engagement and refinement would take place before final approval.

6. ANY OTHER BUSINESS

6.1 Issues for Escalation to the Board of Directors

- Ongoing risk associated with delivery of the workforce transformation programme, including achievement of workforce savings targets and the impact of low staff turnover on workforce planning.
- Continuing increase in incidents of violence and aggression and the need for sustained organisational focus, oversight and action.

6.2 Any Other Business

There were no items of any other business

Date of the next meeting: Thursday 24 September 2026 at 14:00 –16:00 in the Dulwich Room, Hambleton Wing, KCH, Denmark Hill.

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



ACADEMIC COMMITTEE IN COMMON
8th July 2026, 2.00pm – 4.45pm
Dulwich Room, King's College Hospital

A G E N D A

1.	Welcome, introductions, apologies <i>Apologies were received from: Steve Weiner (KCL Council), Steve Davies (GSTT CFO)</i>	Verbal 2.00pm
2.	Declarations of interest <i>None over and above those already provided.</i>	Verbal -
3.	Minutes from the previous meeting (23 April 2026) <i>Approved</i>	Paper -
4.	Review of the action log <i>Noted.</i>	Paper -
5.	Matters arising <i>In response to a BMJ review of medical education tariffs, the committee agreed assurance was needed that funding is used to support undergraduate training. This will be led by the CFOs.</i> <i>Good progress is being made in the development of the pan-London Applied Research Collaboration.</i> <i>A summary of the June KHP Board meeting was provided, including updates on SC1, the implementation of the KHP partnership framework, and the opportunities presented by the European Hospital Alliance.</i> <i>The merger between Cranfield and King's College London was noted. It is likely to go-live in August 2027. Cranfield is very strong in areas such as health security and applied engineering and has strong links with industry.</i>	Verbal 2.05pm
6.	Clinical academic workforce <i>Following the agreement of the Memorandum of Understanding between the three organisations, the Chief People Officers provided an update on implementation. Positive feedback had been received from the clinical academic community and an audit was underway to properly understand lived experience. The committee discussed the challenges related to ensuring that strong clinical academic pathways are in place to attract and nurture world-class talent. The committee discussed the regarding duration of clinical academic contracts and agreed to look at this further to ensure that in future we have the flexibility to respond to changes in clinical and research advances and shifts in academic priorities. The committee noted some issues related to recharges, which are being resolved by the CFO group.</i>	2.30pm Paper

7.	Research Update	2.45pm	Paper Paper
7.1	Trial Set-Up at King's Health Partners – meeting the 150-day target		
	<i>The committee reviewed the most recent data in relation to meeting the 150-day target for clinical trials. The committee was assured that good progress was being made, but noted stronger leadership was needed in some areas.</i>		
7.2	BRC Update		
	<i>The NIHR Biomedical Research Centre (BRC) competition has been formally launched. The committee received an update on the competition, key considerations, and the proposed approach to the competition for the partners of the ACiC. Specifically, King's College Hospital will be involved in two bids, one focussed on brain and mental health and one more comprehensive BRC themed on shared biology. The bids being developed are distinctive and complementary and mechanisms are in place to ensure synergies and avoid duplication.</i> <i>The committee endorsed the approach, noting the risks and opportunities provided by the process.</i>		
8.	Finance Update	3.50pm	Paper
	<i>The CFOs provided an update on the current financial position across the three partner organisations. Progress is being made in reviewing the CTO. Work is underway to review and resolve recharging issues between partners. The Committee was assured that good progress is being made in developing financial transparency between the three partners.</i>		
9.	Governance update	4.05pm	
9.1	Review of Committee terms of reference		
	<i>A committee effectiveness review was undertaken, which provided assurance that the committee meeting the ambition set out in its term of reference. Trust has been established and progress has been made over the last 12 months. Whilst feedback was generally positive, it was recognised that there was scope to improve feedback from the committee to key stakeholders. The committee terms of reference was reviewed and some changes were recommended. These are attached for board approval.</i>		Paper
10.	Any other business	4.25pm	Verbal
	<i>Date of next meeting: Tuesday 06 October 2026 9am to 12noon (Robens Suite, Guy's Hospital)</i>		



JOINT ACADEMIC COMMITTEE IN COMMON TERMS OF REFERENCE

1. PURPOSE

- 1.1. The purpose of the Joint Academic Committee in Common (ACiC) is to:
 - 1.1.1. enhance the ability of members (King's College Hospital NHS Foundation Trust (KCH), Guy's and St Thomas' NHS Foundation Trust (GSTT) and King's College London (KCL)) to deliver on their strategic organisational objectives relating to clinical academic matters
 - 1.1.2. maximise the opportunity to deliver research that has impact for populations locally and globally, through improved joint decision-making, including in areas of joint investments and combined financial flows across partners.
 - 1.1.3. seek solutions to system and process issues to benefit member organisations.
 - 1.1.4. help shape the trusts' clinical academic portfolios including research and development and health professional education/ clinical academic training.
 - 1.1.5. advise the delegated allocation of relevant resources from each partner organisation required to deliver their strategic objectives.

2. AUTHORITY

- 2.1. The ACiC is established by the Trust boards of directors and the College Council of King's College London, each of which remains a sovereign organisation, to provide a governance framework for the further development of joint working between them.
- 2.2. The ACiC is not a separate legal entity, and, as such, is unable to take decisions separately from the members.
- 2.3. The decisions taken by the ACiC will be the decisions of the individual members. Members shall only exercise functions and powers to the extent that they are permitted to exercise such functions and powers in accordance with their organisation's existing scheme of delegation and accountability arrangements or following prior approval of their board of directors/ College Council.
- 2.4. Matters that have a material impact on South London and Maudsley NHS Foundation trust are out of scope for the Committee.

3. ACCOUNTABILITY

- 3.1. The non-executive directors (NEDs) and the ~~chief medical officers (CMOs)~~[relevant Executive Directors](#) of the member trusts shall be responsible for reporting to their trust boards on the work of the ACiC. For KCL, ~~reporting to Council will be via the Vice-Chancellor's Senior Team (VST)-reports of each meeting are sent to Academic Board, with annual reporting to Council via the Vice-Chancellor's Senior Team (VCST).~~
- 3.2. The ACiC will report to the trust boards and KCL Council on a basis to be determined by those forums.
- 3.3. The minutes of all meetings shall be formally recorded and submitted, together with recommendations where appropriate, to the Boards of the Members/KCL Council.



3.4. ~~Papers~~ [Minutes of relevant matters](#) will be shared with the King's Health Partners (KHP) Board for information [and vice versa](#).



~~3.4.~~

4. PRINCIPLES

4.1. The effective functioning of the ACiC will be enabled by the member organisations adopting the following principles:

- 4.1.1. **Ambition** – Strive to advance clinical academic excellence across all partner organisations by fostering and promoting innovation, research and education
- 4.1.2. **Transparency** – Ensure clear and open decision-making processes and relevant financial flows to enhance accountability and trust among stakeholders
- 4.1.3. **Collaboration and alignment** – Promote cohesive and synchronised efforts among the partner organisations to achieve shared goals, leveraging each organisation's strengths and resources as appropriate
- 4.1.4. **Evidence-based and data driven** – Establish robust qualitative and quantitative metrics to assess impact, track progress, and ensure continuous improvement in outcomes.

5. KEY RESPONSIBILITIES

~~5.1.~~ Oversee the implementation of the shared aspects of the KHP Strategy across the three member entities.

~~5.1.~~

~~5.3.5.2.~~ Support the development of high-quality, large-scale research infrastructure bids (e.g. from NIHR or other funders).

~~5.4.5.3.~~ Receive assurance in relation to existing and future research infrastructure investments between two or more members.

~~5.6.5.4.~~ Enhance student opportunities on joint educational programmes (across all registered professional groups) and consider the provision of high-quality clinical placements delivered to support ambitions of clinical excellence and overseen in line with professions' regulations of clinical placement delivery and assessment.

~~5.6.5.5.~~ Maximise joint asset opportunities including biobanking, sample access and data sharing and optimise the impact of joint organisational structures including the Joint Research Office.

~~5.7.5.6.~~ Enhance staff opportunities – e.g. prioritisation/recognition of teaching / research contributions of clinical (academic) staff; prioritisation of strategic joint appointments across all professions.

~~5.8.5.7.~~ Advise on the co-ordination and development of innovation and commercialisation in relation to clinical academic research.

~~5.8.~~ Benchmark key outputs across the partnership, through bringing together existing reports and requirements from external organisations.

~~5.9.~~

~~5.9.~~ Receive assurance in relation to the delivery of key Key Performance Indicators (KPIs) e.g. delivery of commercial trials.

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6. MEMBERSHIP

6.1. The Committee in Common membership will comprise of the following:

- 6.1.1. Chief Academic Officer (CAO) for GSTT, KCH and KCL.
- 6.1.2. GSTT: one NED, CMO, Chief Financial Officer (CFO), [CPO](#)
- 6.1.3. KCH: one NED, CMO, CFO, [CPO](#)
- 6.1.4. KCL: one NED, one of Health Faculty Executive Deans, CFO, [CPO](#)
- ~~6.1.4.6.1.5.~~ [GSTT/KCH/KCL corporate / partnership lead to facilitate read across with other aligned committees](#)

6.2. The ACiC will be chaired by the CAO. In their absence, the chair should identify one of the other non-executive directors to chair the Committee.

6.3. Where a member of the Committee is unable to attend a meeting, subject to the agreement of the Committee chair, they should appoint a deputy and ensure that the deputy is properly briefed. Deputies will have the same speaking and voting rights as their principals.

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

7. ATTENDANCE

[7.1.](#) Members can nominate attendees for specific items as agreed with the chair.

~~7.1.7.2.~~ [With agreement of the Chair, key stakeholders will have standing invitation to the meeting.](#)

~~7.2.7.3.~~ External observers will be invited on an ad hoc basis. Such observers will have no decision-making rights.

~~— The executive lead for governance (or their nominated deputy) for the organisation hosting the meeting will be in attendance.~~

8. QUORUM

8.1. The ACiC will be quorate if ~~five representatives~~ [at least two members from each organisation](#) are present (including at least one representative from each entity), ~~one of whom must be in addition to~~ the Chair or their nominated deputy.

8.2. Deputies will be mandated.

9. FREQUENCY OF MEETINGS

9.1. The ACiC will meet on a quarterly basis, or such other frequency as agreed between the members

9.2. Any member body may call extraordinary meetings of the ACiC at their discretion subject to providing at least five working days' notice to ACiC members.

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- 9.3. The ACiC may decide to take items by correspondence. In such cases, members will be given no fewer than five working days to respond, and the items will be formally noted at the following meeting of the ACiC and recorded in the minutes.



10. DECISION MAKING

- 10.1. The ACiC will aim to achieve consensus wherever possible.
- 10.2. Each of the members will represent their organisation and only make decisions at the ACiC in respect of their own organisation in accordance with any delegated authority.
- 10.3. The CAO will be responsible for organising the agenda for meetings of the ACiC in accordance with the Key Responsibilities and emergent matters.
- 10.4. All matters for decision will come from the CAO.
- 10.5. If a vote is required, each member body shall have one vote.
- 10.6. Member entities will retain the power to veto. If a veto decision is made, the dispute resolution protocols will be activated. The veto is only possible at ACiC level.

40.7.

11. CONFLICTS OF INTEREST

- 11.1. ACiC members must refrain from actions that are likely to create any actual or perceived conflicts of interests.
- 11.2. ACiC members must disclose all potential and actual conflicts of interest and ensure that such conflicts are managed in adherence with their organisation's conflict of interest policies and statutory duties.

12. CONDUCT OF BUSINESS

- 12.1. The provision of secretariat duties will be through the office of the Chair with support from the rotate between the three partner organisations.
- 12.2. Circulation of the meeting agenda and papers via email will take place at least five working days prior to the meeting.
- 12.3. If members wish to add an item to the agenda they must notify the Chair and secretariat who will confirm this with the other members accordingly.
- 12.4. The minutes of ACiC meetings will be sent to representative members within ten days of each meeting. It will be the members' responsibility to disseminate minutes and notes from the ACiC within their respective organisations.

13. REVIEW

- 13.1. These terms of reference will be reviewed on an annual basis.

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June 20265

AGENDA ITEM:

Report to:	Board of Directors						
Date of meeting:	15 th July 2026						
Subject:	Report from the Chief Executive						
Author(s):	Siobhan Coldwell, Director of Corporate Affairs						
Sponsor:	Matthew Trainer, Chief Executive Officer						
History:	Standing report to this meeting						
Status:							
Decision/Approval		Discussion	✓	Assurance	✓	Information	✓

Purpose

This paper outlines the key developments and occurrences since the last Board meeting held on 14th May 2026 that the Chief Executive wishes to discuss with the Board of Directors.

Recommendations:

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

Strategy alignment

High Quality Patient Care	✓	Strong Successful Partnerships	✓
A Great Place to Work	✓	Timely and Efficient Care	✓
Pioneering Research, Innovation and Education	✓	Financial Sustainability	✓

Key implications

Strategic risk - Link to Board Assurance Framework	The report outlines how the Trust is responding to a number of strategic risks in the BAF.
King's Improvement Impact (KIM):	<i>n/a</i>
Quality Impact	<i>The report highlights a number of initiatives aimed at improving quality.</i>
Health Equity Impact	<i>The report highlights a number of initiatives aimed at improving health equity</i>
Workforce Impact	<i>The report notes workforce developments.</i>
Research/Innovation Impact	<i>n/a</i>
Digital Impact	<i>n/a</i>
Financial Impact	<i>n/a.</i>
Legal/ regulatory compliance	<i>The report provides a summary of the Trust's latest position in the National Oversight Framework. .</i>
Communications and Engagement	<i>The report highlights examples of good news.</i>
Use of Artificial Intelligence Tools	<i>n/a</i>
Committee that will provide relevant oversight Board of Directors unless otherwise stated	

King's College Hospital NHS Foundation Trust

Report from the Chief Executive Officer

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1. Introduction

- 1.1. This Board report marks my first as Chief Executive of King's College Hospital NHS Foundation Trust. It is a huge honour to have been appointed to the role. I am delighted to be coming back to the place where I first worked in a hospital. King's is widely respected for its brilliant people and fantastic care, and I look forward to working with my new colleagues.

2. National Oversight Framework

- 2.1. In June, NHS England published the Q4 5052/26 NOF data. The league table provides a ranking for all Trusts, and segmentation. The full results for the Trust can be found at appendix 1, but in summary the Trust position has improved slightly, from 89th to 81st, and the Trust remains in segment 3. As the Trust is in receipt of deficit support funding, the Trust cannot be higher than segment 3, regardless of performance against the indicators.

3. Industrial Action

- 3.1. The Resident Doctors Industrial Action (IA) planned for June 2026 was called off, and it has subsequently been announced that a settlement has been reached. There is no doubt that the extended period of industrial action has been challenge, but Team King's has worked brilliantly to care for our patients and minimise the disruption as much as possible. I would like to thank colleagues across the organisation for their hard work in managing these periods of industrial action. As a Trust we remain committed to delivering the 10 point resident doctors plan, and progress is being tracked through the Board's People, Education and Inclusion Committee.

4. Maternity Services

- 4.1. On 30 June 2026, NHS England published Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England alongside a system-wide response setting out urgent actions for trusts, integrated care systems and NHS England. The report follows extensive engagement with women, families, staff and leaders and highlights the need for a fundamental cultural and operational shift to improve safety, experience, equity, accountability and public confidence in maternity and neonatal services.
- 4.2. In response, NHS England has issued a 10-Point Action Plan focused on immediate priorities that all organisations are expected to progress ahead of publication of a National Maternity and Neonatal Action Plan in December 2026. These actions focus on strengthening board oversight, listening to women and families, improving patient safety, addressing inequalities, ensuring workforce responsiveness and embedding compassionate, trauma-informed approaches to care and complaints handling.
- 4.3. The actions include:
- Roll-out of Martha's Rule across maternity and neonatal services.
 - Enhanced use of real-time patient experience, outcomes and audit data at Board level.
 - Joint accountability between Medical Directors and Chief Nursing Officers for maternity and neonatal services.
 - A national staff listening exercise ("Amos into Action").

- Full implementation of the Perinatal Equity and Anti-Discrimination Programme.
- Review of workforce deployment and 24/7 service responsiveness.
- Review and assurance of homebirth services.
- Strengthening responses to incidents, complaints and concerns through openness, candour and compassion.
- Delivery of safe maternity triage services, supported by NHS England audit requirements and guidance.
- Continued assurance regarding post-death care following the Fuller and Nottingham reviews.

4.4. In addition, the Government has announced:

- £10.6 million funding in 2026/27 to support recruitment of newly qualified midwives.
- Establishment of a national Maternity and Neonatal Commissioner.
- £41 million investment to improve maternity and neonatal estate safety and quality.

4.5. Many of the expectations outlined within the report align with work already underway within King's College Hospital NHS Foundation Trust, including the ongoing focus on safety improvement, the roll out of Martha's rule to Maternity, patient experience, workforce development, equity, learning from patient safety incidents and strengthening Board oversight of maternity services. However, the publication creates a renewed requirement for organisations to review local arrangements against the national actions and demonstrate clear evidence of implementation and impact. A further update on specific actions and implications will follow in due course in line with the NHS England ask for organisations to begin early planning and engagement locally to ensure rapid mobilisation following publication of Baroness Amos' investigation report.

5. Minimum Standards of Care

5.1. On Friday 3rd July, all Trusts received a letter from Sir James Mackay, Chief Executive of NHS England, setting out minimum a patient should experience when their referral has been accepted in secondary care. They have been designed alongside key stakeholders, including patient groups and could also be beneficial for other pathways.

5.2. The standards are defined in 3 parts:

- what patients should expect at referral
- what they can expect while they are on the waiting list
- the information they can expect to receive about their appointment

5.3. Trust boards should assess their current performance against each standard and set out how they will improve where they are not meeting a standard. Trust boards are also expected to publish a statement in 2026/27 setting out their approach to complying with the minimum standards, followed by an annual statement reflecting their assessment of progress against them. Colleagues are working to understand our current position and develop plans as necessary and will report to the Performance, Transformation and Improvement Committee over the coming months.

6. New facilities at King's

- 6.1. There have been a number of upgrades to King's facilities in recent months. We were pleased to welcome Sir James Mackay, Chief Executive of NHS England, to open the Endoscopy and Diagnostic Centre at the PRUH. The new facility will enable specialist staff to see up to 4,500 additional suspected cancer patients each year. Professor Bu Hayee, Gastroenterology Consultant and Clinical Director at King's, said: "The new facility is already making a positive difference to the patients accessing endoscopy services at the PRUH. We know that early diagnosis for conditions such as cancer is absolutely crucial, and the new Endoscopy and Diagnostic Centre at the PRUH will help ensure local people can have access to faster diagnosis and potentially life-saving treatment."
- 6.2. Neonatal services at the PRUH have been expanded and upgraded, and can now care for babies born much earlier. The unit is now officially designated as a Local Neonatal Unit, which means the hospital can now treat babies born from 27 weeks of pregnancy onwards. Dr Rashmi Gandhi, Lead Consultant Neonatologist for LNU at the PRUH, said: "For those families living locally, being able to stay close to home will offer much needed comfort for families when they are often at their most vulnerable – reducing the need to travel long distances, whilst ensuring their babies continue to receive high-quality care."
- 6.3. King's has become the first hospital in the UK to open an outdoor Critical Care garden on its roof. The King's Critical Care Roof Garden is located on top of the hospital's 60-bed critical care unit at Denmark Hill, allowing patients to receive full life support, whilst feeling the therapeutic benefits of nature. Dr Tom Best, Clinical Director of King's Critical Care, said "Some of our most unwell patients spend weeks or even months in critical care receiving intensive and often invasive treatment to give them the best chance of recovery."
- 6.4. "Many experience hallucinations or delirium in the clinical environment, which can be extremely frightening and delay recovery. Research shows that time spent in nature can reduce delirium, improve recovery outcomes, and lift the spirits of patients and their families. "It's important to treat the whole person and this outdoor critical care unit helps meet our goal of caring for the mind as well as the body."

7. Changes to Haematology cancer care at the PRUH

- 7.1. We are making some changes to the delivery of haematology cancer care at the PRUH. The changes will involve bringing all specialist haematology inpatient cancer care provided by the Trust together at Denmark Hill, and establishing a Haematology Day Unit at the PRUH. This means that the Chartwell ward at the PRUH will become the Haematology Day Unit and provide a vital service for patients accessing emergency and planned haematology care at the hospital.
- 7.2. The decision to move forward with these changes follows a period of engagement with haematology patients, families and local stakeholders. Feedback received was

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carefully considered, alongside the case for change, as well as the impact on patients and staff.

7.3. Outpatient haematology care is not part of these changes, and will continue to be provided at PRUH in the same way as it is currently. Urgent and emergency haematology care will also continue to be provided at the PRUH, and due to the creation of a dedicated Haematology Day Unit, patients will be seen more quickly.

7.4. The changes will support equity of access to specialist haematology cancer care for all local patients, and also give patients faster access to cutting-edge treatments and the latest clinical trials. It will build on existing arrangements, whereby some haematology cancer patients from Bromley and other neighbouring areas who require highly specialist treatment are already transferred to King's College Hospital for this aspect of their care.

7.5. A date for when the changes will take effect will be communicated in due course, and there are no changes to haematology services at the PRUH for the time being. A detailed implementation plan, including a full timeline for when the changes will take effect, is currently being developed and will be shared with patients and partner organisations in the near future. Our current aim is to make these changes operational by Autumn 2026.

8. Board Committee Meetings since the last Board of Directors Meeting (14 May 2026)

People, Education and Inclusion Committee	15 May 2026
Finance and Commercial Committee	4 June 2026
Performance, Transformation and Improvement Committee	4 June 2026
Board Development Session	12 June 2026
Audit and Risk Committee	18 June 2026
People, Education and Inclusion Committee	1 July 2026
Finance and Commercial Committee	2 July 2026
Academic Committee in Common	8 July 2026
Quality and Research Committee	8 July 2026
Performance, Transformation and Improvement Committee	9 July 2026

9. Good News Stories and Communications Updates

9.1. [New collaboration between King's Business School and King's College Hospital to help drive business excellence](#) King's Business School has formalised a new partnership with King's College Hospital NHS Foundation Trust, bringing together excellence in vital support areas that are essential to the delivery of high-quality healthcare. Roy Clarke, Chief Financial Officer at King's College Hospital NHS Foundation Trust, said: "This collaboration reflects a shared commitment to developing future talent and supporting innovation across the health sector. The benefits are mutual, enabling our teams at King's to stay up to date with the latest thinking and theory, with students undertaking placements with us boosting their understanding of day-to-day life in the NHS, and the challenges and opportunities this

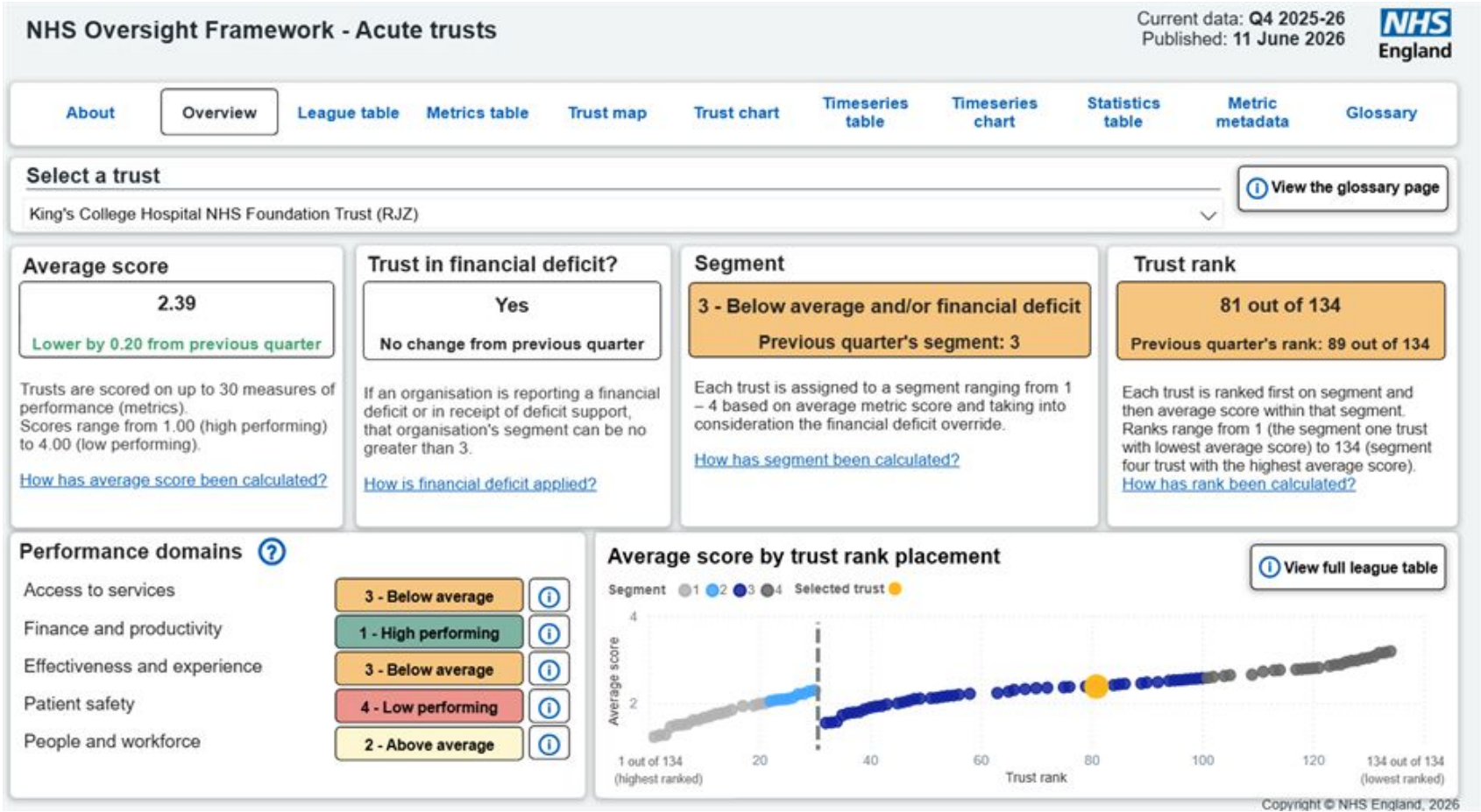
brings. We are excited about the potential of this partnership, and the shared opportunities for learning it provides.”

- 9.2. [New Collaborators Hub opens at King's](#) The Patient Services, Experience and Involvement Team at King's has launched the King's Collaborators Hub – an online platform and two hospital spaces – to better connect with its patients, their families and carers, and people from local communities. Karen Taylor, Head of Patient Services, Experience and Involvement at King's, said: “We want to make sure that everyone has a chance to shape the care they receive at King's. Whether you have an idea about how we can make improvements, an interest in a particular service we provide, or would like to be more involved with the work of the Trust, your views will help shape our future.”
- 9.3. [King's Liver Team features in a new E4 documentary](#) *Made in Chelsea: Sam Vanderpump's Story*, follows the 29-year-old reality star as he starts his journey on the liver transplant waiting list and navigates life as a dad-to-be. Sam Vanderpump who has end-stage liver disease was filmed at many of his appointments, including his transplant assessment, at our Denmark Hill site with King's Hepatology and Liver Transplant Teams. Dr Deepak Joshi, Consultant Hepatologist at King's, said: It's really brave that Sam has chosen to use his platform to raise awareness about liver health and the importance of organ donation. The documentary gives insights into the reality of being active on the liver transplant waiting list in the UK today.”
- 9.4. [New welcome guide for King's patients](#) King's has launched its Welcome to our hospitals guide for adult inpatients. Funded by King's College Hospital Charity, the latest guide has been designed to be simple, accessible and easy to follow, helping patients, their carers and families prepare for a hospital stay. Karen Taylor, Head of Patient Services, Experience and Involvement at King's, said: “We know that being admitted to hospital can be a daunting experience, and we hope our new guide will help alleviate any fears, answer some common questions, and give patients and carers confidence to ask questions if they feel unsure or concerned about anything during their stay.”
- 9.5. [King's exits Recovery Support Programme](#) NHS England has confirmed that King's is no longer in NHS Oversight Framework Segment 4 and has been removed from the Recovery Support Programme. The move follows a period of sustained improvement by King's in vital areas such as financial planning and governance, strategy, operational performance, and leadership and culture.
- 9.6. [Angela Rippon joins King's volunteers to launch nationwide weekend of community action](#) Broadcaster and TV presenter Angela Rippon dropped in to lend a hand with the breakfast service on a ward for older patients at King's College Hospital on Thursday 14 May, to highlight the benefits of volunteering. Angela Rippon CBE, said: “I've spent my career telling other people's stories, but it's the volunteers I've met along the way who've taught me the most — they're busy, they're every age from every walk of life, and they all say the same thing: giving their time makes them feel better. That's the message: this isn't about sacrifice, it's about looking after yourself by looking after someone else. “
- 9.7. [London hospital teams join forces to save 4-year-old girl](#) Dr Trisha Radia, Clinical Director for Child Health at King's, said: “Every day, we witness exceptional work to look after our patients, but this team effort across two different hospitals was truly

extraordinary. Several colleagues gave up their own time, working hours after their shifts ended, to make sure Paisley-Rose had the treatment she urgently needed. "The commitment from everyone involved in Paisley-Rose's care was inspirational; this is a wonderful example of the difference we can make when we work together."

- 9.8. [King's College Hospital's first visually impaired volunteer](#) Edesiri Eyeregba, who has a vision and hearing impairment, applied for a volunteer role at King's as a way of building experience and improving his employment prospects when leaving college later this year. He has now become the first volunteer with a vision impairment at King's, currently working in an admin role at the PRUH. Amber Peters, Volunteer Service Manager at King's, said: "It's important that our volunteers come from all walks of life, so that we represent the communities we serve. It's a pleasure to have Edesiri volunteering at the hospital, he is an inspiration to us all."
- 9.9. [Inspiring the next generation of NHS leaders at King's](#) Jessop Primary School students visit King's College Hospital to explore career opportunities in healthcare. The event was organised as part of the King's Young Ambassadors Programme, an initiative run by the Trust, where a group of patient ambassadors aged 9 – 11 years old from Jessop Primary school regularly visit the hospital to take part in health-related education and wellbeing sessions. Sarah Harris, Head of Nursing, Children and Young People at King's, added: "It was fantastic to have the opportunity to show the different ways we help patients here at King's. The children's enthusiasm and curiosity made the sessions really enjoyable, and we are so grateful to teams across the hospital who took the time to demonstrate their expertise and passion for healthcare."
- 9.10. [An alternative to open heart surgery](#) Specialist heart surgeons at King's College Hospital NHS Foundation Trust have used an endoscope to perform an aortic valve replacement for the first time. Mr Habib Khaan, Consultant Cardiothoracic Surgeon at King's, said: "This type of endoscopic assisted surgery could be transformative for patients with heart valve disease, with the potential for a much smoother recovery. We hope this will be the first of many more patients to benefit from this innovative procedure at King's."
- 9.11. [Patients with Parkinson's practice Tai Chi in new research study](#) Researchers at King's are exploring how specialised Tai Chi sessions can help people living with Parkinson's with their posture control and balance, and manage symptoms including fatigue, pain, and sleep disturbance. Julie Whitney, Consultant AHP for Older People at King's, is leading on the study, which is taking place at the Parkinson's Foundation Centre of Excellence. She explained: "Previous research has suggested that Tai Chi could bring health benefits for people with Parkinson's, potentially helping to improve coordination, balance and wellbeing and there is good evidence it reduces falls in older adults. We are now investigating whether these enhanced Tai Chi sessions, tailored to people living with Parkinson's, could have a meaningful impact on symptoms and quality of life."

APPENDIX 1 NOF Q4 (2025/26) King's College Hospital NHS Foundation Trust



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ACCESS TO SERVICES

Select a trust

King's College Hospital NHS Foundation Trust (RJZ)

Select domain(s), sub-domain(s) and metric(s)

Access to services

Quarter	Segment		Trust in financial deficit?							
Q4 2025/26	3 - Below average and/or financial deficit		Yes							
Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Access to services	Cancer care	Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	Q4 2025/26	77.93	%	4.56 ↑	2.62	72 out of 117	79.34	80
Access to services	Cancer care	Percentage of patients treated for cancer within 62 days of referral	Q4 2025/26	65.82	%	4.85 ↑	3.29	89 out of 118	70.24	75
Access to services	Elective care	Percentage of patients waiting over 52 weeks for elective treatment	Mar-26	1.34	%	-0.51 ↑	2.53	86 out of 130	0.96	1
Access to services	Elective care	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Mar-26	66.38	%	2.48 ↑	2.19	52 out of 130	64.83	
Access to services	Elective care	Difference between planned and actual 18 week performance	Mar-26	1.22	percentage points	1.15 ↑	1.00	61 out of 130	0.99	0
Access to services	Urgent and emergency care	Percentage of emergency department attendances admitted, transferred or discharged within four hours	Q4 2025/26	70.98	%	-0.86 ↓	3.16	86 out of 123	74.01	78
Access to services	Urgent and emergency care	Percentage of emergency department attendances spending over 12 hours in the department	Q4 2025/26	10.36	%	0.80 ↓	3.01	82 out of 122	8.71	

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Effectiveness and Experience

Select a trust

King's College Hospital NHS Foundation Trust (RJZ)

Select domain(s), sub-domain(s) and metric(s)

Effectiveness and experience

Quarter

Q4 2025/26

Segment

3 - Below average and/or financial deficit

Trust in financial deficit?

Yes

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Effectiveness and experience	Effective flow and discharge	Average number of days from discharge ready date to actual discharge date (including zero days)	Mar-26	1.00	days	-0.09	2.94	83 out of 128	0.80	
Effectiveness and experience	Patient experience	Summary Hospital-level Mortality Indicator	Jan 24 - Dec 25		score		2.00			
Effectiveness and experience	Patient experience	CQC inpatient survey satisfaction rate	2024		score		2.00			

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FINANCE AND PRODUCTIVITY

Select a trust

King's College Hospital NHS Foundation Trust (RJZ)

Select domain(s), sub-domain(s) and metric(s)

Finance and productivity

Quarter	Segment		Trust in financial deficit?								
Q4 2025/26	3 - Below average and/or financial deficit		Yes								

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Finance and productivity	Finance	Planned surplus/deficit	2025/26 plan	-4.06	%	0.00	4.00	101 out of 134	-1.54	0
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 12 2025/26	0.24	%	0.07	1.00	61 out of 134	0.03	
Finance and productivity	Finance	Combined finance	Q4 2025/26				2.00			
Finance and productivity	Productivity	Implied productivity level	Q3 2025/26 vs Q3 2024/25	12.18	%	7.18	1.07	4 out of 134	2.57	

PATIENT SAFETY

Select a trust				Select domain(s), sub-domain(s) and metric(s)						
King's College Hospital NHS Foundation Trust (RJZ)				Patient safety						
Quarter	Segment			Trust in financial deficit?						
Q4 2025/26	3 - Below average and/or financial deficit			Yes						
Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Patient safety	Patient safety	Number of MRSA bacteraemia cases (12 months)	Mar-26	9.00	count	1.00 ↓	3.75		3.50	0
Patient safety	Patient safety	Proportion of E. coli bacteraemia	Mar-26	1.16	rate	0.01 ↓	2.71		1.17	1
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2025	6.18	out of 10	0.10 ↑	3.10	94 out of 134	6.32	
Patient safety	Patient safety	Proportion of C. difficile infections	Mar-26	1.20	rate	-0.04 ↑	2.87		1.09	1

WORKFORCE AND PEOPLE

Select a trust				Select domain(s), sub-domain(s) and metric(s)						
King's College Hospital NHS Foundation Trust (RJZ)				People and workforce						
Quarter	Segment			Trust in financial deficit?						
Q4 2025/26	3 - Below average and/or financial deficit			Yes						
Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
People and workforce	Retention and culture	Sickness absence rate	Q3 2025/26	4.73	%	0.24 ↓	1.35	23 out of 134	5.59	
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2025	6.68	out of 10	0.10 ↑	2.85	83 out of 134	6.80	

AGENDA ITEM:13**BOARD/COMMITTEE REPORT COVER PAPER**

Report to:	Trust Board meeting - Public						
Date of meeting:	15 July 2026						
Subject:	Strong Successful Partnership						
Author(s):	Liz Shutler – Director of Strategy						
Sponsor:	Julie Lowe – Deputy Chief Executive Officer						
History:							
Status:							
Decision/ Approval		Discussion	✓	Assurance		Information	

Purpose

The purpose of this report is to update the Board on the:

- progression of the strong successful partnership ambition in the King's Strategy – 2026 to 2031;
- latest developments with KHP and SC1;
- local government changes following the recent local elections in Bromley, Lambeth and Southwark;
- latest news on the Integrator in Bromley for which King's is the host; and
- plans to progress Population Health Management and Healthcare Equity.

Recommendations:

- 1.1 The Board is asked to discuss and note the report.

Strategy alignment

High Quality Patient Care		Strong Successful Partnerships	✓
A Great Place to Work		Timely and Efficient Care	
Pioneering Research, Innovation and Education		Financial Sustainability	

Key implications

Strategic risk - Link to Board Assurance Framework	<i>None identified. The strategy provides a framework for managing and monitoring delivery of the Trust's six strategic ambitions and will support oversight through existing governance arrangements.</i>
King's Improvement Impact (KIM):	<i>The delivery framework has been developed using King's Improvement Method principles. Strategic ambitions have been translated into annual measures supported by data, A3 thinking, Strategy Deployment Reviews (SDRs), balanced scorecards and frontline performance management through daily huddles and coaching.</i>
Quality Impact	<i>The strategy places high-quality care at the centre of the Trust's ambitions. Delivery of the framework is intended to improve patient safety, clinical effectiveness, patient experience and outcomes through a structured approach to performance monitoring and continuous improvement.</i>
Health Equity Impact	<i>A separate Health Equity Strategy has been developed to support delivery of the Trust's ambitions in relation to reducing health inequalities and improving equitable access, experience and outcomes. Equality Impact Assessments (EqIAs) will be completed as required for individual strategic programmes and initiatives arising from the strategy.</i>
Workforce Impact	<i>The strategy includes a strategic ambition to make King's a great place to work, with a focus on staff wellbeing, engagement, inclusion, leadership and organisational culture. Delivery of the strategy will require ongoing workforce development and staff involvement.</i>
Research/Innovation Impact	<i>Research, innovation and education are core strategic ambitions within the strategy. The framework includes measures to support growth in research activity, innovation adoption and educational opportunities across the organisation.</i>
Digital Impact	<i>Digital transformation is recognised as a key supporting strategy. A Digital Strategy has been developed alongside the Trust Strategy to support delivery of the strategic ambitions. Delivery will support the appropriate use of digital technologies, data and innovation to improve patient care, operational performance and experience. Digital opportunities and associated risks will be managed through existing governance arrangements.</i>
Financial Impact	<i>The strategy includes a strategic ambition focused on financial sustainability and the Financial Strategy is a key supporting strategy.</i>

	<i>Delivery of the framework will support prioritisation of resources, productivity improvement and achievement of the Trust's long-term financial objectives. No additional financial commitments are requested through this paper.</i>
Legal/ regulatory compliance	<i>The strategy supports the Trust's responsibilities to deliver safe, effective and sustainable services in line with NHS requirements and regulatory expectations. No specific legal or regulatory issues arise directly from this paper.</i>
Communications and Engagement	<i>The strategy has been informed by extensive engagement with patients, communities, staff and partners. Ongoing communication and engagement activity will support implementation of the strategy and reporting of progress against its ambitions.</i>
Use of Artificial Intelligence Tools	N/A
Committee that will provide relevant oversight	
Trust Board	

1. Purpose of the Report

1.1 The purpose of this report is to update the Board on the:

- progression of the strong successful partnership ambition in the King's Strategy – 2026 to 2031;
- latest developments with KHP and SC1;
- local government changes following the recent local elections in Bromley, Lambeth and Southwark;
- latest news on the Integrator in Bromley for which King's is the host; and
- plans to progress Population Health Management and Healthcare Equity.

2. Strong Successful Partnerships

2.1 Following publication of the King's Strategy – 2026 to 2031, the DCEO (along with all the lead Executives), has been developing the A3 for the 'Strong Successful Partnerships' Ambition. The use of A3s is a key element of the King's Improvement Method (KIM) and is a simple, structured way to think through and communicate a problem and its solution, focussing actions on data led analysis and decision making. A copy of the draft A3 is included in Appendix One.

2.2 As the A3 will be used to measure the strength and effectiveness of our partnerships, it has been agreed that it will be co-produced with our partners and a meeting has been held with leaders in Bromley to agree an approach. A small group is going to position the A3 alongside the ongoing programme of work in the Borough and a workshop will be held with partners, across the patch, to finalise the metrics that will be used and the forum that will lead development, tracking and action on the A3.

KHP and SC1

2.3 Following the publication of the [KHP Strategy to 2030](#), all partners agreed that the way KHP was working needed to evolve. A review of how KHP collaborates and make decisions showed that it could strengthen clarity, improve consistency and deepen collective accountability. KHP has therefore refreshed its Partnership Framework to create a transparent and joined-up model of partnership working.

2.4 The Framework provides a clear and practical structure for how partners coordinate work, prioritise investment and ensure impact and in particular how it will:

- deliver the shared strategic priorities i.e. delivering personalised health; accelerating digital health; and improving population health;
- streamline governance and decision-making - the Framework introduces a clearer, more consistent governance model that supports joined-up planning and accountability.
- offer a consistent approach to investment and prioritisation - the Framework sets out a single approach for choosing and resourcing partnership initiatives, ensuring investments in work that delivers the greatest impact for patients, communities, staff, and the wider system;
- strengthen quality, risk, and assurance - the partnership provides shared visibility of risks, quality concerns, and opportunities so we can act earlier and together; .
- support sustainable growth and future partners; and

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- improve communications and engagement.
- 2.5 Alongside the Framework is a Partnership Charter, which describes the behaviours that make effective collaboration possible, including trust, openness, inclusivity and collective accountability. This Charter helps ensure leaders and teams across KHP act in a way that supports shared success and strengthens our culture.
- 2.6 The next step is to implement the Framework across KHP including establishing the refreshed governance groups, aligning portfolio priorities, updating terms of reference, and communicating the new arrangements across all organisations. The Framework will be reviewed regularly to ensure it continues to support impactful and sustainable partnership working.
- 2.7 **SC1 London** has continued to strengthen its position as south-central London's growing health and life sciences innovation district, bringing together its seven founding partners of King's College London, Guy's & St Thomas' Foundation, Lambeth and Southwark Councils and King's College Hospital, South London and Maudsley and Guy's and St Thomas' NHS Foundation Trusts.
- 2.8 Since the last Board update, [SC1 London has launched its new strategy](#) setting out a clear direction for the next two years that is built around four core pillars:
- Innovation and enterprise: Supporting the movement of bold ideas from lab to life and supporting health equity for all;
 - Community and talent: Shaping a future that benefits and is driven by local communities;
 - Place: Unlocking the full potential of our life sciences buildings and the spaces in between; and
 - Networks: Bringing people, places and partners together to be more than the sum of their parts.
- 2.9 These pillars underpin the partnership's three strategic priorities:
- Support the growth of world-class health and life science innovation clusters across SC1 London;
 - Position SC1 London as a go-to destination for global health and life sciences investment; and
 - Build a strong and inclusive health and life sciences talent pipeline for the future that benefits both communities and employers
- 2.10 Eight initiatives will be delivered in support of the strategy's priorities. These initiatives reflect the strengths of our partnership and the opportunities we are best placed to seize together (please see strategy website linked above for detail). The SC1 London team, in collaboration with partner colleagues, is now focussing on strategy delivery for the benefit of its partners and local communities. All of this is summarised graphically in Appendix Two.
- 2.11 An internal review of SC1's current interim governance arrangements has explored a number of options for the partnership's governance during the delivery of the new strategy.

- 2.12 This month, King's Health Partners Board members supported the recommendation of an enhanced version of current governance arrangements, with the addition of greater communication channels with partners through strategic advisor roles and stronger feedback loops back to partner organisations between meetings. A nomination for a strategic advisor representative has been requested from KCH. The enhanced governance recommendation will be taken to the SC1 London Board on 21 July for final approval.

Local Government Changes

- 2.13 In **Bromley** the Conservatives increased their majority by two seats and remain in control of the council, with the pre-election Leader remaining in charge. Reform UK doubled its representation from 3 councillors to 6, making it one of the gainers in the borough. Labour lost ground (falling from 11 to 8 councillors), the Liberal Democrats increased their representation to 6 councillors and local independent party, Chislehurst Matters, retained its 3 councillors, demonstrating continued support for locally focused politics in parts of eastern Bromley.
- 2.14 With an enlarged Conservative majority, the administration is expected to continue its existing priorities, including protecting much of Bromley's Green Belt while managing housing targets; maintaining relatively low council tax compared with many London boroughs; focusing on road maintenance, parking and suburban transport; and continuing regeneration projects in town centres such as Bromley and Orpington. Although the Conservatives strengthened their position, Bromley's politics are more diverse than they were a decade ago.
- 2.15 **Lambeth** experienced one of the most dramatic shifts in London local government. Labour lost its long-standing majority and the Green Party emerged as the largest party on the council. Following negotiations after the election, Lambeth formed its first-ever Green-led administration with support from the Liberal Democrats.
- 2.16 Key implications include a change in political leadership after many years of Labour control, with a greater emphasis on coalition-building and cross-party working. There may be potential policy shifts in areas such as housing, climate action, transport and community engagement as the new administration establishes its priorities.
- 2.17 **Southwark** also saw a political realignment. Labour remained the largest party but lost its overall majority for the first time since regaining control in 2010 and the council moved to No Overall Control (NOC). A majority in Southwark requires 32 seats and the final composition was Labour: 29 seats; Green: 22 seats; and Liberal Democrats: 12 seats.
- 2.18 Similarly to Lambeth, the most notable change was the increase in Green representation. The key implications would seem to be that decision-making will require greater collaboration between parties; there is likely to be an increased scrutiny of policy proposals and budget decisions with a stronger opposition influence.
- 2.19 For organisations working with both boroughs, the practical consequence is a greater need for stakeholder engagement, consensus-building, and demonstrating alignment with a broader range of political priorities than was required under previous majority administrations.

Integrator in Bromley

- 2.20 Discussions at the Integrator have recently focussed on governance at place level; wider strategic commissioning and contracting arrangements. A draft MOU has been developed to act as the shared delivery operating framework for partners, setting out how organisations will work together to deliver neighbourhood health through the integrator model. It clarifies roles, governance, delivery scope and reporting expectations and establishes the role of the Integrator Host in supporting system coordination and transparency.
- 2.21 The MOU is explicitly non-legally binding and operates alongside existing statutory and contractual arrangements. The approach is aligned with national direction on neighbourhood health, integrated working and place-based delivery and has been designed to remain flexible as policy and system arrangements continue to evolve.
- 2.22 It also aligns with emerging South-East London work on integrator functions, clinical governance and system enablers. The draft was discussed at One Bromley Executive on 19 May 2026 and the overall direction was supported; however, feedback highlighted a need to strengthen a number of areas, in particular:
- clinical governance and accountability arrangements;
 - clarity on the role of the integrator host and assurance mechanisms;
 - articulation of legal position, liability and boundaries
 - clearer description of what will change in practice; and
 - stronger alignment with future contracting and system developments.

Population Health Management and Healthcare Equity

- 2.23 The next phase of the Population Health Management and Healthcare Equity (PHMHE) programme will focus on working with partners to better understand population need, identify priority cohorts and develop more coordinated approaches to prevention and care. Priorities will include frailty, multiple long-term conditions, Core20PLUS5 and children and young people. Progress will depend on closer working across South-East London, particularly where improving outcomes requires better use of data, joined-up pathways and coordinated action across organisational boundaries.
- 2.24 King's role as the Integrator for Bromley provides an important opportunity to put this approach into practice. The focus on frailty will enable King's and its partners to bring together data and insight from across services, identify people at greatest risk and provide more proactive support across hospital, primary care, community and local authority services. Learning from this work will help inform wider approaches to population health and healthcare equity across King's and the wider system.
- 2.25 King's will also work with partners to make better use of data and insight to understand and address healthcare inequity. Areas of collaboration will include the digital equity initiative, improving ethnicity coding, developing Core20PLUS5 data and dashboard capability and building a better understanding of wider social determinants of health. King's will continue to contribute to and learn from the South-East London healthcare equity programme and the Shelford Health Inequalities Community of Practice, sharing learning and adapting effective approaches for use across the Trust and wider system.

- 2.26 Over time, the PHMHE programme will provide a stronger framework for partnership working by bringing together population data, clinical expertise, operational insight and community perspectives. This will enable King's and its partners to identify priorities, develop and evaluate targeted interventions and scale approaches that improve access, experience and outcomes for our patients while making better use of collective resources.

3. Recommendation

- 3.1 The Board is asked to discuss and note the report.

Appendix One

Strong Successful Partnerships - A3

STRATEGIC AMBITION: Strong Successful Partnerships

Executive Sponsor(s): Julie Lowe
Other Team Members:

SRO(s):

Last Updated: 20/05/2026

DEFINE: Problem Statement
Patients are not receiving joined-up, personalised care in the right place and at the right time. This results in unnecessary time in and, visits to hospital and concurrently, a poor use of NHS resources. All partners would benefit from a stronger, digital and data-enabled programme to help drive decision-making and evidence, to impact on this problem, making better use of resources, so services across the system could support people more effectively and efficiently.

DEFINE: Background
King's vision is to **Transform Healthcare** and one of its strategic objectives is to drive this transformation through building strong and successful partnerships that enable the whole system to provide outstanding care to the patients and communities we all serve. In April 2026, 1 in 4 acute beds at King's were occupied by patients with no criteria to reside, equivalent to an average of 215 acute beds, of these approximately 61 (the position minus 115 discharges made on the day) were related to a shared responsibility or the responsibility of external partners.

DEFINE: Target State: SMART Goal
Transfer up to 30% of hospital activity (to include ED attendances, elective inpatients, emergency inpatients, day cases and outpatient activity) into an appropriate, alternative setting by 2031. Initially, the following data will be used as breakthrough objectives to drive success, a reduction in:
• Delayed discharges - not meeting criteria to reside (NMCTR), cohorts C, D and E (either shared or external partners); and
• TBC following co-creation with partners.

DESCRIBE: Current State: Identify Target / Actual / Gap


Consistently around 27% of King's beds are occupied by patients NMCTR, of which approximately 21,987 bed days (per year) are accounted for by patient cohorts whose are delays either a shared responsibility or the responsibility of external partners (i.e. patient cohorts C, D and E - care transfer hub process; interface process; and capacity). A 30% reduction in bed days by 2031 would equate to 6,596 bed days or 18 beds as detailed in the trajectory included in the graph on the left.

Graph to be inserted once second metric is agreed with partners

Commentary to be included once second metric is agreed with partners

DESCRIBE: Analysis
The top four reasons for NMCTR (cohorts C, D, E):

Category	Value
Capacity	1,158
Interface process	1,157
Care transfer hub process	1,157
Delayed discharges	1,157

The top four reasons for delay in cohorts C, D and E account for 9,348 the delayed bed days.

Analysis to be inserted once second metric is agreed with partners

Commentary to be included once second metric is agreed with partners

Key Drivers

Capacity:
RCH/NHt not yet available

Interface Process:
RCH/NHt care arrangements still underway
Bed based rehab, rehabilitation or recovery service

Care Transfer Hub Process:
Waiting for confirmation of care needs/pathway

TBC

TBC

TBC

DESIGN/DELIVER: Interventions/Countermeasures

DIGEST: Sustain Plan

Activity to sustain	Owner	Sustain method and frequency	Report to

Reliability Level:
(1) Individuals: Feedback, checklists, training, basic standards
(2) Procedures: Embedded standard work, reminders, constraints
(3) Systems: Process design, fail safes, physical layout, built-in feedback, automated systems, concentration of responsibility

Maturity Bars:
0: Untested idea
1: Early tests / POCA
2: Multiple POCA
3: Early implementation
4: Working well in operation

Progress

Barrier

SC1 London Strategy and Catalyst Initiatives

The SC1 London Strategy

Pillars	Innovation & Enterprise	Place	Networks	Community & Talent
Priority	World-class clusters: Support the development of world-class health and life science innovation clusters across our district.			
Priority	Premier London destination: Position SC1 as a London leader for global health and life sciences investment and location.			
Priority	Inclusive growth for our communities: Build a strong, inclusive health and life sciences talent pipeline for the future.			

SC1 London catalyst initiatives

Place-making: We will support place-making plans across our clusters, from simple signage or street art, to major vision masterplan developments, ensuring our spaces spark discovery and attract the people who will drive it.

Insights for impact: We will map and promote the cutting-edge innovations taking place across our clusters to help foster opportunities for partners, investors and innovators in our district.

Buildings for discovery: We will help two million sq ft of consented innovation, research and development spaces reach their full potential, bringing together companies and potential occupiers to help unlock buildings as engines of discovery.

Supporting underrepresented communities: We will launch programmes that address unmet needs, including SC1 London work experience and internships targeting underrepresented local residents to provide entry points into health and life sciences careers.

SC1 careers hub: We will create a new skills and careers hub that provides local people of all ages with clear and accessible information about health and life sciences pathways, while connecting residents with training, jobs and progression routes.

Growing our network: We will build strong relationships with founding, London and international partners to champion life sciences in the district, London and the UK as a world-class driver of innovation and economic growth.

Promoting the power of partnership: We will promote SC1 London locally, nationally and globally - from flagship events to UKREiF and London Life Sciences Week - so more people choose to work, invest and collaborate in the district.

Influencing: We will engage with developers, investors, talent and decision-makers to enhance the profile and development of our clusters within the district, for example by developing an investment pitch package.

AGENDA ITEM: 15

Report to:	Board of Directors meeting - Public						
Date of meeting:	15 July 2026						
Subject:	Maternity & Neonatal Quality & Safety Integrated Report (April, May 2026)						
Author(s):	Mitra Bakhtiari, Director of Midwifery Dr Lisa Long, Clinical Director Women's Health						
Sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery						
History:	KE/QRC						
Status:							
Decision/ Approval		Discussion		Assurance	✓	Information	✓

Purpose

This report provides the Board with assurance regarding the safety, quality, and performance of maternity services in line with the Perinatal Quality Oversight Model (PQOM). It presents a triangulated overview of key safety, quality, workforce, and patient experience indicators to support effective oversight, identify emerging risks, and monitor improvement actions

- The Trust remains compliant with completion of the Perinatal Mortality Review Tool (PMRT), ensuring all eligible cases are reviewed and learning identified.
- In the reporting period, two cases were referred to the MNSI, neonatal death following emergency caesarean for vaginal breech, neonatal therapeutic cooling following shoulder home birth complicated by shoulder dystocia. Families fully counselled in pregnancy and supported postnatally.
- The trust received no MOSS signal.
- The most frequently reported incidents continue to be unexpected term admissions to the neonatal unit (ATTAIN). The Trust has sustained performance against the national key performance indicator below 6%.
- The independent review of maternity services in Nottingham, led by Donna Ockenden, was published on 24 June 2026 and Barness AMOS maternity review on the 30 June 2026.
- In response to the publications NHSE have issued a ten point plan focussed on immediate priorities to progress ahead of the publication of the National Maternity and Neonatal action plan in December 2026.

- Perinatal mortality rates remain comparable with organisations of a similar size. The principal contributing factors continue to be extreme prematurity and congenital anomalies. 8 cases met criteria for review in the reporting period
- The midwifery vacancy rate remains stable, and the Trust continues to achieve compliance with one-to-one care in labour and the supernumerary status of the Band 7 Labour Ward Coordinator.
- Mandatory training compliance remains above the Trust target of 90% across the multidisciplinary maternity and neonatal workforce.
- Maternity indicators show a continued sustained rise in the caesarean section rates in line with the national picture.
- Maternity Incentive Scheme (MIS) Year 8 requirements have been reviewed. Two areas of focus are an implementation plan for the maternity care bundle and achieving compliance with relevant British Association of Perinatal Medicine (BAPM) standards.
- The Trust commenced its Perinatal Equity and Anti-Discrimination Programme in June. This programme provides a structured assessment of organisational leadership, culture and practice in relation to racial equity. The findings will inform targeted actions to improve equity, enhance experiences and reduce inequalities in maternity and neonatal outcomes.
- Progress against the Care Quality Commission (CQC) maternity action plan continues to be monitored through established governance arrangements, with updates provided through the Maternity Quality and Safety Assurance Programme.
- The perinatal leadership team is progressing a cultural leadership program that commenced in Sep 2025, focusing on shared vision, with positive culture and safety and to enable changes that address the morale, behaviour and culture within teams. (Appendix 1)

Recommendations:

The Board is asked to note the report for evidence and assurance of the MATNEO service.

Strategy alignment

High Quality Patient Care	✓	Strong Successful Partnerships	
A Great Place to Work	✓	Timely and Efficient Care	✓
Pioneering Research, Innovation and Education		Financial Sustainability	

Key implications

Strategic risk - Link to Board Assurance Framework	High Quality Patient Care
King's Improvement Impact (KIM):	The report reflects KIM by demonstrating learning from data, feedback, measuring progress through KPIs, to enhance maternity and neonatal care quality and safety
Quality Impact	Board Safety Champions oversight and national priorities linked to maternity investigations and reviews.
Health Equity Impact	Perinatal culture leadership, improving culture in maternity and neonatal services, supporting the equality assessment, and creating inclusive environment.
Workforce Impact	Training for MATNEO staff to maintain and improve capabilities and skills. The management of safe staffing and the impact on the service safety and experience.
Research/Innovation Impact	Use of digital technology to support engagement and access to information. Redesign of community services based on population data of births and feedback from women, families and birthing people.
Digital Impact	Digital poverty risks considered within the LMNS with mitigation for access to data.
Financial Impact	Failure to achieve all 10 Safety Actions of the Maternity Incentive Scheme will result in the Trust not recouping the additional 10% contribution, amounting to circa £2.3 million.
Legal/ regulatory compliance	Care Quality Commission (CQC); Maternity & Newborn Safety Investigations (MNSI); Mothers, Babies: Reducing Risk through Audits & Confidential Enquiries (MBRRACE-UK); CNST Maternity Incentive Scheme (MIS)
Communications and Engagement	Maternity & Neonatal Voices Partnership (MNVP), Local Maternity & Neonatal System (LMNS)
Use of Artificial Intelligence Tools	Not applicable
Committee that will provide relevant oversight Quality & Research Committee	

AGENDA ITEM: 15**BOARD/COMMITTEE REPORT COVER PAPER**

Report to:	Board of Directors meeting - Public						
Date of meeting:	15 July 2026						
Subject:	Corporate Risk Register & Risk Management Refresh						
Author(s):	Steve Walters, Assistant Director of Quality Governance						
Sponsor:	Tracey Carter, Chief Nurse and Executive Director of Midwifery						
History:	Corporate Risk Register reviewed at Risk and Governance Committee June 2026						
Status:							
Decision/ Approval		Discussion		Assurance	✓	Information	✓

Purpose

- Assurance of risk management processes in place to address corporate risks
- Overview of progress against the risk management refresh

Recommendations:

The Board of Directors is asked to note the report for evidence of assurance provided regarding the ongoing improvements to the risk management processes.

Strategy alignment

High Quality Patient Care	✓	Strong Successful Partnerships	✓
A Great Place to Work	✓	Timely and Efficient Care	✓
Pioneering Research, Innovation and Education	✓	Financial Sustainability	✓

Key implications

Strategic risk - Link to Board Assurance Framework	<i>There are clear links between the BAF and the corporate risk register, identified within the BAF itself.</i>
King's Improvement Impact (KIM):	<i>Risk analysis will provide a benchmark for identifying priorities under KIM</i>
Quality Impact	<i>There are quality elements to most risks and linked to the QIA process as part of PIDs and business cases.</i>
Health Equity Impact	<i>Health equity risks are considered as part of the risk assessment process.</i>
Workforce Impact	<i>Key workforce related risks are included in the Corporate Risk Register.</i>
Research/Innovation Impact	<i>Explain whether the proposal supports research activity, innovation, education, digital transformation, service redesign or adoption of new technologies and practices.</i>
Digital Impact	<i>Digital risks are included as part of the Corporate Risk Register.</i>
Financial Impact	<i>The financial risks are included and there are elements in other risks</i>
Legal/ regulatory compliance	<i>CQC and other regulators review the organisational risk register and wider risk management processes</i>
Communications and Engagement	<i>Reputational risk in some areas</i>
Use of Artificial Intelligence Tools	<i>Nil.</i>
Committee that will provide relevant oversight Audit & Risk Committee overall risk and BAF process, sub board committees for associated risks	

Main Report

- The Trust's highest risk relates to our financial expenditure control (3609) which is graded 25, followed by the risk relating to efficiency requirements (3608) and strategic investments (3620)
- Outside of financial risks our highest risk relates to corridor care, which has been broadened in scope to cover all sites and the NHSE definition, i.e. also including areas outside of the Emergency Department
- Overall, three risks have been opened since the last report, two closed, one score increased and one score reduced.

- Risk deep dives are scheduled for all corporate risks through 2026, and these will be shared with Board assurance committees to inform their work and improve their oversight.
- Work to refresh Trust risk processes and the corporate risk register has continued, with an updated Gantt chart/development plan included as part of the report. This focuses on embedding the approach of addressing risks by ensuring mitigating actions are taken in a timely manner as appropriate to the organisational risk appetite.

Full detail is provided in the attached presentation.

Risk Management

Report to Trust Board – 15 July 2026

This report provides:

- Overview of progress against the risk management refresh being undertaken
- Details of the assurance of risk management processes in place to address corporate risks
- Overview of next steps to further enhance risk management at all levels in the organisation.

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Section 1

Risk Refresh -

- Summary overview of progress
- Risk management refresh Gantt chart

The Trust Board is advised that both programmes are on track and there are no exceptions to report currently.

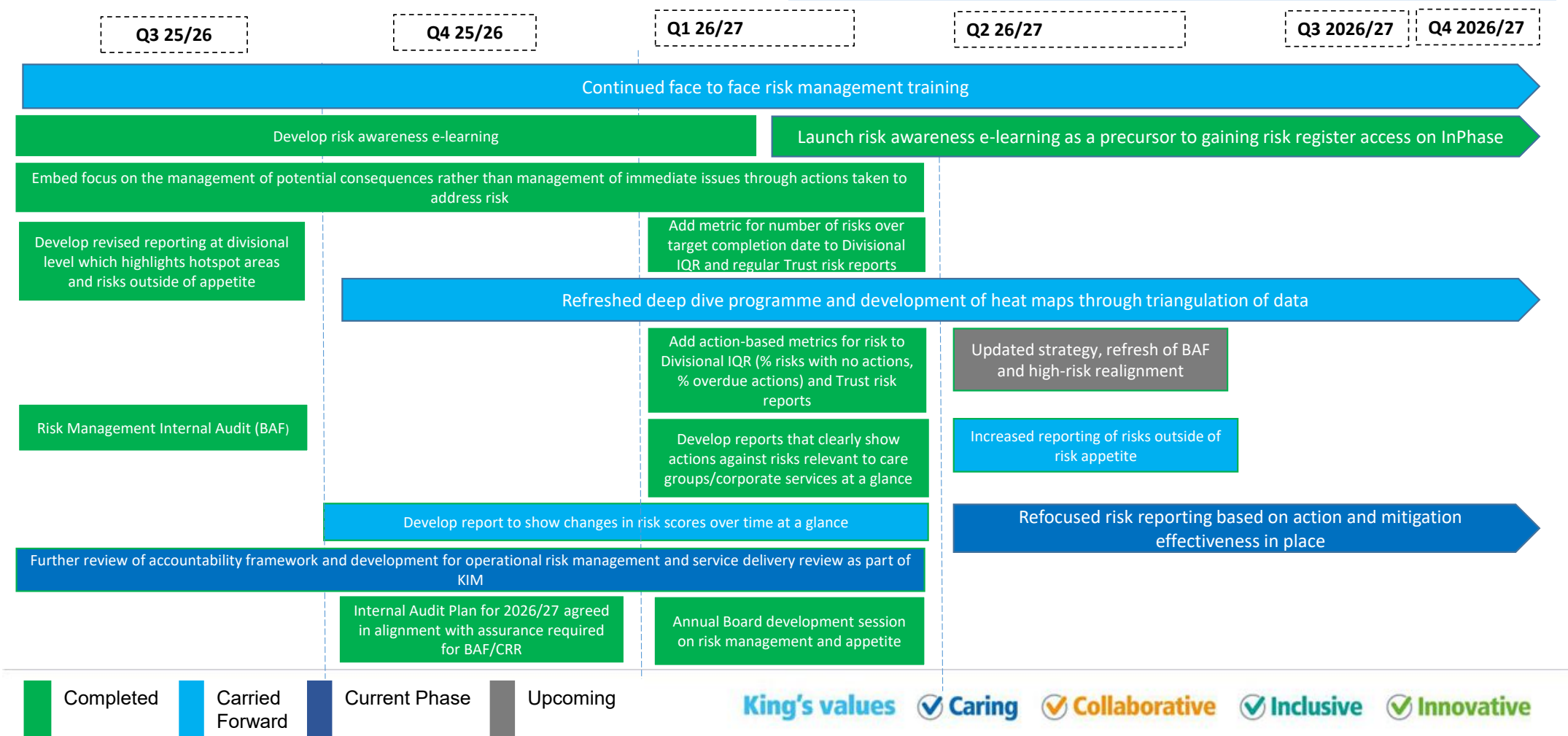
Risk Refresh



- There is continued progress to embed for the enhanced risk management processes across the Trust.
- The Divisions are now completing their second cycle of reviews under the 3 times a year reporting framework. This has already led to some closures or reframing of longstanding red risks, particularly in Division B.
- The Gantt chart in slide 4 shows progress in key areas since the last report, most notably the introduction/rollout of risk management e-learning and the introduction of the revised reporting metrics which focus on completion of actions to ensure timely risk reduction.
- These changes will drive a re-focus of discussions towards actions to effectively to reduce risk to a level the organisation is willing to accept, monitoring these, and where not possible to reduce risk to be clear about the reasons why. As they embed this will lead to risk mitigation plans that are clearer, more timely and more effective.

Risk Refresh - Summary

- Developing reports to show score changes over time at a glance has been delayed due to technical issues with the InPhase system which are being investigated by the supplier
- Increased reporting of risks outside of appetite will commence now the board development session has taken place



Risk Refresh

Risk
Assurance

Next Steps

Section 2

Risk Management Assurance

Corporate risk register

Current Risk exposure profile

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✓ Innovative

Risk Refresh

Risk
Assurance

Next Steps

Corporate Risk Register Management May-June 2026

In May and June the following changes were made to the Corporate Risk Register. The majority of these changes were linked to a review and reset of all finance related risks for the new financial year:

Risk	Current Score (LxC)	Proposed Score (LxC)	Change
3610: Investment Decisions	2x5 =10	3x5 =15	Likelihood score increased based recognising that we are at the start of the financial year and therefore expect to see business cases coming through. This increases the likelihood of the risk.
3612: Delivery of activity in line with the financial plan	2x5 =10	5x2 =10	Changed to likelihood of 2 consequence of 5 as we have signed contracts for 26/27 (which is much earlier than for 25/26) With the contractual agreements in place our activity plans are confirmed so we have clarity on the delivery plans however should we not achieve these the consequences would be higher.
3613: Cost of Additional Capacity	3x4 =12	Closed	This has been incorporated into Risk 3611
3614: Capital Programme	4x4 =16	3x4 =12	Reduced likelihood score to recognise that we have a clear, robust capital plan with greater grip and control over the capital programme.
3915: Elective Recovery Achievement	2x4 =8	Closed	ERF regime no longer in place and the remaining risk is covered by risk 3926
4120: Strategic Investments	New	4x5 =20	New risk relating to impact if strategic investments subject to central funding bids do not receive support (equivalent risk number 3618 for 25/26 closed in October 2025)
4125: National Review of Band 5 Nurses	New	3x5 =15	New risk relating to the possible financial impact of the national review of Band 5 nurses
4108: Financial Impact of Industrial Action	5x3=15	5x4=20	New risk relating to the impact on Trust position should cost of strikes not be met by additional funding – added May. Increased in score in June from 15 to 20 as confirmed dates for further strike action announced (this will be subject to further review in July given the settlement with resident doctors)

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Risk Register Movement (Since June 2026 R&G)

ID	Risk title	Score	Change	Risk Type
36	Bullying and harassment	12	=	Workforce
72	Data and Cyber security of third party organisations accessing our network	16	=	IT
164	Fraud Bribery and Corruption [tolerated risk]	8	=	Finance
387	Water Contamination	10	=	Quality
391	R03 Malware such as Ransomware Compromising Unpatched Servers	15	=	IT
460	Large Scale Staff Shortage	9	=	Workforce
526	Sustainability and Net Zero	12	=	Sustainability
567	Harm from Violence, abuse and challenging behaviour	12	=	Workforce
3458	Delayed Diagnosis	12	=	Quality
2419	Corridor Care within PRUH	20	=	Quality
3608	Identification & delivery of efficiency requirements	20	=	Finance
3609	Expenditure Control	25	=	Finance
3610	Investment decisions	15	↑	Finance
3611	Validity of activity assumptions	12	=	Finance
3612	Delivery of elective activity in line with financial plan	10	=	Finance
3613	Cost of Additional Capacity	Closed	Closed	Finance
3614	Capital programme	12	↓	Finance
3617	Cost Inflation	8	=	Finance
3682	PRUH (PFI) building - Estate issues	12	=	Estates
3869	Elective Performance 2025/26	16	=	Performance
3915	Elective Recovery Achievement	Closed	Closed	Finance
3926	Withholding of Deficit Support Funding	10	=	Finance
3986	Monitoring to Prevent Patient Deterioration	12	=	Quality
3991	Delayed pathology tests/results	15	=	Quality
4103	Backlog Maintenance Projects 2026/27	16	=	Estates
4104	Care of Patients requiring therapeutic mental health intervention	12	=	Quality
4108	Financial impact of industrial action	15	New	Finance
4120	Strategic investments	20	New	Finance
4125	National review of Band 5 nurses	15	New	Finance

July 2026 (following changes agreed at RGC in June 2026)

Likelihood ↑	5			• 3991	• 2419 • 4108	• 3609 • 4120
	4		• [164] • 3986	• 567 • 3458 • 4104	• 3869 • 4103 • 72	• 3608
	3			• 460	• 36 • 3986 • 3682 • 3611 • 3614	• 391 • 3610 • 4125
	2				• 526 • 3617	• 3926 • 3612 • 387
	1					
		1	2	3	4	5
		Consequence →				

Risk score increased

Risk score decreased

Risk score stable –
no shading

New/newly escalated risk

King's values



Caring



Collaborative



Inclusive



Innovative



Next steps

- Review of strategy to make sure changes made in Q1 are incorporated fully
- Review of impact and effectiveness of revised risk metrics
- A full schedule of deep dive reviews and risk management training continues throughout 2026.

AGENDA ITEM: 18

Report to:	Board of Directors meeting – Public						
Date of meeting:	15 July 2026						
Subject:	Patient Experience Annual Report						
Author(s):	Zoe Fong, Patient Experience Senior Analyst Patricia Mecinska, Assistant Director of Patient Experience						
Sponsor:	Tracey Carter, Chief Nurse and Executive Director of Midwifery						
History:	Patient Experience Committee, KE, Quality & Research Committee						
Status:							
Decision/ Approval		Discussion		Assurance	✓	Information	✓

Purpose

The Trust is required to prepare and publish an annual complaints report by 30th June of each year. To demonstrate the work being undertaken around data triangulation, a comprehensive patient experience report has been drafted that brings together complaints data alongside Patient Advice and Liaison Service contacts and Friends and Family test results.

Between April 2025 and March 2026, King's College Hospital recorded 62,211 instances of feedback from our patients and their friends, families and carers who utilised a formal complaints process, accessed our Patient Advice and Liaison service, submitted compliments and/ or completed the Friends and Family Test to share their experiences.

The Trust received 1,451 formal complaints; this represents 23% increase compared to the previous year. The main themes of formal complaints included communication, patient care, and values and behaviours displayed by our staff.

Patient Advice and Liaison service recorded 35,119 contacts, representing 22% reduction from the previous year. The decrease in contacts primarily reflects fewer queries relating to MyChart and general information requests. Despite the overall decrease in the number of contacts, concerns increased by 13% and enquiries by 5%. Compliments received through the service have continued to rise in recent years, with a total of 642 recorded, representing a 22% increase compared to the previous year.

The Trust also collected 25,641 responses to the Friends and Family Test with scores improving for most services, particularly maternity, emergency care and inpatient. However, outpatient services saw a slight decrease. The most common positive theme related to staff

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behaviour and patient care, while facilities, waiting times and communication were the most frequently reported negative themes.

The Trust implemented numerous initiatives based on patient feedback, focusing on communication, environment and waiting times, which were highlighted as significant areas for improvement across all feedback channels. There is however limited evidence of impact of improvement initiatives which the Trust will focus on in 2026-2027.

Recommendations:

The Board of Directors is asked to note this report for evidence and assurance.

Strategy alignment

High Quality Patient Care	✓	Strong Successful Partnerships	
A Great Place to Work		Timely and Efficient Care	✓
Pioneering Research, Innovation and Education		Financial Sustainability	

Key implications

Strategic risk - Link to Board Assurance Framework	High Quality Patient Care and the report provides a positive control on risks 3419 and 3458
King's Improvement Impact (KIM):	King's Improvement Method will be deployed to secure improvements to services based on patient feedback and reflects learning.
Quality Impact	The report considers experiential aspects of quality care at King's
Health Equity Impact	Forms part of Equality Impact Assessment (EqIA) for broader aspects on patient experience.
Workforce Impact	Implications for staff experience closely linked to patient experience and engagement and organisational culture linked to themes i.e. communication and listening.
Research/Innovation Impact	Adoption of artificial intelligence and MYCHART interfaces to engage with patients and families.
Digital Impact	Opportunities on interpreting are being explored and digital for access of information.
Financial Impact	Not proceeding with digital and AI opportunities can be impactful to engagement/experience and length of stay
Legal/ regulatory compliance	The Trust is required to publish the report on its website by 30 th June 2026, and this has been undertaken.
Communications and Engagement	The Trust is required to publish the report on its website by 30 th June 2026, and this has been undertaken.
Use of Artificial Intelligence Tools	AI tools used for summary of data analysis.
Committee that will provide relevant oversight	
Quality & Research Committee	

King's College Hospital NHS Foundation Trust

Patient Experience Annual report: Complaints, Patient Advice and Liaison Service and Friends and Family Test performance

2025-2026

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1. Executive summary

Between April 2025 and March 2026, King's College Hospital recorded 62,211 instances of feedback from our patients and their friends, families and carers who utilised a formal complaints process, accessed our Patient Advice and Liaison service, submitted compliments and/ or completed the Friends and Family Test to share their experiences.

The Trust received 1,451 formal complaints; this represents 23% increase compared to the previous year. The main themes of formal complaints included communication, patient care, and values and behaviours displayed by our staff.

Patient Advice and Liaison service recorded 35,119 contacts, representing 22% reduction from the previous year. The decrease in contacts primarily reflects fewer queries relating to MyChart and general information requests. Despite the overall decrease in the number of contacts, concerns increased by 13% and enquiries by 5%. Compliments received through the service have continued to rise in recent years, with a total of 642 recorded, representing a 22% increase compared to the previous year.

The Trust also collected 25,641 responses to the Friends and Family Test with scores improving for most services, particularly maternity, emergency care and inpatient. However, outpatient services saw a slight decrease. The most common positive theme related to staff behaviour and patient care, while facilities, waiting times and communication were the most frequently reported negative themes.

The Trust implemented numerous initiatives based on patient feedback, focusing on communication, environment and waiting times, which were highlighted as significant areas for improvement across all feedback channels. There is however limited evidence of impact of improvement initiatives which the Trust will focus on in 2026-2027.

2. Trust-level data

On 1st July 2025, the Trust reorganised to a new divisional management structure, replacing site-based model previously in place. The data within this report, including the historical comparisons, reflects the new organisational structure.

2.1. Complaints

In 2025-2026, the Trust received 1,451 formal complaints. This represents 23% increase in comparison to the same period last year. Complaints are graded depending on complexity into categories, red, amber, green.

	2022-2023	2023-2024	2024-2025	2025-2026	Change
Number of complaints received	928	1,120	1,184	1,451	+ 23%

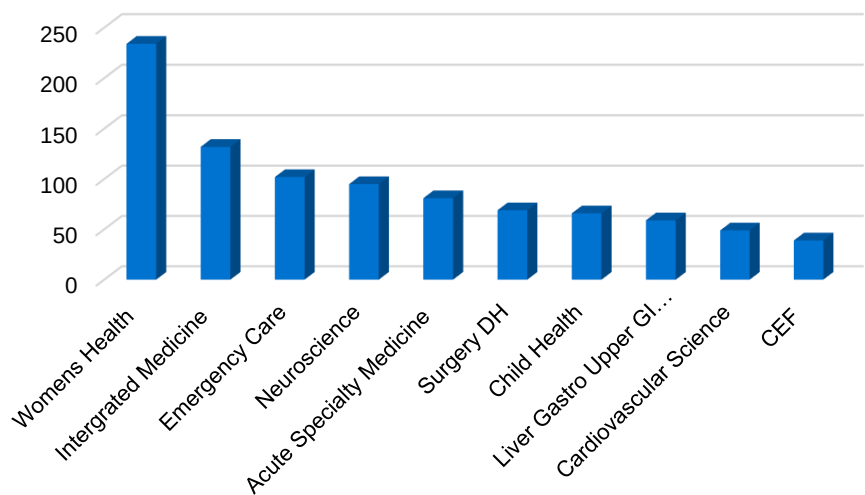


Figure 1. Top 10 Formal Complaints by care group

Of the complaints received, 664 related to Outpatients services. This represents 39% increase in the number of complaints relating to this area. Communication, attitudes and behaviours of staff, and matters relating to appointments were the most prominent reasons behind the complaints. Inpatient services received 317 complaints whilst 206 complaints related to emergency care. Apart from communication, complaints focused on patient care needs not being adequately met. Lastly, maternity services recorded 116 complaints that touched on behaviours from clinical staff including midwives, communication and patient care.

Data analysis indicated that the top five reasons behind formal complaints include communication, patient care, values and behaviours, admissions and discharges, and appointments.

During the reporting period, the Trust responded to 1,220 complaints with the following outcomes:

Upheld**	568
Partly Upheld**	559
Not Upheld**	93

** please note due to reporting period some complaints remain open as they will not be due for closure until June/July if red or amber and received in March/April

During the previous year, the approach to informal complaints was revised to better define complaints compared to the Patient Advice and Liaison Service. In 2025-2026, the Complaints Team managed 27 informal concerns which required mediations or relevant action to resolve but were not a formal complaint. This is a significant decrease from 2024-2025 when 530 informal concerns were actioned by the Complaints Team. While the reduction does not necessarily indicate fewer concerns overall, it does demonstrate that there is improved clarity around the distinction between Complaints and Patient Advice and Liaison service with appropriate management of issues through the correct service pathway.

2.1.1. Reopened Complaints

The NHS Complaints Standards are clear that once a response has been provided, a provider can signpost to the Ombudsman if the complainant remains unhappy. This

reflects a 'do it once and do it well' approach. However, the Trust has continued to reopen some complaints when a further response is felt could be offered, resulting in 48 reopened complaints during the year.

2.1.2. Learning From Complaints

The Trust complaints responses reflect the commitment to learning and improving from our complaints. Complaints do feed into individual appraisals and are shared with clinical supervisors where indicated. Responses detail personal and team reflections and discussion of complaints, including presentation of complaints in peer group teaching sessions. At a care group level complaints are a set agenda item to ensure specialties regularly consider their complaints and any themes noted. Examples of improvements and changes made are outlined below:

- Integrated Medicine – Pathway review instigated for those patients transferred from other sites for specialist review, to ensure clearer communication and appropriate prioritisation.
- Specialist Medicine - Staff to undertake enhanced training in compassionate conversations and honest discussions about deterioration prognosis.
- Neurosciences – Active monitoring of outpatient cancellations, working with appointments team to maximise clinic slots, in addition review of cancellation letters to ensure clear communication for patients.
- Radiology - Discussion and review of the ankle fracture pathway between Consultant Radiologists and Consultant Orthopaedic Surgeons has been initiated as result of the complaint review to improve for future patients.
- Women's Health – Drafting of wound care advice sheet for surgical patients (Gynaecology).
- Women's Health – Sonographers to attend bereavement training to enhance care provided to those patients suffering early pregnancy loss.
- Child Health - Weekly referral meeting set up to review and identify urgent referrals for sooner appointments.

These improvements will benefit future patients; the care groups present regularly to the Divisional Quality Governance meetings which includes complaints speciality and learning is monitored within this setting/ these meetings.

2.2. Parliamentary Health Service Ombudsman Referrals

Parliamentary and Health Service Ombudsman offers a second stage review where the Ombudsman considers there has been an injustice. Between 1st April 2025 and 31st March 2026, seven complaints were referred to the Ombudsman, four of which have been resolved informally in agreement with the complainant and the Ombudsman. In general, these resulted in low level financial remedies. Of those taken forward for full review the following outcomes are noted:

- A Denmark Hill Surgery and Critical Care complaint was partly upheld by the Ombudsman. However, there were no recommendations or actions required
- Two complaints were upheld; these are both being monitored through Divisional Quality Governance meetings:

- A Haematology complaint in regard to communication around the administration of medication, where the relatives had raised concern at the time of care delivery. Complaint taken for review concluded as upheld with recommendations.
- A Neuroscience complaint was upheld by the Ombudsman; recommendations were to consider how the care group will define and report serious incidents, ensure CT scan undertaken post shunt insertion prior to discharge. The action plan was submitted to the Ombudsman

The Ombudsman publishes reports for those complaints that have been subject to full review on their website.

2.3. Patient Advice and Liaison Service

The Patient Advice and Liaison service recorded **35,119** contacts during the period, reporting an overall reduction of 22% in comparison to 2024-25.

PALS Type	2023-2024	2024-2025	2025-2026	Change
Compliment	298	527	642	+ 21.82%
Concern	3,764	4,548	5,151	+ 13.25%
Enquiry	5,248	5,093	5,343	+ 4.90%
Information Request	11,004	16,731	11,358	- 32.11%
MyChart	9,016	17,724	12,461	- 29.69%
Feedback	131	172	164	- 4.65%

In contrast to previous years, information requests have decreased by 32% and the number of contacts relating to MyChart has fallen by almost 30%. This may signify a plateauing effect of the amount of support required by the Trust's communities since Epic implementation in October 2023 alongside the success of improvements deployed. However, the decrease needs to also be considered in the context of reduced staffing levels within MyChart helpdesk with the team operating at an average of 65% staffing capacity throughout the year.

The Trust has seen 22% increase in the number of compliments recorded (642) by Patient Advice and Liaison service with 15% of these received by the Women's Health care group.

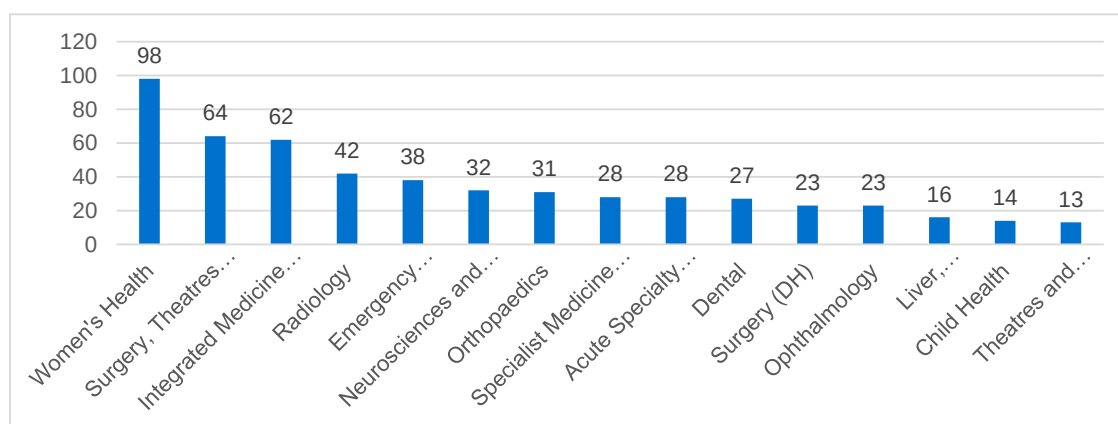


Figure 2. Patient Advice and Liaison service compliments received by care group (top 15)

Despite the overall reduction in the number of contacts recorded for the year, complex casework activity increased by 13% to 5,151 concerns reported. Since 2022, there has been a 243% increase in the number of concerns reported over the three-year period.

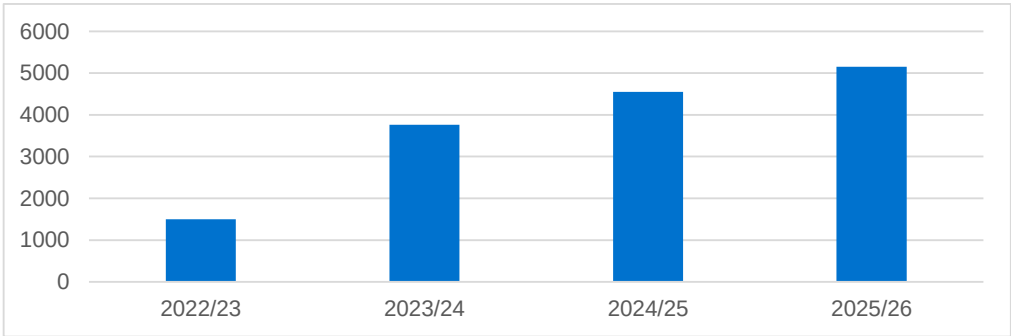


Figure 3. Concerns raised through Patient Advice and Liaison Service since April 2022

A total of 5,343 enquiries were also recorded, representing a further 5% increase in activity. The most significant increase in casework compared to previous years was within Division A, which experienced a 24% increase, particularly across Women’s Health and Radiology care groups.

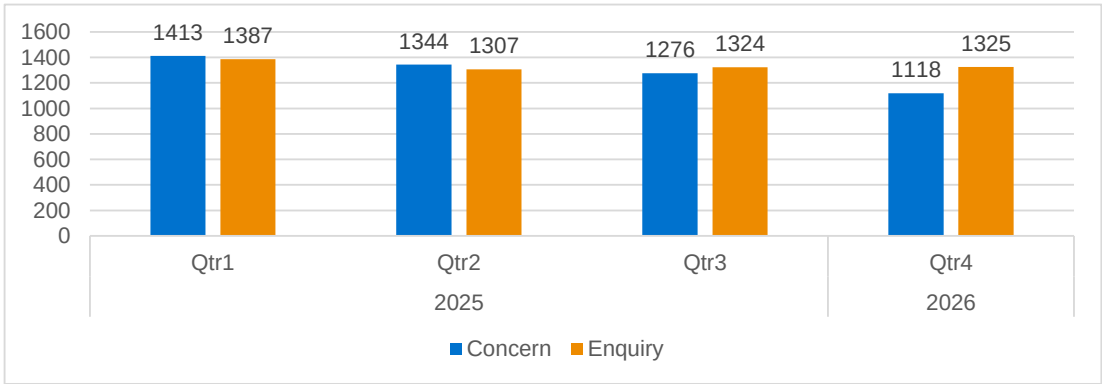


Figure 4. Patient Advice and Liaison service concern and enquiry breakdown by quarter

The Trust responded to and resolved 31,629 contacts within 5 working days, achieving an overall response rate of 90%, consistently exceeding the key performance indicator of 85%.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% closed within 5 days	88.9	87.9	91.9	91.5	91.2	92.9	91.4	90.3	90.5	89.0	88.0	85.9

Appointments and communication issues continue to be the most prominent themes identified across all Patient Advice and Liaison contacts during 2025-2026 with 7,842 cases recorded across these two categories. Compared to the previous year, this represents a 15% increase in the number of contacts specifically raised by patients and relatives relating to appointments, communication or both. As communication is a cross-cutting theme that underpins patient experience, it consistently emerges as a leading area of feedback. Effective communication is a fundamental part of good patient care.

Notably in June 2025, July 2025 and January 2026, the number of contacts relating to delays in patients receiving appointments and issues reported in communicating with

patients spiked. The industrial action taken by resident doctors in July 2025 and December 2025 may be associated with the prevalence due to clinic alterations. However, the January 2026 increase has not plateaued and is continuing into the current financial year.

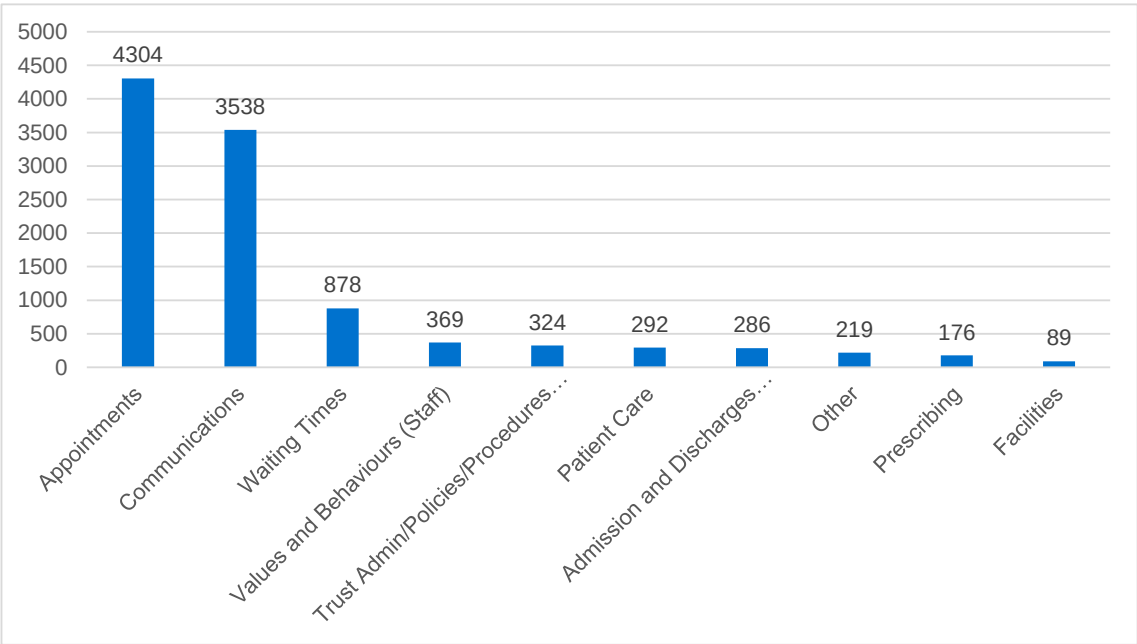


Figure 5. Patient Advice and Liaison service top 10 subjects

Further notable themes include:

- Long waiting times for surgery and cancelled procedures – uncertainty and communication quality for patients waiting.
- Communication with patients – concerns with fragmented communication, limited explanations, inconsistent information, poor access to clinical teams, and the quality of communication.
- Communication with relatives/carers regarding inpatient care, treatment and management – families feeling excluded or uninformed about care plans, requiring help to access support/information, clarification of treatment, updates, delays or changes in care.
- Discharge decisions and communication – relatives/carers raise concerns and challenge decisions when they feel a discharge is premature, planned discharge to home v transfer options for continuous care, medication and follow-up arrangements (including with community teams).
- Delay in reporting back to patients/ GP Practices on test/imaging results
- Delay in providing follow-up appointments or other discharge plan recommendations.
- Delays in providing referrals to other clinical teams.

2.4. Friends and Family Test

The Trust recorded 25,641 responses to the Friends and Family Test survey between April 2025 and March 2026, 4% improvement from the previous year. The Trust’s Friends and Family Test scores improved across inpatient and day case, maternity and emergency care services, with a minor decrease in outpatient. Emergency care services have improved by 15% since 2022.

Service	2022-2023 score	2023-2024 score	2024-2025 score	2025-2026 score	Change
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Inpatient and Day Case	93.8%	92.5%	93.4%	95.6%	+ 2.2
Outpatient	90.3%	90.6%	94.4%	94.3%	- 0.1
Maternity	88.9%	91.7%	91.1%	94.2%	+ 3.1
Emergency	64.2%	67.5%	72.1%	73.6%	+1.5

Service	Top 3 Positive Themes	Top 3 Negative Themes
Inpatient & Day Case	Staff Behaviour Patient Care Emotional and Physical Support	Food and Drink Facilities Waiting
Outpatient	Staff Behaviour Patient Care Waiting	Waiting Communication Facilities
Maternity	Patient Care Staff Behaviour Emotional and Physical Support	Communication Facilities Waiting
Emergency	Staff Behaviour Patient Care Waiting	Waiting Communication Quality of Care

2.5. Demographics of respondents

Over the past 12 months, there has been increased focus on capturing protected characteristics of individuals providing feedback and sharing their experiences. This has included the introduction of new processes and targeted training for Patient Advice and Liaison Service staff. As a result, approximately 90% of casework recorded in 2025-2026 included partially completed or completed protected characteristic data, a 19% increase from the previous year.

Analysis of Friends and Family Test respondents and Patient Advice and Liaison Service contacts identified broadly consistent demographic patterns across age, gender, ethnicity and disability. Overall, the data suggests that the average respondent identified themselves as a 55-year-old female of white ethnic origin and living with a long-term health condition or illness. This is broadly consistent with national NHS patterns, where engagement is typically higher among older patients, females, and those with ongoing health issues. However, when compared to the diverse and relatively younger population served by King's College Hospital across Southwark, Lambeth and Bromley, there is indication that the respondents are not fully representative. For instance, Southwark and Lambeth has a median age in the early 30's with just over half the population female. Over the next 12 months, there will be further work to explore the demographic profile of our patient population to assess whether the contacts and respondents are representative.

2.5.1. Patient Advice and Liaison Service

The age of the patient involved in raising a concern or enquiry varied significantly, with the average age of 55 years old. Although the age was skewed positively above the age of 55, another peak between age of 28 to 45 years old was also noted. Within this peak, a significant portion of respondent identified as female. Overall, 60% of contacts identified as female and the most prominent disability types of a long-term health condition or illness.

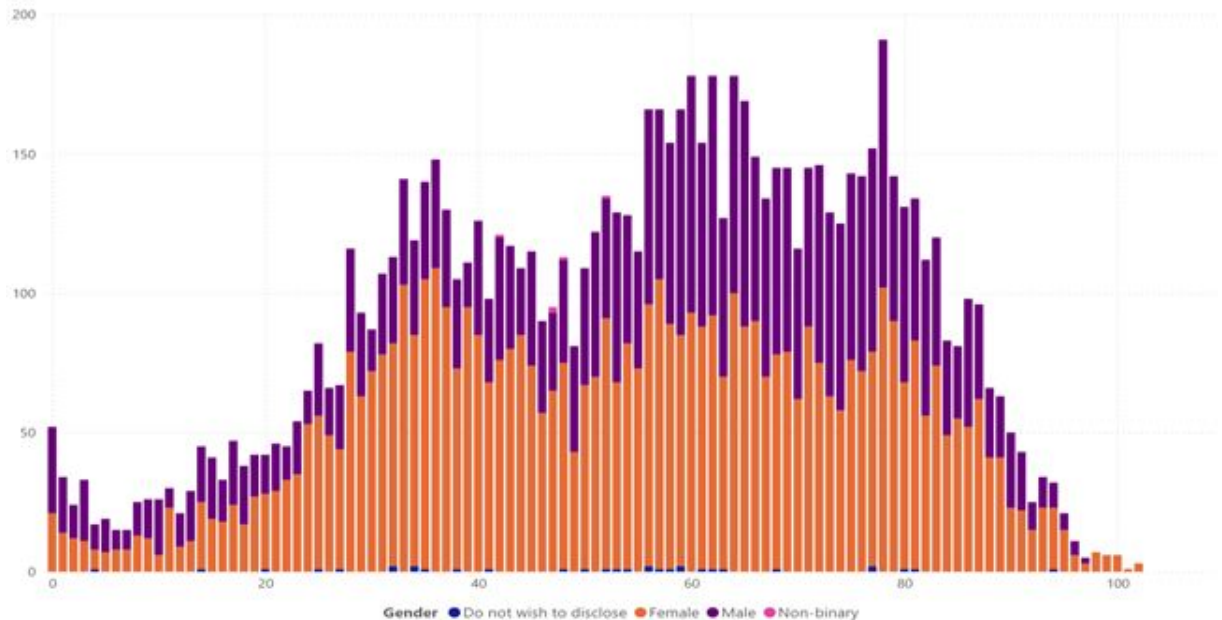


Figure 6. Age of the patient involved in concern or enquiry raised through Patient Advice and Liaison Service, by the gender identity

66% of contacts who provided their ethnicity identified as White British. Patients who had a long-term illness or health condition were more also likely to raise a concern, compared to other contacts who reported other types of disability. Among those who provided information on religion or faith, the majority identified as Christian or reported having no religion and the distribution between concerns and enquiries was broadly evenly distributed.

2.5.2. Friends and Family Test

Overall, 23,371 respondents provided some or all their protected characteristics, which equated to 91% of responses collected. Similar to Patient Advice and Liaison Service, many respondents were over the age of 50 years old, although a secondary peak could be seen for those in their 30's.

Analysis of experience of care based on positive Friends and Family Test score, indicated poorer experience for patients with a Learning Difficulty and Learning Disability including Autism. Across all protected characteristics, respondents who chose not to disclose their demographic information reported a poorer experience, indicating potential reluctance to share this information in certain incidents although the numbers are small in comparison. Patients who identified as bisexual were more likely to negatively score their experience. Although analysis of comments did not highlight a correlation, it also highlights the importance of collecting demographic information to continuously monitor when certain groups of people may experience poorer care.

2.5.3. Complaints

Formal complaints received during the year were predominantly associated with patients aged between 26 to 55 years old, accounting for 48% of complaints. These were mainly

raised directly by the patient. Complaints received for patients over the age of 55 were more likely to be from both the patients and their relatives. Looking at the gender of the patients involved in the formal complaints, 65% were female. Females between 24 to 45 years old were significantly more likely be the patient in a complaint compared to males within the same bracket. The average age of a male patient in a complaint was 50 years old and above with a prominent spike at 78 years old. Analysis of the ethnicity recorded highlighted patients from a White or Black ethnic background were more likely to raise a severe complaint compared to other groups. However, as up to half the complaints did not have an ethnicity recorded, it is unclear whether there is a correlation between ethnicity and severity of complaint. In Maternity, patients who identified as Black ethnicity were more likely to raise a complaint with a red rag rating, although the numbers were minimal, highlighting the importance of collecting protected characteristics to monitor experiences of care.

3. Division A

3.1. Complaints

Division A received 440 complaints in 2025-2026 broken down as follows:

Red	64
Amber	174
Green	202

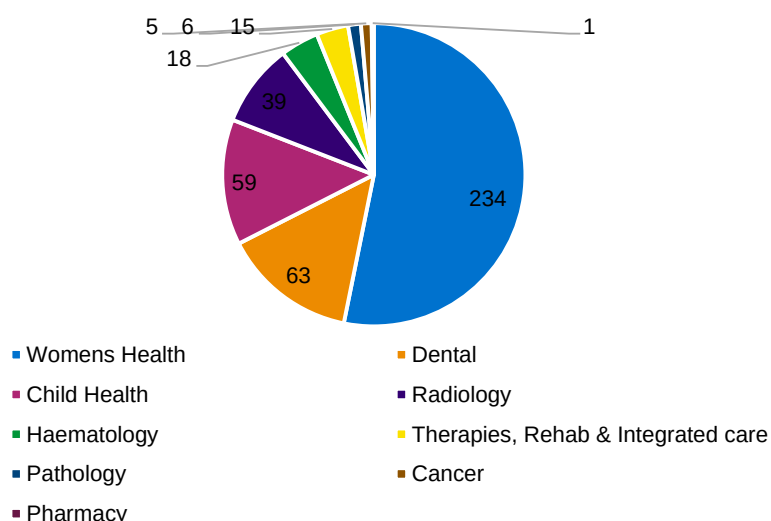


Figure 7. Figure 8. Formal Complaints received for Division A

Women's Health care group received 88% of the complaints for Division A. Compared to the previous year, the number of formal complaints received by this care group has almost doubled. Issues around communication with the patient, including patients not feeling listened to and having conflicting information presented, were the most prominent subjects of complaints. Values and behaviours of staff were also commonly highlighted, particularly within Gynaecology and Antenatal Care, where patients told us about instances of incivility and unprofessional behaviour among nursing, midwives, medical and administrative staff. Patients within the Women's Health care group have also reported their care needs not being adequately met (29) or failure to provide adequate care.

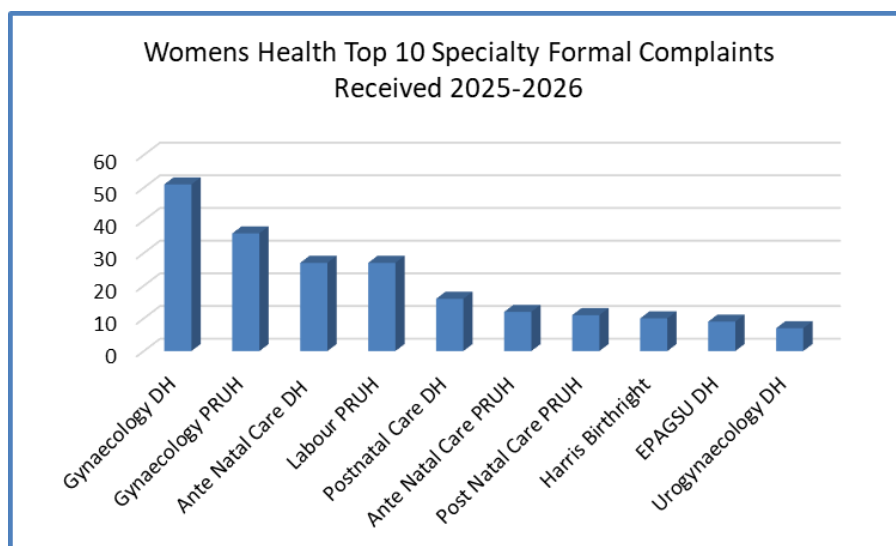


Figure 8. Breakdown of Formal Complaints specialty in Women's Health

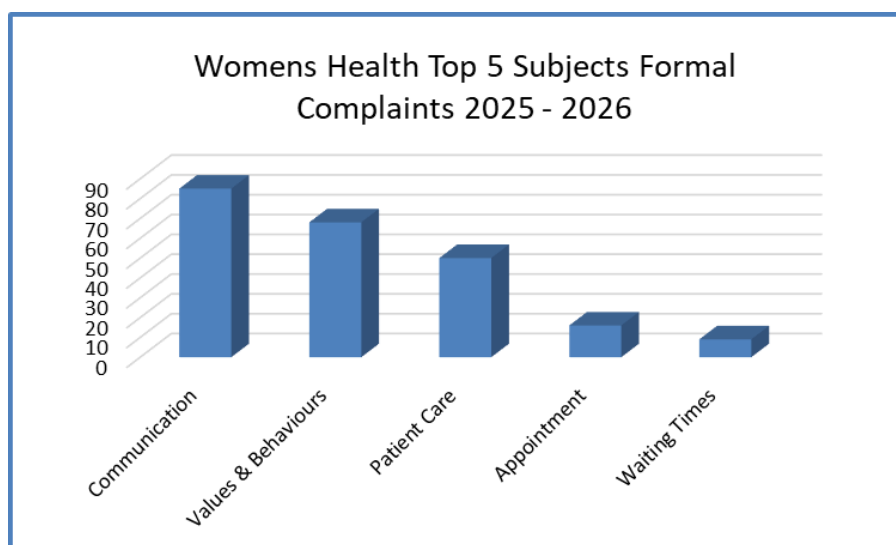


Figure 9. Top 5 subjects in Women's Health Formal Complaints

Within Division A, further 14% of complaints related to Dental care group (63), 16% increase compared to the previous year. Communication and appointments were the most prominent themes with complaints primarily relating to difficulties in communicating and delays in appointments or referrals impacting care.

3.2. Patient Advice and Liaison Service

A total of 2,669 contacts were recorded for Division A between April 2025 to March 2026. Overall, there has been a 27% increase in the number contacts received, although there has also been a 28% increase in the number of compliments.

PALS Type	2023-2024	2024-2025	2025-2026	Change
Compliment	104	166	213	+ 28.3%
Concern	579	886	1,087	+ 22.7%
Enquiry	791	1,058	1,323	+ 25.0%

Information Request	5	5	*	*
Feedback	30	38	46	+ 21.0%

Women's Health care group received the highest number of Patient Advice and Liaison service contacts within the Division, accounting for over 35% of casework. Women and birthing people raised concerns relating to long waiting times to receive appointments as well as significant waiting times for gynaecological operations and procedures. These concerns were further exacerbated by difficulties in contacting the clinics whilst in pain. Within Antenatal care, women highlighted incidents of incivility and issues of communication. Compared to the previous year, there has been 24% increase in case work for Women's Health overall. Concerns and enquires related to Gynaecology rose by 17%, whilst maternity rose by 33%.

Radiology care group received the second highest number of contacts within the division, including 396 concerns raised. There was 11% increase in the number of concerns overall and 35% increase in total casework with a recurring theme of patients being unable to contact radiology teams. Delays in appointments and significant late reporting of results were also highlighted. Further data analysis identified a significant rise in concerns relating to CT scanning, which nearly doubled compared to the previous year and were largely driven by delays in communicating results to patients.

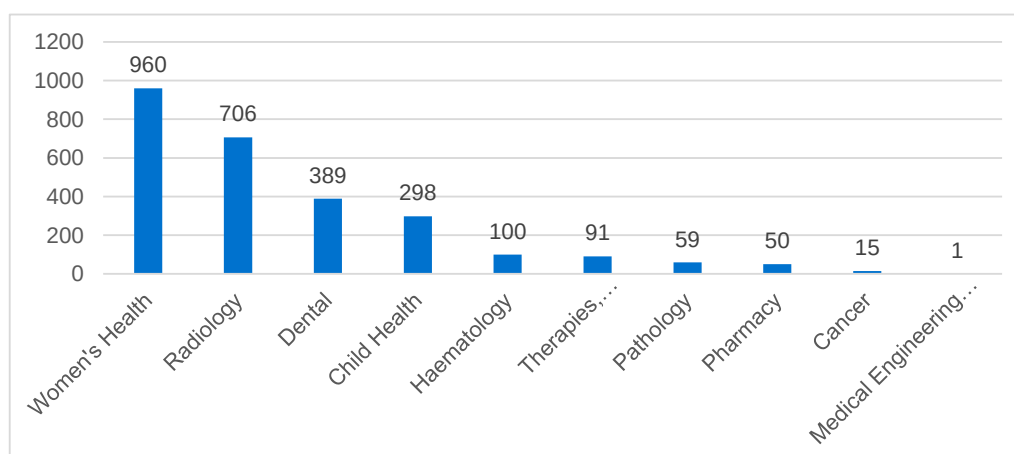


Figure 10. Number of Patient Advice and Liaison Service contacts for Division A

Division A received 213 compliments with 46% attributed to Women's Health. These were predominately for maternity, accounting for 71%. Feedback mentions kind and professional staff providing exemplary care and treatment. Here are some examples of positive comments:

Gynaecology: *"I was referred under the 2-week wait pathway and was seen by a very calm and kind doctor who discussed the treatment I would need. The arrangements were all made swiftly by the admissions team. The pre-assessment staff were kind and explained everything to me and on the day of my surgery, staff took care of me and while I was so nervous, the whole service was brilliant. The kindness, care and professionalism from everyone really stood out. I am also enjoying the experience of MyChart."*

Radiology: *"I had to attend my appointment in the Nuclear Medicine Department, and I cannot lie flat due to arthritis in both knees and left hip. The staff found pillows and wedges to elevate my legs and to support my back pain so that I could have two scans. Afterwards, the staff assisted me to my mobility scooter and to the accessible toilet. The staff were brilliant and I would like to pass on my thanks".*

Dental: “I felt it was important to write and express my heartfelt thanks for the exceptional care my son received during a very difficult and worrying time for our family. Following his frontal sinus fracture on 6 December 2025, and his transfer from the Princess Royal University Hospital to Denmark Hill, the entire team showed extraordinary professionalism, kindness and dedication throughout his care. Thanks to your expertise and support, my son has made a remarkable recovery, something for which I will always be deeply grateful”

Child Health: “Our son underwent an emergency appendectomy. The whole team on the short stay paediatric ward took such good care of him throughout his stay. We feel extremely lucky to have a hospital like King’s, so close to us.”

3.3. Friends and Family Test

3.3.1. Inpatient and Day Case

Inpatient and day case service for Division A received an overall score of 97.1% for the year from 1,329 responses, 0.9% increase in score from the previous year.

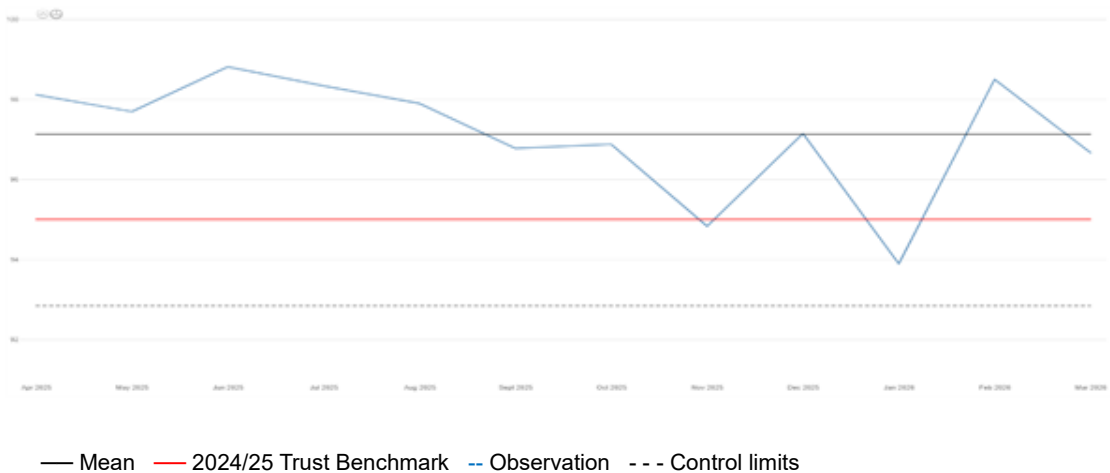


Figure 21. Friends and Family Test performance for inpatient and day case services for Division A

When looking at sentiment analysis, 4,012 sub-themes within the free text comments were identified of which 75% were positive in nature. There has been a small increase in positive themes identified, supporting the overall improvement of recommendation scores. Sub-themes were grouped, and the main positive and negative themes were analysed:

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Staff Behaviour	1,062	Facilities	396
Patient Care	1,015	Food and Drink	271
Emotional and Physical Support	146	Communication	233

Throughout the year, patients commended staff on their positive attitudes, quality of care and emotional support provided which was a significant portion of feedback. Staff were often described as friendly and compassionate, which had a positive influence on their experience. Facilities were commonly noted as requiring improvement, which included

maintenance of toilet and shower on the wards, temperature and cleanliness. Food and drink were also mentioned often. Waiting for treatment, medication and support was frequently reported, along with communication with patient.

3.3.2. Outpatient

Outpatient service for Division A received an overall score of 97.0% for the year from 893 responses.

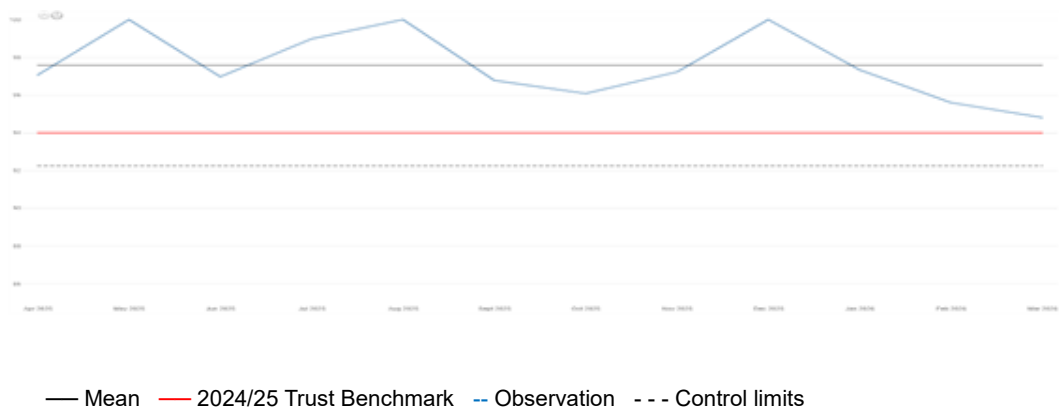


Figure 32. Friends and Family Test performance for outpatient services for Division A

88% of 2,504 sub-themes identified from the free-text comments were positive in nature. Sub-themes were grouped, and the main positive and negative themes were analysed:

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Staff Behaviour	744	Waiting	63
Patient Care	560	Communication	28
Emotional and Physical Support	173	Facilities	28

Overall, over 50% of feedback focused on praising the care provided and the staff on their conduct and attitude. Respect and dignity were often displayed and staff were described as informative and caring. Delays in getting appointments, the time spent in the waiting room and appointment were seen to be contributors to poorer experience scores. Some patients also felt that communication of reasons behind delays should be provided more often.

3.3.3. Maternity

Maternity services received an overall score of 94.2% for the year and from 841 responses; a small increase compared to the previous year.



Figure 43. Friends and Family Test scores for maternity services

When looking at sentiment analysis, 2,360 sub-themes within the free text comments were identified, of which 71% were positive in nature. The sub-themes were grouped, and the main positive and negative themes were analysed:

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Staff Behaviour	605	Communication	94
Patient Care	565	Facilities	72
Emotional and Physical Support	102	Waiting	72

Staff were continuously praised for the quality of care provided throughout the year. Many patients reported positive interactions with staff, commenting on their professionalism and respect and dignity shown. Within antenatal, issues with communication, overrunning of clinics and some incivility contributed to poorer scores throughout the year. In Labour and postnatal wards, women noted conflicting information was sometimes provided or wanted to be kept informed more regularly. Facilities in labour wards were mentioned as requiring some improvement, such as controlling the temperature and cleanliness of toilets.

3.4. Improving our services in Division A

Utilising patients' feedback, the Division has deployed numerous improvement initiatives with a sample of these highlighted below:

Care group	Service	Patient feedback	Improvements undertaken
Women's Health	Maternity	New parents wanted to learn more about infant first aid.	Infant first aid sessions led by St John Ambulance are regularly (monthly) delivered in the Oasis unit at Princess Royal University Hospital
Cancer Services	All	More support needed for patients post treatment – highlighting what's available	Bespoke task and finish group set up to look at potential to expand the content of health and well-being events and publicity
Child Health	Inpatient	Lower scores on the Care Quality	Recruitment of more play specialists

		Commission's survey for staff playing with children or doing any activities with them while they were in hospital	Spread a Smile entertainers enrolled to provide activities such as storytelling and 4 x music sessions per month. This also includes additional special events throughout the year.
Child Health	Inpatient	In the CQC survey, parents reported the wards were not always suitable for children of 0-7 years of age.	Play specialists deployed in all ward areas Playrooms have been refurbished.
Radiology - Breast Screening	Outpatient	Patients wanted clearer information and access to correspondences	Breast screening awareness video developed to encourage attendance and improve uptake. Development of easy-read correspondence for women with learning disabilities to improve accessibility and understanding. Introduction of digital invitation and results letters by the Breast Screening Hub to improve accessibility and communication with clients

Example outcomes from improvements

Following the Infant first aid sessions led by St John Ambulance, attendees were asked to share their feedback and opinions to assess impact. Respondents were overwhelmingly positive about the sessions and reported feeling more confident and prepared to provide basic infant life support. The training demonstrated a reduction in anxiety around dealing with emergencies and 100% would recommend the course to other parents.

4. Division B

4.1. Complaints

Division B received 500 complaints in 2025-2026 broken down as follows:

Red	138
Amber	184
Green	500

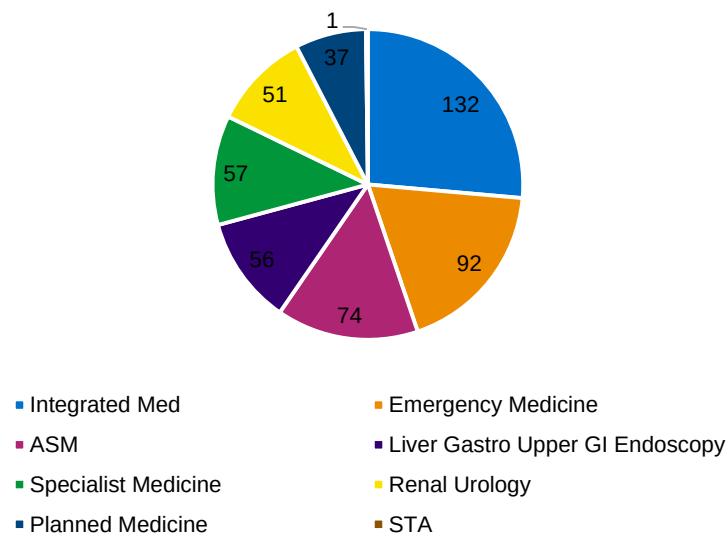


Figure 54. Formal Complaints recieved for Division B

Within the Division, 26% of complaints received were for Integrated Medicine care group (132). The Emergency Department at Princess Royal University Hospital received the largest portion of these complaints and often included the theme of care needs not being adequately met along with lack of communication. Staff attitude and the waiting time within the department also featured in the complaints.

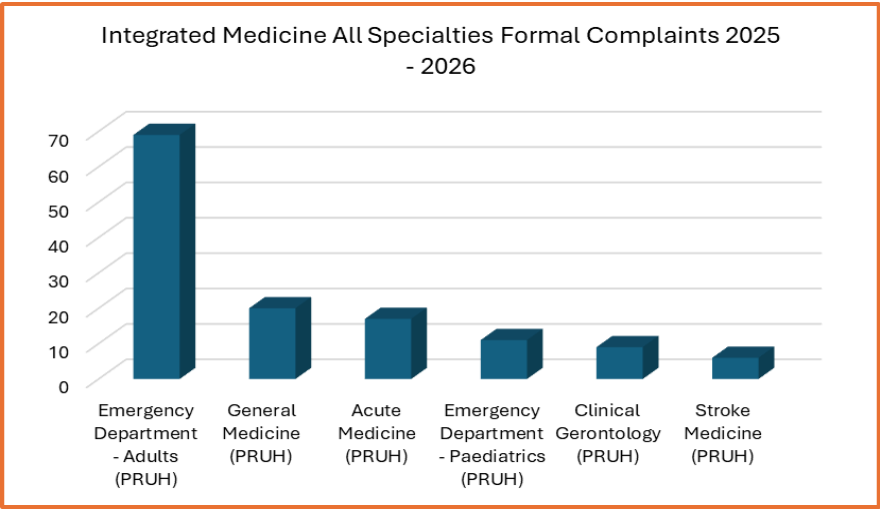


Figure 15. Breakdown of Formal Complaints in Integrated Medicine care group

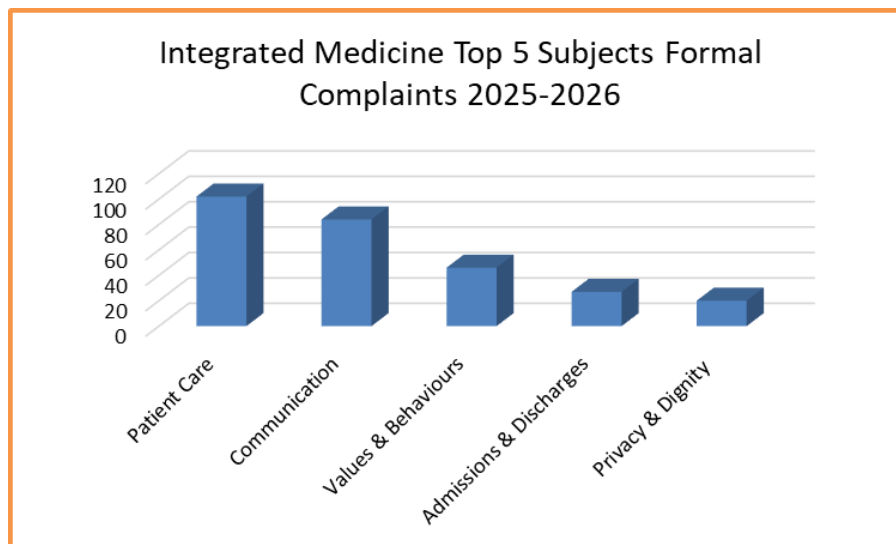


Figure16. Top 5 subjects in Integrate Medicine

Emergency Medicine care group had the second highest number of complaints (92), all for the Emergency Department at Denmark Hill. The themes of these complaints shared some similarity with Princess Royal University Hospital's Emergency Department, but there was a slight greater focus of the attitude displayed by nursing and medical staff.

74 complaints were received for Acute Specialty Medicine, a small decline of 6%. Communication, discharge arrangements and patients care were some of the themes noted within the complaints.

4.2. Patient Advice and Liaison Service

A total of 3,351 contacts were recorded for Division B between April 2025 to March 2026. Overall, there has been a 5% increase in the number of contacts for the Division.

PALS Type	2023-2024	2024-2025	2025-2026	Change
Compliment	115	183	191	+ 4.8%
Concern	1,115	1,597	1,803	+ 12.9%
Enquiry	885	1,333	1,296	- 2.8%
Information Request	7	9	1	- 88.8%
Feedback	35	49	60	+ 22.4%

Integrated Medicine care group received 660 contacts during the year, 25% increase compared to the previous year. The primary themes related to communication with patient and relatives, including delays in receiving information. Within the care group, the Emergency Department received the highest number of contacts; however, the General Medicine specialty also accounted for a significant volume of casework with concerns raised by relatives regarding communication and discharge processes on the wards.

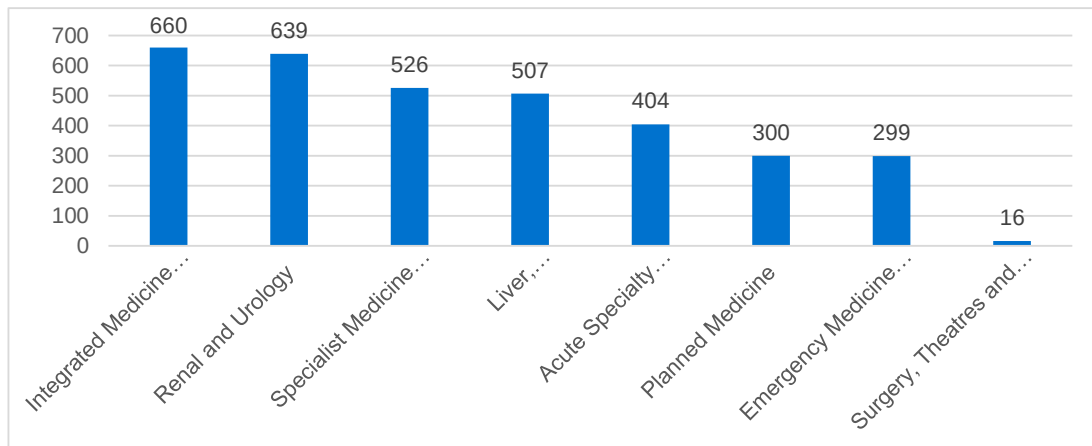


Figure 17. Number of Patient Advice and Liaison Service contacts for Division B

Renal and Urology care group recorded 639 contacts during the year with 40% of these relating to Urology. There has been 17% increase in contacts and 30% increase in concerns compared to the previous year. Analysis of themes highlighted issues with communicating with the patients and family, issues with the length of time waiting for surgery and delays in receiving an appointment.

Division B recorded 191 compliments, almost 5% increase when compared with the previous year. Feedback mentions exemplary care and treatment.

Accident and Emergency department at Denmark Hill: *“After falling heavily in the park, I went to King’s Emergency Department, which was the first time I have been there. From registration through to pharmacy, I was looked after professionally and compassionately by staff who helped me through a painful day as easily as possible. In a difficult and stressful working environment, some staff showed enormous patience and expertise.”*

Same Day Emergency Care at Princess Royal University Hospital: *“I attended SDEC after a fall. I expected to be waiting for hours but the staff were efficient, and I had tests carried out quickly and a young volunteer came and talked to me and that was lovely. I am grateful for the way I was looked after and for the kindness of your staff and volunteer to be recognised.”*

Specialist Medicine: *“I am under the care of several different specialists, including Gastroenterology, Cardiology and Respiratory, and would like to thank the secretaries who I have dealt with. Without exception, they have been empathetic, proactive and supportive. They have liaised with consultants when I needed questions answered, organised sooner appointments where possible and always helpful and pleasant”.*

Renal and Urology: *“I underwent tests with follow up scans under the care of Urology team. On all occasions, I was treated with care and dignity, and staff explained things to me clearly checking to make sure that I understood”.*

4.3. Friends and Family Test

4.3.1. Inpatient & Day Case

The overall positive experience scores for Inpatient and Day Case in Division B was 95.1% from 8,107 responses, 2% improvement in positive experience compared to the previous year and a statistically significant improvement when looking over the 24-month period.

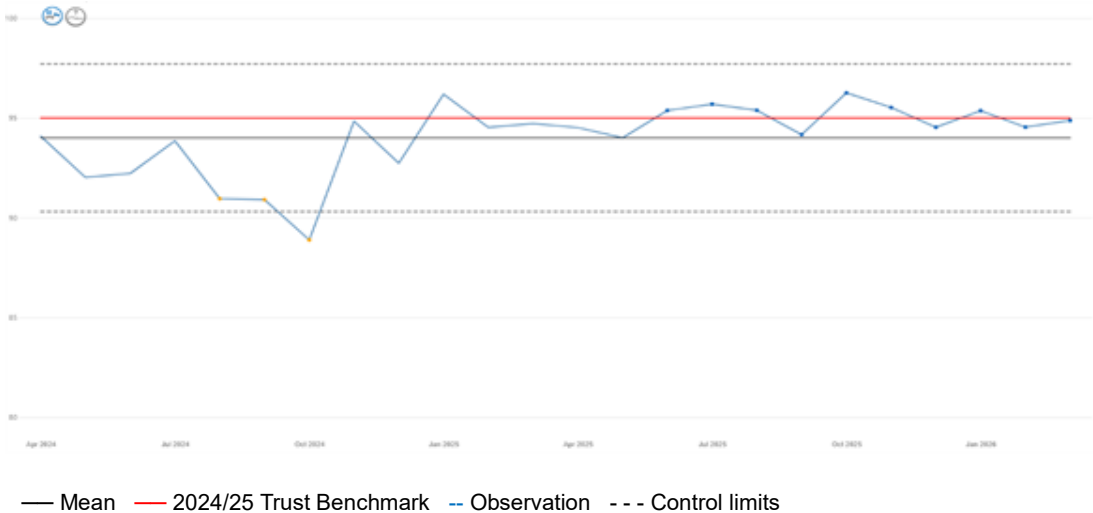


Figure 18. Friends and Family Test scores for inpatient and day case services for Division B

19,549 sub-themes within the free text comments were identified of which 79% were positive in nature. The sub-themes were grouped, and the main positive and negative themes were analysed:

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Staff Behaviour	5,786	Food and Drink	532
Patient Care	4,698	Facilities	432
Emotional and Physical Support	494	Waiting	401

Analysis of positive sentiments highlighted high levels of care and positive attitude from staff. This included staff being seen as approachable and displaying respect towards patients. Food and drink comments throughout the year suggested higher quality and availability of food could improve experience. Disruption to sleep due to noise was also frequently mentioned. Suggestions for improvement in facilities included temperature, additional space around beds, cleaner areas and maintenance of toilets or shower facilities.

4.3.2. Outpatient services

Division B collected 2,707 responses from Outpatient services with an overall score of 96.6%. Although there was a small decrease in the positive rating of experience, there was a 373% increase in the number of responses compared to the previous year through several initiatives deployed with departments to increase responses.

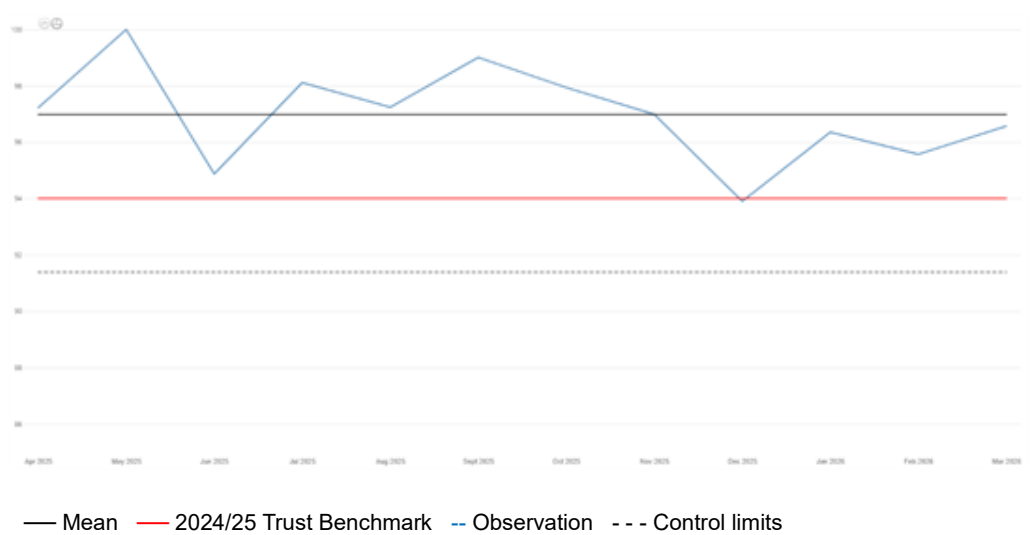


Figure 196. Friends and Family Test scores for outpatient services for Division B

88% of 7,385 sub-themes identified from the free-text comments were positive in sentiment and grouped into the following themes:

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Staff Behaviour	2,253	Waiting	152
Patient Care	1,520	Communication	97
Communication	381	Facilities	65

Many patients reported feeling listened to by the healthcare professionals during their appointments. In contrast, clinics overrunning and delays in appointments impacted experience and were often mentioned as an improvement suggestion. Further suggestions for improvement included better information on what to expect prior to appointments.

4.3.3. Emergency Care & Same Day Emergency Care

Emergency service received an overall score of 67.8% for the year from 3,099 responses.



Figure 20. Friends and Family Test scores for Emergency services Division B

For emergency services, 12,387 sub-themes in free-text comments were noted and grouped into larger main themes. Just over half of the themes identified within comments were positive in sentiment.

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Patient Care	1,523	Waiting	1,732
Staff Behaviour	1,448	Communication	603
Waiting	525	Quality of care	603

In line with previous years, waiting was the most common theme identified throughout the year, which was predominately negative in sentiment. In the Emergency Departments at both sites, significant amount of time spent waiting to be seen by a medical professional and receiving diagnostic tests and treatment, greatly contributed towards poorer experiences. Patients also noted the department feeling extremely busy with limited seating. However, staff were praised for their professionalism and expertise. Within the Same Day Emergency Care setting, patients were more positive about their experience, despite waiting being identified as an area for improvement.

4.4. Improving our services in Division B

As a result of patient feedback, the Trust continues to deploy improvement initiatives including:

Care group	Service	Patient feedback	Improvements undertaken
Specialist Medicine - Diabetes	Inpatient	Patients reporting communication issues with knowing how to manage diabetes care after discharge with community services	Written discharge plan from diabetes team initiated and available to GP and community teams
Specialist Medicine - Diabetes	Outpatient	Patients contacting the Trust for questions about their diabetes care.	Virtual clinics were started in October 2025 to capture some of the patient phone calls and

			reviews that occur frequently in-between clinics.
Specialist Medicine - Diabetes	Outpatient	Patients missing appointments and unsure the reason behind being asked to attend the clinics.	Volunteers deployed to telephone patients prior to clinic to ensure patients still require appointment and provide support on directions
Emergency Medicine & Integrated Medicine	Emergency	Errors in patients sent through incorrect pathways and therefore prolonging length waiting before receiving care.	Changes made in thresholds to determine patient pathway to Emergency Department or Same Day Emergency Care
Emergency Medicine & Integrated Medicine	Emergency	Patients reported delays in registering on arrival and observations in the department showed long queues.	The entrance of the Emergency Department entrance was refurbished to create a larger space and improve the patient flow. The Digital Front Door (eTriage) was launched to improve triaging patients to Urgent Care or Emergency Care. Patients use iPad kiosks to self-register on arrival and support is available from volunteers.
Emergency Medicine & Integrated Medicine	Emergency	Lower CQC scores in patients feeling safe whilst waiting and incidents of violence and aggression towards staff.	Choose Kindness campaign was launched, aimed at creating a safe and inclusive environment for all. Posters are placed around the departments.

Example outcomes from improvements

Following the launch of Digital Front Door in Emergency Department, patients were asked to provide feedback on using the kiosk to assess its effectiveness and impact. Many respondents positively rated their experience of using the touchscreen to check-in and highlighted their ease of use. The feedback provided also emphasised the importance of the volunteers support for those who require assistant to complete the check-in.

5. Division C

5.1. Complaints

Division C received 448 complaints during the year broken down as follows:

Red	92
Amber	150
Green	206

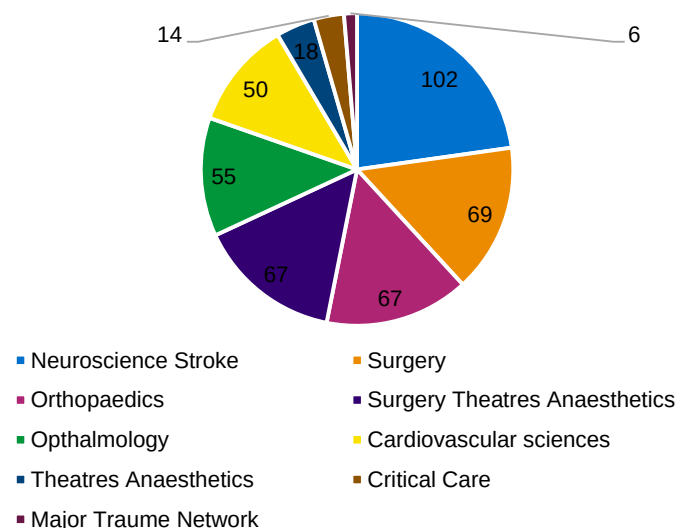


Figure 21. Formal Complaints received for Division C

Neuroscience care group received 102 complaints, 9% increase compared to the previous year. Within the care group, neurosurgery accounted for a significant portion of these complaints that focused on poor communication provided to patients, waiting times for operations, adequate care not provided and cases of incivility displayed by medical staff.

The Surgery care group at Denmark Hill received 69 complaints, a small increase compared to the previous year. The wait for operations and communication issues was noted within the complaints. In the Orthopaedic care groups, similar themes were also highlighted.

5.2. Patient Advice and Liaison Service

A total of 4,800 contacts were recorded for Division C between April 2025 to March 2026. June 2025 saw the highest number of contacts with a total of 532. In comparison to the previous year, there has been a 7% increase in the number of contacts.

PALS Type	2023-2024	2024-2025	2025-2026	Change
Compliment	98	147	214	+ 45.6%
Concern	1,307	1,871	2,079	+ 11%
Enquiry	1,714	2,425	2,454	+ 1.1%
Information Request	1	6	13	+ 116%
Feedback	22	54	35	- 35.2%

The Neurosciences care group received the highest number of contacts for both the Trust and Division C with a total of 1,339 contacts including 635 concerns raised. Of the total casework for the Division, 20% is attributed to the care group with concerns predominantly relating to Neurosurgery. Throughout 2025-2026, feedback was consistent in patient reporting negative experiences navigating the pathways, challenges in contacting the clinical departments for support and long waits for appointments, surgery, information and results. The delays for specialist neuro imaging results have impacted patients waiting for their care to be reviewed and this has been

an ongoing situation for some time and is a principal reason for contact and support. Patient feedback has also highlighted difficulties experienced by patients trying to contact clinical teams.

The Ophthalmology care group received 803 contacts during the year, 11% increase from the previous year, with a focus on issues concerning appointments, including delays, communication with the patient and failure to provide follow-up as the most notable themes. The delays affecting patients attending eye injection clinics (Macular degeneration injections) have been ongoing and the service has continued to work to increase capacity and mitigate delays. Recruitment restrictions and loss of essential administration posts have compounded the quality of communication and impacted patient experience. Additional resource for injection capacity has been approved in June 2025 for a fixed period.

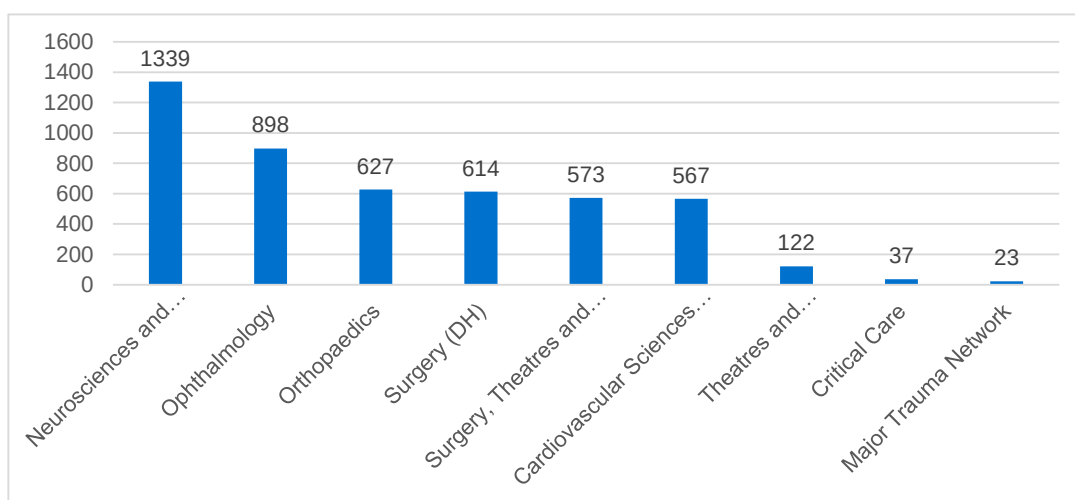


Figure 22. Number of Patient Advice and Liaison Service contacts for Division C

Throughout 2025-2026, Division C recorded 214 compliments, 45.6% increase when compared with the previous year. Feedback mentions exemplary care and treatment.

Neurosciences and Stroke: *“Throughout the time my dad was an inpatient on Ontario Ward (Orpington), you worked tirelessly to support him, not just medically but as a person. He was a long stay patient receiving rehabilitation. His needs were complex, the journey was long, and the discharge process was anything but straightforward, yet at every stage, you continued to show patience, determination and genuine compassion. The doctors were thoughtful and the nursing team gave reassurance, encouragement and dignity every single day.”*

Ophthalmology: *“I have been a patient of the Eye Department for over 23 years but attended a different clinic today. I am so impressed with the staff, equipment and how the tests were done was exceptional. They were all carried out by a member of staff who kept me informed of what was happening; he treated me with care and dignity as a 72-year-old lady, disabled with limited mobility. I enjoyed my experience.”*

Orthopaedics: *“I would like to thank all the team, the Surgeon who did my operation, the Plaster Room, and all the nurses who looked after me during my hospital stay on Surgical 5 (PRUH). The service I received, and the care given, was excellent. Everyone was so caring and helpful, and everything was explained in detail, regarding my treatment.”*

Surgery, Theatres, Anaesthetics, Endoscopy: *“I was a patient in the Day Surgery (PRUH) and wanted to tell you how outstanding two nurses were that looked after me.”*

They both showed such kindness and compassion and went over and beyond to make me comfortable both emotionally and physically. They anticipated my every need and allowed me privacy while keeping an eye on me from a distance. I had a troublesome day with regards to my procedure, but they chatted to me to keep my spirits up. I also witnessed them care for another patient who was hard of hearing with amazing patience and empathy.”

5.3. Friends and Family Test

5.3.1. Inpatient and Day Case

Inpatient and Day Case service in Division C received an overall score of 96% from 6,910 responses, remaining largely the same with a 0.2% difference.

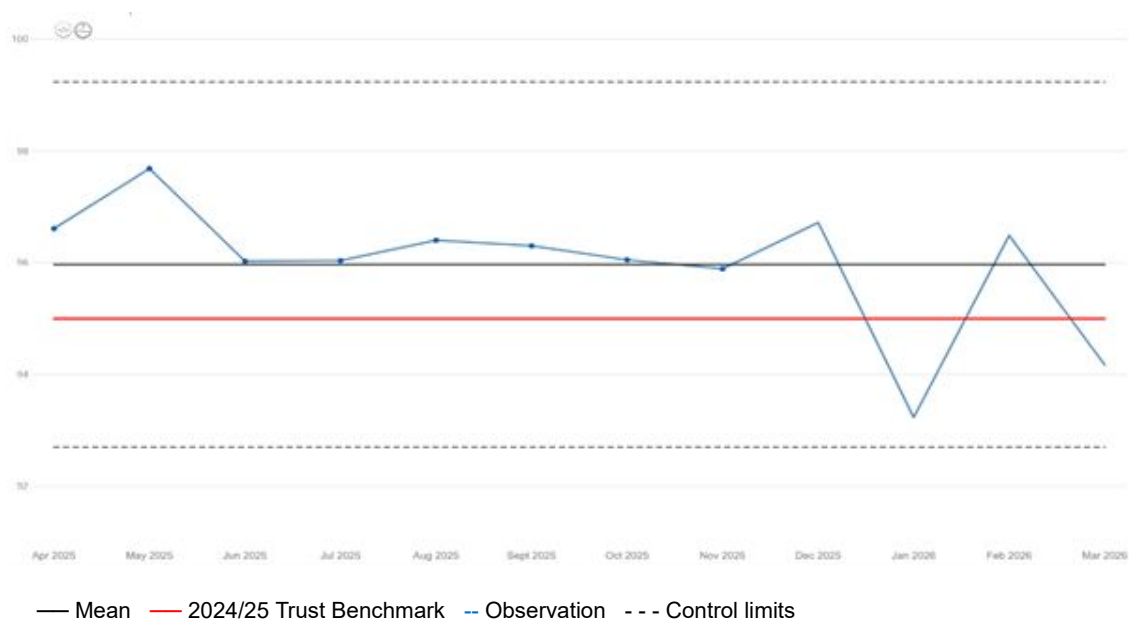


Figure 23. Friends and Family Test scores for inpatient and day case services for Division C

Of 19,225 sub-themes within the free text comments, 77.8% were positive in nature. The sub-themes were grouped, and the main positive and negative themes were analysed:

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Staff Behaviour	5,663	Food and Drink	513
Patient Care	5,067	Facilities	494
Emotional and Physical Support	475	Communication	414

During the year, patients stated staff were often approachable and treated them with respect and dignity. Staff frequently made those who they cared for feel safe and the quality of care provided was praised. Food and drink were the largest improvement theme, as patients mentioned the quality and choice of food provided could be better. Whilst noise at night, waiting for treatment and issues with communication were common themes for further development, facilities were also commonly mentioned. This included maintenance problems, allocation of beds and overall cleanliness.

5.3.2. Outpatient services

Outpatient service for Division C received an overall score of 83.8% for the year from 817 responses. Although there has been a 10% decrease in score, the number of responses collected during the year almost doubled. February 2026 saw the largest number of responses collected, which were primarily from Ophthalmology care group.

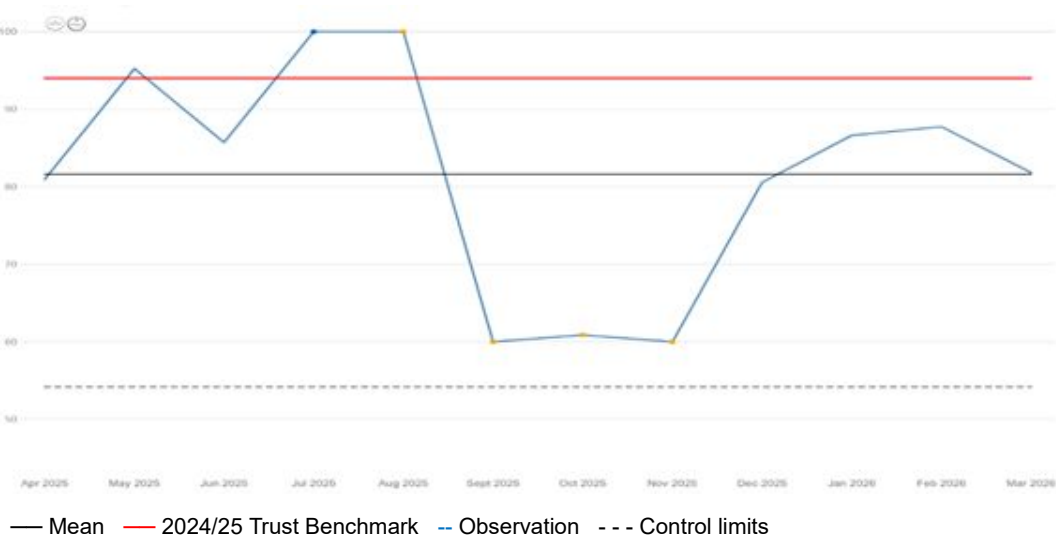


Figure 24. Friends and Family Test scores for outpatient services for Division C

65.1% of the 2,298 sub-themes identified were positive in nature:

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Staff Behaviour	495	Waiting	268
Patient Care	339	Facilities	85
Waiting	201	Communication	81

42% of comments around waiting were positive in sentiment. Whilst some patients noted clinics running effectively and on time, others attributed delays in clinics to poorer experience. Availability of appointments and waiting lists were further noted by respondents. Medical staff were described as professional, caring and helpful by many patients.

5.3.3. Same Day Emergency Care

Same Day Emergency Care in Division C received an overall score of 94.8% for the year from 768 responses, a 3% deterioration in score but a 66% improvement in responses.

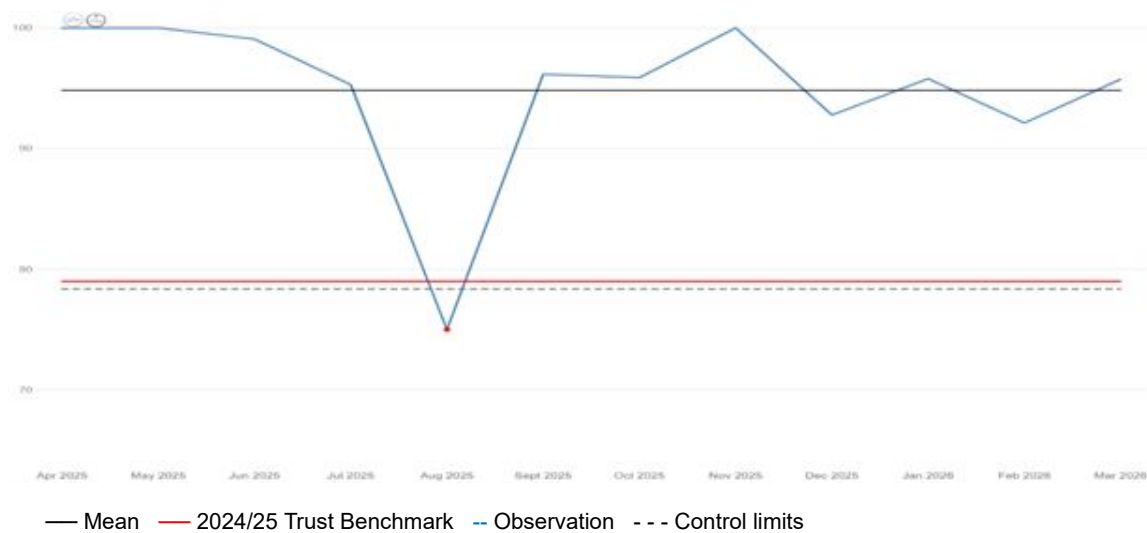


Figure 25. Friends and Family Test scores for Same Day Emergency Care services for Division C

2,096 sub-themes in free-text comments were noted and grouped into larger main themes. 76.8% of themes identified within comments were positive in sentiment.

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Staff Behaviour	622	Waiting	129
Patient Care	491	Facilities	43
Waiting	83	Communication	30

Throughout the year, a significant portion of feedback highlighted the positive interactions between staff and patient. This included treating patients with kindness, dignity and respect. Suggestions for improvement included better pain management for those waiting and improved communication.

5.4. Improving our services in Division C

As a result of patient feedback, the Trust continues to deploy improvement initiatives including:

Care group	Service	Patient feedback	Improvements undertaken
Neurosciences - Neurosurgery	Outpatient	Patients reported issues with contacting the service	A new telephone system and new group emails have been set up to distinguish the different neurosurgery specialities to better support patients queries
Surgery	Inpatient	Patient feedback from Friends and Family Test and Care Quality Commission's Inpatient survey indicated patients did not always understand	Patient information leaflets reviewed to ensure readability and plain language is used. A new process was established to review communications through governance.

		the answers provided to their questions.	Training provided to nursing staff to remind them to ask patients if they understand or have any questions.
Neuroscience	Inpatient	After patient's death in 2023, family's feedback highlighted how distressing the patient found being cared for on an adult ward	Five rooms on Murray Falconer ward have been given a major overhaul and are now more suitable for young people aged between 16 and 24 (often referred to as teenage and young adults) requiring specialist neurosurgical care.

Example outcomes from improvements

Following the implementation of the new telephone system and group emails in Neurosurgery, the service has seen a 30% reduction in concerns raised around communication.

Analysis of feedback from patients under the age of 24 years old staying on Murray Falconer Ward has seen an increase in patients and their parents positively talking about the dedicated rooms for them, citing its impact on their recovery and wellbeing.

6. Plans for 2026/2027

To build on the successes of 2025-2026 and enhance not only our data collection but also improvements initiatives and compliance with targets and Key Performance Indicators, in the next 12 months the Trust will:

- (1) continue enhancing response timescales for formal complaints
- (2) revise 'Learning from Complaints' process
- (3) pilot and test innovative solutions within Patient Advice and Liaison Service
- (4) increase capture and visibility of patient compliments by implementing a QR code enabled 'Thank you' system linked to the Trust's recording system
- (5) design and deploy an outcomes framework to better understand the impact of its improvement initiatives
- (6) deploy a programme of work to improve patients' feedback around food and drink within adult inpatient settings that is based on a series of co-designed events that were held in early 2026
- (7) utilise quality improvement methodology to improve patients' experiences of Early Pregnancy loss including work to improve access and quality for Early Pregnancy Triage telephone line, pregnancy loss follow-up clinics and additional resources for bereaved families. This work has been established in response to the increase in complaints relating to the service.