King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Board of Directors – Public**
Date	**Wednesday 16 September 2026**
Time	**14:00 – 16:30**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill, London SE5 9RS**

No.	Agenda item	Lead	Format	Purpose	Time
STANDING ITEMS					
1.	Welcome and Apologies	Chair	Verbal	Information	**14:00**
2.	Declarations of Interest	Chair	Verbal	Information	
3.	Chair's Actions	Chair	Verbal	Approval	
4.	Minutes of the Meeting held on 15 July 2026	Chair	Enclosure	Approval	
5.	Action tracker	Chair	Enclosure	Discussion	
6.	Patient story	Chief Nurse and Executive Director of Midwifery	Presentation	Information/ Discussion	**14:10**
7.	Report from the Chief Executive Officer	Chief Executive Officer	Enclosure	Discussion /Assurance	**14:30**
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	**14:55**
10.	Highlight Reports from Committee Chairs 10.1. Finance & Commercial Committee x2 10.2. Performance, Transformation and Improvement Committee x2 (1x verbal) 10.3 Audit and Risk Committee (verbal)	Committee Chairs	Enclosure	Assurance	**15:10**
11.	Report from the Chair of the Board	Chair	Verbal	Information	**15:25**
STRATEGY, PLANNING AND DELIVERY					
12.	Trust Supporting Strategies • Digital Strategy • Green Plan to 2028 • Innovation Strategy • People & Culture Strategy	Deputy Chief Executive	Enclosure	Approval	**15:35**

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	• Population Health Management and Healthcare Equity Strategy				
13.	Trust Winter Plan 2026/27	Chief Delivery Officer	Enclosure	Approval	**15.45**
GOVERNANCE AND ASSURANCE					
14.	Board Capability Assessment	Director of Corporate Affairs	Enclosure	Approval	**15:55**
15.	Standing Financial Instructions	Chief Financial Officer	Enclosure	Approval	**16.05**
16.	Maternity & Neonatal Quality & Safety Integrated Report	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**16:15**
17.	Risk Register Report	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**16:25**
COUNCIL OF GOVERNORS					
18.	Council of Governors' Update	Lead Governor	Enclosure	Information	**16:30**
ANY OTHER BUSINESS					
	No Items				
FOR INFORMATION					
19.	NHS People Standards	Chief People Officer	Enclosure	Information	*
DATE OF THE NEXT MEETING					
	Date of the next meeting: The next meeting will be held on Tuesday 17 November 2026 at 1400 – 1630.				

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

King's College Hospital NHS Foundation Trust

Board of Directors - Public

DRAFT Minutes of the meeting held on 15 July 2026 at 14:00 – 16:30
The Education Centre, Princess Royal University Hospital, Farnborough Common, Orpington BR6 8ND

Members:		
Non-Executive Directors:		
	Dame Christine Beasley	Non-Executive Director (Acting Chair)
	Sir David Behan	Non-Executive Director (via MS Teams)
	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 (via MS Teams)
	Dr Angela Spatharou	Non-Executive Director
Executive Directors:		
	Prof. Tracey Carter MBE	Chief Nurse & Executive Director of Midwifery
	Roy Clarke	Chief Financial Officer
	Angela Helleur	Chief Delivery Officer
	Julie Lowe	Deputy Chief Executive Officer
	Damian McGuinness	Chief People Officer
	Matthew Trainer	Chief Executive Officer
	Mamta Shetty Vaidya	Chief Medical Officer
In attendance:		
	Dr Adjoa Appiah	Deputy of Maternity Unit (for item 14, Maternity and Neonatal report)
	Dr Mitra Bakhtiari	Director of Midwifery (for item 14, Maternity and Neonatal report)
	Alan Bolchover	Kings Charity (for item 7, King's Charity)
	Lorraine Chan	Staff Story (for item 6, Staff Story)
	Siobhan Coldwell	Director of Corporate Affairs
	Lisa Edwards	Staff Story (for item 6, Staff Story)
	Kat Hughes	Chief of Staff – CEO Office
	Vanisha Mistry	Corporate Governance Officer
	Chris Rolfe	Director of Corporate Communications
	Rachel Young	Staff Story (for item 6, Staff Story)
	Justine Vella	Staff Story (for item 6, Staff Story)
	Adrian Williams	Kings Charity (for item 7, King's Charity)
	Yun Fai Wong	Staff Story (for item 6, Staff Story)
	Governors	
	Members of the public	
Apologies:		
	Prof Graham Lord	Non-Executive Director

Item	Subject
26/64	**Welcome and Apologies** The meeting was chaired by Non-Executive Director, Christine Beasley, as the Chair, Sir David Behan, attended virtually due to a period of recovery. Professor Anthony Schapira also attended virtually. Apologies were received from Professor Graham Lord.
26/65	**Declarations of Interest** Declarations of interest were noted in relation to Non-Executive Director, Dr Jane Fryer and Executive Director, Roy Clarke in relation to their role as Trustees of the Kings College Hospital Charity.
26/66	**Chair's Actions** There were no Chair's actions to report during this period.
26/67	**Minutes of the meeting held on 14 May 2026** The minutes of the meeting on 14 May 2026 were approved as a correct record.
26/68	**Action tracker** The board noted the actions.
26/69	**Staff story** The Chair welcomed the Speech and Language Therapy (SLT) team and highlighted the value of hearing directly from frontline staff. The team had been invited to present following a recent purpose walk, during which their commitment, innovation and focus on improving patient care had been recognised. The Board welcomed Lisa Edwards, Lorraine Chan, Yun Fai Wong, Rachel Young and Justine Vella. The team outlined the SLT service, which comprises 14 staff providing specialist assessment and intervention across the Princess Royal University Hospital (PRUH) and Orpington Hospital frailty wards. They described their role in supporting patients with communication and swallowing disorders across five clinical pathways and highlighted recent achievements, including a new team office, a quality improvement project on equitable swallowing assessment, and plans to develop an in-house Fibreoptic Endoscopic Evaluation of Swallowing (FEES) service. The Board received a presentation on the benefits of FEES, explaining how bedside assessment could provide earlier diagnosis and clinical decision-making without the need for radiation or transfer to radiology. Patient case studies demonstrated how delayed access to FEES could prolong treatment, rehabilitation and hospital stay, while reducing patients' quality of life. The Board noted that a local FEES service could improve patient outcomes and experience, reduce demand on radiology services, shorten length of stay and support the Trust's strategic priorities for quality, productivity and patient-centred care. During discussion, Board members commended the team's leadership, collaboration and commitment to continuous improvement. The team explained that staff engagement had been central to identifying improvement priorities and described the impact of delayed FEES access on rehabilitation and recovery. Members discussed the financial funding implications of establishing a FEES service. The team advised that previous funding bids had been unsuccessful but that supporting evidence, including data from the Denmark Hill site, was available to inform a business case. The Board recognised the significant contribution of the SLT service and the importance of swallowing rehabilitation in improving clinical outcomes and patients' quality of life.

26/70	**King's Charity** The Chair welcomed Adrian Williams, Chair of King's College Hospital Charity, and Alan Bolchover, Chief Executive, to the meeting. The Board noted the Charity's progress over the past year, including the appointment of its new Chief Executive and the development of a closer strategic relationship with the Trust. The Charity outlined its role in supporting patients, staff and research across the Trust, highlighting investments of around £25 million over the past decade in research, equipment, staff development and improvements to the patient environment. Recent examples included neonatal and liver research, the surgical robot at Denmark Hill, the Critical Care Garden and refurbishment of patient facilities. Members heard that the Charity's ambition was to become a more strategic partner by providing flexible funding aligned to the Trust's priorities for patient care, staff wellbeing, research and innovation. Future fundraising would focus on community engagement, digital campaigns, corporate partnerships and strengthening relationships with patients, staff and local communities. The Charity also outlined its longer-term ambition to secure up to £100 million of charitable investment by 2035. During discussion, Members sought assurance that fundraising priorities aligned with the Trust's strategic objectives. The Charity confirmed it was working closely with the Executive Team while continuing to support clinician-led research through robust governance and independent review processes. Members discussed opportunities to increase staff engagement in fundraising and expand partnerships with local businesses and organisations. The Charity welcomed these suggestions and committed to strengthening communication, supporting locally led fundraising initiatives and broadening corporate engagement. The Chair thanked the Charity for its presentation and welcomed its continued development as a strategic partner. The Board looked forward to receiving a further update on progress over the coming year.
26/71	**Board Assurance Framework** The Director of Corporate Affairs presented the latest Board Assurance Framework (BAF), noting that it comprised ten strategic risks, four of which remained rated red, all of which had been reviewed by the relevant Board committees. The Board approved the addition of a new strategic risk relating to capability, talent and leadership, recognising the importance of leadership, succession planning and talent management in supporting organisational change. The proposal had been endorsed by the People, Education and Inclusion Committee. Members noted the proposed increase in the financial sustainability risk rating to reflect concerns about the Trust's underlying financial position, particularly the continuing Cost Improvement Programme (CIP) gap, despite delivery of the in-year financial plan. The Board also noted ongoing challenges in meeting national commercial clinical trial performance standards, although progress had been supported by additional funding from King's College London and an external review of the research and development function. A refreshed Quality Assurance Framework was also noted, providing stronger oversight of clinical quality and assurance through the Quality Committee. Members discussed continued operational pressures, particularly within the Emergency Department, including corridor care and deteriorating long-waits performance. The risk would continue to be monitored, with the potential for further review if pressures persisted. The Board also discussed the relationship between workforce-related risks and agreed that the relevant committees should review the structure and scoring of these risks, including the distinction between target risk and risk tolerance.

	ACTION: It was agreed that the relevant committees should review the workforce related risks to ensure there was clear distinction between them and that the Board Assurance Framework remained appropriately structured. **SC** **ACTION**: It was suggested that the distinction between target risk and risk tolerance should be reviewed. The Audit Committee and relevant risk-owning committees were asked to consider this further and report back as appropriate. **SC** **The Board approved and reviewed the addition of the new strategic risk relating to capability, talent and leadership, and agreed the proposed changes to the Board Assurance Framework.**
26/72	**Integrated Performance Report** The Chief Delivery Officer presented the Integrated Performance Report, highlighting areas of improvement alongside ongoing operational challenges. Chief Medical Officer stated there were improvements in the management of complaints, with enhanced thematic analysis demonstrating that learning from complaints was being embedded across Clinical Care Groups. The Board welcomed the improved visibility of actions taken in response to patient feedback and the evidence of organisational learning. The Board also noted improved performance against the national commercial research target to recruit the first patient within 150 days of trial approval. Although performance remained below the national standard, Members acknowledged the positive trajectory and the actions being taken to improve delivery. Chief Nurse & Executive Director of Midwifery drew attention to continued improvements in incident management, particularly the increasing proportion of incidents receiving a proportionate response. Members also noted sustained improvement in harm-free care and the enhanced monitoring of quality indicators at both divisional and site level to identify unwarranted variation and support targeted improvement. The Board reviewed Friends and Family Test results for the Emergency Departments and Maternity services. While response rates had improved, patient feedback continued to highlight concerns regarding emergency department waiting times and communication within maternity services. Members noted that these themes were informing ongoing quality improvement work. The Chief Delivery Officer reported that operational performance remained under pressure, with deterioration in four-hour emergency access performance following sustained demand and system pressures. Referral-to-treatment (RTT) performance remained ahead of plan overall, although increasing numbers of patients waiting over 52 and 65 weeks, particularly in ophthalmology and bariatric surgery, were being addressed through targeted recovery plans. Diagnostic performance continued to improve, although increasing demand for CT and MRI services remained a challenge. The Chief People Officer reported strong workforce performance, including reduced vacancies and the lowest sickness absence rate for over a year, while noting ongoing work to improve mandatory training, staff experience and leadership through the emerging People Strategy. The Chief Financial Officer reported that the Trust remained ahead of plan at Month 2 and continued to forecast delivery of its year-end financial position. Members noted, however, that the position remained dependent on non-recurrent measures and that delivery of recurrent cost improvements remained the principal financial risk. During discussion, Members considered opportunities to streamline consultant recruitment, improve the sustainability of RTT recovery through pathway redesign and capacity improvements, and support more integrated models of specialist care across London.

	The Board noted the latest position against the performance and quality metrics contained within the report and the actions being taken to address the areas of operational, workforce and financial challenge.
26/73	**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 of the Finance and Commercial Committee reported that the Committee had met twice since its previous update. Members noted the increase in the financial sustainability risk rating within the Board Assurance Framework from 20 to 25, reflecting the Trust's underlying financial challenges despite appropriate mitigations being in place. The Committee also received assurance that procurement of the new soft facilities management contract for the Denmark Hill site was progressing and noted that strategic reviews of elements of the Trust's capital programme and estates strategy would be brought to the Committee and Board in the autumn **People, Education and Inclusion Committee** The Chair of the People Committee updated the Board on the Committee's work across workforce performance, wellbeing, culture and organisational development. Members noted improvements in workforce reporting, continued focus on reducing sickness absence, delivery of the Workforce Plan and workforce savings, and feedback from the staff survey and exit interviews. The Committee also considered the Freedom to Speak Up Guardian's report, proposals to strengthen inclusion through an Inclusion Council, staff safety following a presentation on violence and aggression, and the annual Guardians of Safe Working report. Members agreed to strengthen oversight of workforce risks within the Board Assurance Framework through clearer metrics and measurable actions. **Audit and Risk Committee** The Chair of the Audit Committee reported on the Committee's recent meeting, highlighting the successful completion of the 2025/26 Annual Report and Accounts ahead of the national deadline. Members welcomed the unmodified external audit opinion and Value for Money conclusion, together with positive feedback on the quality of the accounts and the Trust's financial controls. The Committee also noted that the Cost Improvement Programme was no longer identified as a Value for Money concern and agreed that a further review of the maturity of the Trust's risk management arrangements would be undertaken. The Board congratulated the Finance team and all those involved on this significant achievement. **Quality and Research Committee** The Chair of the Quality and Research Committee updated the Board on the Committee's recent meeting, highlighting encouraging early improvements in the identification and management of deteriorating patients, with evidence of reduced cardiac arrests and unplanned intensive care admissions. Members also discussed learning from incident reporting and litigation, reinforcing the importance of a strong reporting culture to improve patient safety. The Committee agreed to revise its agenda to strengthen focus on the Trust's highest quality and research priorities, which the Board welcomed. **Performance, Transformation and Improvement Committee** The Chair of the Performance, Transformation and Improvement Committee updated the Board on progress across the Committee's work programme. Members welcomed improvements in bariatric services, discussed the importance of maintaining momentum in delivering transformation and efficiency programmes, and provided early feedback on the draft Digital Strategy. The Board agreed that the strategy should remain practical, dynamic and aligned with national digital priorities, with further discussion planned at the September Board meeting. **Academic Committee in Common**

	The Chair of the Academic Committee in Common presented the Committee's update, noting progress against the 150-day commercial research trial performance target. Members also discussed the importance of maintaining flexible clinical academic contracts that can adapt to changing research priorities and evolving roles. *Sheena MacKay left the meeting.*
26/74	**Report from the Chief Executive Officer** The Chief Executive presented his first report to the Board and thanked colleagues for their warm welcome. He highlighted the recent CQC Well-Led review, which rated the Trust as "Requires Improvement" and identified areas for further focus, including staff engagement, listening to concerns and ensuring decision-making reflects colleague feedback. The Board also noted positive feedback on partnership working, community engagement, health inequalities and sustainability, alongside progress made since the inspection. The Chief Executive highlighted several recent achievements, including the opening of the new Endoscopy and Diagnostic Centre at PRUH, expansion of neonatal services to a Local Neonatal Unit, and the opening of the Critical Care Garden in partnership with the Trust charity. The Board recognised the positive impact of these developments on patient care, staff wellbeing and organisational pride. The Board also received an update on planned changes to haematology cancer services, including the consolidation of specialist care at Denmark Hill and the creation of a dedicated day unit at the PRUH. Members noted that the changes followed engagement with patients and stakeholders and aimed to improve clinical pathways while maintaining local access to appropriate services.
26/75	**Report from the Chair of the Board** It was noted that there was no Chair's Report presented at this meeting.
26/76	**Partnership Working** The Deputy Chief Executive Officer provided an update on key external partnerships. The Board discussed the refreshed SC1 life sciences strategy, noting its stronger focus on opportunities that could directly benefit patients and staff, and welcomed the opportunity to strengthen the Trust's involvement. Members also noted recent local government changes across Bromley, Lambeth and Southwark, which may influence future partnership working. The Board also received an update on the development of the Integrated Care Partnership approach and the Trust's role as integrator host. The discussion reflected previous Board discussions and focused on clarifying the Trust's responsibilities and the role neighbourhood teams will play in delivering care across Bromley. **The Board noted the update and the continued importance of effective partnership working with local authorities and wider partners.**
26/77	**Maternity and Neonatal report** The Board welcomed Mitra Bakhtiari, Director of Midwifery, and Dr Adjoa Appiah, Deputy Clinical Director for Women's Health Care Group. The Board noted that the full report had been reviewed by the Quality and Research Committee and discussed key findings from Perinatal Mortality Review Tool (PMRT) reviews and recent national maternity reviews. The Board noted that reviews of reported deaths and Maternity and Newborn Safety Investigations had identified no evidence that care provided contributed to outcomes, with maternity performance remaining in line with expectations. Priorities for improvement included culture, equity, implementation of Martha's Rule, maternity triage improvements and alignment with updated national frameworks.

	Members discussed the importance of balancing personalised care and women's choices with evidence-based practice, alongside strengthening engagement with women, families and local communities, particularly those experiencing health inequalities. The team highlighted ongoing work to build links with community organisations and improve early access to maternity services. The Board recognised the impact of national maternity reviews on staff and welcomed the focus on learning, wellbeing and a systems-based approach through the Patient Safety Incident Response Framework (PSIRF). Members agreed that a future discussion should consider the longer-term strategy for maternity and neonatal services, including future models of care, workforce needs and innovation. The Board thanked the maternity team for their commitment and recognised the importance of celebrating positive experiences alongside continuing improvement work. **ACTION:** The Communications and Engagement team to explore opportunities to better showcase positive patient experiences across maternity and other high-volume services, ensuring communications highlight everyday examples of good care and the experiences of patients and families, alongside major service developments. **Chris Rolfe** **The Board noted the report for evidence and assurance of the MATNEO service.** *Dr Angela Spatharou left the meeting.*
26/78	**Risk Register Report** The Board received an update on the Corporate Risk Register. It was noted that a number of corporate risks had already been discussed through the Board Assurance Framework and wider Board discussions. The Chief Nurse and Executive Director of Midwifery highlighted that, 12 months into the new divisional structure, the organisation was entering its second cycle of risk reviews through the Risk and Governance Committee. This process had supported the review, closure, and reframing of a number of longstanding risks, enabling more focused discussions and improved risk management. The Board noted the continued progress in refreshing the risk register and the improved visibility of risk management activity across the organisation. It was recognised that effective risk management needed to be embedded throughout the organisation, rather than solely at Board level. The Board noted that the report had also been considered in detail by the Audit and Risk Committee. **The Board noted the report as providing assurance on the continued improvement and embedding of risk management processes across the organisation.**
26/79	**Council of Governors' Update** The Board welcomed Jane Lyons, Lead Governor, who provided an update on behalf of the Council of Governors. The Lead Governor welcomed the new Chief Executive and highlighted the continued contribution of Governors through committee participation, patient and public engagement, ward visits and support to the Board. The Board discussed the potential impact of proposed NHS legislative changes on the future role of Councils of Governors, noting the importance of maintaining strong community representation, patient voice and public engagement. The contribution of both experienced and

	newly appointed Governors was recognised, and the Board thanked all Governors for their continued commitment.
26/80	**Any other Business** No further items of business were raised for discussion.
26/81	**For Information** The following report was noted: • Patient Experience Annual report.
	Date of the next meeting: Date of the next meeting: 16 September 2026 at 14.00 - 16:30 at the Dulwich Room, Hambleden Wing, Denmark Hill, London SE5 8BQ.

Public Board Action Tracker - 16 September 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	**Completed**	Provider Capability Assessment on the agenda, uses the insightful board domains.
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 October 2026
BoDPB2609	15/07/2026 26/71	**Board Assurance Framework** That the relevant committees should review the workforce related risks to ensure there was clear distinction between them and that the Board Assurance Framework remained appropriately structured.	SC	16/09/2026	Open	This will take place at the PEIC meeting at the end of September.
BoDPB2610	15/07/2026 26/71	**Board Assurance Framework** It was suggested that the distinction between target risk and risk tolerance should be reviewed. The Audit Committee and relevant risk-owning committees were asked to consider this further and report back as appropriate.	SC	16/09/2026	Open	to be taken forrward in the next round of committees.
BoDPB2611	15/07/2026 26/77	**Maternity and Neonatal report** The Communications and Engagement team to explore opportunities to better showcase positive patient experiences across maternity and other high-volume services, ensuring communications highlight everyday examples of good care and the experiences of patients and families, alongside major service developments.	CR	Ongoing	Open	The team are working with the Director of Midwifery and her team, and are looking at potential case studies to showcase the work they do both internally and externally.

	PENDING - ACTIONS					
	Date & Ref	**Action**	**Lead for Action**	**Due**	**Status**	**Update**

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 7

Report to:	Board of Directors
Date of meeting:	16 September 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 15th July 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**	✓

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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):	*n/a*
Quality Impact	*The report highlights a number of initiatives aimed at improving quality.*
Health Equity Impact	*The report highlights a number of initiatives aimed at improving health equity*
Workforce Impact	*The report notes workforce developments.*
Research/Innovation Impact	*n/a*
Digital Impact	*n/a*
Financial Impact	*n/a.*
Legal/ regulatory compliance	*The report provides a summary of the Trust's latest position in the National Oversight Framework. .*
Communications and Engagement	*The report highlights examples of good news.*
Use of Artificial Intelligence Tools	*n/a*
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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8. Board Committee Meetings
9. Good News Stories and Communications Updates

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1. Introduction

1.1. I have now been back at King's for just over two months, and I wanted to take this opportunity to thank everyone for making me so welcome. I have had a busy few weeks meeting colleagues across all our sites, as well as stakeholders from our key partnerships.

2. Enforcement Undertakings

2.1. In early September, the Trust received confirmation that the Trust has met all the requirements of the enforcement undertakings that NHS England had imposed on the Trust. This set of undertakings were imposed following the financial governance issues that came to light in early 2024, and which required wide-ranging improvements in strategy, leadership and governance (corporate and financial). This represents a significant step forward for the Trust, which has had undertakings against its licence since 2017, and I'm grateful for the efforts of all the staff involved in delivering these improvements. Nevertheless, I recognise that there is more to do, and we are on a journey to positively transform the organisation, so that we consistently deliver high-quality services that are financially sustainable. Our most immediate challenge is the £62.9m shortfall in our recurrent savings plan, which poses a material risk to our ability to maintain our improved financial position heading into the second half of the year.

3. Industrial Action

3.1. The British Medical Association (BMA) has confirmed that its consultant members have voted in favour of taking industrial action. This mandate will last for 12 months, but at the time of writing, the Trust has not been notified of any details relating to planned action.

4. Internal Professional Standards

4.1. In July, we launched a new set of Internal Professional Standards. These are designed to improve patient flow, strengthen collaboration between teams, and ensure high quality care across our urgent and emergency care pathways. These standards focus on how patients are referred, assessed and managed between our Emergency Departments and speciality teams. Key benefits include reducing delays in ED, improving decision making within and between teams, and importantly, ensuring patients are seen by the right team in the right place at the right time.

5. CQC Inspections

5.1. Since we last met, the CQC has published three inspection reports relating to services delivered on the Denmark Hill site. Their review of surgical services upgraded our rating from Requires Improvement to Good and highlighted several positive changes as well as a positive approach to learning from incidents and good support to patients.

5.2. They also published their reviews of urgent and emergency care and children and young people. The ratings for both services are unchanged since they were last inspected. King's College Hospital's rating also remains as 'Requires Improvement' overall.

5.3. In respect of urgent and emergency care, the inspection team found areas of good practice in urgent and emergency care at the hospital. This included a positive culture in which staff were able to raise concerns and ask for help. The service also regularly

monitored its outcomes to improve them, and staff worked well in partnership with external organisations. Staff were also kind and understanding to patients.

5.4. However, the CQC also found staff didn't always comply with infection prevention and control measures; equipment wasn't always used safely; and that some patients experienced long-waits and overcrowding. The inspection team did recognise, however, that demand for urgent and emergency care at the hospital was high, and that there had been improvements in some areas identified during their previous inspection of the service.

5.5. Staff delivering services for children and young people at the hospital were described by patients as warm, helpful, kind, competent, professional, and respectful. Staff were observed providing a multi-disciplinary service for children and young people, and the King's Schoolroom was praised for supporting secondary school children to undertake their exams during their hospital stay. However, the inspection team also found a number of areas for improvement in relation to learning from incidents, mandatory training, staffing, records management, and risk assessments.

5.6. A number of improvement actions were put in place immediately after the CQC's inspection of both services in June, and further work is ongoing to ensure all remaining issues are addressed.

6. Transforming Services – Patient Letters

6.1. We have made an important change in relation to how we communicate with patients. Most adult patients will now receive appointment and clinic letters via text message, email or through the MyChart app, rather than by post. This change to applies to all services. Paper letters are still available for patients who prefer them and every patient can opt out of digital and text communications by speaking to a member of administrative or reception staff. This is a positive change and will help ensure more efficient communication with patients about their appointments. The move away from paper will also reduce costs and support our efforts to be a greener, more sustainable organisation.

7. Managing the Trust's Estates

7.1. In July, I updated the Board about a number of new facilities. Further to those developments, I can confirm that we are progressing with plans to relocate the outpatient pharmacy at Denmark Hill from its current location into Willowfield. The dates for the scheduled move will be shared in due course.

7.2. As we come to the end of one of the warmest summers on record, I have also asked our capital and estates colleagues to consider what improvements can be made to our estates in order to mitigate some of the challenges we experienced over the summer. An estates strategy is being drafted and will be shared later this year. In the meantime, I would like to thank all our staff for their superb efforts to keep our patients safe and to support each other during multiple periods of extremely hot weather.

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8. Board Committee Meetings since the last Board of Directors Meeting (15 July 2026)

Governor Patient Safety and Experience Committee	16 July 2026
Governor Strategy Committee	23 July 2026
Finance and Commercial Committee	30 July 2026
Council of Governors	30 July 2026
Performance, Transformation and Improvement Committee	6 August 2026
Finance and Commercial Committee	3 September 2026
Audit and Risk Committee	10 September 2026
Performance, Transformation and Improvement Committee	15 September 2026
Governor Patient Safety and Experience Committee	15 September 2026

9. Good News Stories and Communications Updates

9.1. **King's Consultant Pharmacist elected Honorary Treasurer of the Intensive Care Society** Reena Mehta, Consultant Pharmacist in Critical Care at King's, has been elected as the Intensive Care Society's new Honorary Treasurer. Reena was elected by members of the society's council following an open nomination process and will take up the role in December 2026. Reena said: I look forward to working with colleagues across the society to support its continued growth, impact and long-term sustainability."

9.2. **King's recognised for excellence in Parkinson's care** King's College Hospital has once again been recognised as a Parkinson's Foundation Centre of Excellence, reaffirming its position as one of only two centres in the UK to hold this official classification. Miriam Parry, Parkinson's Disease Nurse Consultant and Clinical Coordinator of the Parkinson's Foundation Centre of Excellence at King's, said: "We are incredibly proud to have been redesignated as a Parkinson's Foundation Centre of Excellence. This recognition reflects the dedication, expertise and compassion of our entire multidisciplinary team and the commitment of everyone involved in delivering outstanding care for people living with Parkinson's disease."

9.3. "The scar I bear is a reminder of what I did to save my son's life" Summiya Begum shares her story of becoming a living organ donor to save her son, saying: "the surgical team at King's that operated on both myself and Yasin were absolutely fantastic. We were in the best hands possible, and we will forever be grateful for their skills, professionalism, and care. They are superheroes."

9.4. **King's Consultant Physiotherapist wins national research leadership prize** Dr Charles Reilly, Consultant Physiotherapist in Chronic Respiratory Disease at the Trust, has been awarded the National Institute for Health and Care Research (NIHR) Rising Research Leaders Prize (NIHR20). Commenting on this achievement, Dr Reilly said: "I am honoured to receive the NIHR Rising Research Leaders Prize, and recognition of the contribution I have made via research to improve care and outcomes for those living with chronic breathlessness due to advanced respiratory disease."

9.5. **"Saving my son remains the greatest privilege of my life"** Gary Jackson shares the story of his son, Harry, and how Professor Nigel Heaton, Consultant Transplant Surgeon

at King's, performed a life-saving liver and bowel organ transplant. Gary said: “The transplant surgery was tough, but nothing compares to seeing Harry looking healthier and stronger afterwards. Watching him recover and knowing that I had been able to play such a significant part in giving him that chance is something I’ll never be able to put fully into words. It remains the greatest privilege of my life, and I would do it all again without a second thought."

King's College Hospital NHS Foundation Trust

AGENDA ITEM:

Report to:	Board of Directors						
Date of meeting:	16th September 2026						
Subject:	Board Assurance Framework (BAF)						
Author(s):	Siobhan Coldwell, Director of Corporate Affairs						
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.

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	

King's College Hospital NHS Foundation Trust

Ref	Risk Summary	Executive Lead(s)	Assurance Committee	Current risk (LxC)	Change	Target Risk Score*	Update September 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 3rd September 2026** • The risk is well integrated into financial reporting and was raised to 25 in July 2026, due to the partially identified CIP programme. Some assurance received as recovery plans are in place, but further high priority actions were requested.
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 3rd September 2026** • The committee discussed challenges in delivering the capital programme within the financial year and noted the risk will be more fully reviewed once the estates strategy has been agreed (Nov 2026).
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.

King's College Hospital NHS Foundation Trust

Ref	Risk Summary	Executive Lead(s)	Assurance Committee	Current risk (LxC)	Change	Target Risk Score*	Update September 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	**Reviewed at the Board of Directors on 15 July 2026** • Risk was considered alongside a detailed update on partnership activity.
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)**	↔	16	**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	**Information Security/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 9 September 2026** • Board cyber training arranged for September. • Addition priority in relation to operating systems patching added, with dedicated resource identified • Recognition of the increased threat posed by AI • New head of ICT Cyber Security appointed.

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 567Harm from violence, abuse and challenging behaviour
- To be updated with corporate risks being refreshed

Risk Scoring:

	consequence	Likelihood	Score
Risk score Q1	4	4	16
Risk score Q2	4	4	16
Target (Mar 27)	4	3	12

Appetite rating
Averse: Safe staffing levels
Cautious: Wellbeing / Rightsizing
Open: Culture
Eager: Learning and Development

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

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

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

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:

	Consequence	Likelihood	Score
Risk score Q1	4	3	12
Risk score Q2	4	3	12
Target (Mar 27)	4	3	12

Appetite rating

Averse: Safe staffing levels

Cautious: Wellbeing / Rightsizing

Open: Culture

Eager: Learning and Development

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

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/DEII 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.

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 Oejctive: 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:

	Consequence	Likelihood	Score
Risk score	NEW	NEW	NEW
Target (Mar 27)	NEW	NEW	NEW

Appetite rating

Averse: Safe staffing levels

Cautious: Wellbeing / Rightsizing

Open: Culture

Eager: Learning and Development

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

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				

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:

	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

Risk Appetite:

Control environment	Averse
Cost Improvement Programme	Open

Future Risks

- Shortfall in CIP identification and delivery compared with the pace of change set out in approved financial strategy
- Additional efficiencies through 'frontier shift' are not planned and delivered at the pace required by financial strategy
- Accelerated pace of change to address distance to 'fair shares' vs approved pace of change in financial strategy
- Failure to control expenditure and activity in line with plan resulting in underlying financial performance deviating from the pace of change required by financial strategy.
- Cash shortfall associated with under delivery of financial plan and associated risk of withdrawal of deficit support funding
- Failure to deliver cost weighted activity in line with plan resulting in income shortfalls.

Future Opportunities:

- Alignment of efficiency development with the King's Improvement Method (KIM) with 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

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: *Green: Overall findings on design showed controls are effectively designed and our testing showed controls are operating effectively.*
- 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

Update on activity and mitigations since the last meeting:

-

Strategy Objective: Critical infrastructure
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:

	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

Appetite rating

Risk Appetite:

Compliance	Minimal
Experience	Open

Future Risks

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

Future Opportunities:

- Availability of capital
- Soft FM tender at DH
- Decant wards to facilitate estates work
- Estates strategy

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.

Strategy Objective: Critical Infrastructure
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**

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

Actions since the last review (June 2026):

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:

	Consequence	Likelihood	Score
Gross score	5	4	20
Risk score	3	4	12
Target (Mar 27)	3	4	12

Appetite rating

The Trust has significant appetite to pursue innovation and challenge current working practices in pursuance of its commitment to clinical excellence, providing that patient safety and experience is not adversely affected.

Future Risks

- Access to funding and commercial research opportunities.
- Ability to meet the 150-day target for commercial trials by end March 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

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

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 August 2026**

2026/27 Priorities: (High-Quality patient care)

- Developing a quality culture
- Improving how we measure the quality of care
- Foster a culture of continuous learning
- 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:
4104 Care of patients requiring therapeutic mental health intervention (12)
3986 Monitoring to prevent patient deterioration (12)
567 Support following harm from violence, abuse and challenging behaviour
3419 Corridor Care (20)
3458 Delayed Diagnosis (12)
3991 Delayed pathology results (12)
387 Water Contamination (10)
36 Bullying & Harassment (12)
4103 Backlog Maintenance projects (16)

Risk Scoring:

	Impact	Likelihood	Score
Gross	5	4	20
Previous quarter mitigated	4	3	12
Current mitigated	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.
- Quality governance structures not embedded through clinical audit, HSMR, SHMI, PSIRF impacting ability to support continuous learning through shared practice and learning from mistakes to improve care.

Future Opportunities:

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

Controls: • Risk management policy procedures and strategy • 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 • Divisional Strategy deployment reviews (SDR's) 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. • Divisional Governance Boards with oversight of care group quality governance, and regulatory performance i.e. CQC. • Patient safety committee with oversight of learning and PSII investigations • Corporate induction and programme of mandatory training for all staff • Appraisal, CPD and revalidation arrangements for registered professionals • Inphase • Policy and clinical guidelines framework • MEG Audit Process – self assessment • Integrated Quality Report • Workforce establishment reviews in place as part of safer staffing and linked to escalation routes • Risk management training. • PALs & complaints team fully resourced. • Worry & concerns implemented (Martha's Rule). • Staff vaccination programme • Quality Assurance Framework (QAF) being implemented to provide quality checks and meeting regulatory compliance • Quality Account priorities based on key themes to support continuous improvement in care • Safeguarding policies update **Gaps in Controls** • Care group quality governance development programme to support care groups progress governance and risk management arrangements. • Martha's rule in ED, Maternity and NICU being developed. • Developing programme of divisional quality dashboards • Safer Care in rollout phase • Limited change capacity in leadership teams could impact clinical service redesign, leading to benefits for improvements in care not being realised. • Improvement capability not consistent across teams and services to support continuous improvement and the benefits realisation. • Safeguarding governance refresh		**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) • MIS Incentive Scheme full compliance 2025/6. • Patient outcomes and national clinical audit results. • CQC inspection (Surgery at DH) rated as Good. **Partial:** • CQC Inpatient results 2025 require improvement • CQC inspections (CYP, Maternity (DH/PRUH), Adult Medicine (DH) ED (DH) rated as requires improvement (2026) • CQC Well-Led (July 2026) – Requires Improvement **Negative:** • Draft HTA report (August 2026) – critical and major shortfalls • FSUG themes in relation to patient safety, confidence in speaking up • Never events numbers increase **Gaps in Assurance** • Awaiting outcome of CQC service inspections (Medical and Gerontology at PRUH and Orpington)	**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 Medine rated as requires improvement. • Positive assurance from KPMG internal audit review of MEG • Recruitment of Patient Expert Partners underway • Duty of Candour improvement needed • Corridor Care metrics now reporting • Aligns with People BAF on transforming workforce and impact on quality & safety.

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 Nurse **Committee Quality and Research Committee** **Last review: date August 2026**

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Audit of care group monitoring of learning response completion and actions with results to feed into wider review of learning assurance process and arrangements as part of PSIRF policy review.	CNO/CMO	February 2027	Reduce variation; improve productivity and evidence of learning including improvement plans	In progress
Inclusion of thematic learning from completed learning responses in IQR	CNO/CMO	March 2027	Improve continuous learning; dissemination of learning to care groups and divisions with reduction in complaints and themes	Planned
Implementation of the Trust Quality Priorities 2025/27	CNO/CMO	March 2027	Improved patient safety, outcomes and experience; with reduction in never events and improvement in recognition of deterioration through reduced incidents with patient deterioration and focussed interventions in the divisional SDR's .	Ongoing.
High Value Care initial pathway development	CMO	March 2027	Improve quality and experience of care; improved quality and safety and patient satisfaction.	Ongoing
Full implementation of quality assurance framework	CNO	January 2027	Improved consistency of quality of care; identification of areas of focus and improvement in quality and safety metrics (meeting regulatory requirements)	In progress

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 SEPT 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:

	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

Risk Appetite
Open

Future Risks
- ICS/ICB reform – transition leads to uncertainty and distraction.
- Changes to Specialised commissioning (SLOSS)
- Changes to NHS England especially changes to network arrangements

Future Opportunities:
- 10 year plan and changes at local level (opportunities to transform service provision.
- 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.

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
- Well-Led Report published in July 2026 provides positive assurance.

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: SEPT 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: Sept 2026**

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:

	Impact	Likelihood	Score
Gross	4	5	20
March 2026	4	5	20
April 2026	4	4	16
July 2026	4	4	16
Sept 2026	4	4	16
Target (Mar 27)	4	4	16

Risk Appetite

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
- Impact of Winter

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
- Recovery plans reviewed at August Performance Board (cardio-vascular, general surgery, ophthalmology)
- Cancer recovery plan and SEL cancer meeting with NHS England now in place to oversee delivery
- UEC plans in place but have yet to show impact

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
- Internal Audit Data Quality Review of ECS data ' significant assurance with minor improvement opportunities'

Gaps in Assurance
- Local management of waiting lists

Rationale for current score

- Trust operational performance is off trajectory and but the position may be recoverable.
- Cancer ITT referrals impacting on overall performance
- LPRR Level 2 for DMO1
- LPRR Level 3 for cancer delivery, planned care and 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 operational in Q2, but endoscopy backlog undermining DMO1 recovery
- UEC provider delivery failing below contracted performance levels at DH.
- Removal of waiting list initiative funding
- 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: SEPT 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

Strategy Objective: High Quality Care: Strengthening patient care through better use of digital technology
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: September 2026**

2026/27 Priorities:

- Decommissioning of legacy systems
- Delivery of the digital roadmap
- Introduction of the Network Access Control software/hardware
- Improved management of OS patching

Relevant significant risks on Corporate and Trust RR:

391R03 Malware such as Ransomware Compromising Unpatched Servers

Risk Scoring:

	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

Risk Appetite:

Information Security	minimal

Future Risks

- External threat actors
- Potential increase in speed of compromise due to use of AI and quantum computing tools. Whole system compromise time frames reducing from hours to seconds.
- 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
- Include automated cyber defences as they mature and become affordable.
- National CSOC enabling isolation of devices and compromised accounts.
- Board training on cyber security

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

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.
- Resource constraints within ICT limit speed at which changes can be enabled

• National Cyber-security Cantre 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				

Strategy Objective: High Quality Care: Strengthening patient care through better use of digital technology
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: date September 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	30/12/2026	Timely patch application to servers	Initiation
Move non-windows servers under Microsoft Defender	DCE	30/12/2026	Addition protection of non-windows devices on network	On-going
Explore Independent Recovery Environment (IRE) risk assessment and options	DCE	31/06/2026	Digital board agreed to complete risk assessment, then generate options paper	Completed
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	Organised for 16th September 2026

Activity since the last review:

- Allocation of dedicated resource to identify and, where possible, resolve root cause of non-application of patches.
- Pilot of out-of-hours isolation of compromised devices by National Cyber-Security Operations Centre
- Replacement Head of ICT Cyber Security interviews completed and suitable candidate has accepted offer

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 August 2026**

2026/27 Priorities: (High-Quality patient care)

- Developing a quality culture
- Improving how we measure the quality of care
- Foster a culture of continuous learning
- 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:
4104 Care of patients requiring therapeutic mental health intervention (12)
3986 Monitoring to prevent patient deterioration (12)
567 Support following harm from violence, abuse and challenging behaviour
3419 Corridor Care (20)
3458 Delayed Diagnosis (12)
3991 Delayed pathology results (12)
387 Water Contamination (10)
36 Bullying & Harassment (12)
4103 Backlog Maintenance projects (16)

Risk Scoring:

	Impact	Likelihood	Score
Gross	5	4	20
Previous quarter mitigated	4	3	12
Current mitigated	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.
- Quality governance structures not embedded through clinical audit, HSMR, SHMI, PSIRF impacting ability to support continuous learning through shared practice and learning from mistakes to improve care.

Future Opportunities:

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

Controls:

- Risk management policy procedures and strategy
- 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
- Divisional Strategy deployment reviews (SDR's) 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.
- Divisional Governance Boards with oversight of care group quality governance, and regulatory performance i.e. CQC.
- Patient safety committee with oversight of learning and PSII investigations
- Corporate induction and programme of mandatory training for all staff
- Appraisal, CPD and revalidation arrangements for registered professionals
- Inphase
- Policy and clinical guidelines framework
- MEG Audit Process – self assessment
- Integrated Quality Report
- Workforce establishment reviews in place as part of safer staffing and linked to escalation routes
- Risk management training.
- PALs & complaints team fully resourced.
- Worry & concerns implemented (Martha's Rule).
- Staff vaccination programme
- Quality Assurance Framework (QAF) being implemented to provide quality checks and meeting regulatory compliance
- Quality Account priorities based on key themes to support continuous improvement in care
- Safeguarding policies update

Gaps in Controls

- Care group quality governance development programme to support care groups progress governance and risk management arrangements.
- Martha's rule in ED, Maternity and NICU being developed.
- Developing programme of divisional quality dashboards
- Safer Care in rollout phase
- Limited change capacity in leadership teams could impact clinical service redesign, leading to benefits for improvements in care not being realised.
- Improvement capability not consistent across teams and services to support continuous improvement and the benefits realisation.
- Safeguarding governance refresh

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)
- MIS Incentive Scheme full compliance 2025/6.
- Patient outcomes and national clinical audit results.
- CQC inspection (Surgery at DH) rated as Good.

Partial:

- CQC Inpatient results 2025 require improvement
- CQC inspections (CYP, Maternity (DH/PRUH), Adult Medicine (DH) ED (DH) rated as requires improvement (2026)
- CQC Well-Led (July 2026) – Requires Improvement

Negative:

- Draft HTA report (August 2026) – critical and major shortfalls
- FSUG themes in relation to patient safety, confidence in speaking up
- Never events numbers increase

Gaps in Assurance

- Awaiting outcome of CQC service inspections (Medical and Gerontology at PRUH and Orpington)

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 Medine rated as requires improvement.
- Positive assurance from KPMG internal audit review of MEG
- Recruitment of Patient Expert Partners underway
- Duty of Candour improvement needed
- Corridor Care metrics now reporting
- Aligns with People BAF on transforming workforce and impact on quality & safety.

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 Nurse **Committee Quality and Research Committee** **Last review: date August 2026**

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Audit of care group monitoring of learning response completion and actions with results to feed into wider review of learning assurance process and arrangements as part of PSIRF policy review.	CNO/CMO	February 2027	Reduce variation; improve productivity and evidence of learning including improvement plans	In progress
Inclusion of thematic learning from completed learning responses in IQR	CNO/CMO	March 2027	Improve continuous learning; dissemination of learning to care groups and divisions with reduction in complaints and themes	Planned
Implementation of the Trust Quality Priorities 2025/27	CNO/CMO	March 2027	Improved patient safety, outcomes and experience; with reduction in never events and improvement in recognition of deterioration through reduced incidents with patient deterioration and focussed interventions in the divisional SDR's .	Ongoing.
High Value Care initial pathway development	CMO	March 2027	Improve quality and experience of care; improved quality and safety and patient satisfaction.	Ongoing
Full implementation of quality assurance framework	CNO	January 2027	Improved consistency of quality of care; identification of areas of focus and improvement in quality and safety metrics (meeting regulatory requirements)	In progress

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 9.

BOARD REPORT COVER PAPER

Report to:	Public Board
Date of meeting:	16 September 2026
Subject:	Integrated Performance Report Month 4 (July) 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

The performance report to the Kings Board Committee outlines published monthly performance data for July 2026 achieved against key national operational performance targets (noting that latest submitted cancer performance and quality data is June 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	*The summary report provides detailed performance against the core NHS constitutional operational standards.*
King's Improvement Impact (KIM):	*n/a*
Quality Impact	*There is no direct impact on clinical issues, albeit it is recognised that timely access to care is a key enabler of quality care.*
Health Equity Impact	*n/a*
Workforce Impact	*Describe the implications for staffing, workforce capacity, skills, wellbeing, engagement, recruitment, retention, training or organisational culture.*
Research/Innovation Impact	*n/a*
Digital Impact	*n/a*
Financial Impact	*Trust reported financial performance against published plan.*
Legal/ regulatory compliance	*Report relates to performance against statutory requirements of the Trust license in relation to waiting times.*
Communications and Engagement	*Trust's quarterly and monthly results will be published by NHSE.*
Use of Artificial Intelligence Tools	*n/a*
Committee that will provide relevant oversight Kings Board Committee	

Main Report

<u>Performance:</u>

Elective Activity @ M4:
At a Trust level, 107% of planned activity was delivered with activity levels operating above plan in each week of July.

Emergency care:

- 4 hour All Types performance deteriorated to 70.22% for July, but was below the operating plan trajectory of 76.2%.

Actions Underway:

- Development of care group 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.

RTT:

- There has been a run of 8 months RTT Incomplete performance above the mean to July 2026, despite a slight deterioration in July to 66.84% in July, which was below the operating plan.
- The total RTT PTL decreased by 30 patients to 89,916 for July but remains above the Operating Plan target of 83,955. This PTL growth from April is mainly attributable to the increase in patients waiting under 18 weeks.

Actions Underway:

- To address the 65-week RTT position in Surgery, a comprehensive programme of work is underway to improve pathway management, maximise available capacity and reduce the number of long-waiting patients.

- Internal processes have been agreed to support monitoring of additional activity funded by the recently approved SIF business case.

- NHSE continue to support pathway re-design work in Womens Health and Ophthalmology care groups which whilst not finished by the end of August, was almost complete at this point.

Cancer performance:

- **Cancer performance 62-day:** Submitted June 2026 62-day cancer performance is 70.7%, below the 76.2% target for the month.

- **28-day FDS:** Submitted June 2026 28-day FDS performance is 78.84%, just below the 80% standard.

- **Cancer performance 31-day**: Submitted June 2026 31-day performance is 95.1%, meeting the operating plan target of 95.1% for the month.

Actions underway:

- Delivery of lung pathology actions and review of prostate trial for same day Synnovis processing of biopsies.

- Non recurrent funding available for radiology reporting backlog.
- Pathology review meetings (see previous slide for more info).
- HpB radiology recruitment (from September 2026) and surgery recruitment (from August 2026).
- DH colorectal cancer theatre utilisation longer term plan in action (covering anaesthetics, wards, surgery and theatres).
- Trust wide review of theatre demand and capacity underway including cancer pathway demand.

Diagnostics:

- There has been a run of over 9 months DM01 performance below mean to June 2026.
- Despite this, performance deteriorated by 1.29% to 19.14% in July, the Operating Plan target of 16.0% has not been achieved.

Actions underway:

- SIF funding has been identified for additional activity in both MRI and CT to support performance recovery.
- A revised endoscopy recovery action plan is in place with additional internal and external capacity being used.

Quality, Safety and Patient Experience Summary:

Safe

- **No new PSIIs** or never events were identified in June; the proportion of incidents causing significant harm remains **below the national average**, although reporting per 1,000 bed days is below some peers.
- No PSII completion dates are overdue, but **incident-review backlogs and learning responses** over five months remain above target, delaying learning and compassionate engagement.
- June recorded **157 hospital acquired pressure ulcers**, including 3 unstageable, 1 category 3 and 2 category 4, with prevention actions being strengthened .
- **Violent incident levels are high** and a recent case caused significant staff injury; all 15 previously outstanding mechanical-restraint reviews are now complete.
- **20 E. coli BSI cases** were reported in May; **70% had a urinary source** and **30% catheter-related**. Targeted catheter reviews and a hydration campaign are underway.

Caring

- Inpatient/day case FFT remains stable; **77%** of themes positive (on an overall 94% recommendation score), but food, heat, waiting, noise and communication are recurring issues.

- ED FFT at **65.9%** from **555 responses**, **below the 79% national** average; waiting and communication dominate negative feedback.
- Outpatients collected **1,270 responses**, highest since September 2023, but overall performance remains below benchmark.
- Maternity FFT scored **82.9%** from 41 responses, with small sample sizes limiting interpretation.

Responsive

- Complaints are **56% higher** than June last year, but backlog control is improved; **none are 12+ weeks overdue**.
- Top complaint reasons: communication, values/behaviours, and patient care; highest care groups include **Women's Health, Child Health, and Neurosciences**.

Well-Led

- Safer staffing mitigations are active; one area fell below 80% RN/RM fill: Medical 1 PRUH, 77% nights.

Workforce

- The sickness absence rate is 4.46% and remains within the middle quartile when benchmarked against other large London Trusts. This reflects a stable and broadly positive position, with the Trust continuing to maintain sickness absence at a manageable level despite the wider pressures across the NHS workforce.

- Trust Vacancy rates increased slightly to 6.40% and continued to significantly outperform the 10% Trust target. This reflects good progress in workforce stabilisation and vacancy management in line with Trust priorities.

- Core Skills compliance is still below the 90% target; however, it has improved from 89.14% in June to 89.18% at the end of July, despite continued underperformance in key areas, including resuscitation. Targeted recovery actions are in place, with a focus on high-risk modules and strengthened accountability to return to compliance by September 2026.

- AfC time-to-hire remains within KPI for 7-9 but slightly outside KPI for bands 1-3 & 4-6.

- Medical time-to-hire has decreased slightly to 107 days from 106 days against the 100 days KPI. However, still demonstrates continued progress overall towards alignment with national benchmarks and in filling critical roles. It should also be noted that volumes in this group are currently very low (c.4-8 per month).

Finance

- As of July, the KCH Group (KCH, KFM and KCS) has reported a £9.0m deficit year to date. This represents a £8.0m favourable variance to the March 2026 NHSE accepted plan. The Trust is forecasting to achieve the breakeven plan, on the basis that further remediation takes place beyond the current 'do something' scenario.

- The underlying position year to date is a £47.4m deficit after removal of non-recurrent items, £4.9m adverse to plan.

- The Trust has confirmed plans to deliver £19.8m of CIP a planning gap of £65.1m against the £84.9m target. £11.9m (60% of forecast delivery) has moved into Gateway 3 since 1 January 2026, £1.7m since June 2026. The Trust has delivered year-to-date recurrent savings of £6.1m (£1.3m pay and £4.8m non-pay), resulting in a year-to-date adverse planning variance of £11.5m.

- The July WTE position has increased by 7 WTE, from 14,352 WTE to 14,359 WTE.

Key Actions:

- At the end of July, the Trust has confirmed plans to deliver only £19.8m of CIP, a planning gap of £65.1m against the £84.9m target. Only £11.9m (60% of forecast delivery) has moved into Gateway 3 since 1 January 2026, £1.7m since June 2026. A Chief Executive led reset of the transformation programme with Board approval in September to underpin this new intervention is required, to make a step change in delivery.

- Delivery of remediation by Divisions A, B and Corporate is required to address July 2026 adverse performance against the agreed Phase 1 and Phase 2 run rate intervention trajectories, to ensure full delivery.

- Enhanced controls are being implemented on temporary staffing bookings, a fortnightly temporary workforce delivery group has been established 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.

- 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.

NHS
King's College Hospital
NHS Foundation Trust

Integrated Performance Report

Month 4 (July) 2026/27

Trust Board

16th September 2026

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

Report to:	*Kings Trust Board*
Date of meeting:	*16th September 2026*
Subject:	*Integrated Performance Report 2026/27 Month 4 (July 2026)*
Author(s):	*Steve Coakley, Director of Performance & Planning;* *Simon Lee, Assistant Director of Performance and Planning*
Presented by:	*Angela Helleur, Chief Delivery Officer*
Sponsor:	*Angela Helleur, Chief Delivery Officer*
History:	*None*
Status:	*For Discussion*

Summary of Report

This report provides the details of the latest performance achieved against key national performance, quality and patient waiting times targets for July 2026 returns. Cancer performance and quality metrics are reported a month in arrears and therefore relate to June 2026.

Action required

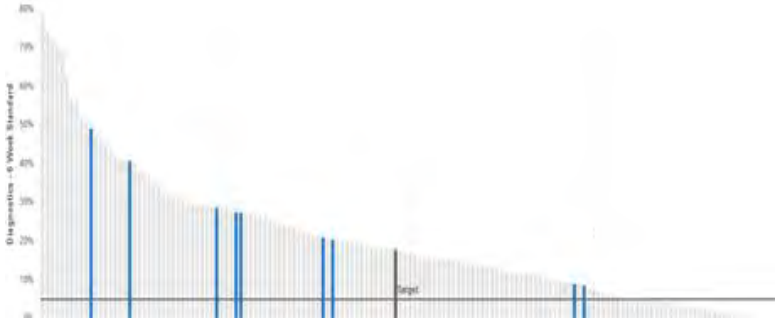
- *The Committee is asked to note the latest available 2026/27 M4 performance reported against key deliverables as set out in the national FY2026/27 Operating Plan guidance.*

Key implications

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

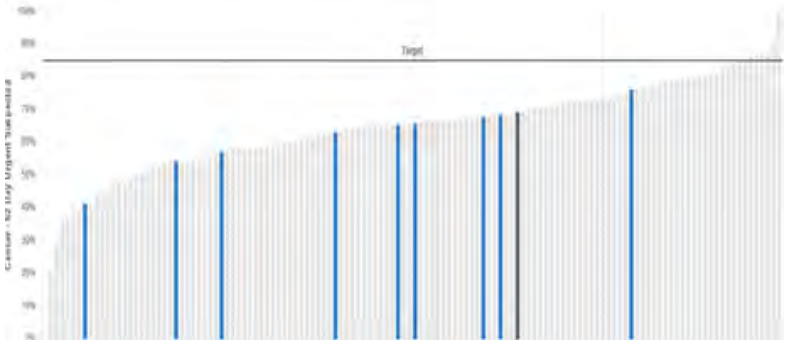
Performance

Benchmarked Trust performance
Based on latest national comparative data published

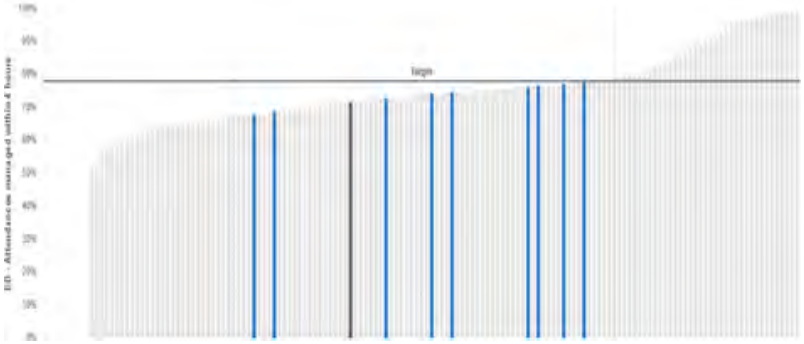


The chart above shows the national ranking against the DM01 diagnostic 6-week standard. **Kings is ranked 79 out of 154 selected Trusts based on June 2026 data published.**

The chart above shows the national ranking against the RTT 65-week waits. **Kings is ranked 143 out of 150 selected Trusts based on latest June 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 47 out of 130 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 89 out of 149 selected Trusts based on latest April 2026 data published.**

Performance

Domain 1: Performance Metric Assurance Summary

Metric Group / Metric Name	Reporting Month	Current Value (Month)	Previous Value (Month)	Assurance (Monthly)
Cancer				
Cancer 28 day FDS Performance - Submitted	2026-06	78.84%	79.51%	Fail
Cancer 31 day Performance - Submitted	2026-06	95.10%	96.86%	Fail
Cancer 62 Day Performance - Submitted	2026-06	70.75%	65.76%	Fail
Number of Urgent Suspected Cancer pathways waiting over 62 days	2026-07	130	129	Fail
Diagnostics				
DM01 >6 week performance	2026-07	19.14%	17.85%	
Emergency Care				
A&E 4-hour performance (UEC Sitrep)	2026-07	70.22%	71.66%	Fail
Attendances in A&E over 12 hours %	2026-07	14.37%	12.64%	Fail
Inpatients				
Average Discharge Delay - SUS	2026-07	8.83	9.81	
Average Length of Stay (Elective) - Model Hospital Definition	2026-07	8.8	7.2	No Target
Average Length of Stay (Non-Elective)	2026-07	9.0	9.0	Fail
Elective Inpatient Spells - SUS	2026-07	19330	18068	
Elective Inpatient Spells (Operational Planning) - SUS	2026-07	18986	17744	
G&A bed occupancy (UEC Sitrep)	2026-07	99.33%	98.86%	Fail
Non-elective patients discharged by day 7 % - SUS	2026-07	-34.60%	59.48%	
Patients Discharged by Discharge Ready Date % - SUS	2026-07	18.63%	62.25%	
Stranded Patients (LoS 7+ days) - Sitrep	2026-07	567	619	No Target
Operational Planning				
First Outpatient Attendances - SUS	2026-07	41218	41042	
First Outpatient Attendances - SUS (+Operational Planning inc. logic)	2026-07	38507	38153	
Follow Up Outpatient Attendances - SUS	2026-07	137922	135805	
Follow Up Outpatient Attendances - SUS (+Operational Planning inc. logic)	2026-07	111109	109921	
Outpatients				
First appointment <18weeks	2026-07	81.9%	82.1%	Pass
First attendance or procedure %	2026-07			
Outpatient DNA rate	2026-07	8.8%	8.5%	Fail
Outpatient PIFU Outcomes %	2026-07	4.3%	4.2%	Fail
RTT				
% 52-week Waiters	2026-07	2.10%	1.90%	Fail
RTT 52 week waits	2026-07	1890	1708	Fail
RTT 65 week waits	2026-07	264	165	Fail
RTT Incomplete Performance	2026-07	66.84%	67.52%	Fail
Theatres				
Theatre Cases Performed per 4 hr Session	2026-07	1.46	1.47	No Target
Theatre Late Starts	2026-07	1470	1408	No Target
Theatre OTD Cancellations	2026-07	467	556	No Target
Theatre Utilisation (Capped)	2026-07	58.68%	59.12%	No Target

Executive Summary

- **Diagnostics**: There has been a run of over 9 months DM01 performance below mean to June 2026.
- Despite this, performance deteriorated by 1.29% to 19.14% in July, the Operating Plan target of 16.0% has not been achieved.

- **RTT incomplete performance:** There has been a run of 8 months RTT Incomplete performance above the mean to July 2026, despite a slight deterioration in July to 66.84% in July, which was below the operating plan.
- The total RTT PTL decreased by 30 patients to 89,916 for July but remains above the Operating Plan target of 83,955. This PTL growth from April is mainly attributable to the increase in patients waiting under 18 weeks.

- **Cancer performance 62-day:** Submitted June 2026 62-day cancer performance is 70.7%, below the 76.2% target for the month.

- **28-day FDS:** Submitted June 2026 28-day FDS performance is 78.8%, just below the 80% standard.

- **Cancer performance 31-day:** Submitted June 2026 31-day performance is 95.1% which achieved the operating plan target of 95/1% for the month.

- **Emergency care**: 4 hour All Types performance deteriorated to 70.22% for July, but was below the operating plan trajectory of 76.2%.

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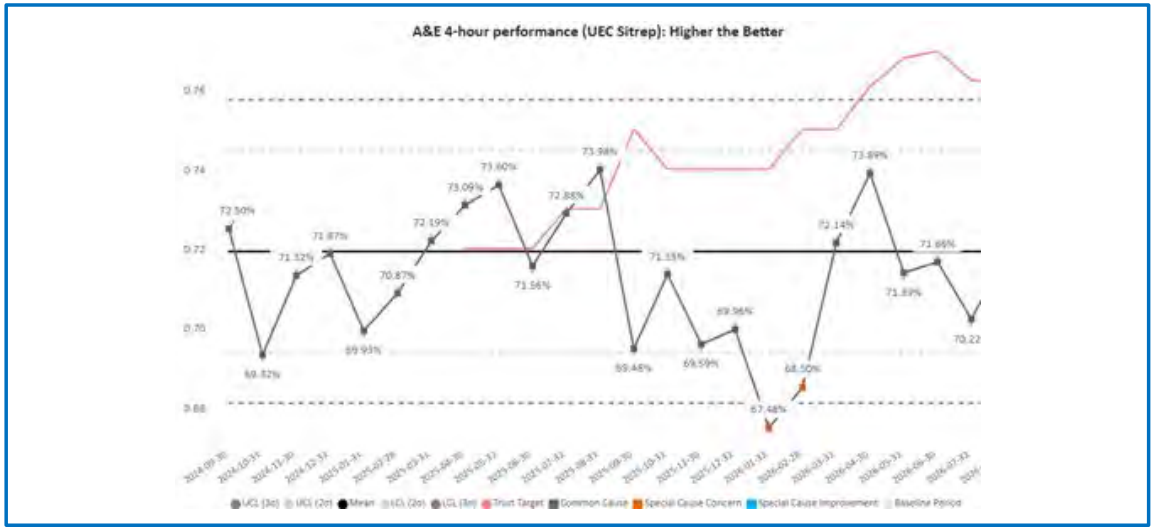
Performance

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.

July 2026	Operating Plan July 2026
70.22%	**76.2%**

- 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

- 4 hour All Types performance deteriorated to 70.22% for July, below the operating plan trajectory of 76.2%.
- Launch of revised specialty admission guidance and Internal professional standards as part of the clinical operational standards (27 July).
- Launch of revised long length of stay review SOP and roll out across sites.

Current Issues

- DH Type 3 performance remained static at 91.71%, however, there has been a continuation of improved attendances at 185 per day (-3 MoM).
- 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.

Key Dependencies

- 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.

Future Actions

- Development of care group 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.

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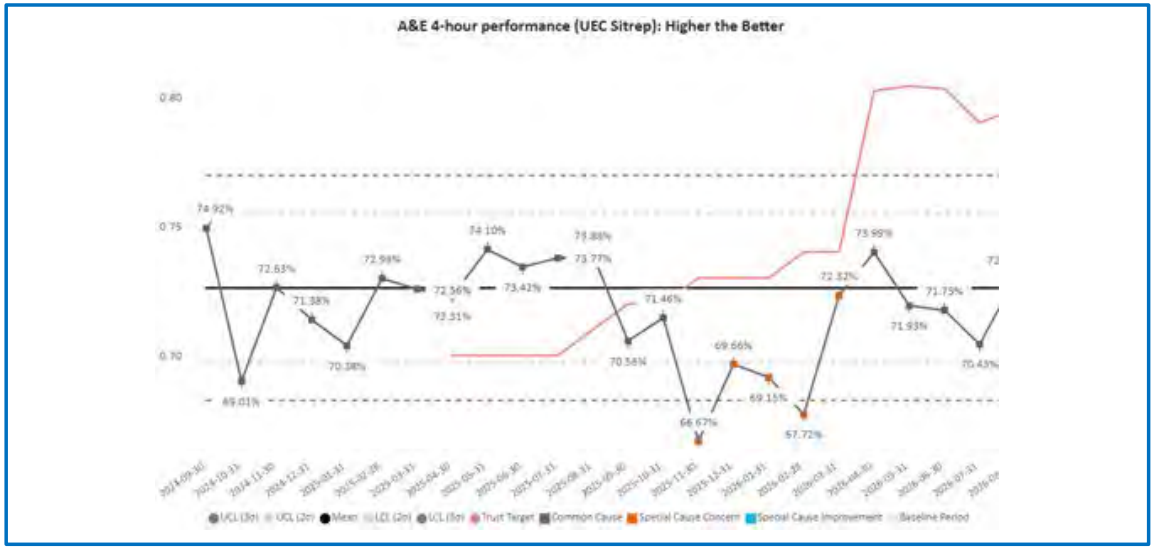
Performance

UEC 4-hour Emergency Care Standard – Denmark Hill

Background/national target description
Ensure at least 78% of attendees to A&E are admitted, transferred or discharged within 4 hours of arrival.

July 2026	Operating Plan July 2026
70.43%	**79%**

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



Update since previous month

- 4 hour All Types performance remained below the operating plan of 79% at 70.43% in July.
- Launch of revised specialty admission guidance and Internal professional standards as part of the clinical operational standards (27 July).

Current Issues

- Type 1 attendances were in line with July 2025, with ambulance conveyances 3.6% lower.
- DH Type 3 performance remains static at 91.37%, with 185 attendances per day (compared to 188 per day in June, 181 in May, and 163 in April.
- Significant challenges with long Mental Health patient stays in ED, leading to cubicles being blocked for assessment.

Key Dependencies

- 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.

Future Actions

- Development 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 triage process and SDEC pathways opportunities.

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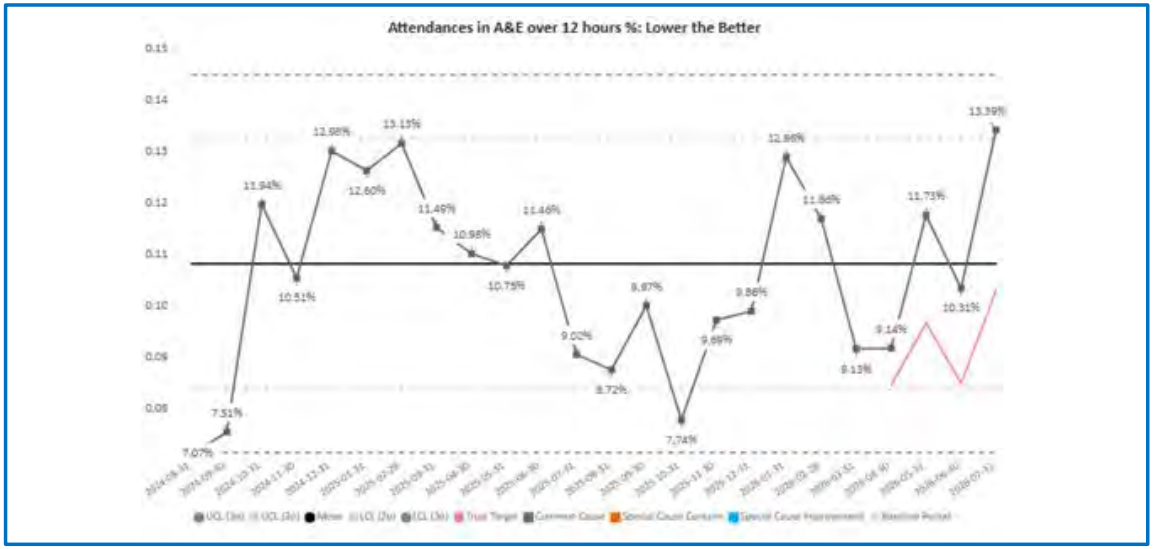
Performance

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

July 2026	Operating Plan July 2026
13.39%	10.3%

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



Update since previous month

- The percentage of patients waiting in ED over 12 hours increased to 13.39%, above the target of 10.3% for the month.

Current Issues

- LAS ambulance attendances remain stable with an average of 96 per day.
- Increasing MH referrals (5% Year on Year growth), and a 22% growth in 12 hour breaches (Year on Year).
- 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 review demand changes and consider pathway changes that support appropriate management of patients.

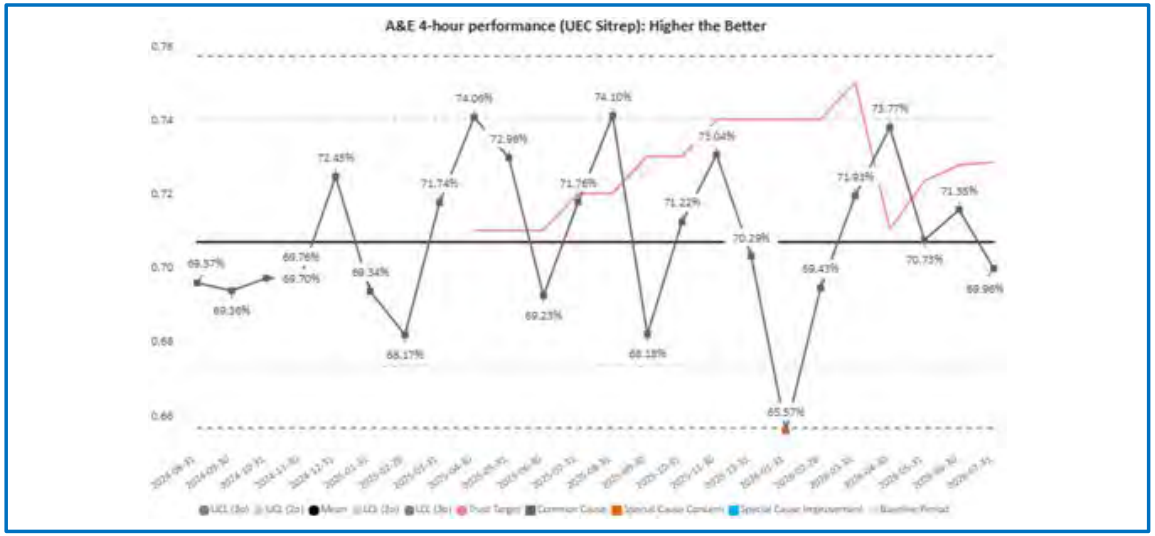
Performance

UEC 4-hour Emergency Care Standard – PRUH

Background/national target description
Ensure at least 78% of attendees to A&E are admitted, transferred or discharged within 4 hours of arrival.

July 2026	Operating Plan July 2026
69.96%	72.8%

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



Update since previous month

- All type performance increased to 69.96% in July, remaining below the Operating Plan target.
- The Acute Gerontology Unit opened in June 2026.
- Launch of revised specialty admission guidance and Internal professional standards as part of the clinical operational standards.
- Launch of revised Long length of stay review SOP.

Current Issues

- There has been a 6% Yr on Yr increase in ambulance conveyances, with an average of 80 per day in July.
- There has been an increase in Type 3 treated attendances (183 per day), this is a 11% Year on Year growth.
- LAS calls to the geriatric SPOA remain low and an unrealised opportunity.
- Corridor congestion due to admitted demand, but a significant reduction compared to FY2025-26.

Key Dependencies

- Attendance avoidance pathways in the community and the use of Universal Care Plans (UCP).
- Re-direct pathways from ED into out-of-hospital providers.
- Optimisation of referral pathways to SDECs to take lower risk presentations.
- Flow into MH inpatient wards.
- Flow into G&A inpatient wards.

Future Actions

- Finalisation of care group improvement plans for the FY2026-27 flow programme.
- Focus on increasing pathways out of ED into SDEC and SAUU.

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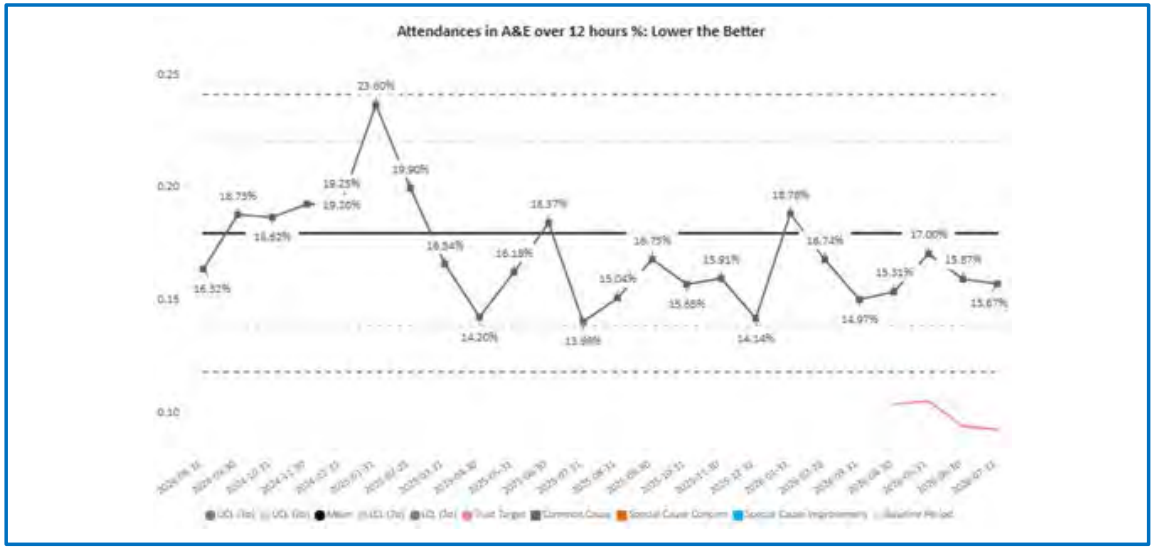
Performance

UEC 12-hour stays – PRUH

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

July 2026	Operating Plan July 2026
15.67%	9.2%

- 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
• Reduction in 12 hour stays in June to 15.67% but remained above the Operating Plan target of 9.2%.	• 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.	• Improved flow for patients with a mental health Decision To Admit into partner organisations. • Flow from ED into inpatient admission wards. • Reduction in length of stay across inpatient wards through the site flow programme.	• Ongoing partnership meeting with Oxleas to support oversight of mental health patient management and pathway improvement.

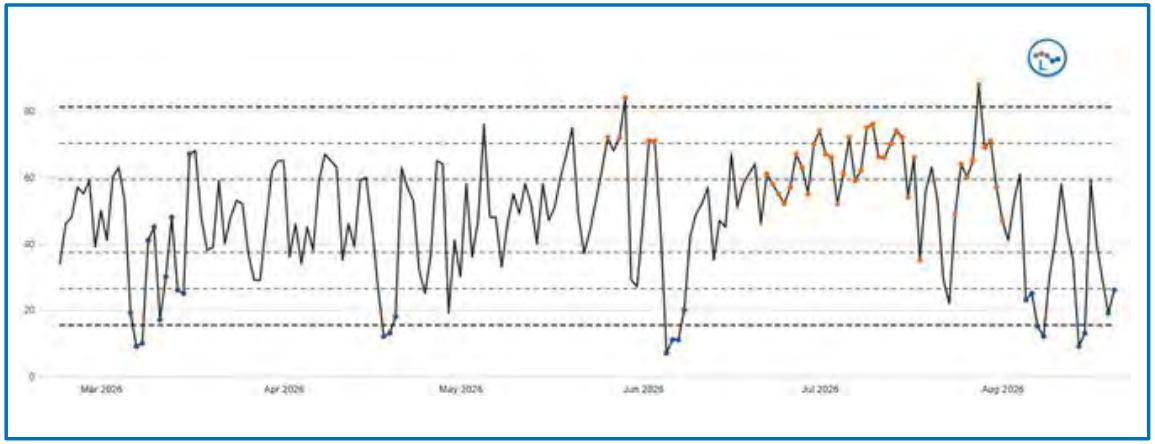
Performance

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.

July 2026
1913

- 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.

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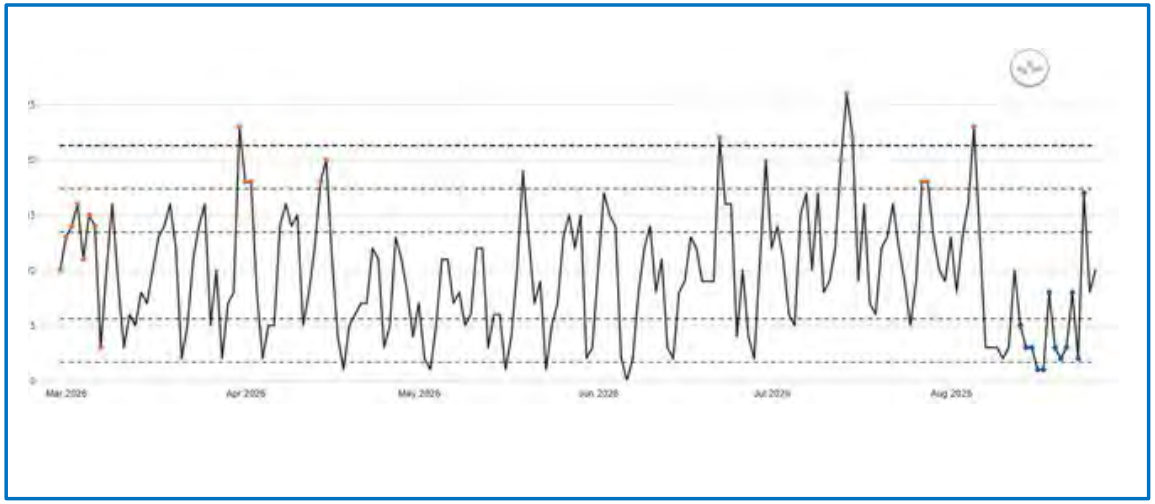
Performance

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.

July 2026
389

- 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 further rolled out to support reduction in LoS.

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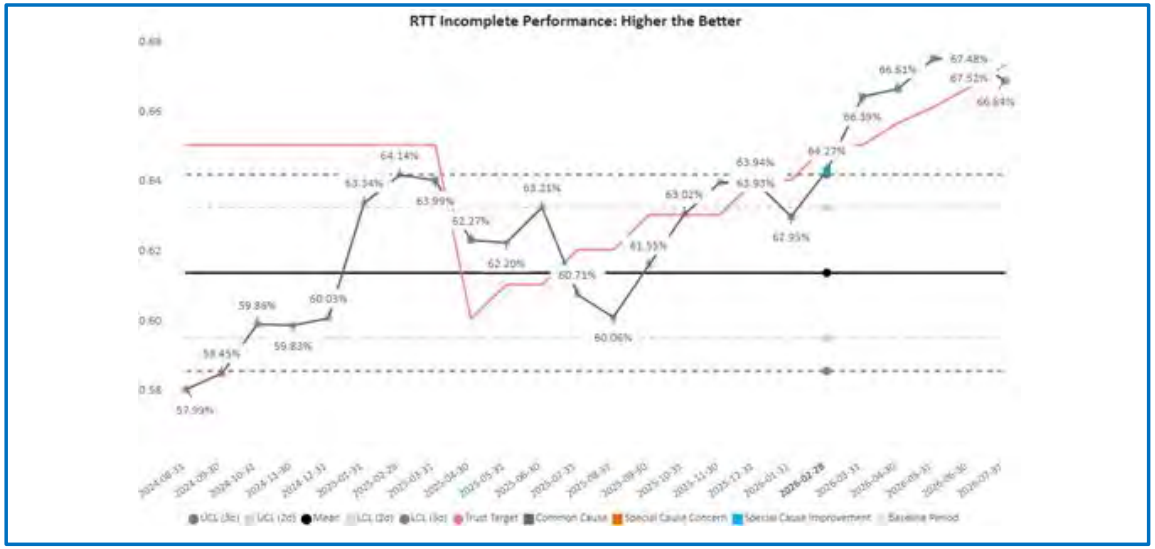
Performance

RTT Incomplete Performance

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

July 2026	Operating Plan July 2026
66.84%	67.3%

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



Update since previous month

- There has been a run of 8 months RTT Incomplete performance above the mean to July 2026, despite a slight deterioration in July to 66.84% in July, which was below the operating plan.
- The total RTT PTL decreased by 30 patients to 89,916 for July but remains above the Operating Plan target of 83,955. This PTL growth from April is mainly attributable to the increase in patients waiting under 18 weeks.

Current Issues

- 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 number of SIF schemes have now been initiated.

Key Dependencies

- Delivery of Trust activity plan in key areas of operational challenge within standard Trust capacity available.
- SIF and extended SEL ICB business case has been approved so that implementation of activity-driven PTL reduction plans can commence.

Future Actions

- Internal processes have been agreed to support monitoring of additional activity funded by the recently approved SIF business case.
- NHSE are supporting pathway re-design/optimisation work in Women's Health and Ophthalmology care groups.

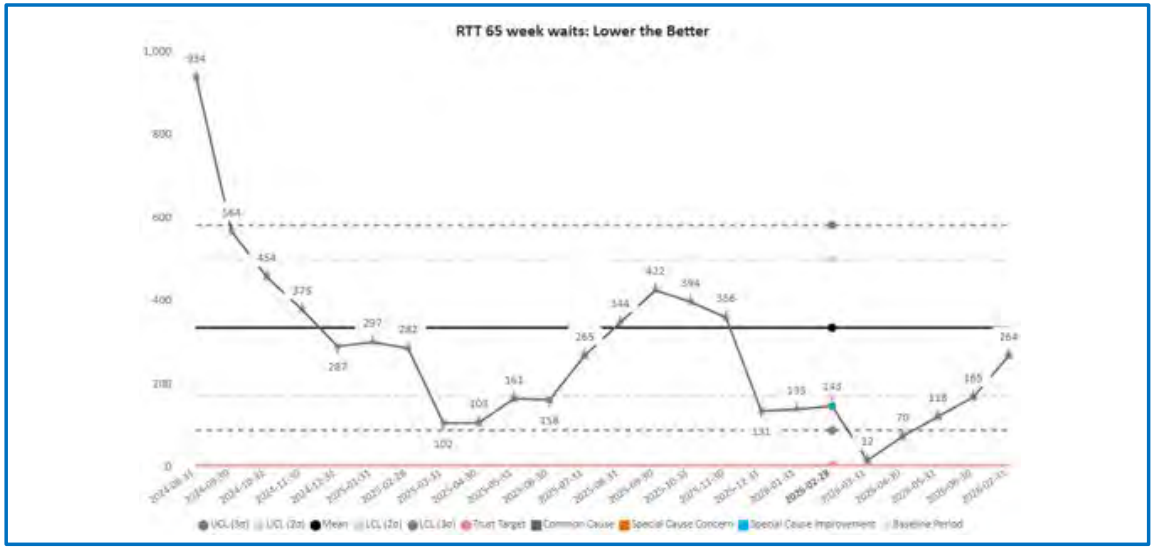
Performance

RTT – 65 Weeks

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

July 2026	Operating Plan July 2026
264	0

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



Update since previous month	Current Issues	Key Dependencies	Future Actions
• The number of patients waiting over 65 weeks increased from 165 patients in June to 264 in July, and above the zero breach Operating Plan requirement. • Of the 65 week wait patients there are 66 patients in General Surgery, 51 in Ophthalmology, 51 in Vascular Surgery, 30 in Bariatric Surgery and 33 in Colorectal Surgery.	• The key challenge remains in Surgery care group at DH and Ophthalmology. • There is a longer-term capacity issue in the vascular lab which impacts the vascular pathway significantly for routine procedures.	• Delivery of Trust activity plan in key areas of operational challenge within standard Trust capacity available.	• To address the 65-week RTT position in Surgery, a comprehensive programme of work is underway to improve pathway management, maximise available capacity and reduce the number of long-waiting patients. • A trajectory for the vascular pathway needs to be undertaken with the vascular lab to fully understand the position.

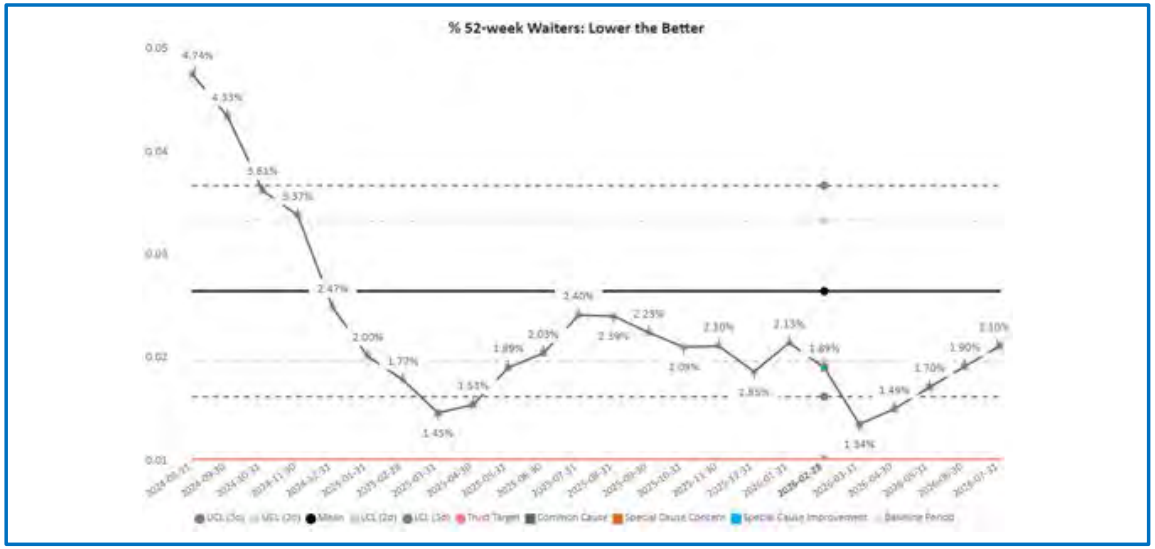
Performance

RTT – % 52 Week Waiters

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

July 2026	Operating Plan July 2026
2.10%	0.90%

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



Update since previous month

- The number of patients waiting over 52 weeks increased further from 1,708 in June to 1,890 in July, above the target of 763.
- This represents 2.10% of the total PTL and above the target of 0.90%. Over 1,298 patients are waiting on admitted and over 590 on non-admitted pathways.
- Nearly 1,500 patients waiting in Division C including over 490 patients waiting in Ophthalmology.

Current Issues

- Demand and capacity modelling work which focussed on the DH Surgery care group has identified a shortfall in available capacity, even if 95% of non-urgent capacity was dedicated to long wait PTL bookings.

Key Dependencies

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

Future Actions

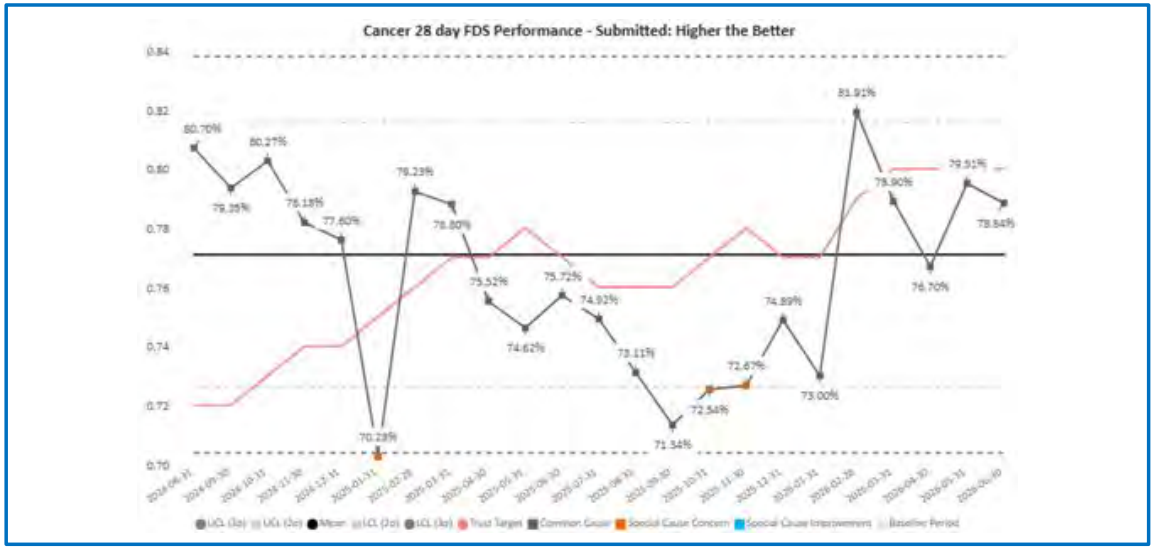
- Enhanced senior clinical and operational oversight continues, with line-by-line review of long wait risks across both admitted and non-admitted cohorts.
- Governance arrangements have been changed and the Deputy Chief Delivery Officer is also chairing line-by-line review meetings for Surgery, Ophthalmology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

Performance

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.

June 2026	Operating Plan June 2026
78.84%	80%



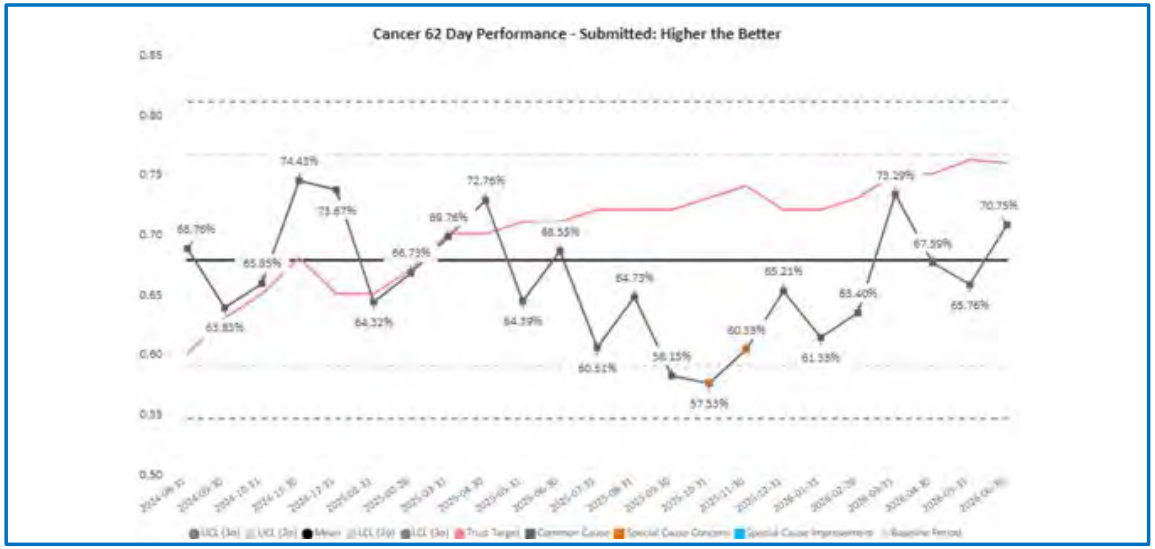
Update since previous month	Current Issues	Key Dependencies	Future Actions
• Submitted June 2026 28-day FDS performance is 78.4%, just below the 80% standard.	• Pathology reporting turnaround times. • PRUH endoscopy backlog recovery (from new unit opening in April 2026). • Other challenges include GI and Urology CT reporting, Gynaecology and Urology diagnostics plus Breast and Head & Heck outpatient capacity within July.	• 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 recovery from new endoscopy build.	• PRUH endoscopy backlog recovery (additional lists in place, weekly review between endoscopy and cancer services). • Cancer pathway specific Synnovis pathology processing improvement actions, and recruitment to vacant PRUH pathologist post alongside establishment of cross site working. • Non recurrent funding available for radiology reporting backlog.

Performance

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.

June 2026	Operating Plan June 2026
70.75%	75.9%



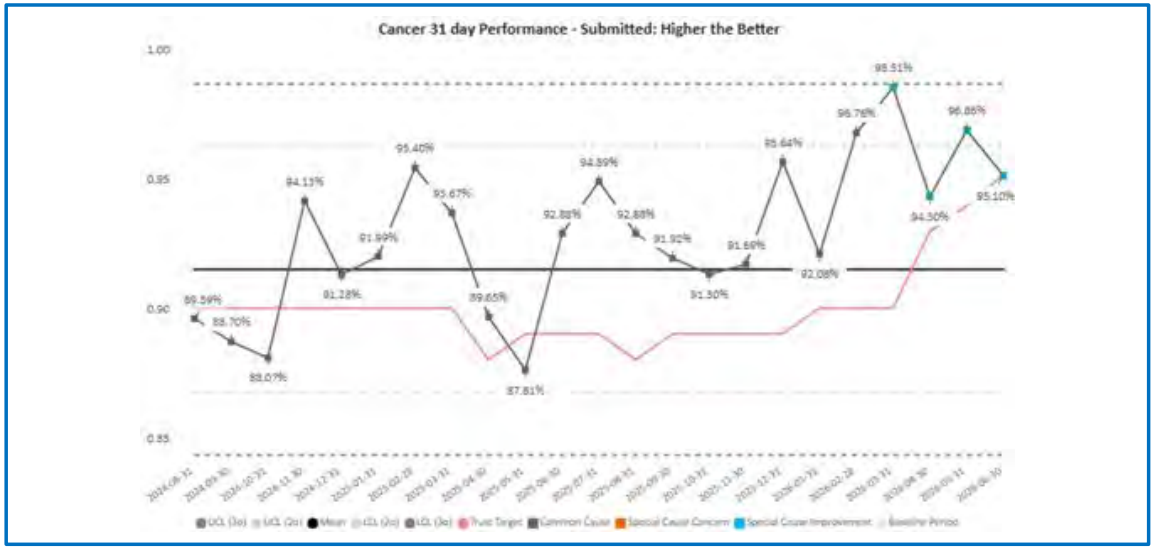
Update since previous month	Current Issues	Key Dependencies	Future Actions
• Submitted 62-day performance for June 2026 was 70.7%, below the 76.0% Operating Plan target.	• Pathology reporting delays (see previous slide for more info). For 62-day pathways delays add on average one week to each pathway due to needing discussion in a weekly cancer MDT meeting. • Complexities of breast pathways with additional imaging. • HpB surgical workforce. • Radiology reporting and IR capacity. • PRUH endoscopy capacity.	• Synnovis pathology turnaround times. • Clinical review of breast diagnostic pathway (now to be locally led). • Radiology demand exceeds capacity overall (for both cancer pathways and all Trust standards). • PRUH endoscopy backlog.	• Pathology review meetings (see previous slide for more info). • HpB radiology recruitment (from September 2026) and surgery recruitment (from August 2026). • PRUH endoscopy backlog recovery (see previous slide) • Non recurrent funding for radiology reporting backlog and local review of IR capacity.

Performance

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.

June 2026	Operating Plan May 2026
95.10%	95.10%



Update since previous month	Current Issues	Key Dependencies	Future Actions
• Submitted 31-day performance was 95.1% in June 2026 meeting the NHS Operating Plan target	• DH surgical capacity (breast, colorectal, HPB) • IR radiology capacity	• HPB surgical and radiology capacity	• DH colorectal cancer theatre utilisation longer term plan in action (covering anaesthetics, wards, surgery and theatres). • Trust-wide review of theatre demand Liver interventional radiology scheduling process being streamlined. • Additional HPB surgeon commenced in August 2026.

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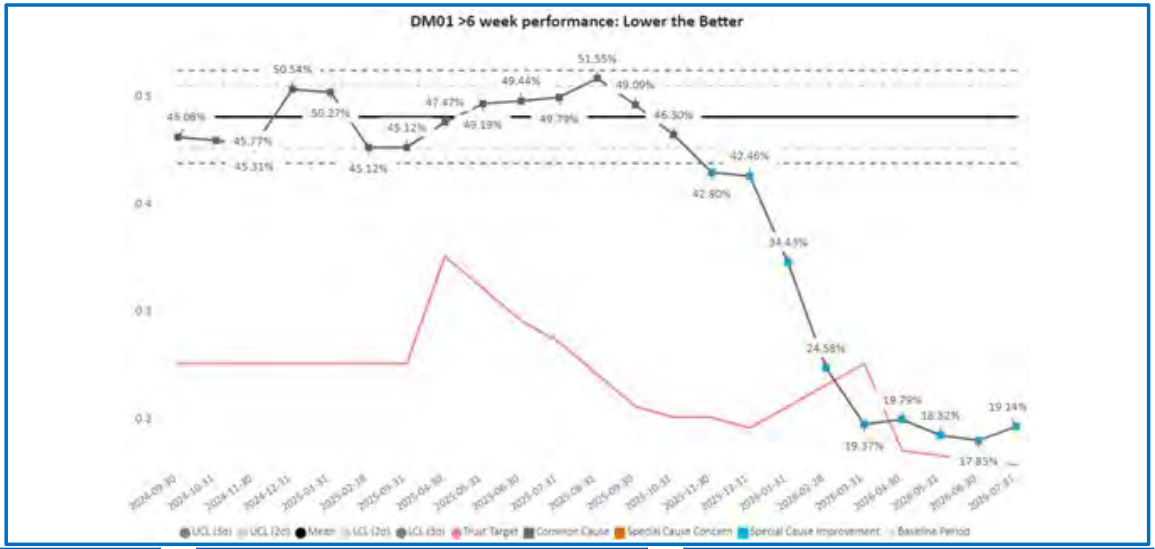
Performance

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

July 2026	Operating Plan July 2026
19.14%	16.0%



Update since previous month	Current Issues	Key Dependencies	Future Actions
• There has been a run of over 9 months DM01 performance below mean to June 2026. • Despite this, performance deteriorated by 1.29% to 19.14% in July, the Operating Plan target of 16.0% has not been achieved.	• The total number of 6+ week breaches increased by just over 600 patients, despite the endoscopy backlog increasing. • Endoscopy service backlog has increased by a further 86 breaches for July with over 1,300 breaches. Available PRUH capacity continues to be impacted in the short-term with the opening of the new endoscopy unit.	• The Acute Provider Collaborative (APC) is leading a sector-wide demand and capacity modelling exercise in Imaging for South East Londo. A further meeting is being held on 31 July to progress. • Work has commenced to re-develop the Trust's demand and capacity and forecasting model as part of the wider Operating Plan work programme, in support of 2027/28 planning.	• MRI/CT – mitigation actions to be supported by non-recurrent CDC has not been approved by NHSE. To determine level of funding in the SIF business case to support MRI/CT recovery work. • A revised endoscopy recovery action plan is in place, with additional internal and external capacity being delivered. • External validation team has completed their diagnostic DM01 and planned pathway validation work with a ca 40% validation removal/update rate.

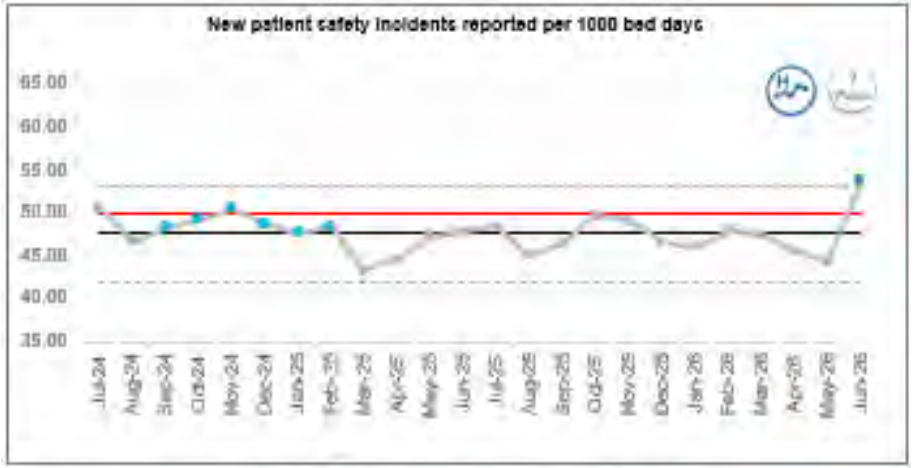
Quality

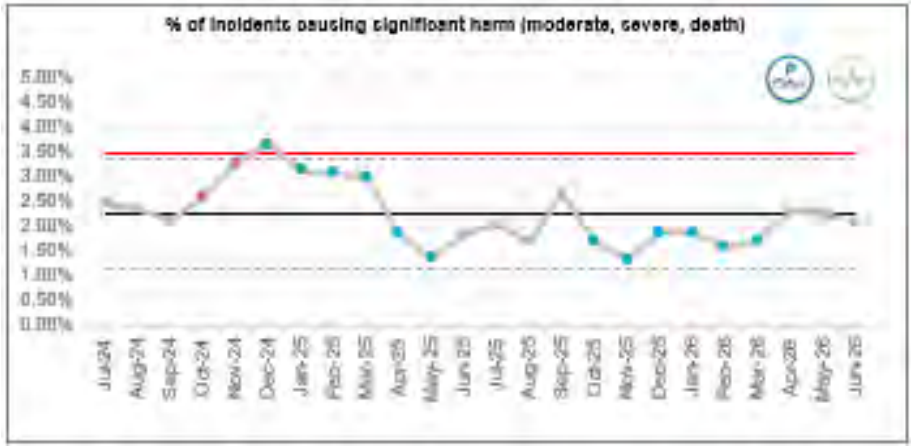
Domain 2 – Quality Summary (June 2026)

Safe	• **No new PSIIs** or never events were identified in June; the proportion of incidents causing significant harm remains **below the national average**, although reporting per 1,000 bed days is below some peers. • No PSII completion dates are overdue, but **incident-review backlogs and learning responses** over five months remain above target, delaying learning and compassionate engagement. • June recorded **157 hospital acquired pressure ulcers**, including 3 unstageable, 1 category 3 and 2 category 4, with prevention actions being strengthened . • **Violent incident levels are high** and a recent case caused significant staff injury; all 15 previously outstanding mechanical-restraint reviews are now complete. • **20 E. coli BSI cases** were reported in May; **70% had a urinary source** and **30% catheter-related**. Targeted catheter reviews and a hydration campaign are underway.
Caring	• Inpatient/day case FFT remains stable; **77%** of themes positive (on an overall 94% recommendation score), but food, heat, waiting, noise and communication are recurring issues. • ED FFT at **65.9%** from **555 responses**, **below the 79% national** average; waiting and communication dominate negative feedback. • Outpatients collected **1,270 responses**, highest since September 2023, but overall performance remains below benchmark. • Maternity FFT scored **82.9%** from 41 responses, with small sample sizes limiting interpretation.
Responsive	• Complaints are **56% higher** than June last year, but backlog control is improved; **none are 12+ weeks overdue**. • Top complaint reasons: communication, values/behaviours, and patient care; highest care groups include **Women's Health, Child Health, and Neurosciences**.
Well-Led	• Safer staffing mitigations are active; one area fell **below 80%** RN/RM fill: **Medical 1 PRUH, 77% nights**.

Quality

Safe – Incidents





The Trust did not commission any new PSIIs in June 2026 and no new never events were identified.

Special cause variation is seen in the proportion of incidents causing significant harm, with the Trust consistently under the national average for this statistic. This indicates a proportionally low number of patients coming to significant harm during their care and a positive overall reporting culture. There is though room for improvement with reporting per 1000 bed days below that of some peer organisations.

% of incidents causing significant harm (moderate, severe, death)

What is the data showing us?
Special cause variation is seen in the proportion of incidents causing significant harm, with the Trust consistently under the national average for this statistic.

Actions being taken to improve:
Positive assurance. Safety culture programme currently being developed and rolled out which should improve psychological safety for staff and therefore further improve reporting culture.

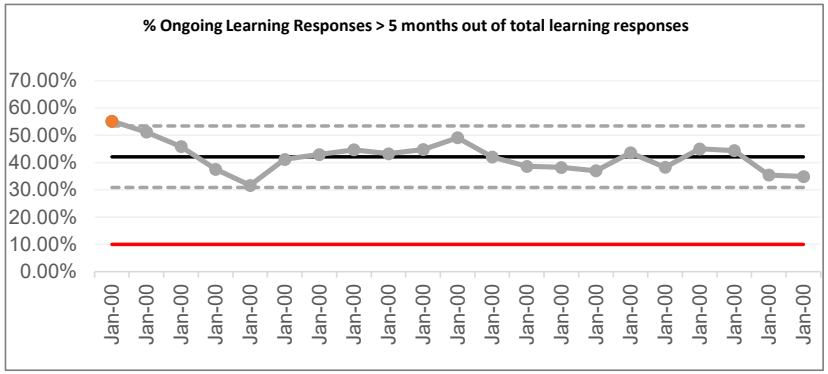
What is the impact for our patients:
This indicates a proportionally low number of patients coming to significant harm during their care and a positive overall reporting culture.

Quality

Safe – Incidents

Special cause variation is also seen in the volume of patient safety incidents awaiting review at PSIRF Panels and the proportion of learning responses taking greater than five months to complete. The impact of both on our patients (and staff) is delayed learning and improvement following incidents, and delays in the compassionate engagement steps which can compound harm for those affected.

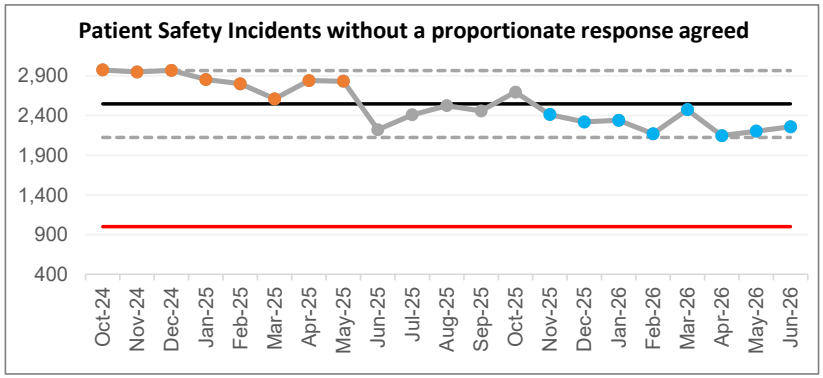
New 14-and 30-day performance data was agreed at KE was introduced last month and data back-dated to July 2025. This is being incorporated into divisional escalation and management processes and is expected to improve over the coming months. Data for past months is also expected to improve as information is retrospectively recorded on InPhase by Care Groups.



% Ongoing Learning Responses > 5 months out of total learning responses
What is the data showing us?
We are consistently missing our target of bringing down the number of learning responses taking more than 5 months to complete. Data shows common cause variation in current performance.

Actions being taken to improve:
Divisional teams, with the support of Patient Safety Team, are working with Care Groups with the highest volume of outstanding learning responses.

What is the impact for our patients:
The impact of delayed learning responses is both delayed improvement following incidents, and delays in the compassionate engagement steps which can compound harm for those affected.



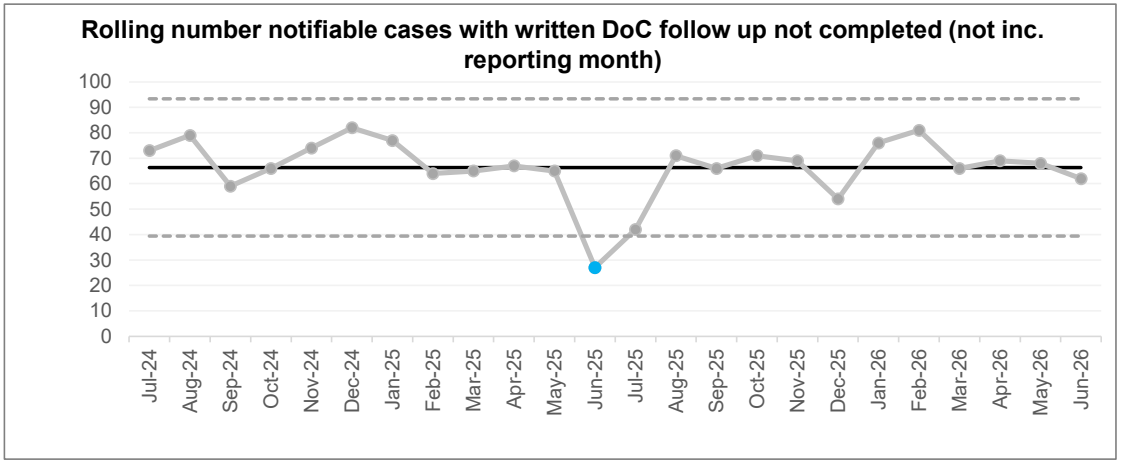
Incidents without a proportionate response agreed
What is the data showing us?
The data shows special cause improvement sustained for the past seven months, however it also shows that performance remains significantly worse than target.

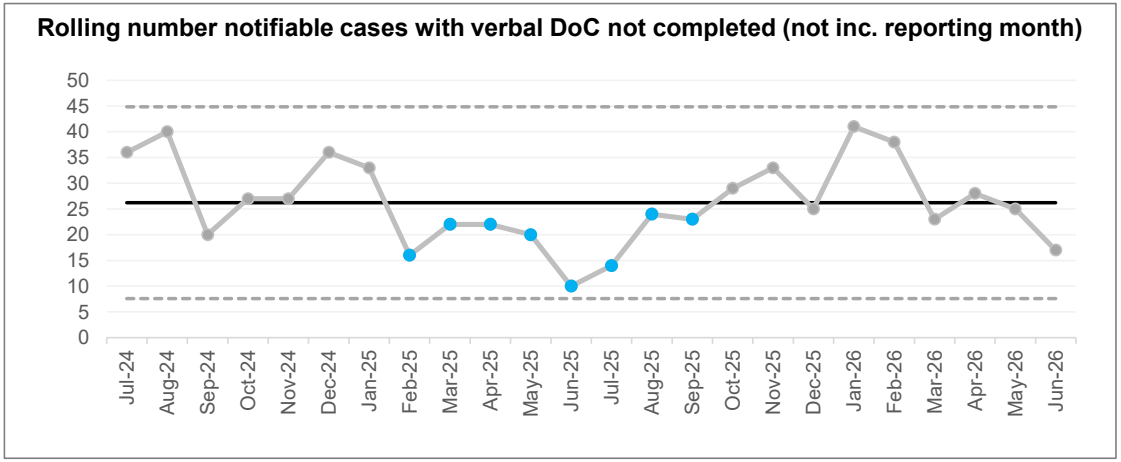
Actions being taken to improve:
Divisional teams, with the support of Patient Safety Team through PSIRF Panels, are working with Care Groups with the highest volume of outstanding incidents requiring review.

What is the impact for our patients:
Improved numbers of outstanding incidents without a proportionate response agreed shows trajectory towards improving responsiveness and assurance to patients, and the more timely execution of improvements made to services

Quality

Safe – Duty of Candour





Duty of Candour performance is within standard variation. New 14-and 30-day performance data was agreed at KE and has been introduced this month, and this will form part of divisional escalation and management processes which should then lead to improved performance over the coming months. Both currently show common cause variation.

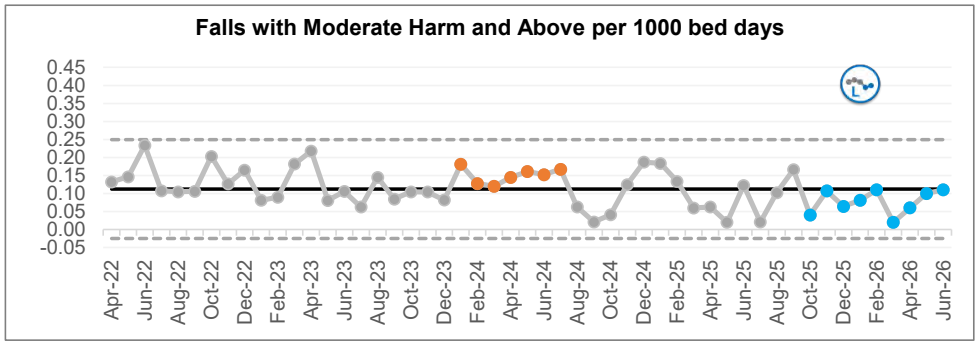
For the 14-day verbal metric, performance sits below the 90% target and has fallen slightly over the past two months. This is principally driven by Division B. Timeless of written duty of candour has improved this month overall, and the number cases where verbal DoC has not been completed at all has fallen

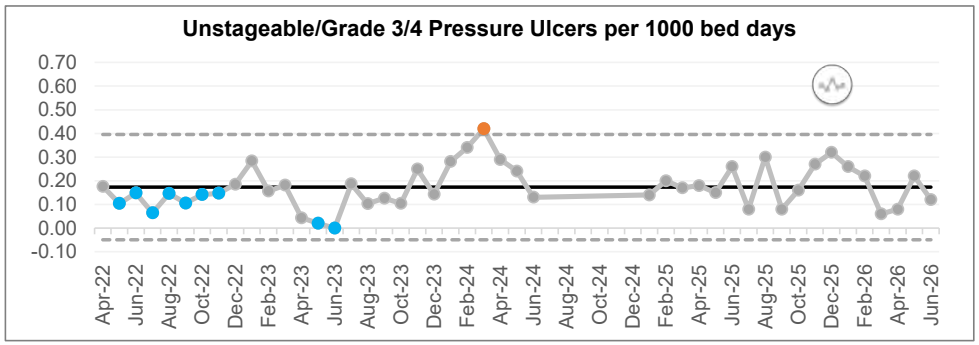
Quality

Safe – Falls & Pressure Ulcers

Enhancements are being made to Epic documentation, including improvements to falls and pressure ulcer flow sheets and the introduction of Purpose-T to support standardised skin assessment from August. In parallel, a revised Trust Falls Policy and Strategy is being developed, accompanied by a targeted poster campaign to reinforce key prevention messages across clinical teams. A Medstrom Clinical Adviser role has also been introduced to provide hands-on support to staff in optimising the use of equipment to prevent falls and pressure damage. In addition, deconditioning prevention initiatives are being implemented within Denmark Hill AMUs, with a focus on promoting patient mobility and independence from the point of admission.

There are ongoing pilots and developing plans to support faster transfers from the Emergency Department, reducing prolonged trolley waits and enabling patients to receive more timely assessment and care in appropriate inpatient settings. Alongside this, medium-term initiatives are being explored to reduce the use of corridor beds within the Emergency Department, while opportunities for wider implementation of criteria-led discharge processes are being assessed to improve patient flow.





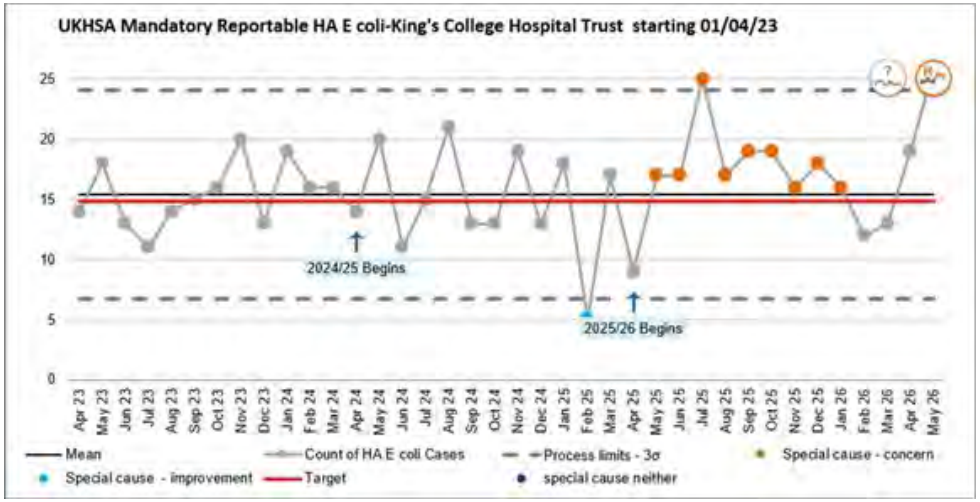
What is the data showing us?
The numbers of falls resulting in moderate harm and unstageable/Grade 3 and 4 pressure ulcers remain low. Falls with moderate harm or above is demonstrating special cause variation improvement, which suggests that performance is currently improving. This is linked to changes in falls documentation in Epic and better oversight of falls documentation completion at a ward level. For Category ¾ and Unstageable pressure ulcers, common cause variation identified for Trust-wide data. 157 pressure ulcers in June. 3 x unstageable and 1 category 3 and 2 x category 4. 45 x DTI's

Actions being taken to improve:
Enhancements are being made to Epic documentation, including improvements to falls and pressure ulcer flow sheets and the introduction of Purpose-T to support standardised skin assessment from August. In parallel, a revised Trust Falls Policy and Strategy is being developed, accompanied by a targeted poster campaign to reinforce key prevention messages across clinical teams. A Medstrom Clinical Adviser role has also been introduced to provide hands-on support to staff in optimising the use of equipment to prevent falls and pressure damage. In addition, deconditioning prevention initiatives are being implemented within Denmark Hill AMUs, with a focus on promoting patient mobility and independence from the point of admission.

What is the impact for our patients:
For patients, these actions are intended to improve the early identification and management of falls and pressure ulcer risk, reduce avoidable harm, support mobility and independence, and deliver more consistent, safer care across all sites.

Quality

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



There is a rise in cases of *E.coli* BSI this month. Of the 20 cases in May 2026, the sources of infection were:

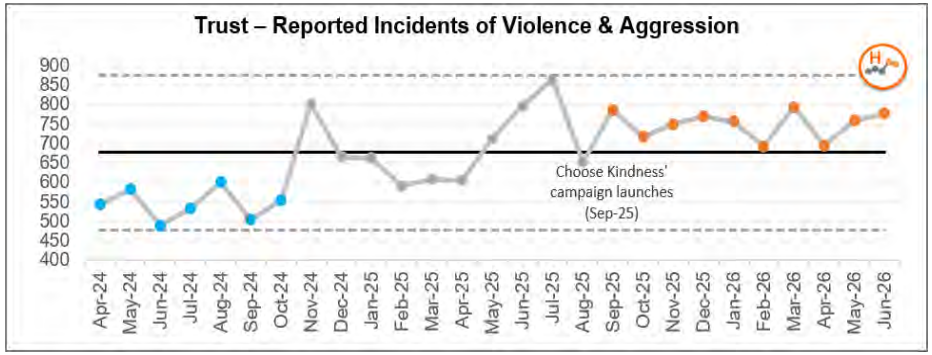
Lower respiratory tract	5% (n=1)
Urinary tract (no catheter)	40% (n=8)
Urinary tract (catheter-related)	30% (n=6)
Other/no identified focus	10% (n=2)
Hepatobiliary	10% (n=2)
Skin & Soft tissue	5% (n=1)

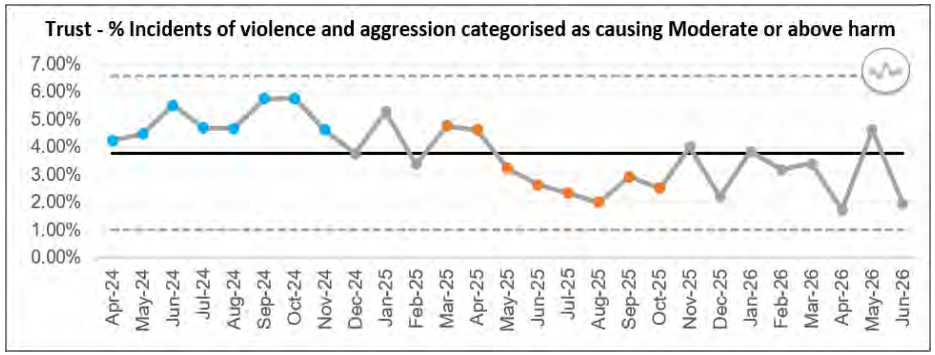
The 6 cases of catheter-related BSI were on Women's Surgical, David Marsden, Medical 3, Quebec and Surgical 6 (2 cases).

Urinary catheter reviews have commenced in the highest risk wards. The Hydration campaign has been launched.

Quality

Safe – Violent Incidents & Mechanical Restraint





Sites	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Total	% Total
Denmark Hill	561	539	505	546	466	520	558	3695	70.45%
Orpington	1	4	1	6	4	8	0	24	0.46%
PRUH	200	204	182	237	215	228	210	3719	70.91%
Southern Sites	7	8	6	7	8	1	7	44	0.84%
Grand Total	770	756	694	799	694	757	775	5245	100.00%

We continue to provide bespoke debriefs and staff support functions after incidents have occurred, our restraint reviews in the last month highlighted a case where a HCA sustained significant injuries after being assaulted. All appropriate after-care was put in place, and the Clinical Vulnerabilities team remains deployed to assist in responding to patients at risk of escalation with the team remaining focused on balancing inclusive healthcare vs determining that treatment cannot be safely co-ordinated.

The Trust Exclusion Panel, which met last month, discussed two cases with actions appropriately identified to support onward engagement.

Restraint reviews continue to be completed across the Trust. Previously there were 15 outstanding episodes of mechanical restraint that required a formal review. These have been completed this month. The vision remains to support a trust wide process and build on the respectful partnerships formulated with security and ED colleagues who have developed a comprehensive multi-agency review framework for reviewing episodes that occur within our Emergency Departments at each site.

Recent reviews have included actions such as:
Debriefing staff who have experienced significantly troubling incidents
HR considerations in respect of staff whose behaviour has been identified as a concern
Information sharing with system partners where patients leave our care into specific mental health care settings.
Data deep dive into themes, reporting methods and reporting accuracy to taking place; expected improvements in data quality to be seen in the September data onwards.

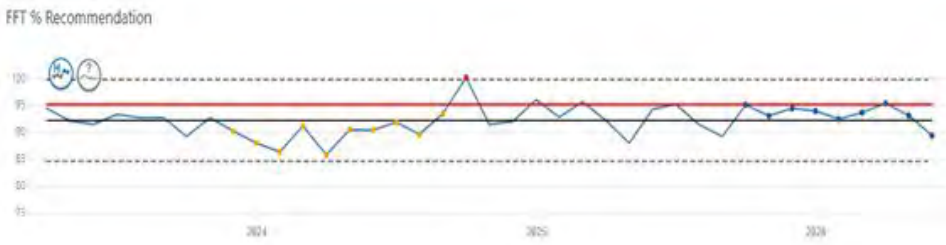
The build of DASA within EPIC is being undertaken – we do not currently have a timescale but hope to provide this within the next IQR and what impact we expect to measure.
Levels of incidents reported across the Trust remain high, indicating good levels of reporting from staff, despite concern around the occurrence of violent incidents at our sites. In addition to incident reviews and InPhase submissions, both safeguarding teams and the clinical vulnerabilities department are routinely inputting into clinical settings and offer specialist advice and guidance on the best approach to manage a person exhibiting aggressive behaviour.

Quality

Caring – Friends & Family Test – Inpatient & Day Case

Division B

Acute Specialty Medicine



Critical Care

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, despite the not reaching the national average for several of the months.

Acute Specialty Medicine is noted to have statistically improved over period but remain below average. **Liver, Gastroenterology and Endoscopy** care group continue to show sustained improvement in scores.

Statistical deterioration of scores has been noted for **Critical Care** care group, despite normally performing above Trust benchmark. Statistical improvement has been noted **in Neurosciences**, however the score for June was 89.7% from 39 responses.

Actions being taken to improve:
The Patient Experience Team will support efforts to increase response rates in wards that have recorded low or no survey responses over the past 12 months. Monthly Care Group reports are now being shared, providing area-specific patient experience data and insights. Each report includes tailored recommendations and information on the support available from the Patient Experience Team to help improve engagement and response rates.

In addition, the Patient Experience Team is working in partnership with the Neurosciences service to develop a Spinal School programme for patients awaiting spinal surgery. The programme will provide clear, consistent information about the surgical pathway, expected outcomes, recovery, and rehabilitation. This initiative aims to improve communication, support shared decision-making, and better manage patient expectations prior to surgery, helping patients feel more informed, prepared, and supported throughout their care journey.

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:
In June 2026, food and drink was the most prominent negative main theme, which included the food quality and choice. The continued heatwave also saw in increase in patients mentioned the temperature on the wards being very warm, which was the most prominent sub-theme. Waiting for treatment, noise, issues communication and maintenance of the wards continue to also be mentioned by patients negatively.

On 7th July, the Trust was made aware of an issue regarding the delivery of paper forms to our supplier, iWantGreatCare, which has resulted in a loss of reportable results in June. We are currently investigating this incident with urgency and have asked iWantGreatCare to provide full assurance and clarity on the matter.

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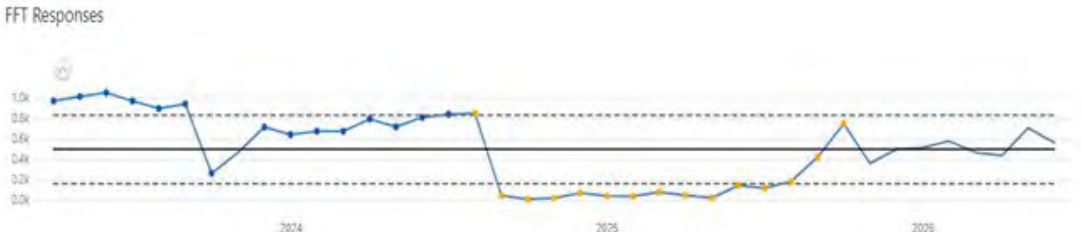
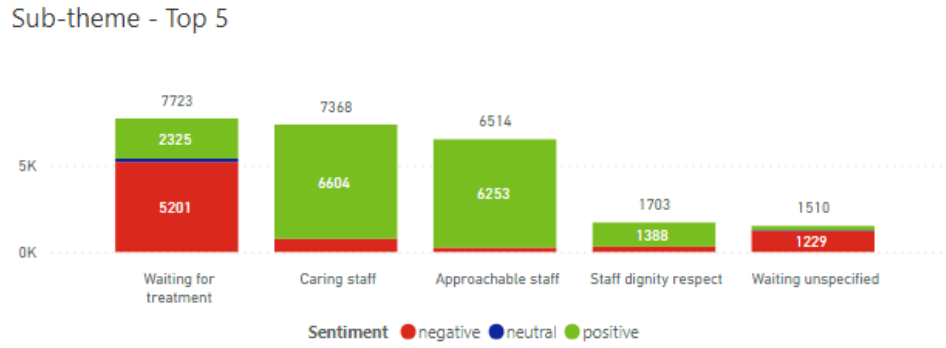
Quality

Caring – Friends & Family Test – Emergency Department





What is the data showing us?
Special cause variation of concerning nature for Emergency Care, as the Emergency Department continues to score below the national average of 79%. In June 2026, the service received an overall score of 65.9% from 555 responses.

Actions being taken to improve:
Work is underway to introduce new entry and exit information to provide details about waiting, expectations and what they are free to do whilst waiting as well as any follow up support like how to manage common conditions at home, if and when patients should return to ED and access to support in the community.

The improvement of the ED journey map to improve clarity for patients upon arrival so that we can manage expectations better. Wait time screen still in development to share expected wait times with patients in real time, again to manage expectations and reduce waiting anxiety and reflections.

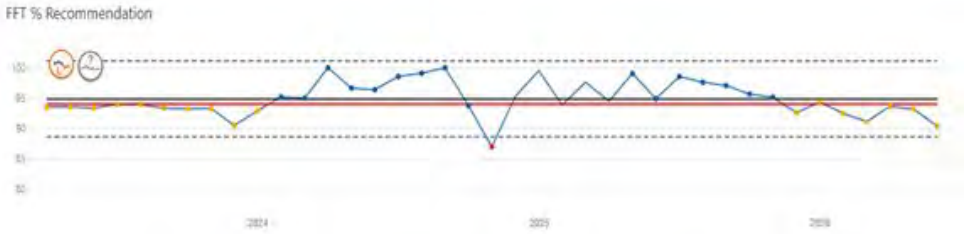
The final approval of the patient Experience A3 includes areas for ED and work will begin soon, targeting some already known challenges, specifically around communication and wait times in the department.

Positive Feedback:
44% of the themes collected were positive in sentiment, with patients commending the care received and behaviour displayed by staff.

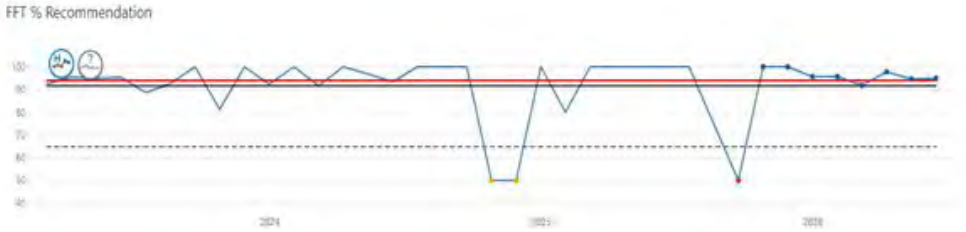
Improvement Feedback:
A significant portion of feedback provided cited waiting as a main contributor to poorer experience. Within the Emergency Departments across both sites, patients expressed long waiting times to be seen, which was further exasperated by the environment and communication.

Quality

Caring – Friends & Family Test – Outpatients



Child Health



Orthopaedics

What is the data showing us?
Special cause of concerning nature has been noted for **Outpatient services overall**, with the Trust not obtaining the benchmark and national average since February 2026. However, a significant increase in responses is likely to have impacted this sudden change. In June 1,270 responses were collected, the highest since September 2023.

Special cause of improving nature for **Child Health**, who has also seen an improvement in responses collected compared the previous year. **Women's Health** is also consistently achieving a FFT rating of 100% since May 2025.

A significant proportion of outpatient feedback within **Division C** continues to come from **Ophthalmology** and **Orthopaedics.** While Ophthalmology has consistently performed below the Trust benchmark since September 2025, there has been a notable increase in overall feedback responses during June.

Response volumes increased from 49 in May to 315 in June, largely as a result of targeted work by the Patient Experience Team. Using EPIC reporting functionality, the team identified and contacted patients directly via email, encouraging them to share their experience. This proactive approach has significantly improved response rates and provided a more robust dataset to support service improvement and patient experience monitoring across the division.

Actions being taken to improve:
The Patient Experience Team will support efforts to increase response rates in outpatient areas that have recorded low or no survey responses over the past 12 months. Monthly Care Group reports are now being shared, providing area-specific patient experience data and insights. Each report includes tailored recommendations and information on the support available from the Patient Experience Team to help improve engagement and response rates.

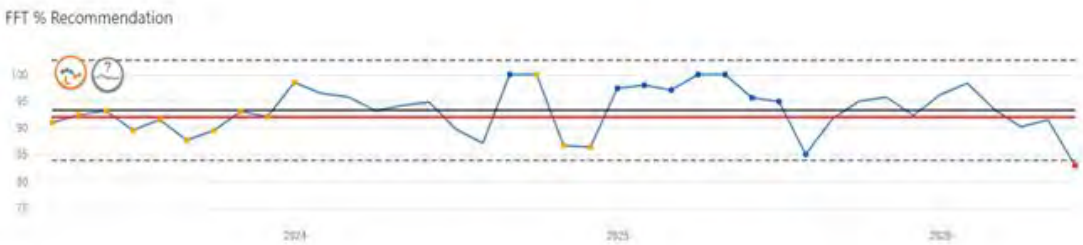
In response to patient feedback themes relating to outpatient services, the Patient Experience Team will work with colleagues to understand the issues raised, identify any improvement activity already underway, and determine where further support may be required within Care Groups. Targeted actions will be developed where needed to improve the outpatient experience.

Positive Feedback:
85% 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.

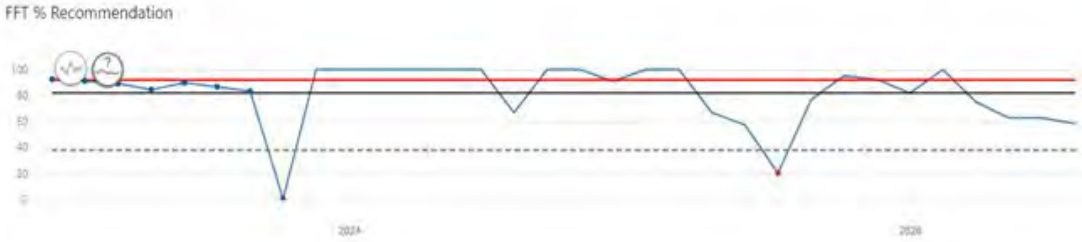
Improvement Feedback:
21% of the themes identified were negative in sentiment. Long waiting past the stated appointment time was noted from patients across all Divisions and noted improvement communication from staff when clinics are running late. Issues with the blood test booking system was picked up by several responses.

Quality

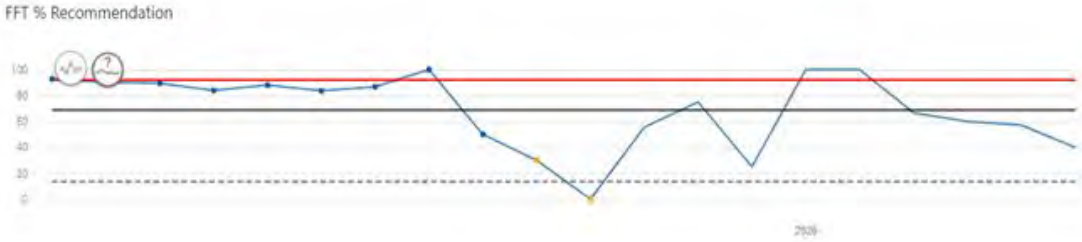
Caring – Friends & Family Test – Maternity



Denmark Hill Antenatal



Fetal Medicine



What is the data showing us?
Special cause of concerning natured for Friends and Family Test scores in Maternity. In June, the service received a score of 82.9% from 41 responses.

Antenatal at Denmark Hill continues to impact overall responses, particularly in **Fetal Medicine**. The responses remain small and therefore it is challenging to identify root causation.

Actions being taken to improve:
Following meetings with the service, the use of volunteer support will be piloted to ensure we are showing a more accurate picture of experience, based on number of patients seen.

As part of the maternity action plan created from the national surveys, there are several actions underway over the current 12-month period related to improving communication and information. This includes reviewing existing information on Epic, training for staff, and information provided to women.

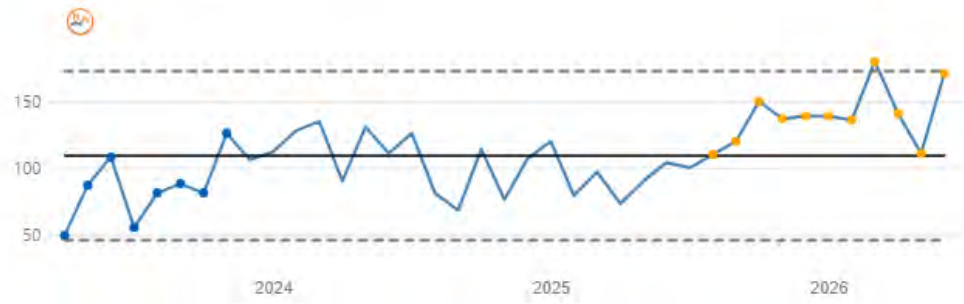
Positive Feedback:
68% of the themes identified were positive in sentiment. Midwives and medical staff were praised on the kindness, support and quality of care provided.

Improvement Feedback:
Although responses are too minimal to draw conclusions, some women issues with communication, staff attitude and waiting prior appointments.

Quality

Responsive - Complaints

Formal Complaints Opened



Complaints % Closed within due date

Numbers received remain far higher than June last year (+56%), following increase for the previous 11 months triggering high special cause concern. The increase in complaints is reflective of the ongoing national NHS trend – benchmarking will be conducted once data is available. Both Denmark Hil and PRUH & Southern Sites have seen an apportioned increase in the number of complaints received, so there is no distinct site-specific trend showing, however Denmark Hill's complaints numbers are showing to be outside of the normal process limits, whilst PRUH & Southern Sites are showing an increase, but still within normal process limits.

Networking across NHS Complaints Leads indicates that most are struggling to cope with the increased numbers and responding in a timely way. Our complaints SOP seems to be supporting Kings well, as a result of our green pathway which enables proportionate responses to more straightforward issues. Continued downward trend of complaints exceeding their due date by 4 weeks or more reflects maintained low/no backlog, and in general those overdue are within 4 weeks, this is significant progress compared to last year.

Expected decrease in the numbers closed due to increase in the numbers of complaints received over past 3 months – this was discussed at Clinical Governance Leads forum around the time complaints are taking to respond to within the care groups and the challenges this brings with increased numbers received each month.

No special cause variation for any complaints closure metrics. Supported by a continued focus on overdue complaints and those complaints due within 2 weeks which are discussed at regular Divisional meetings.

- No complaints are 12 weeks or more overdue.
- 4 weeks overdue remain low

Ombudsman outcomes remain positive – Request for continued focus at specialty/care group governance meetings to evidence discussion and learning from complaints as we know the ombudsman and CQC will expect this on complaints.

Top 3 Reason for Complaints - June (Trustwide)

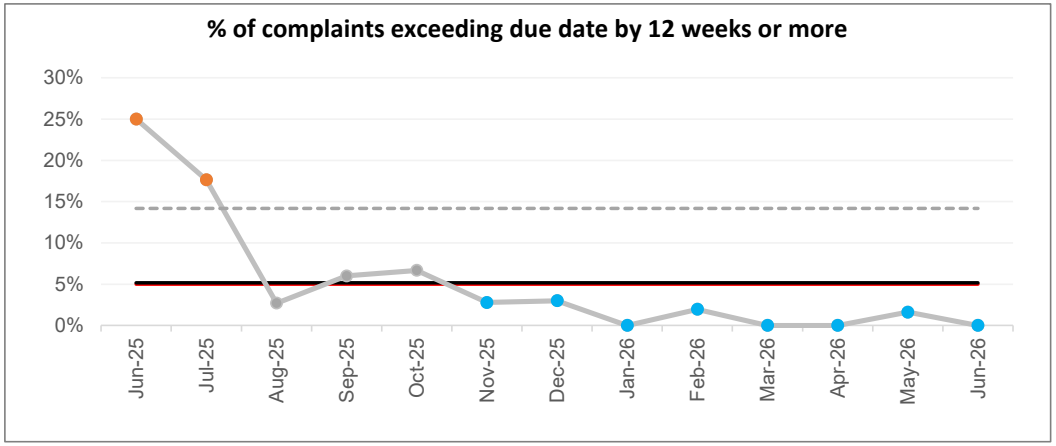
- Communication with patients
- Values & Behaviours
- Patient Care

Top 3 Care Groups – June (Trustwide)

- **Women's Health** – 16%
- **Child Health** – 9%
- **Neurosciences** – 9%

Quality

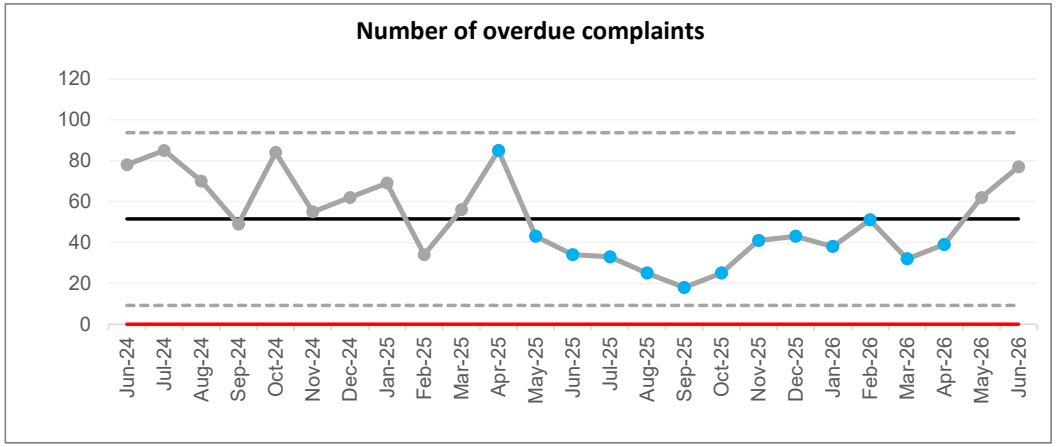
Responsive – Complaints



What is the data showing us?
Sustained low special cause variation shown for this metric for the last 8 months following increased engagement with divisions, care groups, and due to complaints SOP and rating pathway to support in proportionate response provision.

Actions being taken to improve:
All care groups to clear any complaints 2 weeks or more overdue now, and to clear the few that are already over 4 weeks overdue to halt others moving into the 4-week overdue position by next month. Data for 4-week metrics will be published in this report once available.

What is the impact for our patients?
More timely response offers a positive experience when raising concerns, feeling heard validated alongside opportunity to evidence the care groups commitments to improve/learn



What is the data showing us?
Increase in numbers overdue showing for the past 2 months following extended period of improvement, however this is still within the upper and lower process limits as common cause variation – understood that this increase is a result of the increase in overall complaints received, placing strain on both the Complaints Team, Care Groups and Clinical Governance leads to expedite responses alongside responding to PALS contacts, and managing PSIRF processes

Actions being taken to improve:
In addition to the regular Divisional and Care Group focussed complaints meetings during July 2026 there has been additional tracking of overdue complaints with an aim to reduce by 50% in month. Overdue complaints are being pulled centrally for oversight/closure by complaints manager and head of complaints. Proceeding with approval to recruitment Band 4 vacancy to support general admin and in addition processes around bank are being revised to support timely improvement.

What is the impact for our patients?
Less timely response will make complainants feel unheard and that their concerns are not valid or feedback valued.

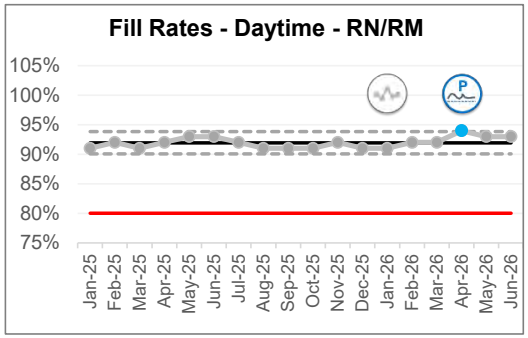
Quality

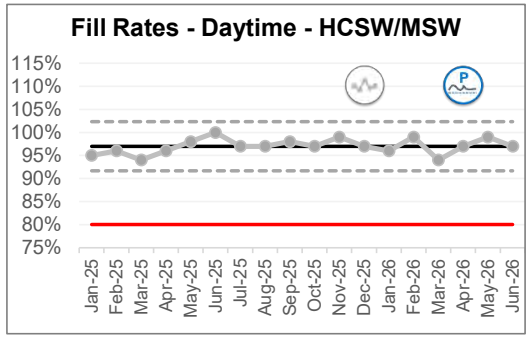
Well-led – Safer Staffing

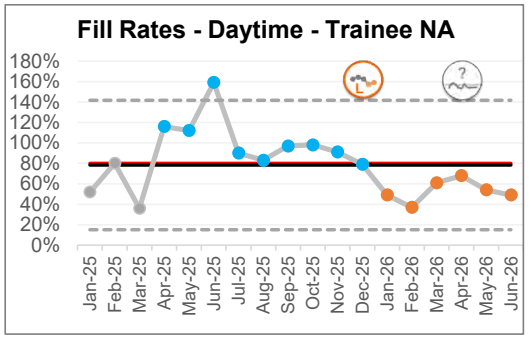
Fill Rates

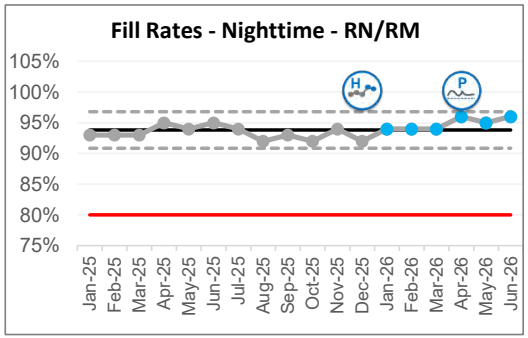
Positive assurance and special cause improvement shown for fill rates for daytime and nighttime for both HCSW and RN/RM.
Low special cause concern noted for fill rates for Daytime Trainee NA, however, this affects a very small number of staff in a few clinical areas only. Currently the Trainee NA programme is on the last full cohort following the qualification of this cohort. Where there are less on shift than planned, this role will be covered by HCAs so is not indicative of unsafe staffing in isolation.
1 areas reported registered fill rates of <80% - Medical 1 (PRUH) - 77% Nighttime

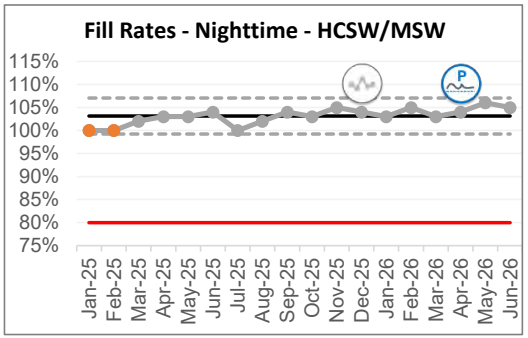
Representative of the proportion of planned care hours delivered against the hours scheduled by the clinical team. *Fill rate calculations do not include additional shifts needed for enhanced care, and are based on core template of staffing, producing inflated >100% figures.*











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Workforce

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	2026-07	13348.08	13389.95	No Target	
Advert Open to Conditional Offer (AfC)	2026-07	22.2	32.2	Pass	
Advert Open to Conditional Offer (Consultants)	2026-07	56.7	41.0	Fail	
Agency Cost	2026-07				
Appraisal %	2026-07	92.56%	53.83%	Pass	
Average days lost to sickness per FTE/employee	2026-07	7.5	7.1	No Target	
Bank Cost	2026-07				
Core Skills %	2026-07	89.18%	89.14%	Fail	
Disciplinary Cases(formal)	2026-07	27	26	No Target	
Dismissals	2026-07	3	2	No Target	
Early Resolution Cases (formal)	2026-07	19	26	No Target	
Establishment FTE	2026-07	14345.09	14347.89	No Target	
Flu Vaccination Uptake (%)					16/08/26
Gross Salary Bill	2026-07				
Headcount (Substantive)	2026-07	14371	14415	No Target	
Leavers < 12 Mths Service % (voluntary)	2026-07	21.11%	27.40%	No Target	
Leavers Headcount	2026-07	124	93	No Target	
Proportion of Apprenticeship levy spent	2026-07	5%	2%	No Target	
Sickness %	2026-07	4.72%	4.46%	Fail	
Sickness Long Term %	2026-07	2.18%	2.19%	Pass	
Staff mix (substantive, honorary and volunteers)	2026-07				
Starters Headcount	2026-07	80	112	No Target	
Turnover Voluntary %	2026-07	7.64%	7.67%	Pass	
Vacancy %	2026-07	6.40%	6.12%	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 4.46% and remains within the middle quartile when benchmarked against other large London Trusts. This reflects a stable and broadly positive position, with the Trust continuing to maintain sickness absence at a manageable level despite the wider pressures across the NHS workforce.
- A dedicated Sickness Absence Improvement Project Group will be established in late August/early September 2026 to oversee the development and delivery of a Trust-wide improvement programme. The group will focus on identifying the key drivers of sickness absence, implementing targeted interventions, strengthening management capability, and improving attendance outcomes in support of the Trust's People and Culture Strategy, workforce productivity and financial recovery objectives.

- Core Skills compliance is still below the 90% target; however, it has improved from 89.14% in June to 89.18% at the end of July, despite continued underperformance in key areas, including resuscitation. Targeted recovery actions are in place, with a focus on high-risk modules and strengthened accountability to return to compliance by September 2026.
- In line with the KE paper recommendations, targeted communications, and focused line managers' intervention, alongside strengthened reporting and monitoring, is intended to drive improved compliance in these priority areas.

- Trust Vacancy rates increased slightly to 6.40% and continued to significantly outperform the 10% Trust target. This reflects good progress in workforce stabilisation and vacancy management in line with Trust priorities.
- AfC time-to-hire remains within KPI for 7-9 but slightly outside KPI for bands 1-3 & 4-6,
- Medical time-to-hire has decreased slightly to 107 days from 106 days against the 100 days KPI. However, still demonstrates continued progress overall towards alignment with national benchmarks and in filling critical roles. It should also be noted that volumes in this group are currently very low (c.4-8 per month)

- Voluntary turnover has slightly decreased to 7.67% but remains well below the 13% target. Notably, turnover has consistently remained under target since October 2023, reflecting sustained retention performance.

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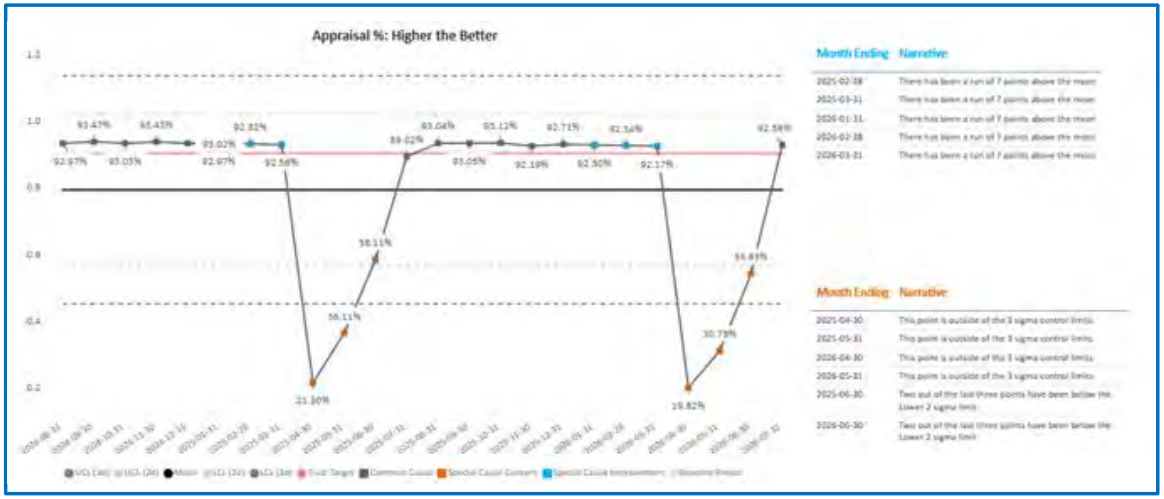
Workforce

Appraisal Rate

Background / target description:

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

Jul 2026	Target
92.56%	90%



What is the Data Telling Us

Non-Medical:

- The Trust exceeded its 90% AfC Appraisal compliance target with **92.92%** at the end of July 2026.
- This was the first time in over four years the Trust has hit target by the close of the appraisal window.
- All 3 Divisions, Corporate and other sites hit over 90% within the appraisal window.
- The current in-month figure (19/08/2026) shows 94.6% which is the highest return rate in over four years.
- A KE paper was produced towards the end of July setting out recovery actions which led to an increased number of submissions.

Medical:

Medical appraisal compliance has increased to **91.00%**, exceeding the Trust target of 90%. Engagement with the lowest compliance care groups, revising our compliance window to factor in the 28 day post appraisal sections completion & enhancing our data cleanse for leavers has all contributed to this

Future Actions

Non-Medical:

- Reminders are being sent to staff who have not yet submitted their appraisal, along with weekly exception reports being sent to Divisional People Teams, Divisional and Care Groups leaders for follow ups.
- Reconciliation exercise is underway to identify those staff who are currently not able to submit an appraisal, i.e. LTS, Maternity, etc to allow focus to be placed on those 'in work' who have yet to submit their appraisal.
- Consideration to be given to undertaking a quality assurance exercise to assess appraisal standards across the Trust.

Medical:

- Monthly compliance reports are shared with Clinical Directors, People Business Partners, and General Managers.
- 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.
- The process for managing long-term non-compliance is being view by the RO, Deputy Assoc MD for Appraisal & Medical People team to try to ensure this is addressed promptly.

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Workforce

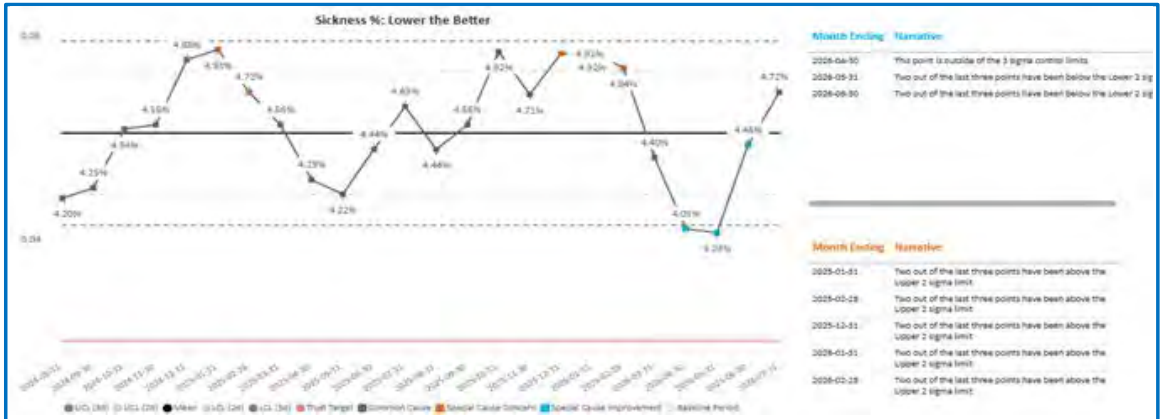
Sickness Rate

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.

Jul 2026	Target
4.72%	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.



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.

What is the Data Telling Us

- The sickness absence rate has increased by 0.26% from 4.46% in June 2026 to 4.72% in July 2026, in overall absence performance as the Trust.
- In total, 2,760 staff were reported as absent due to sickness during July, an increase of 105 on the previous month.
- The highest absence reasons based on the number of episodes were due to:
  - Gastrointestinal problems (17.6%)
  - Cold, Cough, Flu – Influenza (14.0%)
  - Other musculoskeletal problems (9.1%)

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.
- 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.
- A sickness absence deep dive paper to King's Executive (KE), was approved. As part of the agreed recommendations, investment has been secured to support a comprehensive review of sickness absence across the organisation. Through this investment, we will be recruiting to a Band 6/7 role to support the delivery of this programme of work and work collaboratively with an external organisation to help shape and deliver this important initiative.

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Workforce

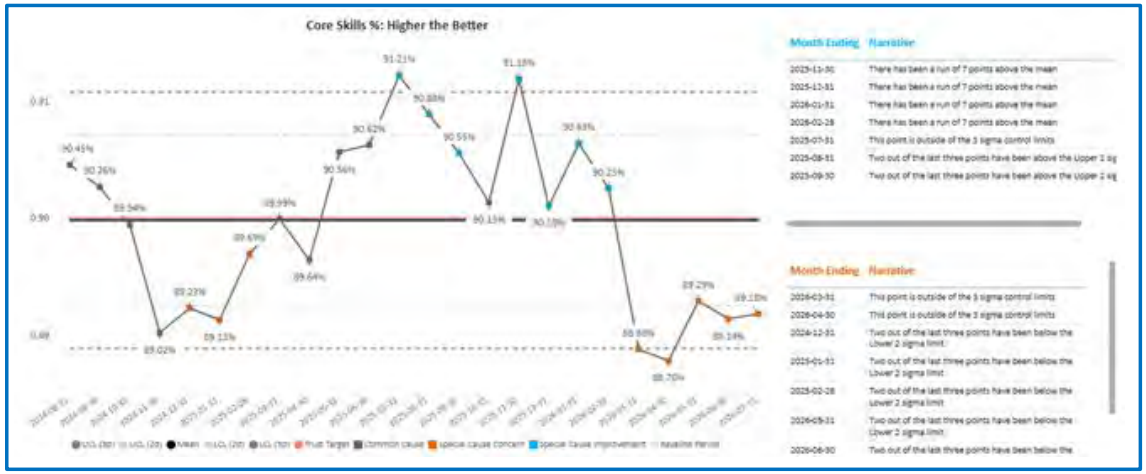
Statutory and Mandatory [Core Skills] Training

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.

Background / target description:

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

Jul 2026	Target
89.18%	90%



What is the Data Telling Us

- Despite a small increase, the Trust compliance is **89.18%**, remaining just below the 90% target for the fourth consecutive month.
- Medical & Dental dropped this last month to 80.54% and are now the only staff group below the 90% threshold. As the second largest staff group (~2,700 staff), their underperformance continually impacts on the overall Trust compliance.
- Division A maintained a static compliance last month on 88.31%, however, Divisions B and C both saw their compliance drop. B: 89.43% [-0.29%) and C: 88.57% [-0.21%], Given the numbers involved, this will have contributed to the Trust not progressing towards the 90% target last month.
- The four lowest Care Groups this month and requiring targeted intervention are: Pathology 83.68% (-0.55% on last month) and Haematology 85.32% (-0.07% on last month), plus two new care groups Child Health on 85.69% and Emergency Care on 85.70%.
- The largest compliance gaps remain within Resuscitation 76.63% (down from 78.89%), and Infection Prevention & Control 86.75% (down from 87.26%). Manual Handling was 87.33% this month which was an increase from 86.62%.
- Level 2 ABLS Resuscitation remains the highest-risk training area at 77.90% which is a drop of 0.9% on the previous month.
- With strengthened divisional leadership engagement and targeted interventions, especially with Medical and Dental staff, achievement of the 90% Trust compliance target by September 2026 remains achievable.
- A KE Paper was submitted outlining the actions and recommendations required to accelerate improvement and secure sustained compliance gains.

Compliance remains close to target, with improvement activity increasingly concentrated on a small number of high-impact staff groups, care groups, and mandatory training subjects. This provides a clear and achievable pathway to exceeding the Trust's 90% target.

Future Actions

Theme & Actions	Owner	Start Date
Strengthen Accountability and Leadership Ownership		
• Issue clear communication from divisional/corporate leadership	Divisional Chiefs	July 2026
• Add core skills recovery messaging to CEO briefings and Trust communications.	Corp Comms	Sept 2026
• Review Core Skills Policy to clarify accountability and local responsibilities	Head of Core Skills	Oct 2026
• Agree escalation thresholds for persistent non-compliance	Head of Core Skills	Oct 2026
Accelerate Compliance Recovery in Priority Areas		
• Develop targeted recovery plans for the lowest-performing areas.	Care Groups Leadership	July 2026
• Implement a focused improvement plan for Medical and Dental staff.	Head of Core Skills / Div Chiefs	Aug 2026
• Identify high-risk subjects requiring local risk assessments	SMEs & Head of Core Skills	Sept 2026
• Conduct a deep-dive review of Resuscitation compliance	Core Skills Business Partner	July 2026
Improve Data Quality, Visibility and Assurance		
• Launch line manager data cleanse, prioritising staff with no manager assigned	LEAP Manager	July 2026
• Improve compliance data availability for People Business Partners and line managers	LEAP Manager	July 2026
• Review ESR/LEAP interface and passporting arrangements	LEAP Manager	July 2026
• Enhance monthly reporting with exceptions, risks and mitigation actions	Head of Core Skills	July 2026
Remove Barriers to Training Compliance		
• Explore pre-rostering for high-release training programmes	Head of Core Skills	Oct 2026
• Develop LEAP video tutorials covering booking training and compliance checking	LEAP Manager	July 2026
• Improve access to compliance information and self-service tools	LEAP Manager	July 2026

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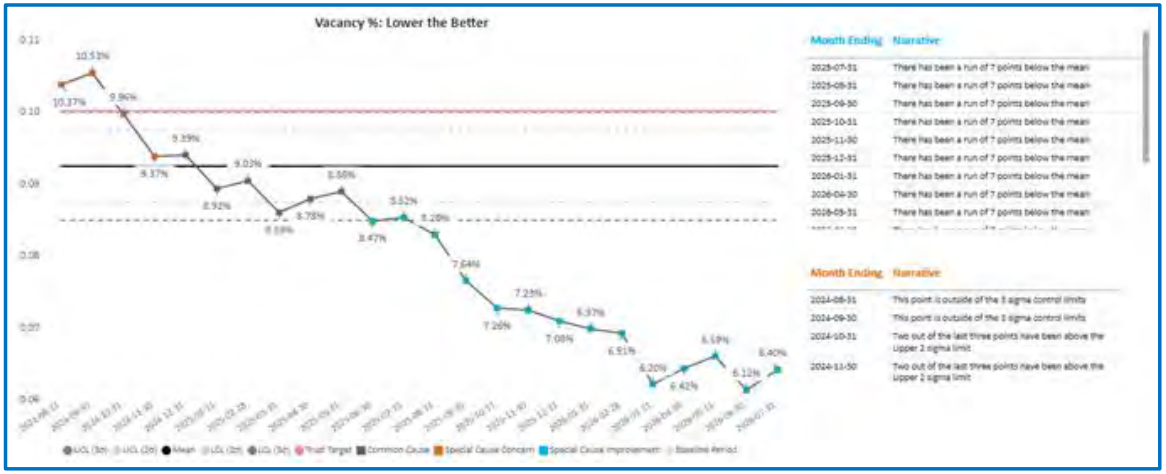
Workforce

Vacancy Rate

Background / target description:
• The percentage of vacant posts compared to planned full establishment recorded on ESR. *Note: When the actual FTE is higher than the establishment FTE the vacancy % is displayed as zero.*

Jul 2026	Target
6.40%	10%



What is the Data Telling Us

- The overall vacancy rate has decreased slightly to 6.12% this month and remains within the 10% target, reflecting continued improvement in workforce stability.
- AfC time to hire also remains broadly within KPI across all bands:
  - Band 1–3 at 61.5 days (slightly outside 60-day target)
  - Band 4–6 at 80.3 days (outside 70-day target)
  - Band 7–9 at 71.2 days (well within the 90-day target)
- Medical time-to-hire has decreased slightly to 107 days from 106days against the 100 days KPI. However, still demonstratescontinued progress overall towards alignment with nationalbenchmarks and in filling critical roles. It should also be noted thatvolumes in this group are currently very low (c.4-8 per month)
- Overall resourcing performance remains stable with strong control 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

- Following the successful implementation of our new vacancy control process for substantive recruitment, a new app is being developed for release in Q2 that will support the Trust in managing pay-impacting changes outside of recruitment.
- 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. Trac is being utilised to drive this and will work alongside the revised vacancy control process.
- Continue to recruit in line with local and external ‘triple lock’ process.
- A new data quality team has now been setup and will be working across Q2 to implement new RPA processes and data quality processes to streamline both recruitment and in-lifecycle employee changes.
- Operational changes planned for Q1 to streamline audit and checking processes have been implemented which will start to free up resources and allow us to address areas of slight underperformance in time to hire.

Workforce

Turnover Rate

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

Jul 2026	Target
7.64%	13%

What is the Data Telling Us

- Voluntary turnover has decreased slightly to 7.64% in July 2026 from 7.67% in June 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 June were:
  - Relocation (237%)
  - Promotion (17%)
  - Retirement(10%)

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.

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Workforce

Employee Relations

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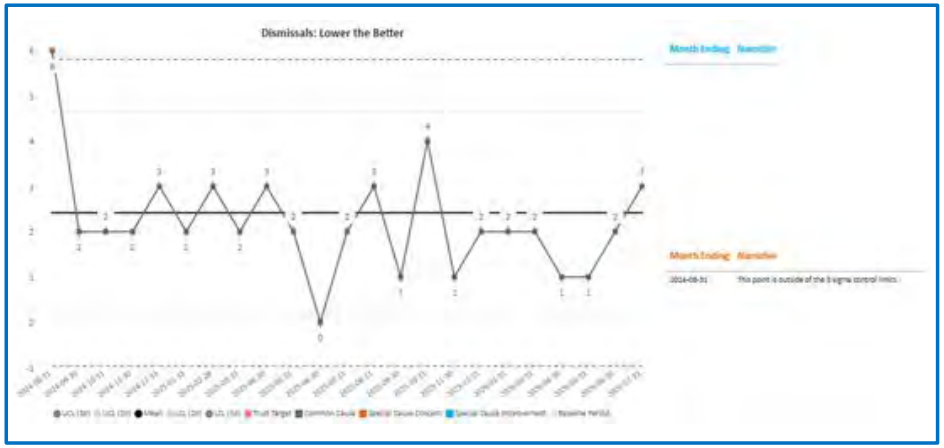
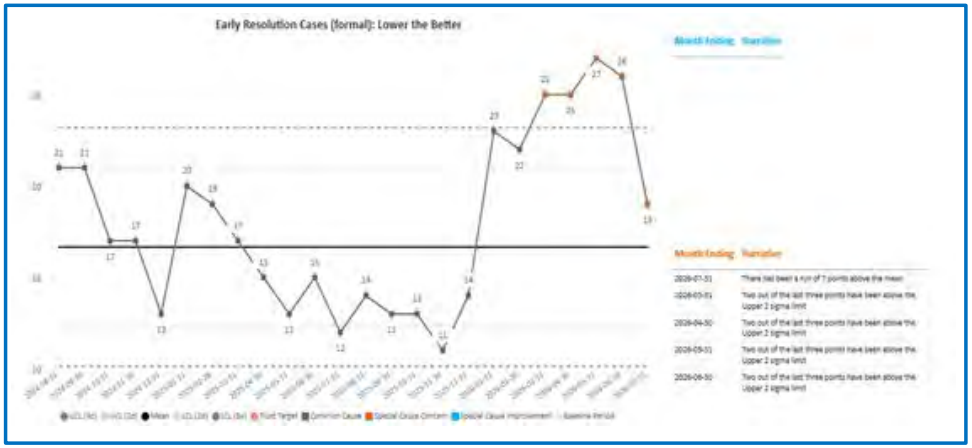
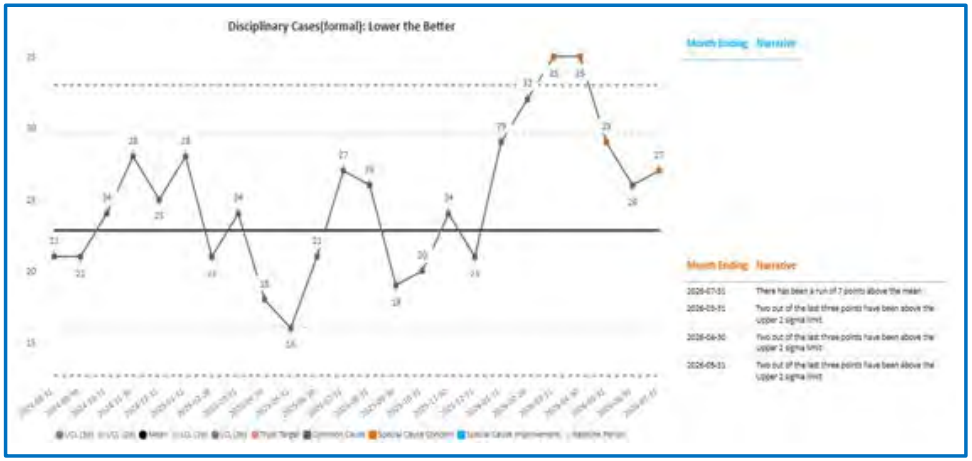




What is the Data Telling Us

As of 31 July 2026, there were 27 open formal disciplinary cases, an increase of 1 from the previous month. There were 19 formal early resolution cases, submitted by 25 people. 2 of the 19 cases are collective cases involving 8 of the 25 people, and a significant decrease on the previous month. Average investigation completion time has remained at the target of 12 weeks for the fifth consecutive month. In July, 10 formal disciplinary cases were closed, which continues to demonstrate steady momentum in case resolution. Of the closed cases, some of these had taken longer than anticipated owing to the staff involved being absent and unable to engage in the process, as well case complexity, impacting on the average completion time.

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



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Workforce

Workforce Equity: Key exceptions and assurance – Ethnicity (July 26)

What is the Data Telling Us

Monthly Sickness by Category and Ethnicity Group

Sickness Category	Global Majority (BME)	White	Not Stated
Sickness ST %	2.83%	2.04%	2.65%
Sickness LT %	2.25%	2.10%	1.88%
Sickness %	**5.08%**	**4.14%**	**4.53%**

ST – Short term sickness / LT – Long term sickness

- Sickness has increased for both global majority (+0.76) and white staff (+0.57) since July across both short- and long-term sickness. The overall sickness percentage difference has increased between these two groups from 0.75% to 0.94%. Sickness for the not stated category has increased by 0.69%.
- Whilst there is a marginal increase to the differential gap between global majority and white staff, data demonstrates that global majority staff are more negatively impacted within their roles by musculoskeletal problems. A greater proportion of global majority staff are represented in bands 1 – 7, across roles involving significant manual handling and direct patient care.
- Investment has been secured to support a comprehensive review of sickness absence across the organisation, in which EDI will be the golden thread woven throughout to identify areas of inequality.

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.

Relative likelihood of white staff being appointed compared to global majority (BME) staff

No. of adverts for this period is 82

Stage	Minority ethnic	White	Not Stated	Grand Total
Applications	3,741	439	79	4,259
Shortlisted	301	96	10	407
Appointed	56	28	1	85
Appointment from Shortlisting %	18.6%	29.2%	10.0%	20.9%
Relative likelihood		**1.57**		

- Amended reporting demonstrates a more accurate likelihood and the disparities that exist between global majority and white applicants.
- Whilst data suggests King's is an attractive employer for global majority talent, the conversion of application to shortlist is significantly lower (8% conversation rate) compared with white applicants (22% conversation rate.)
- Inclusive Recruitment Training is under review following necessary changes and potential training compliance impact, following the Lord Mann review and recommendations adopted in full by NHS England.
- We will develop new recruitment training materials, inclusive of the incoming standardised anti-racism training packages by NHS England.

Relative likelihood of global majority (BME) staff entering the formal disciplinary process compared to white staff

Metric	Minority Ethnic	White	Not Stated	Trust
Formal Disciplinaries (YTD)	69	29	5	103
Staff in post (month end)	8,439	5,325	607	14,371
Formal Disciplinaries rate	0.8%	0.5%	0.8%	0.7%
Relative likelihood	**1.5**			

- The reporting period for this data set has been amended, providing a more accurate representation of disparity within Disciplinary processes month on month.
- Our current disparity demonstrates that global majority staff are 1.5 times more likely to enter the formal disciplinary process compared to white staff, and remain overrepresented.
- Race and ethnicity remain a key organisational priority for improvement as stated within the new people and culture strategy.
- An externally commissioned review of our WRES data is currently in progress, with the aim of identifying root causes and recommended interventions to reduce disparities for staff.
- Addressing these disparities will be a key area of focus within the People and Culture Strategy.

Workforce

Workforce Equity: Key exceptions and assurance – Disability (July 26)

What is the Data Telling Us

Monthly Sickness by Category and Disability

Sickness Category	Disabled	Non-Disabled	Not Declared
Sickness ST %	3.52%	2.48%	2.68%
Sickness LT %	4.84%	2.01%	2.97%
Sickness %	**8.36%**	**4.49%**	**5.65%**

ST – Short term sickness / LT – Long term sickness

- Disabled staff sickness rates (8.36%) remain disproportionately high at nearly twice percentage the rate of non-disabled staff (4.49%).
- This clear disparity directly mirrors wider trends found across national Workforce Disability Equality Standard (WDES) indicators; metric 3 (capability), 6 (feeling pressure to come to work), and 8 (implementing adequate adjustments.)
- A clear and persistent "Not Declared" rate of 5.65% highlights the current culture of non-disclosure, and lack of people processes to capture this information.
- The ongoing disparity points to potential systemic issues with foundational support for disabled staff, specifically a lack of consistent line manager interventions.
- People Business Partners will be tasked with identifying and targeting specific operational "hotspot" areas where disability-related sickness is significantly higher than the Trust average and target of 3.5%.
- We have commenced socialising WDES 2025/26 data with stakeholders, to co-produce actions that will address disparities for disabled staff.

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.

Relative likelihood of non-disabled staff being appointed compared to disabled staff
No. of adverts for this period is 82

Stage	Disabled	Not Disabled	Not Declared	Grand Total
Applications	**150**	4063	46	4,259
Shortlisted	**28**	372	7	407
Appointed	**7**	76	2	85
Appointment from Shortlisting %	**25.0%**	20.4%	28.6%	20.9%
Relative likelihood		**0.82**		

- During this period, once shortlisted, Disabled candidates out-performed non-disabled candidates, achieving a higher conversion rate to appointment (25.0% vs. 20.4%).
- This outcome aligns directly with WDES Metric 2 (Relative likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff). The relative likelihood ratio now stands in favour of disabled candidates.
- The volume of candidates with an unknown or undeclared disability status remains high during this reporting period.
- Whilst this is a positive step forward, work will continue to review granular data and identify structural bottlenecks in recruitment that hinder disabled candidates from being appointed to senior roles (Band 8a and above.)

Relative likelihood of disabled staff entering the formal disciplinary process compared to non-disabled staff

Metric	Disabled	Non-Disabled	Not Declared	Trust
Formal Disciplinaries (YTD)	**5**	89	9	103
Staff in post (month end)	**567**	12,713	1,091	14,371
Formal Disciplinaries rate	**0.9%**	0.7%	0.8%	0.7%
Relative likelihood	**1.3**			

- Disabled staff experience a slightly higher formal disciplinary rate (0.9%) compared to non-disabled staff (0.7%).
- While numbers remain low (5 cases out of 567 staff), the data highlights that disabled staff are 1.3 times more likely to enter a formal disciplinary process than their non-disabled colleagues. Electronic Staff Record (ESR) disability declaration requires intervention, in contrast to the annual anonymous staff survey, where 15–20% of staff consistently identify as disabled each year.
- The data demonstrates a potential risk that performance issues related to missing reasonable adjustments are being escalated to formal cases, rather than managed supportively at local level, correlated with sickness absence, and wider WDES metrics.
- Our WDES data is being actively socialised among staff networks and People teams for engagement and discussion on the necessary actions that must be taken to reduce disparities before going through governance processes.

Finance

Domain 4: Finance - Executive Summary

As of July, the KCH Group (KCH, KFM and KCS) has reported a £9.0m deficit year to date. This represents a £8.0m favourable variance to the March 2026 NHSE accepted plan. The Trust is forecasting to achieve the breakeven plan, on the basis that further remediation takes place beyond the current 'do something' scenario.

The underlying position year to date is a £47.4m deficit after removal of non-recurrent items, £4.9m adverse to plan.

Income £11.5m adverse variance:

- The Trust is reporting a £2.0m adverse year-to-date variance against NHS patient care income. The worsening in the deficit position from £3.3m to £9.0m in Month 4 largely reflects lower in-month activity performance and the alignment of previously unassigned commissioner activity to fixed payment contracts.
- Private patient income is £1.7m below plan year to date, primarily due to the underperformance of the CAR-T cell CIP. The income shortfall is offset by a corresponding reduction in expenditure. Given the low-volume, high-value and inherently variable nature of this activity, the CIP remains forecast to be fully delivered by year-end.
- There was also £1.7m over performance on Local Authority contracts and a further £2.4m on overseas visitors and the injury cost recovery scheme.
- £9.4 underperformance in Other Operating income relates to subsidiary income from external contracts and is mitigated by reduced expenditure.

Pay £7.3m adverse variance:

- The adverse variance is driven by £9.0m undelivered CIP against plan resulting in pay expenditure remaining above plan.
- Nursing pay is a £2.5m adverse variance mainly due to Bank spend driven by sickness cover, escalation and enhancement. The adverse position was partially offset by an Administrative & Clerical pay underspend.
- There was a £1m impact for shift cover for the Resident Doctors strike impact.
- The Trust's WTE has increased by 7 since June, primarily driven by an increase in Nursing Bank utilisation.

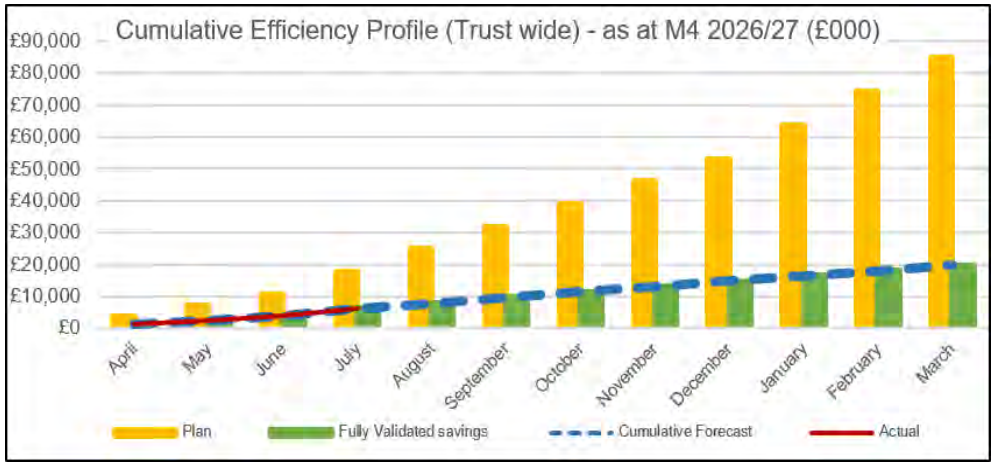
Non-pay £25.5m favourable variance:

- The favourable variance is driven by £13.4m underspend on Clinical Supplies and Healthcare, attributable to subsidiary non-pay expenditure on external contracts, offsetting income underperformance.
- The remaining favourable variance is due to budgeted inflation expected to crystallise in future months.
- The favourable position offset pressures of £1.3m overspend in Patient Transport Services and £2.5m under delivery of CIP.

CIP

- The Trust has confirmed plans to deliver £19.8m of CIP a planning gap of £65.1m against the £84.9m target. £11.9m (60% of forecast delivery) has moved into Gateway 3 since 1 January 2026, £1.7m since June 2026. The Trust has delivered year-to-date recurrent savings of £6.1m (£1.3m pay and £4.8m non-pay), resulting in a year-to-date adverse planning variance of £11.5m.

	Current Month			Year to Date		
	Budget	Actual	Variance	Budget	Actual	Variance
NHSE Category	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income From Patient Care Activities	155.7	147.2	(8.5)	622.6	620.6	(2.0)
Other Operating Income	12.0	9.9	(2.1)	47.9	38.5	(9.4)
Operating Income	**167.7**	**157.2**	**(10.6)**	**670.6**	**659.1**	**(11.5)**
Employee Operating Expenses	(91.8)	(94.2)	(2.4)	(373.2)	(380.5)	(7.3)
Operating Expenses Excluding Employee Expenses	(78.8)	(65.6)	13.2	(300.9)	(275.4)	25.5
Non Operating Expenses	(3.1)	(3.0)	0.1	(19.8)	(19.0)	0.8
Trust Surplus / (Deficit)	**(6.0)**	**(5.6)**	**0.3**	**(23.4)**	**(15.8)**	**7.6**
Less Control Total Adjustments	**(0.2)**	**(0.1)**	**0.3**	**6.4**	**6.8**	**0.4**
Adjusted Financial Performance (NHSEI Reporting)	**(6.2)**	**(5.7)**	**0.6**	**(17.0)**	**(9.0)**	**8.0**
Less: Non-recurent Deficit Support Income (National)	(3.7)	(3.7)	0.0	(14.8)	(14.8)	0.0
Non-recurrent Deficit support income (Local)	(2.7)	(2.7)	0.0	(10.7)	(10.7)	0.0
Non-recurrent benefits and industrial action	0.0	0.0	0.0	0.0	(12.9)	(12.9)
Adjusted Financial Performance excluding NR Items	**(12.6)**	**(12.1)**	**0.6**	**(42.5)**	**(47.4)**	**(4.9)**
Other Metrics						
Cash and Cash Equivalent	74.3	123.4	49.1	74.3	123.4	49.1
Capital	4.0	0.9	(3.1)	11.1	3.6	(7.6)
CIP	7.0	2.2	(4.9)	17.6	6.1	(11.5)



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Finance

Domain 4: Finance - Executive Summary (Continued)

As of July, the KCH Group (KCH, KFM and KCS) has reported a £9.0m deficit year to date. This represents a £8.0m favourable variance to the March 2026 NHSE accepted plan. Excluding non-recurrent support, this results in an underlying deficit of £47.4m, £4.9m adverse to plan.

Industrial Action, Enhanced Care, escalations and sickness 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 July WTE position has increased by 7 WTE, from 14,352 WTE to 14,359 WTE.

Medical Bank temporary staffing reduced by 3 WTE between June and July. In contrast, Nursing Bank utilisation increased by 52 WTE, primarily driven by higher enhanced care demand and changes in service delivery resulting in higher use of escalation areas.

The 2026/27 plan includes a national NHS target to reduce temporary staffing by 4.3% for bank staff (£4.0m) and 0.4% for agency staff (£0.4m). Currently, the Trust is exceeding the Bank cap by £4.0m year to date; largely within Nursing bank staffing (£2.5m). This was exacerbated in April by additional backfill requirements during industrial action. Additionally, April to July 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.

Finance

Domain 4: Finance - Executive Summary (Continued)

As of July, the KCH Group (KCH, KFM and KCS) has reported a £9.0m deficit year to date. This represents a £8.0m favourable variance to the March 2026 NHSE accepted plan.

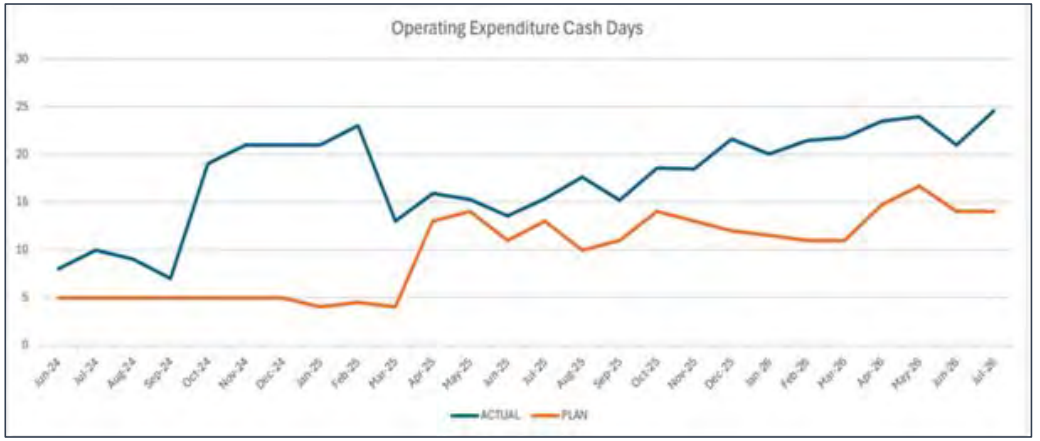
Cash: Month end cash balances have increased slightly between June and July 26.

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 July 2026, Trust confirmed capital sources for 2026/27 core projects stands at £69.2m, an increase of £0.9m from June 2026 as a result of charity and grant funding. With the MOPAC agreement fully signed in July 2026, the sources have been updated to include the £9.0m grant under external funding and reduce the NHSE element accordingly. July 2026 year-to-date expenditure is £3.6m, against a year-to-date planned spend of £11.1m, giving a year-to-date variance of £7.5m. Revised delivery plans are in place to ensure slippage is recovered and projects delivered by year end.

The capital programme is significantly backloaded with 45% of spend forecast in Q4. This increases the risk of slippage late in the year, resulting in the Trust not getting full value from its capital budget. The Executive must review capital forecasts and plans within their areas of responsibility, take action as needed to ensure programme delivery by 31st March 2027, Finance must be notified of any underspends for repurposing as soon as possible to ensure these can be used productively.



Key Actions

1. At the end of July, the Trust has confirmed plans to deliver only £19.8m of CIP, a planning gap of £65.1m against the £84.9m target. Only £11.9m (60% of forecast delivery) has moved into Gateway 3 since 1 January 2026, £1.7m since June 2026. A Chief Executive led reset of the transformation programme with Board approval in September to underpin this new intervention is required, to make a step change in delivery.
2. Delivery of remediation by Divisions A, B and Corporate is required to address July 2026 adverse performance against the agreed Phase 1 and Phase 2 run rate intervention trajectories, to ensure full delivery.
3. Enhanced controls are being implemented on temporary staffing bookings, a fortnightly temporary workforce delivery group has been established 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.
4. 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.

Finance

Domain 4: Finance - Executive Summary - Risk

The Trust identified the key strategic and operational financial risks during planning, and these are included on the corporate risk register and will continue to be monitored and reviewed throughout the year. 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 July, CIP is £11.5m 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.

Risk E relates to the financial impact of activity management in line with contractual arrangements. This risk has increased because of lower costed activity performance in July.

Risk H relates to the risk of strategic investments subject to central funding bids not receiving full revenue and capital support, which has reduced due to progress in the central approval process.

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.

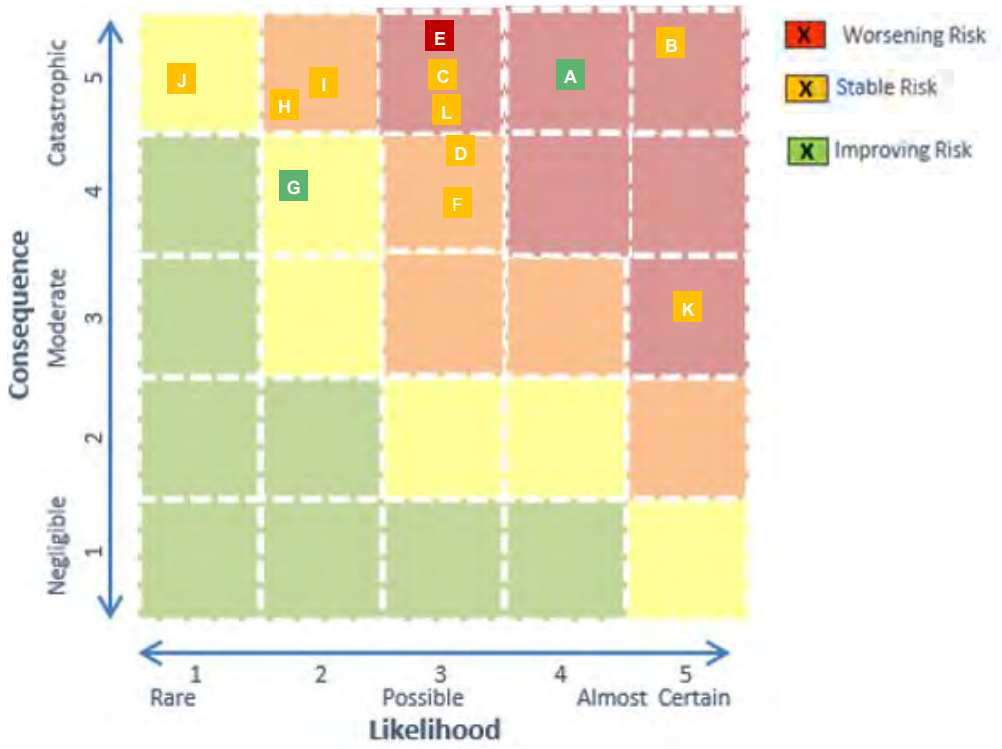
Risk J is related to the risk of changes to VAT regulations (COS 45) which could have a material impact on VAT recovery from April 2026 onwards.

Risk K relates to staff Industrial Action, which has crystallised at £1.0m net cost impact year to date.

Risk L relates to the financial impact of the implementation of the band 5 nursing review being in excess of available funding.

Regulatory Risk

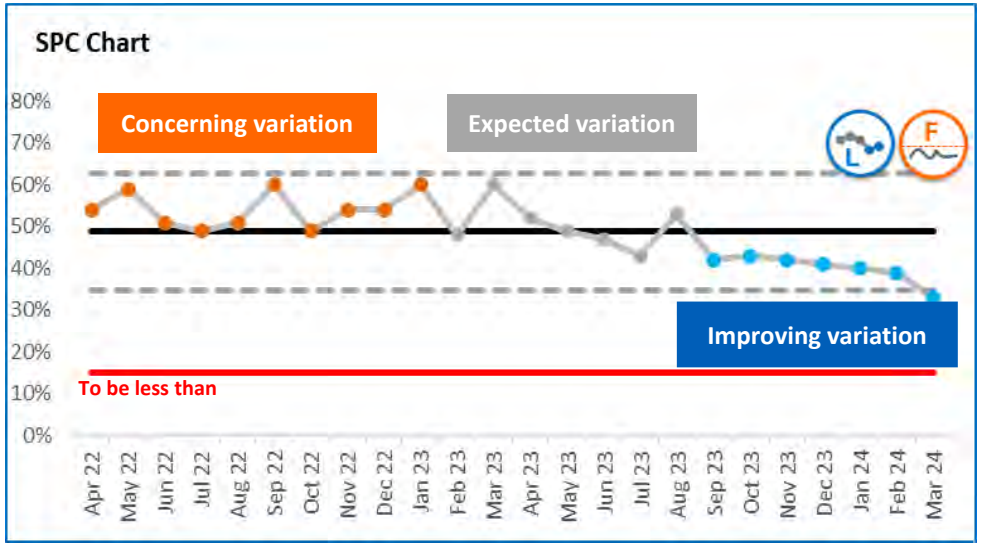
The Trust is currently in NOF segment 3 based on the lates published data (Q4 2025/26). Finance and Productivity is the only domain in which KCH is currently scoring above average, due to a positive variance to plan year to date and improvements in implied productivity. This is despite the Trust's planned 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 plan	-4.06	%	4.00	101 out of 134	-1.54
Finance	Variance year-to-date to financial plan	Month 12 2025/26	0.24	%	1.00	61 out of 134	0.03
Finance	Combined finance	Q4 2025/26			2.00		
Productivity	Implied productivity level	Q3 2025/26 vs Q3 2024/25	12.18	%	1.07	4 out of 134	2.57

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



UPL

Average

LPL

Target

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?

King's College Hospital NHS Foundation Trust

AGENDA ITEM:10

BOARD/COMMITTEE REPORT COVER PAPER

Report to:	Trust Board meeting – Public
Date of meeting:	16 September 2026
Subject:	Highlight Reports from the Chairs of Board Sub committees
Author(s):	Zowie Loizou and Vanisha Mistry, Corporate Governance Officers.
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 15 July 2026. The following reports are included:

1. Finance and Commercial Committee (30 July and September meetings),
2. Performance, Transformation and Improvement Committee (PTIC) (August),

A verbal update will be provided for the Audit and Risk Committee, and PTIC September meetings.

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**	✓

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Key implications

Strategic risk - Link to Board Assurance Framework	The committees provide oversight and assurance across the Trust's strategic risks and associated BAF controls and assurances.
King's Improvement Impact (KIM):	The report provides assurance on committee oversight of improvement and transformation activity where relevant. There is no direct KIM impact arising from the report itself.
Quality Impact	Links to improved quality of services and to patient safety.
Health Equity Impact	No direct health equity impact arises from the report. Relevant health equity issues identified through committee scrutiny would be reported or escalated to the Board as appropriate.
Workforce Impact	No direct workforce impact arises from the report. Workforce matters and associated risks considered by the committees are reported to the Board where they require assurance, escalation or further attention.
Research/Innovation Impact	The report provides visibility of relevant innovation and transformation matters considered by the committees, including matters requiring Board oversight.
Digital Impact	The Performance and Finance committees discuss digital impact in detail.
Financial Impact	Links to Improvement Plan and financial strategy
Legal/ regulatory compliance	The report supports the Trust's governance and assurance arrangements by enabling the Board to receive updates from its sub-committees in accordance with the Trust's Constitution and governance framework.
Communications and Engagement	N/A
Use of Artificial Intelligence Tools	AI has not been used to write this report.
Committee that will provide relevant oversight Board of Directors	

King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Finance and Commercial Committee – Chair's Report to the Board**
Date	**Thursday 30 July, 2026**
Time	**13:30 – 15:30**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter	
	PART 1				
1.	**STANDING ITEMS**				
	1.1. Welcome and Apologies Apologies were received from Angela Spatharou.	FI	Verbal	Chair	
	1.2. Declarations of Interest No new declarations were made.	FI	Verbal		
	1.3. Chair's Actions There were no Chair's Actions.	FI	Verbal		
	1.4. Minutes of Previous Meeting The minutes were approved.	FA	Enc.		
	1.5. Action Tracker The committee reviewed the action tracker and noted the updates, including the Estates work which was largely on track, with external support commissioned to develop a site control strategy for Denmark Hill and PRUH.	FA	Enc.		
	1.6. Matters Arising There were no matters arising.	FD	Verbal		
2.	**FINANCIAL REPORTING 2026 / 27**				
	2.1. Finance Performance Report – Month 3 The Committee noted a £32.3m underlying deficit, £2.5m adverse to plan, and expressed significant concern over the	FD/A	Enc.	Chief Financial Officer	

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

	£66.8m CIP planning gap and pace of delivery. While grip and control measures had supported the current position, members stressed the need for sustainable transformation, with improved patient flow, reduced temporary staffing, workforce redesign and productivity identified as key opportunities. Executives confirmed that recovery plans and strengthened oversight were being developed, with decisive action required to protect the forecast year end break even position.				
	2.2. Investment Board update The Committee reviewed and approved three business cases exceeding £5m for Trust Board approval; and noted the discussions and approvals from the July Extraordinary Investment Boards.	FD/A	Enc.	Chief Financial Officer	
	2.3. Capital Variation The Committee approved allocating £1.2m of the DH NICU underspend on identified capital cost pressures. The Committee approved allocating £1.5m drawn from the DH NICU underspend, endoscopy building accrual release and a portion of the Willowfield lease novation CDEL credit on rolling replacement budget uplifts and capital projects. Members also agreed to reducing 2027/28 provisional budgets for medical equipment and ICT rolling replacement and backlog maintenance to fund the £3.2m DH NICU cost pressure in that year.	FD	Enc.	Chief Financial Officer	
	2.4. WTE Reduction Trajectory Plans The Committee noted that workforce reductions remained behind plan, with 91 WTE delivered against a requirement of 537 WTE, and recognised that greater savings would need to come through operating model redesign rather than vacancy management alone. Reducing bank staffing was identified as the greatest short term opportunity, alongside targeted recruitment controls, improved patient flow and service transformation. Further action was considered necessary to accelerate delivery and achieve sustainable workforce and financial savings.	FD	Enc.	Chief People Officer	
3.	**GOVERNANCE**				
	3.1. There were Items				

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

4.	**CAPITAL AND ESTATES**				
	4.1. Estates and facilities update The Committee noted good progress across Estates and Facilities, with the Estates Strategy on track for presentation in November 2026 and further work underway to strengthen capital delivery capacity. Members highlighted the need for continued investment estates and facilities to improve staff and patient experience. Progress on fire safety was welcomed, while the Committee also noted ongoing work to address PFI contractual issues and align estates investment with the Trust's wider transformation and decarbonisation plans.	FD	Enc.	Deputy Chief Executive Officer	
	4.2. Sustainability Report The Committee noted the contents of the report; and approved the Green Plan Delivery Board (GPDB), working in partnership with the relevant Finance, Risk, corporate and clinical teams, to develop a coordinated Trust-wide response to the Task Force on Climate-related Financial Disclosures (TCFD) requirements. The proposed approach will be presented to the Finance and Commercial Committee for review and approval prior to inclusion in the Trust's Annual Report.	FD/A	Enc.	Deputy Chief Executive Officer	
5.	**COMMERCIAL**				
	5.1. Subsidiaries Update The Committee noted positive performance across the subsidiaries, including KFM's planned CIP delivery and a positive update on King's Commercial. International activity continued to progress, with strong performance, planned expansion, and developments in new locations. Members also noted strengthened leadership and governance arrangements, ongoing compliance, and the continued contribution of the subsidiaries to the Trust's strategic objectives and income generation.	FI	Enc.	Chief Financial Officer	
6.	**DIGITAL**				
	6.1. Epic Post Implementation Review The Committee; • Noted the findings of the Post Implementation Review and overall delivery of the Apollo Programme.	FD	Enc.	Deputy Chief Executive Officer	

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

	• Took assurance that the core implementation objectives have been achieved and the programme is now in the optimisation phase. • Endorsed the focus on adoption, standardisation, and benefits realisation as the next phase of delivery. • Noted that the review has been undertaken in conjunction with the NHS Tiger Teams and KCH Finance Team. • Noted that the Chief Digital Information Officer has reviewed and approved the Post Implementation Review report.				
7.	**ANY OTHER BUSINESS**				
	7.1. Draft agenda FCC meeting – 3 September 2026 The committee reviewed and approved the draft agenda for the next meeting in September 2026. Executive members were encouraged to continue monitoring progress closely and to ensure that any emerging risks or challenges were identified and addressed promptly to support delivery against the agreed work plan.	FD/A	Enc.	Chair	
	7.2. Issues to be escalated to the Board (Board Highlight report) Delivery of the Cost Improvement Programme was noted as an ongoing organisation-wide responsibility, requiring close collaboration and alignment across teams to achieve the agreed objectives.	FD	Verbal	Chair	
9.	**Date of the next meeting: 3 September 2026** at 09:30 – 11:30 in the Dulwich Room, Hambleden Wing, Denmark Hill				

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

King's College Hospital NHS Foundation Trust

DRAFT AGENDA

Committee	**Finance and Commercial Committee – Chair's Report to the Board**
Date	**Thursday 3 September, 2026**
Time	**09:30 – 11:30**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter	
	PART 1				
1.	**STANDING ITEMS**				
	1.1. Welcome and Apologies Apologies were received from Angela Helleur. Anna Clough was deputising.	FI	Verbal	Chair	
	1.2. Declarations of Interest No new declarations were made.	FI	Verbal		
	1.3. Chair's Actions The Committee noted the ongoing NICU project, with technical and PFI requirements contributing to delays. The residual NHS England funding risk remains unchanged. The Committee agreed that the capital expenditure risk rating should be reviewed in the future, as the current green rating reflects the current 2026/27 position rather than the whole programme of works.	FI	Verbal		
	1.4. Minutes of Previous Meeting The minutes were approved.	FA	Enc.		
	1.5. Action Tracker Members noted the action tracker updates.	FA	Enc.		
	1.6. Matters Arising There were no matters arising.	FD	Enc.		
2.	**FINANCIAL REPORTING 2026 / 27**				
	2.1. Finance Performance Report – Month 4 The Committee noted a £47.4m underlying year-to-date deficit, £4.9m adverse to plan, with the year-end breakeven forecast dependent on further remedial action beyond current levels. CIP delivery	FD/A	Enc.	Chief Financial Officer	

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	remains a significant challenge, with confirmed plans to deliver £19.8m against an £84.9m target, a gap of £65.1m. Adverse variances on income and pay also need to be addressed. A revised remediation plan will be presented to the September Board, focusing on escalation of existing CIP schemes through the gateways, Target Operating Model for future provision and further in year grip and control measures. The Committee also noted capital delivery risks and the need to review and take action to ensure programme delivery, opportunities to increase commercial income and the ongoing PTS cost pressure, and emphasised the need to accelerate financial recovery. The committee noted that failure to close the CIP gap would have consequences for the 2027/28 savings target and the ability to achieve the financial strategy, as well as potentially adversely impacting the Trust's recently improved regulatory position.				
	2.2. Investment Board update The committee reviewed and recommended one business case exceeding £5m for Trust Board approval and noted the discussions and approvals from the August Investment Board.	FD/A	Enc.	Chief Financial Officer	
	2.3. WTE Reduction Trajectory Plans The Committee noted that the Trust remains at approximately 100% of establishment, with vacancy controls maintaining staffing at around 93%, and discussed the opportunity to reduce bank staffing expenditure, which is around £4m above plan. The importance of maintaining an appropriate balance between substantive, bank and agency staffing was recognised, with agency use remaining a last resort. The Committee also considered whether current staffing controls may be overly risk-averse in some areas and agreed that further work should assess staffing requirements against operational demand, safety, CHPPD and productivity measures. A staffing update will be provided.	FD/A	Enc.	Chief People Officer	
3.	**GOVERNANCE**				
	3.1. Board Assurance Framework The Committee reviewed the two risks within its remit, noting that the Financial Sustainability risk remains rated at 25, with mitigation and a further financial	FD/A	Enc.	Director of Corporate Affairs	

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	remediation plan due for Board consideration in September 2026; the target score of 15 by March 2027 remains aligned to delivery of the financial strategy. The Critical Infrastructure risk remains unchanged, with further review planned once the Estates Strategy is developed to ensure the risk rating reflects the current position and mitigations. The Committee also noted formal receipt of the LSC enforcement notice relating to the Department of Health and agreed that the BAF should remain under active review.				
4.	**CAPITAL AND ESTATES**				
	4.1. There were Items				
5.	**COMMERCIAL**				
	5.1 There were Items				
6.	**DIGITAL**				
	6.1. Digital Update The Committee noted progress across the Trust's digital programme, including the planned Lewisham and Greenwich migration to the Epic platform, Bromley Community's business case to join, and development of the Population Health Management Hub to support demand forecasting and service planning. Progress on shared digital connectivity was also welcomed. The Committee agreed that the formal digital roadmap would remain with the appropriate committee, while future updates to this Committee would focus on the financial, contractual and commercial implications of digital investment.	FD	Verbal	Deputy Chief Executive Officer	
7.	**ANY OTHER BUSINESS**				
	7.1. Draft agenda FCC meeting – 1 October 2026 The Committee reviewed the draft agenda for the October meeting and noted that the Estates Strategy report will be moved to the November meeting. The agenda was agreed subject to this change.	FD/A	Enc.	Chair	
	7.2. Issues to be escalated to the Board (Board Highlight report) The Committee noted that the key matters for escalation to the Board relate to the CIP/financial recovery position and the investment approval process. No further matters were raised under Any Other Business.	FD	Verbal	Chair	

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

9.	**Date of the next meeting: 1 October 2026** at 09:30 – 11:30 in the Dulwich Room, Hambleden Wing, Denmark Hill

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

King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Performance, Transformation and Improvement Committee**
Date	**Thursday 6 August 2026**
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 Apologies received from: Matthew Trainer Anna Clough Angela Spatharo	FI	Verbal	Chair	
	1.2. Declarations of Interest There were no declarations of interest over and above those on record.				
	1.3. Minutes of the previous meeting and action tracker The minutes of the meeting held on 9 July 2026 were approved as an accurate record.	FA	Enc.	Chair	
OPERATIONAL PERFORMANCE					
2.	Integrated Performance Report June 2026 performance showed ongoing pressure across urgent and emergency care, but improvements in diagnostics and cancer recovery. RTT performance challenges were linked mainly to reporting and validation issues rather than demand growth. Several actions were agreed to strengthen recovery planning, validation processes and digital solutions.				
3.	RTT Update The Committee reviewed factors driving growth in the waiting list and emphasised the need for sustainable reductions in long waits through improved booking practices, better capacity utilisation, clinical engagement and consistent operational management.				
4.	Flow Programme Update – CIP Progress was reported on initiatives to improve patient flow, reduce length of stay and support financial recovery. Members stressed the importance of cultural change, operational consistency and the development of a target operating model aligned with financial objectives.				
TRANSFORMATION AND IMPROVEMENT					
7.	Transformation Programme – Workforce, CSR & Flow Good progress was noted across workforce and transformation workstreams. The Committee highlighted the need for stronger alignment between transformation activity, operational priorities and the Trust's financial recovery programme.				
GOVERNANCE					
8.	No items.				
9.	**ANY OTHER BUSINESS**				
	Issues for Escalation to the Board of Directors				

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

No	Item	Purpose	Format	Lead & Presenter	Time
	No issues required escalation to the Board. Members requested circulation of the EPIC implementation report previously considered by the Finance and Commercial Committee. Any Other Business There were no items of any other business				
	Date of the next meeting: Tuesday 15 September 2026 at 13.00 – 15:00, Dulwich Room, Hambleden Wing, KCH, Denmark Hill.				

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

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 12.

BOARD REPORT COVER PAPER

Report to:	Trust Board
Date of meeting:	Wednesday 16 September 2026
Subject:	King's Supporting Strategies for 2026-31
Author(s):	Evelyn Oyebanjo, Deputy Director of Strategy Liz Shutler, Director of Strategy
Sponsor:	Julie Lowe, DCEO
History:	- Update provided to KE on 16th February 2026 - Update provided to KE on 7th April 2026 - Update provided to KE on Monday 20th July 2026 - Update provided to KE on Tuesday 1st September 2026
Status:	

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

Purpose

The purpose of this paper is to present:

- King's Supporting Strategies for 2026–31 (with the exception of the Estates and Research and Development Strategies, which will follow at a later date); and
- The proposed plan to monitor progress against the overall King's Strategy for this financial year.

Recommendations:

Board is asked to

i. Review, comment on and approve King's Supporting Strategies for 2026–31; and

ii. Note the plan to monitor progress against the overall King's Strategy for this financial year.

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

King's College Hospital NHS Foundation Trust

Key implications

Strategic risk - Link to Board Assurance Framework	*Supports delivery of the Trust Strategy 2026–31 through development and implementation of supporting strategies.*
King's Improvement Impact (KIM):	*Supporting strategies will support KIM delivery*
Quality Impact	*Supporting strategies will contribute to improvements in quality of care.*
Health Equity Impact	*Relevant strategies incorporate actions to reduce health inequalities. Health Equity Strategy supports delivery of the Trust's ambitions in relation to reducing health inequalities and improving equitable access, experience and outcomes*
Workforce Impact	*Addressed through the People Strategy.*
Research/Innovation Impact	*Addressed through the Research and Development Strategy*
Digital Impact	*Addressed through the Digital Strategy*
Financial Impact	*No direct financial implications arising from this update.*
Legal/ regulatory compliance	*No direct implications. Individual strategies will ensure compliance with relevant statutory and regulatory requirements.*
Communications and Engagement	*Ongoing engagement with relevant stakeholders is informing strategy development. Final strategies will be communicated following approval.*
Use of Artificial Intelligence Tools	*AI tools were not used to prepare this report*
Committee that will provide relevant oversight	

King's College Hospital NHS Foundation Trust

1 King's Supporting Strategies for 2026-31

1.1 To support delivery of King's Strategy 2026–2031, a suite of supporting strategies has been developed. These are enclosed for Trust Board's review. The table below sets out the list of supporting strategies and the governance route to date, for information.

1.2 Following Board approval, the strategies will be reviewed by an external copywriter to ensure the language and content are accessible and appropriate for a public audience before publication. King's Communications Team will also produce a two-page summary, incorporating the graphics used in the main strategy to ensure a consistent look and feel. This summary will be published on the Trust's main website, with an option for readers to request the full strategy if desired.

1.3 Trust Board is invited to provide feedback on:

- Strategic focus and ambition – whether the strategies focus on the most important priorities for King's and set an appropriate level of ambition for 2026–31.
- Alignment and contribution – whether the strategies are clearly aligned with the overall King's Strategy and make a distinct and meaningful contribution to its delivery.
- Completeness and coherence – whether there are any significant gaps, overlaps or inconsistencies across the suite of strategies, and whether together they provide a coherent framework for delivery.

1.4 Supporting Strategies

Supporting Strategy	Please note
Digital	• The strategy was previously approved by KE and subsequently reviewed by D&T in June/July and PC in July.
Estates *(not enclosed)*	• The Estates Strategy will be presented to KE in October, ahead of FCC approval in October and final approval by the Board in November.
Finance *(not enclosed)*	• The Trust approved its 15-year Financial Strategy in 2024, which remains the Trust's financial strategy and continues to support delivery of the King's Strategy 2026–31. • Since then, the collective efforts of colleagues across the Trust have delivered significant progress, including two consecutive years of delivery against financial plan and a reduction of more than £30m in the underlying deficit. • No separate Finance Strategy is therefore being presented as part of the 2026–31 supporting strategy suite.
Green Plan	• The Green Plan was previously approved and launched in January 2026. The version presented has been updated to remove references

	to BOLD; the overall strategic direction and delivery metrics remain unchanged.
Innovation	• The strategy was previously approved by KE and subsequently approved by the Public Board in May.
People	• This strategy brings together King's Workforce and People & Culture strategies, both of which were previously approved by KE and PiEC. This combined People Strategy was approved by KE on 1st September. • Engagement with staff on the Workforce and People & Culture strategies will continue until the end of September. As a result, minor amendments may be made to the People Strategy following its presentation to the Board in September.
Population Health Management & Healthcare Equity	• The strategy was previously approved by KE and subsequently approved by the Public Board in May.
Research and Development	• The Research and Development Strategy has undergone extensive engagement with our partners, including KCL, KHP and SC1 London, as well as with our R&D teams and clinical and operational leaders. It is currently still under development and will be presented to the Board at a later date.

2 Plan to monitor the overall strategy

2.1 The King's Strategy – 2026 to 2031 was published in June 2026. Since then, the focus has been on mobilising the programmes of delivery that will support implementation of the Strategy, rolling out the Strategy Deployment Reviews (SDRs) to support goal cascade and developing the suite of supporting strategies.

2.2 The below sets out the proposed schedule for reporting quarterly activity and progress to the Board. All reports will be presented to KE first for review ahead of submission to the Board.

- November Board – Q1 and Q2 activity and progress
- January Board – Q3 activity and progress
- March Board – Q4 activity and progress

2.3 From 2027/28 onwards, KE and the Board will receive quarterly reports (depending on Trust Board meeting dates) on progress against the King's Strategy – 2026 to 2031, providing regular oversight of delivery, celebrating achievements / success and highlighting areas requiring attention. Each report will cover the six strategic ambitions and provide:

- Performance against measures – progress against the five-year and annual targets.
- Achievements during the reporting period.

- Key risks, dependencies and decisions – significant risks or dependencies affecting delivery, alongside any decisions or actions required from KE or the Board.

King's College Hospital
NHS Foundation Trust

Digital Strategy

2026 - 31

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1. Foreword

Across the NHS, the pressures on our services, our workforce, and our communities have never been greater. At King's, we are proud of the compassion, skill and commitment shown every day by our staff, and we know that the digital capabilities are central so that teams can continue delivering outstanding care in an increasingly complex environment. This strategy sets out how we will harness digital technology not as an end, but as an enabler of better care for every patient we serve.

Over the next five years, we will focus on using data, artificial intelligence and digital innovation to make care faster, simpler and safer for all our patients, while ensuring that no one is left behind. Patients will benefit from timely information, more flexible ways of managing their care, and more joined-up pathways across our sites and partners in South East London. Staff will experience more intuitive systems, fewer administrative burdens, and better access to the data and tools they need to make informed decisions, reducing waste and duplication in our processes and increasing productivity. And as a system partner, King's will play a leading role in shaping a more connected, resilient and digitally mature health and care ecosystem, providing patient-centred, integrated care across all setting of care and leveraging system-wide assets and capabilities, like the OneLondon SDE, to improve population health.

This strategy is for patients, staff, clinical teams, enabling services, partners and our wider communities. It reflects the priorities we have heard clearly from each of these groups: the need for better information flow, accessible digital routes that complement rather than replace face to face care, and technology that strengthens—not strains—how we work. It also commits us to delivering a digitally inclusive service, alongside practical support for those less able to use technology, recognising that true progress means that everyone can benefit from the opportunities that digital offers.

Our success will be measured by the outcomes and experiences we improve, including shorter waits, more coordinated care, reduced variation, empowered staff and more personalised support for our patients, while leveraging technology to deliver care more sustainably. Through this strategy, we will expand our strong digital foundations, reshaping our models of care, supporting our workforce, enhancing productivity, and enabling King's to meet future challenges with confidence. Cybersecurity is also of paramount importance to us, and we will work towards external accreditations to evidence our progress against recognised standards of cyber resilience, while taking advantage of nationally offered investment and support services.

I would like to thank our staff, partners and patients who contributed to shaping this strategy. Together, we will ensure that digital innovation will be adopted safely, ethically and where it clearly improves care or productivity. It will strengthen our values, our care and our impact for the years ahead.

2. Background

Case for change

Healthcare systems are experiencing increasing pressure from growing healthcare need, ageing populations and workforce constraints. In this scenario, King's services will need to adapt to deliver care with the same compassion and maximising the use of resources.

Healthcare organisations need to update their ways of working to reduce unnecessary burden on staff, limit variation in pathways and ensure that the organisation can adapt quickly.

Digital transformation is central to King's response to these challenges, improving quality and access to care, enable greater productivity, and better use of existing resources. For example, in the emergency department digital triage systems are already helping identify patients with the highest risk so that they can be seen faster by the most appropriate healthcare team. Other digital tools are helping us to process referrals faster so that care is started in a timely fashion. Where possible, we use automation in both clinical and non-clinical workflows that have minimal risk and a high volume of transactions, such as notifying prospective employment candidates if they had not been invited further into a recruitment process.

By reducing manual steps and enabling better prioritisation, digital solutions can release capacity in our clinical teams to focus their time on delivering care, while ensuring services remain responsive as demand continues to grow.

Without sustained service transformation, the balance between resources and benefits will decrease for patients, staff and our partners in South East London. For instance, the waiting times are likely to increase -leading to delays in diagnosis and treatment, which may worsen health outcomes. Staff workload and burnout may increase further, which contributes to workforce shortages. As a result, services may find it harder to identify patients that need it most. With sustained transformation, services will evolve from seeing patients on a first-come-first-served basis towards prioritising patients with the greatest clinical need. This is happening thanks to data and digital tools to support triage and pathway management.

The arrival of Epic, our electronic patient record and its patient portal (MyChart) in October 2023, has enabled King's to offer patients digital ways to interact with our services. Looking into the future, it will be easier for our patients to access and manage parts of their care digitally. This means that more appointments need to be available for rescheduling online without speaking to a person. We also need to be able to allow them to book appointments earlier, if they become available, or enable patients to share the data from their fitness devices.

Equally we will need to make the most of approaches that will help us stay connected with those less likely to use technology due to age, illness or other non-medical root causes of ill health. Where possible, we will encourage patients to assign a representative to manage their patient portal, and if appropriate, we will work with the voluntary sector to provide access to technology, like funding broadband costs.

As clinical knowledge expands and data becomes more readily available, services will need to use this more effectively to identify risk earlier and ensure more patients receive care in a timely fashion, preventing disease deterioration rather than managing acute episodes of poor health. This has started to happen with certain metabolic or cardiac conditions.

The Government has positioned Digital and AI at the core of the 3 fundamental shifts for the NHS in the 2025 10 Year Plan: From Analogue to Digital; from Hospital to Community and from Treatment to Prevention. In this context, it has prioritised a number of Digital and AI programmes and capabilities that are already changing the way the NHS delivers its services.

The NHS App is already fully connected to the King's digital patient portal (MyChart), acting as a single digital front door for secondary care. Patients can view referrals, amend or cancel hospital outpatient appointments, access discharge documents, and view past appointment history spanning up to two years.

Beyond the NHS App (Digital Front Door), the upcoming Single Patient Record, the OneLondon Secure Data Environment (SDE), we will be part of other national initiatives such the national rollout of AI capabilities for NHS Trusts, for instance through the Microsoft CoPilot for Health. It will help increase productivity and embed Agentic AI. Participation in these programmes will help us transform end-to-end seamless processes with reduced friction and duplication. At King's we will monitor closely these opportunities and work closely with our local and national partners, to ensure King's continues to lead the way in AI-led innovation for the benefit of our patients and communities.

As care becomes increasingly digital, the Trust's dependence on secure, available and resilient systems will grow. Therefore, cybersecurity must be treated as a patient safety, operational resilience and public trust priority, not solely as a technical requirement.

Overall, if we can maximise the resources available to us, patients will be able to stay in the community as healthy and functional individuals, consulting our health teams when the need arises.

Local context

We have one of the most diverse populations in London and across the UK, with pockets of high deprivation and communities facing inequalities in their access to

health and care and to their outcomes. We also have one of the most transient populations in London, with one in three moving over a period of ten years. As an example, we have one of the lowest breast cancer screening rates in London, which is even lower for our most deprived communities. Mental Health prevalence is also high, placing a significant burden on our populations and on the services, we deliver to them.

King's' primary responsibility is the delivery of high-quality, safe and efficient hospital-based care, including specialist and tertiary services. The focus of this digital strategy is on transforming in-hospital workflows, decision-making, and staff and patient experience.

In addition, King's is a leader in the integrated care system and acts as an integrator organisation in Bromley. King's contributes data, analytics capability and operational insight to support system-wide population health management. This role complements, rather than replaces, the Trust's core hospital function. King's is an advocate of data sharing across organisations and therefore has been safely sharing and receiving data with the London Care Record since its inception in 2020.

The future brings both opportunity and challenge to King's. Demand for healthcare continues to grow. At the same time, pressures on our workforce and finances are increasing and will continue to influence how King's digital strategy is achieved. It is important we continue to play our part in addressing the climate emergency. These challenges require not only resilience, but new ways of thinking,
new partnerships and modern technology to help us deliver high-quality care safely and sustainably.

King's sites are in the heart of South-East London, but patients from Kent, Surrey and Sussex also use our services. This shows how King's services span across a large geographical area. This represents the complexity and opportunity of our region, spanning urban, suburban and rural communities, all with unique health needs. The expansion of our same electronic health record to further providers across South East London, Lewisham and Greenwich NHS Trust, will mean that patients experience a more coordinated and informed care across South East London

Patient feedback has shown strong support for the electronic patient portal, with clear demand and an opportunity for a greater range of appointments to be managed digitally. Patients and families have told us that digital services should make care easier to access, communication clearer, and next steps easier to understand. In response, we are streamlining the volume and consistency of patient communications and improving how patients can respond back to our services.

Our current partnerships with national programmes including the Getting It Right First Time (GIRFT) programme and its Further Faster Follow-Up will be a blueprint for how digital services evolve.

We have a highly engaged, enthusiastic body of data and AI enthusiasts at KCH, who have already produced significant AI-led innovation, and in fact developed in collaboration with KCL and spun off several companies, including Cogstack on extracting value from the data, and Kidney Beam, an app designed by King's staff to support the physical and emotional wellbeing of people living with chronic kidney disease.

At King's we are pioneering the use of artificial intelligence to make it part of our day-to-day activities. We are discovering how evaluate its benefits and risks, and how best to use it. We are currently completing pilots in routine and important workflows of the hospital, such summarisation of the clinical records for ease of patient reviews or compilation of notes to support nursing handover and creation of discharge summaries. We are using several AI tools in our radiology department, and we are building connections between systems so that it becomes easier over time to bring its benefits to staff and patients. Patient pathways -such as diagnosis of skin conditions or remotely supporting patients to be the fittest while waiting for their surgery at home (surgical prehabilitation)- are slowly being improved by the digital options at our reach. We will use the data and AI tools to identify more patients with inherited cardiac conditions, and hopefully, prevent the onset of debilitating symptoms; and we will use digital platforms to modernise care pathways for long terms conditions such as obesity, following the arrival of GLP-1 medications (new gut hormones to regulate appetite). We have been piloting an ambient voice technology integrated in our electronic patient record and we are preparing ourselves to roll it out across the trust.

Finally, we are also exploring robotic process automation and AI for back-office processes such as medicines invoice reconciliation or faster communication to employment candidates on the outcome of the recruitment processes.

Like in any other NHS trust, financial resources are constraints. However, we should be proud of our achievements to keep King's data and systems secure from cyberthreats. We will continue to build on those achievements.

We now need to ensure we can harness the power of AI to move from pilots to organisation-wide value at scale.

National context

Nationally, the expectations over healthcare services are changing. We've described how there is a rising demand for healthcare and continued workforce constraints, yet growing expectations for digital access and communication and an increasing pressure to improve productivity. These trends strengthen the case for more connected, efficient and personalised models of care.

Across successive national strategies, trusts are expected to progress towards:

- digital-first access,
- interoperable records with patients and with other NHS partners like GPs
- productivity through automation and AI,
- stronger cyber resilience,
- and more personalised, preventative care.

From a regulatory and compliance perspective, maintaining external accreditations and building further assurance maturity will remain an important part of our approach to resilience and governance. As such, we continue to meet or approach standards at the NHS Data Security Protection Toolkit, renew our ISO27001 accreditation on information security and expand on our recent achievement of one of the most recognised digital maturity assessments in healthcare (HIMSS for Infrastructure security, Stage 6 of 7). We will also start work towards an accreditation for data centre facilities (Level 3).

Year	Policy / Guidance	Organisation
2019	NHS Long Term Plan	NHS England
2021	What Good Looks Like Framework	NHSX / NHS England
2022	Data Saves Lives	DHSC
2022	A Plan for Digital Health and Social Care	UK Government
2022	National Digital Channels Platform & Integration Strategy (NHS App strategy)	NHS Digital / NHS England
2023	Evaluation of Government Commitments on NHS Digitisation	UK Parliament
2023	NHS digital capability framework	NHS England
2023	NHS Long Term Workforce Plan	NHS England
2024	NHS Priorities and Operational Planning Guidance 2024/25	NHS England
2025	NHS 10 Year Plan	NHS England

Progress so far

We successfully implemented our new electronic patient record in October 2023 replacing fragmented legacy IT systems and paper records. Since the implementation, King's has started to transform the way we provide healthcare, benefiting patients, staff and our regional partners. This is King's' approach to implementing the analogue-to-digital shift, as set out in the NHS 10-year plan (2025).

At King's, the patient portal adoption has reached 53%, creating a strong platform for broader digital engagement and service redesign. We know that patients using the portal are less likely to miss their appointment that those who do not use the patient portal (5% DNA rate for patients using the electronic portal, vs 12% DNA for non-users). Patients can now view letters digitally, reducing reliance on traditional correspondence and improving timely access to information. More appointments will become digitally available for patients to select a more suitable date (self-scheduling), or even, choose an earlier appointment, if it becomes available (FastPass). However, significant inequalities in use of MyChart remain with low access and adoption in certain communities. We will work with the Integrated Neighbourhood Teams across SEL and in particular, Lambeth, Southwark and Bromley, to support patients in leveraging the opportunities MyChart can offer to take charge of their care and provide faster access to core processes (e.g. access to their records).

We are using automation to accelerate the way in which we review and accept referrals from GPs, and we are increasingly using digital questionnaires for multiple purposes, e.g. to check that patients need to remain on a waiting list, or to check on patients after an inpatient admission (virtual wards). In the coming years, using automation and AI will help us deliver against key targets, reduce waiting times for patients who still need care, reduce readmissions or speed up clinically appropriate discharges and ensuring care in the community where needed.

With regards to tests and results we can issue advice to clinicians to prevent getting patients through unnecessary tests, and we are able to share 50% of our laboratory results with patients on the patient portal. We have also piloted how to receive data from personal fitness devices.

We are also using the electronic patient record to ensure that care during patient stays is safer, faster and of good quality. We have improved the visibility of our bed occupancy; we are making patient identification safer for extracting blood at the bedside, and we are making it easier to view when the learning disability team is involved in a patient's stay (reasonable adjustment flag).

We now need to ensure we can harness the power of AI to move from pilots to organisation-wide value at scale: from automation and AI in back-office functions, that will allow us to deliver services more productively, all the way to online triage and patient intelligent navigation, clinical decision support, and improved care pathways.

In relation to needs pending to be addressed in the next 5 years, we want to ensure that children and vulnerable patients, have a representative registered on the electronic patient portal, so that they can be brought to attend appointments and receive communications digitally. Lastly, we should develop a more systematic approach to addressing inequalities around digital health and maximise the opportunities to close the gaps, like collaborating with the voluntary sector to make sure that patients can

afford internet and data costs, that allow them to leverage digital solutions to be able to look after themselves at home.

Over the life of this strategy, we will focus on the following priorities:

- **Expand digital access for patients**: especially online booking, rescheduling and two-way communication.
- **Strengthen digital inclusion**: to ensure patients who face barriers to technology are not left behind.
- **Increase patient representative access**: so that carers, parents and families can support children and vulnerable patients digitally.
- **Optimise our electronic patient record and other core clinical systems**: to improve usability, workflow fit, data quality and staff experience.
- **Improve interoperability across the system**: particularly with primary care, social care and South East London partners.
- **Develop staff digital capability**: through consistent training and support for new ways of working.
- **Scale AI, automation and remote care** — in clinically safe, practical use cases that improve productivity and patient care.
- **Modernise infrastructure and cyber resilience** — to maintain secure, reliable and resilient digital services.
- **Use digital and AI to improve productivity**, reduce waste and duplication in our services, deliver against our targets and specifically support King's to secure ongoing financial sustainability, as per our financial plans.

3. Supporting the organisational strategy

Alignment to the six strategic objectives

The digital strategy has been developed to support the Trust's strategic objectives for 2026–2031 and to enable transformation across clinical and operational services. The digital strategy will be a key enabler towards transforming care by making King's a great place to work, delivering high quality care, which is timelier and more efficient, and enabled across strong successful partnerships as well as being a pioneer of research innovation and education.

Digital tools are a core driver of the transformation our services; the technology strategy is fully aligned with the clinical and operational strategy. Priorities are defined and reviewed on an annual basis to support the 6 trust strategic objectives.

Technology and artificial intelligence are important strategic enablers of safer, more timely and more efficient care.

Modern, intelligent digital systems will help make King's a leading place to work and innovate.

This digital strategy supports the delivery of Trust's six strategic priorities as set out below:

King's 2026-31 strategic ambitions	**How the digital strategy supports the delivery**
1. High-quality patient care	Improving clinical quality and patient safety through better information, audit and assurance. Ensuring that digital inclusion is at the heart of our programmes, improving equitable access and experience.
2. A great place to work	Supporting staff empowerment and experience by reducing administrative burden and improving usability
3. Pioneering research, innovation and education	Ensuring that we have effective governance processes so that innovative proposals are implemented effectively
4. Strong, successful partnerships	Strengthening system working through shared platforms and integrated data
5. Timely and efficient care	Enabling operational efficiency through workflow optimisation, automation and real-time insight

6. Financial sustainability	Supporting financial sustainability by maximising value from existing investments

Digital capability is therefore a core delivery mechanism for Trust objectives.

4. Vision

Vision statement

Using technology to improve the quality of care and treat more patients faster. Adopting innovation to improve patient and staff experience using resilient and secure systems.

What will be different (future state)

Since the implementation of our electronic patient record in 2023, the focus has been to expand our digital functionalities on this platform first, rather than by acquiring other systems. This will accelerate in the next 5 years, and what follows, is a view of what will be different from four different perspectives: patients, staff, our internal services and for our partners. This future state reflects the direction set by the NHS 10 Year Health Plan for England, supporting the three fundamental shifts in care: from analogue to digital, from hospital to community, and from sickness to prevention.

In the future, we can see how digital systems and artificial intelligence will become a building block of our infrastructure.

Digital inclusion will be central to how we design and deliver digital transformation at King's. As we expand digital access, including the patient portal, online booking, remote monitoring and digital communication, we will ensure that these routes complement rather than replace other ways of accessing care. We know that some patients and communities may face barriers to using digital services because of language, disability, age, confidence, access to devices or data, health literacy, deprivation or wider social circumstances. We will therefore use data and patient feedback to understand who is and is not benefiting from digital services, design support around the needs of different communities, and work with carers, representatives, voluntary sector partners and system colleagues to improve access. Our aim is that digital transformation helps to reduce inequalities in access, experience and outcomes, rather than unintentionally widening them.

Patients

- Easier digital access for administrative tasks such as viewing care records scheduling appointments, communicating with clinicians and managing a care pathway, find information on key services appropriate to their care in their area

(using the NHS App intelligent navigation functionality) and information about their condition; and managing their care pathway

- More personalised and proactive care
- Better support for carers and patient representative access
- More remote monitoring / virtual care where appropriate
- confidence that digital services protect their information and remain available.

Staff

- Less manual work and duplication
- Access to a single view of the patient across South East London, which will help us identify and address gaps in care and the patient needs in an integrated way, and reduce the overall Trust and system-wide costs
- A single view of the patient across physical and mental health, will help provide coordinated care to vulnerable patients with a mix of physical and mental health conditions. This should be a fundamental aspiration, in line with the government's Single Patient Record efforts.
- More reliable systems, training and support
- Secure, reliable systems that support care without avoidable disruption.
- Safe regulated use of AI and automation to improve data quality and reduce staff burden
- Access to high quality digital skill training catalogue

Services

- Better productivity and operational flow
- Stronger data for improvement, planning and research
- More modern corporate and enabling services
- Stronger cyber resilience and infrastructure
- tested cyber response, recovery and continuity arrangements.

Partners / system

- Better information sharing across South East London
- More joined-up care pathways across neighbourhood and system partners

5. Strategic objectives and outcomes

Strategic objectives (what we will achieve)

Technology and artificial intelligence are important strategic enablers of safer, more timely and more efficient care:

1. We will support our clinical teams to use our existing digital resources to drive better patient outcomes and maximise access to care.
2. We will maximise the adoption of electronic clinical workflows (>90% of time) such as scanning for medication administration, electronic patient identification, electronic ordering and results for pathology and radiology and scanning prior to breast milk administration; so that those patient interactions become safer.
3. We will increase registrations in our patient portal from 53% to 80%, both from patients as well as their family members and carers, so that those most vulnerable -such as children, the elderly or those with disabilities- can benefit from digital tools.
4. We will develop a digital inclusion strategy.
5. We will support our clinical teams to implement remote monitoring models of care for long term conditions, such as diabetes, or cardiovascular diseases, to ensure patients receive preventive care at home, and reduce clinically avoidable emergency admissions or re-admissions, improving patient outcomes and experience.
6. We will harness the opportunities generated by clinical developments in healthcare -such as new medicines or treatments- to transform patient pathways
7. We will ensure that clinical staff have access to artificial intelligence tools such as summarisation tools and ambient voice technologies either in diagnostic pathways (radiology, histopathology, dental services), outpatient services (ambient voice recognition) or inpatient services. We will ensure that artificial intelligence and software when used for patient care is clinically safe to be used according to national guidance.
8. We will enable our clinical teams to personalise the patient record for their activities, so that they spend less time using the system, and more time with patients.
9. We will use data and analytics to support hospital operations and system population health management. We will redesign critical workflows in our support services using digital tools, automation and AI, which have already

delivered significant efficiencies across the NHS and the UK public sector. This will allow us to deliver services more efficiently and sustainably.

10. We will maintain and extend external assurance of our digital infrastructure and cyber resilience through recognised accreditation framework

Also, as a custodian of highly sensitive patient, clinical, research and corporate information, the Trust is committed to maintaining the highest standards of data sovereignty, security and governance. We will ensure that Trust data is managed, stored, accessed and protected in a manner that safeguards patient confidentiality, supports regulatory compliance, and preserves public trust. Our approach recognises that data sovereignty is not solely about where data resides, but about maintaining clear accountability, transparency, control and resilience throughout its lifecycle. We will adopt technologies and partnerships that strengthen our ability to protect information, make informed decisions, and deliver safe, high-quality care, while ensuring that the Trust retains appropriate oversight and stewardship of its most valuable digital asset—its data."

6. Delivering the strategy

Governance and accountability

The executive lead of the digital strategy is our Chief Digital Information Officer, Denis Lafitte. The accountable owner is Julie Lowe, the Deputy Chief Executive Officer.

The strategy will be monitored at the Digital and Technology board meetings that are held monthly. The Digital Board is given updates from various other forums such as the Apollo board (joint GSTT/King's), the patient portal management group, the forum to evaluate new digital proposals (ICT PMO), the Cybersecurity Oversight Group (CSOG) and the Information Governance Steering Committee (IGSG).

The King's Digital and Technology board reports into the King's Executive, and maintains links as appropriate with the Investment Committee, the Trusts Quality Committee and Performance, Transformation and Improvement Committee including the Outpatient Transformation Programme, and the Urgent and Emergency Care Transformation Programme amongst others.

Optimisation of our electronic patient record is supported through established structures, including:

- Workflow optimisation teams
- Workflow Optimisation Committee
- Apollo Design Authorities

Patient feedback and engagement are captured via the Digital Patient Panel, which links into the MyChart Reference Group and into the trust Digital and Technology Programme board.

Effective engagement with these forums is essential to ensure that King's clinical, operational and strategic priorities are reflected in system design and delivery. Given the scale and complexity of our electronic patient record, participation in these fora requires strong leadership, disciplined prioritisation and sustained management attention. Our governance will evolve as more South East London partners join to use Epic.

Enablers

We commit to:

- maintain our external accreditations and expand on others such as HIMSS INFRAM Stage 7 and ISO accreditation for data centres to ensure that our technology infrastructure is safe, reliable and well managed,

- ensure that digital workflows are developed with our clinical teams and patients, maximising the systems we already have,
- strengthen clinical digital leadership, grow clinician builders and digital champions in divisions,
- continue to align our electronic patient record, for care activities, participation in clinical audits and quality improvement initiatives,
- introduce innovation in a way that is clinically safe, well-governed and aligned to service resilience,
- ensure digital inclusion is embedded during the design of change,
- optimise and extend our electronic patient record as a core platform for clinical and operational transformation,

High-level delivery plan

Year 1 (2026/27)

- Agree annual targets for functionalities of the electronic patient portal such as uptake of patient representative for children, uptake of patient-led appointment re-scheduling services and percentage of video consultations
- Accelerate the transformation of outpatient services by making it easier to interact with our services via our patient digital portal.
- Further roll out artificial intelligence tools to clinical teams
- Ambient voice recognition is scaled across the trust with a view to increasing efficiencies
- Further adoption of AI and advanced technologies, with a focus in radiology and pharmacy
- Strengthen our digital skills programme for all staff
- Release a refreshed digital clinical safety risk strategy
- Scale the use of Microsoft Copilot and Agentic AI to streamline workflows and reduce cost
- Embed digital and AI into King's Improvement Method to transform pathways, including the development of new digital-first pathways, leveraging new R&D and innovation in medicines for key pathways (e.g. digital-first GLP-1 management in collaboration with primary care) and delivering integrated care for complex frail patients

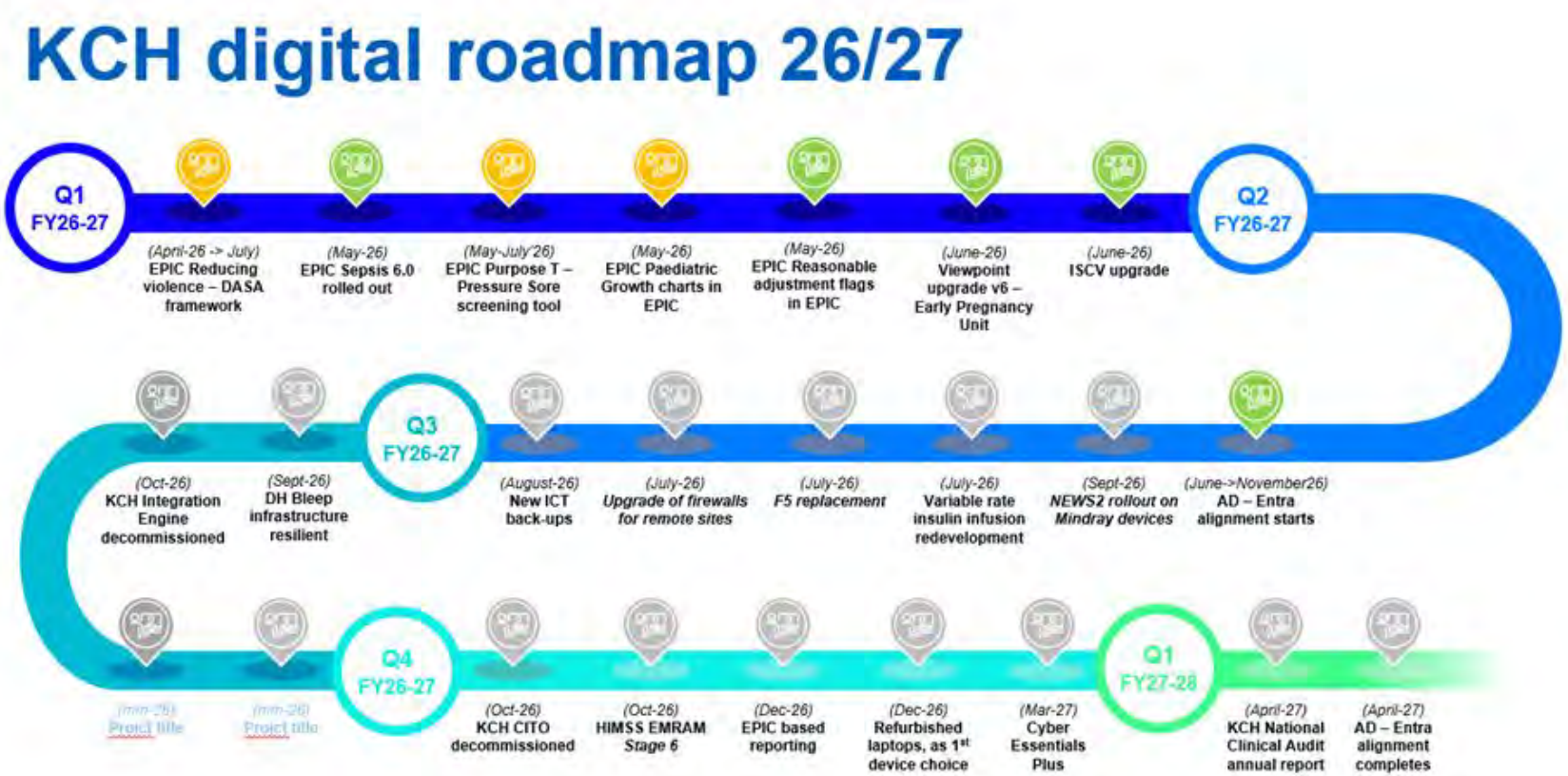
- Improve efficiency in operations, reduce operational cost and deliver our ambitious financial planning and goals
- Launch the transformation of our human resources function through the national Transforming People Services Programme
- Secure our data joining the new Secure Boundary programme national rollout

Years 2–3 (2027/28–2028/29)

- GPs will be able to see patients' hospital care record
- Full adoption of barcode medication administration systems
- Further expansion of real time location services to manage assets within the hospital sites
- Refresh of the connectivity with primary care and community health centres
- Further improvements of the resilience in our network and our resources for business recovery in case of a cyber-incident
- Ensure our patient portal is aligned and integrated with NHS App
- Expand the number of pathways with a digital component.
- Expand the interoperability with the Electronic Referral system.
- Connect King's electronic patient record to the South East London Secure Data Environment with a view to support a South East London data strategy.
- Adopt an industry-recognised framework for staff development and encourage professional registration for all digital, data and technology staff at King's
- Use digital and AI in collaboration with One London, the Integrated Care System and our primary and community care and mental health partners, the Secure Data Environment and King's Health Partners, leveraging skills and assets across South East London and Integrated Neighbourhood Teams, to strengthen population health management, improve care outcomes and reduce inequalities

Years 4–5 (2029/30–2030/31)

- Vast majority of our patients will be registered on our patient portal (80%)
- Frequent digital collection of patient reported outcomes (PROMS)
- Full integration of medical devices with the electronic patient record outside of critical care
- Modernisation of data centres and gaining ISO/IEC 22237 accreditation for Data Centre Facilities & Infrastructure
- Achieved accreditation for data centre facilities (Level 3)


KCH digital roadmap 26/27
Q1 FY26-27
(April-26 -> July) EPIC Reducing violence – DASA framework
(May-26) EPIC Sepsis 6.0 rolled out
(May-July'26) EPIC Purpose T – Pressure Sore screening tool
(May-26) EPIC Paediatric Growth charts in EPIC
(May-26) EPIC Reasonable adjustment flags in EPIC
(June-26) Viewpoint upgrade v6 – Early Pregnancy Unit
(June-26) ISCV upgrade
Q2 FY26-27
(Oct-26) KCH Integration Engine decommissioned
(Sept-26) DH Bleep infrastructure resilient
Q3 FY26-27
(August-26) New ICT back-ups
(July-26) Upgrade of firewalls for remote sites
(July-26) F5 replacement
(July-26) Variable rate insulin infusion redevelopment
(Sept-26) NEWS2 rollout on Mindray devices
(June->November26) AD – Entra alignment starts
(mm-26) Project title
(mm-26) Project title
Q4 FY26-27
(Oct-26) KCH CITO decommissioned
(Oct-26) HIMSS EMRAM Stage 6
(Dec-26) EPIC based reporting
(Dec-26) Refurbished laptops, as 1st device choice
(Mar-27) Cyber Essentials Plus
Q1 FY27-28
(April-27) KCH National Clinical Audit annual report
(April-27) AD – Entra alignment completes

7. Next steps

Detailed planning will be undertaken following the approval of the strategy, but the following actions will be taken forward as next steps:

- Establish the governance and stakeholder engagement needed to develop a digital inclusion strategy.
- Accelerate the roll-out of the electronic patient portal to book and reschedule appointments.
- Launch a campaign to increase the registration of representatives for children and vulnerable adults in the electronic patient portal.
- Build on the digital literacy of our staff to enable them to maximise the benefits from the digital systems.
- Continue our journey with external maturity assessments (such as HIMSS Electronic Medical Record Adoption Model Stage 6 and What Good Looks Like baseline self-assessment)

NHS
King's College Hospital
NHS Foundation Trust

Our Green Plan to 2028

Protecting our patients, people and planet

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Our vision for a greener future

Julie Lowe
Deputy Chief Executive
Net Zero Board Lead

We have a unique opportunity at King's College Hospital NHS Foundation Trust to deliver meaningful change that benefits our patients, people and planet.

Our Trust has a proud history of leading change. Alongside our partner Guy's and St Thomas' Hospital NHS Foundation Trust, we were the first NHS providers to launch a joint Clean Air Plan, recognising that air quality does not respect boundaries. We were also the first Trust in England to install a rapid electric vehicle charger outside an Emergency Department for ambulances visiting King's College Hospital, Denmark Hill.

In 2021, we launched our five-year Green Plan which outlined our commitment to sustainable healthcare. Much has changed since then. The world has come out the other side of a global pandemic, while technologies such as artificial intelligence (AI) are transforming all aspects of our lives – including how we care for our patients and the planet.

In that time, we have also seen the ever-growing impacts of climate change, from heatwaves and flooding to wildfires and drought. We have witnessed an increase in admissions through our own hospital doors during hotter temperatures.

As one of the largest NHS Trusts and an anchor institution, we have a major role to play to reduce our impact on the environment, and thereby improve population health.

Our Green Plan includes an unwavering commitment to incorporate sustainability into everything we do. This means creating Net Zero clinical pathways, enhancing access to our green spaces, electrifying our fleet, improving the air we all breathe, minimising waste and helping our patients, staff and visitors to travel actively and sustainably.

We will harness new technologies to modernise our infrastructure and adapt to climate change, as part of our aim to be at the forefront of healthcare innovation. This includes ramping up energy efficiency, generating renewable power and adopting robotics and automation to deliver more efficient, greener services.

We will shift away from a single-use culture to one that embraces the reuse of our precious materials. Not only will this help us to protect finite resources, but it will also help our budget stretch further in challenging times.

We have a responsibility to deliver sustainable healthcare at our Trust, to make sure that we are looking after patients today, without compromising the long-term futures of our patients, staff or local communities.

Research has shown that a cleaner, greener environment can be crucial for patient healing and recovery. This is not a new concept. Florence Nightingale pioneered the use of nature to support healing in the 19th Century, developing her ideas as part of the first professional school of nursing.

By taking these actions, we will benefit our local environment as well as the brilliantly diverse colleagues and communities we serve.

The case for change

Faced with an interconnected crisis of climate change and biodiversity collapse, it is clear that 'business as usual' is not an option for healthcare organisations.

These issues are contributing to a global health crisis, disrupting services which provide clean air, water and food, while causing vector-borne diseases and respiratory and cardiovascular problems.

Climate change has been described by the World Health Organisation as the greatest threat to global health in the 21st century. Heat-related deaths are expected to double to 10,000 a year in the UK by the 2050s. Poor air quality, meanwhile, hospitalises four Londoners every day.

We also have legal obligations to leave our environment in a better state than we found it. The NHS, which contributes 4-5% of the UK's carbon emissions, pledged to become the world's first Net Zero service by 2040 (for emissions it controls) in the Health and Care Act 2022.

As a Trust, we are aware of our own impact, which has forced us to think differently by looking at sustainability as a way of caring for our patients of today and tomorrow.

Our commitment to a greener future aligns with the Government's 'three big shifts' outlined in the 10 Year Health Plan for England: hospital to community, analogue to digital, sickness to prevention.

This will be made a reality through a coordinated approach, including:

- Delivering home appointments and remote care which reduce emissions from travel
- Implementing digital tools that help staff make the best clinical decisions and reduce emissions
- Helping our staff and patients to walk, wheel and cycle and choose increasingly plant-based diets
- Improving the air that we breathe to prevent and manage illnesses
- Championing the health benefits of access to nature by transforming our green spaces

The Trust plays an important role locally as an anchor organisation. We will lead by example and improve the health and wellbeing of the communities we serve, as outlined in our Trust Strategy. This will involve tackling healthcare inequalities by improving local air quality, which disproportionately affects the most vulnerable and deprived communities.

We will work with our regional and national partners who share our mission – including local authorities, healthcare providers and academic institutions. We will bring stakeholders together to create a greener, cleaner and healthier London.

We will make decisions that make a meaningful difference. This will help us build an NHS fit for the future – focused on world-leading, preventative and low-carbon healthcare. A greener future means better local health, prosperity and a healthier environment. That is the vision of our Green Plan - healing our patients and our planet.

Our organisation

We are one of London's largest and busiest teaching hospitals.

We provide a strong profile of local hospital services for people living in the boroughs of Lambeth, Southwark, Lewisham and Bromley, from our sites at King's College Hospital (Denmark Hill), Princess Royal University Hospital (Farnborough Common) and Orpington Hospital.

We also provide services at Beckenham Beacon and Queen Mary's Hospital, Sidcup. These include accident and emergency services, maternity, care of the elderly, orthopaedics, diabetes, ophthalmology, oncology, dermatology and many more. The Trust also provides a number of community-based services including dentistry.

Our specialist services are also available to patients from a wider area. We provide nationally and internationally recognised treatment and care in liver disease and transplantation, neurosciences, haemato-oncology, and fetal medicine.

King's Strategy 2026-31 sets out what we to achieve over the next five years, with a focus on providing excellent care for patients, and supporting our 14,000 staff.

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

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

King's is recognised globally as a world-leading innovation centre. From conducting the UK's first bone marrow transplant, to helping to establish the world's first voluntary blood donor service, King's has been at the forefront of new healthcare for over a century.

Over 50 years ago, King's established one of the first liver units in the country, and runs the largest liver transplantation programme in Europe, completing over 6,000 successful liver transplants.

We are a founding member of King's Health Partners (KHP) - one of eight accredited Academic Health Science Centres in the UK committed to delivering better health for all through high impact innovation. King's is also a member of the Shelford Group - a group of the top 10 teaching and research-active NHS Trusts in England.

Our impact on the environment

The Trust's carbon footprint is reviewed and calculated annually.

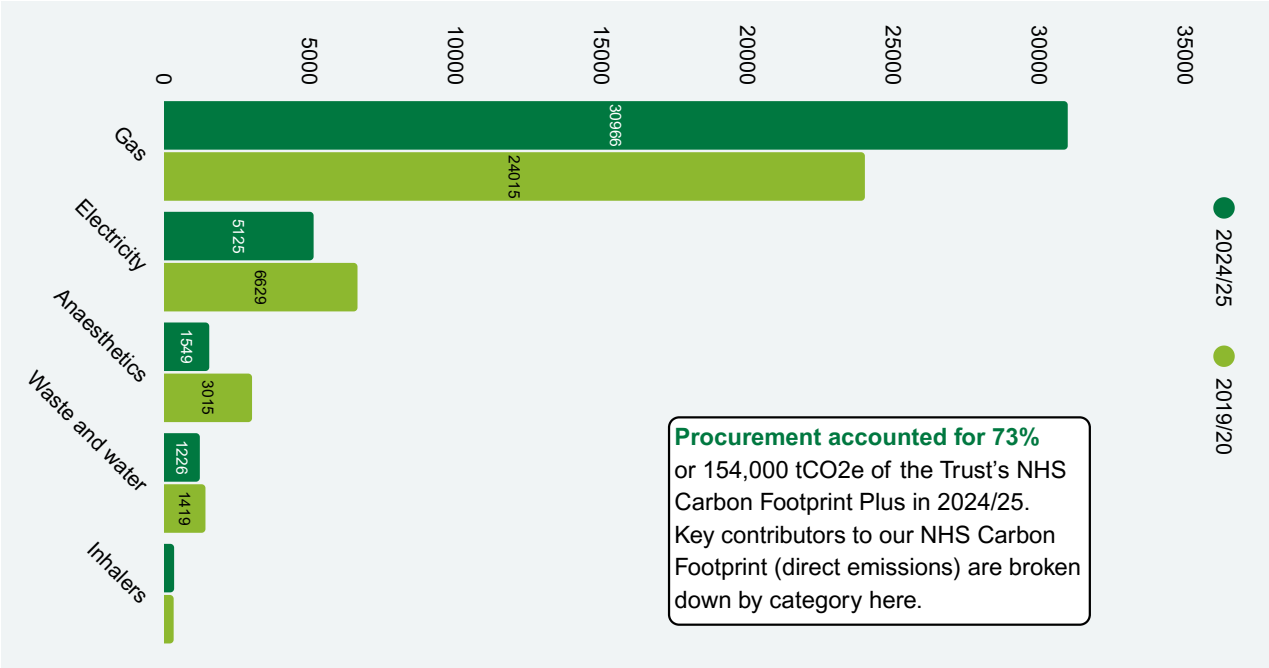
In 2024/25, our NHS Carbon Footprint (emissions we directly control) was 39,696 tonnes CO2e (carbon dioxide equivalent) and our NHS Carbon Footprint Plus (which we can only influence) was 209,911 tonnes CO2e. We have been able to reduce our NHS Carbon Footprint by 2% over the year, while our NHS Carbon Footprint Plus has increased by 5%.

Heating our buildings is one of the main contributors to our overall carbon footprint. With £216,000 funding from the Greater London Authority (GLA) Zero Carbon Accelerator we are exploring the best solutions for King's College Hospital (Denmark Hill) including connecting to the local district heat network. This would increase our resilience and efficiency, and help us achieve a significant reduction in carbon emissions.

We also generate large volumes of waste, with almost 5,000 tonnes disposed in 2024/25 alone. We will continue to focus on improving clinical waste segregation and increasing domestic waste recycling from our current rate of 40%.

We are continuing our work on reducing our contribution to air pollution and have gone beyond national requirements by including 'Air Quality' as a focus area in the Green Plan.

Key contributors to NHS Carbon Footprint (direct emissions) by category in 2024/25 and 2019/20 (tCO2e)



Procurement accounted for 73%
or 154,000 tCO2e of the Trust's NHS Carbon Footprint Plus in 2024/25. Key contributors to our NHS Carbon Footprint (direct emissions) are broken down by category here.

In the graph above, we have compared our NHS Carbon Footprint to our baseline year of 2019/20. Please note these calculations are based on the best available data at the time of reporting and may be refined in future as data quality and methodologies improve.

Our progress so far

Workforce and Leadership

Introduced a Green Champions Network for staff

Net Zero Clinical Transformation

Choose Wisely, Test Smartly campaign aims to reduce unnecessary testing

Air Quality

Launched a Clean Air Plan with Guy's and St Thomas' in 2023

Digital Transformation

24% of outpatient appointments now at home

Adaptation

Launched a Climate Change Adaptation Plan in 2023

Medicines

Stopped using environmentally harmful gas desflurane in 2023

Food and Nutrition

Reduced food waste by 28% since 2023

Travel and Transport

Electric vehicles now make up over 73% of our salary sacrifice scheme

Estates and Facilities

Solar panels installed at 3 of our acute sites

Supply Chain and Procurement

Rolled out Gloves Off campaign to reduce unnecessary glove usage

Engagement while developing the plan

We have undertaken extensive engagement in 2025 so that our plan reflects what matters to the people who use our services, colleagues, leaders, governors and partners.

Engagement has consisted of patient and staff surveys, in-person stalls, drop-in and online sessions, group and individual discussions and all-staff briefings. We designed the engagement to ensure we heard a wide range of voices, including targeted engagement with under-represented groups.

We engaged with:

- 400 patients, members of the local community and our governors
- 250 colleagues

We heard:

- People told us it was very important for the Trust to take action to protect the environment.
- They also wanted these efforts to support the health and wellbeing of staff and patients.
- Patients and the public told us their biggest priority was for us to cut down on waste, improve reuse and recycling and use fewer single-use items.
- They also want us to reduce energy use (e.g. cut down on unnecessary heating, lighting and equipment usage), provide more sustainable catering and create more green spaces.
- Our staff told us that clear and easy-to-follow objectives would encourage them to get more involved in sustainability efforts at work.
- They also want to see direct impact or results of actions, and support from leadership and management.
- Staff also want more frequent training and education to help them make more sustainable choices at the Trust.

Our areas of focus

Workforce and Leadership

Our mission to reach Net Zero relies on our incredible colleagues.

From doctors, nurses and Allied Healthcare Professionals, through to porters, housekeepers and foodservice assistants - every single member of staff has a role to play.

There is already strong support for a greener future. Nationally, 9 in 10 staff back the NHS Net Zero ambition, while 6 in 10 say they are more likely to stay in an organisation taking decisive climate action.

We will educate and empower our staff to make sustainable choices in their everyday lives at work and home. We will also encourage ideas and feedback from our workforce to improve our green actions.

We recognise that we will need our most senior leadership to lead by example. By regularly monitoring our governance structures we will ensure our senior staff and executives are held accountable for delivering our Green Plan.

Progress so far

- Launched a Green Champions Network
- Supported the growth of staff-led sustainability groups (i.e. Clean Air Action Group)
- Integrated sustainability into online corporate inductions and e-learning
- More than 200 colleagues joined our online platform to share ideas and best practice
- 3 staff members enrolled onto a levy-funded sustainability apprenticeship

Workforce and Leadership

Our objectives are:	Examples of how we will achieve this:
Ensure staff and patients have an understanding of Net Zero	• Run three Trust-wide behaviour change campaigns a year • Hold 10 online and in-person educational events (i.e. webinars / Lunch and Learns) a year
Empower staff to take action to reduce environmental impact	• Ensure a minimum of one Green Champion representative within every directorate by 2026 • Achieve a year-on-year increase in staff involved in networks (e.g. Clean Air Action Group / Green Travel Network) • Achieve a year-on-year increase in staff undertaking sustainability training including senior leaders • Achieve a year-on-year increase in the number of staff undertaking a sustainability apprenticeship
Embed sustainability into staff performance objectives	• Integrate sustainability messaging into annual staff appraisal guidance by 2027
Integrate sustainability into Quality Improvement projects	• Incorporate sustainability into Quality Improvement (QI) training by 2027 • Track and measure sustainable QI (SusQI) projects through an online platform by 2027 • Set up an awards scheme for SusQI projects by 2027
Incorporate staff and patient feedback into sustainability activities	• Undertake an annual sustainability survey for staff and patients

Net Zero Clinical Transformation

The best treatment for patients and the planet is high-quality, preventative and low-carbon at every stage.

In line with the Government's 10 Year Health Plan as well as the Trust's Strategy to 2031, we are moving towards community-based, digitally-enabled care that focuses on preventing ill health and reducing health inequalities.

We will champion sustainability across clinical pathways, focusing on areas where we can make the biggest difference, such as acute medicine, emergency care, diagnostics, and long-term conditions such as renal disease.

Progress so far

- Introduced a new electronic patient health record system (Epic) which will support the Net Zero transition
- Established patient-initiated follow-up (PIFU) appointments to cut down on unnecessary follow-up
- Launched a Choose Wisely, Test Smartly campaign to reduce unnecessary testing and carbon emissions
- Building a Critical Care Garden at King's College Hospital, to allow acutely ill patients to experience the therapeutic benefits of nature

Net Zero Clinical Transformation

Our objectives are:	Examples of how we will achieve this:
Enable a new Net Zero Clinical Lead to deliver on our clinical transformation ambitions	• Appoint a Net Zero Clinical Lead by 2026 • Set up a multi-disciplinary working group by 2027 to deliver on clinical transformation ambitions
Decarbonise clinical pathways	• Implement three Getting It Right First Time (GIRFT) Greener Pathway guides by 2028 (addressing a minimum of 95% of recommendations): - 'Fully' achieve a minimum of 75% of recommendations - 'Partially' achieve a minimum of 20% of remaining recommendations
Reduce unnecessary testing and single-use items across all pathways	• Achieve a 5% reduction in number of pathology tests per 1,000 patients by 2026 • Achieve a year-on-year reduction in number of peripheral lines (thin, flexible tubes inserted into a vein) in Emergency Departments per 1,000 patients
Transform pathways to increase patient initiated follow-up (PIFU) appointments	• Ensure 5% of all patients are on PIFU appointments by 2026
Integrate access to greenspaces and nature within clinical pathways	• Open the Critical Care Unit Garden at King's College Hospital, Denmark Hill, in 2026 • Ensure patients can join a ~~Healthy by Nature~~ session by 2028, organised by the Centre for Sustainable Healthcare, to support preventative care

Digital Transformation

Strong digital foundations are essential for transforming care by improving access, quality, productivity and reducing emissions.

Our digital estate, from electronic health records to PCs, laptops, servers and clinical systems, plays a vital role in how we care for patients. However, digital services can also increase emissions.

By embedding sustainability into digital transformation, we can improve access, reduce waiting times, cut paper and travel, and lower our carbon emissions. We will also reduce the digital estate's power consumption, enable energy-saving technology and promote good data hygiene across our workforce.

We will prioritise sustainability in the procurement, design and management of digital services. This includes maximising the benefits of digital transformation to reduce emissions and improve patient care, for example, by reducing the use of paper and providing remote care pathways where clinically appropriate. We will ensure every step of our digital strategy delivers for our patients and our planet.

Progress so far

- Introduction of electronic patient system Epic and patient-facing MyChart has led to a 45% reduction in printing and 16% fewer printers
- Reduced number of in-person appointments, with 24% of outpatient appointments now at home
- Introduced a patient telephone advice service - 43% of calls result in an avoided journey to hospital
- Maximised device lifespan by enhancing warranty and device management
- Decommissioned 700 systems and servers as part of data centre consolidation

Digital Transformation

Our objectives are:	Examples of how we will achieve this:
Accelerate adoption of remote care pathways	• Increase in MyChart sign-ups to 75% of patient population and expand two-way communications in app by 2028 • Deliver and maintain 25% of outpatient appointments as remote by 2026 • Expand GP advice service Consultant Connect and achieve 75% answer rates by 2027
Ensure a digital first approach to reduce paper and printing	• Reduce the number of incorrect Epic workflows and paper-based records duplicated onto Epic year-on-year • Digitise historic paper records in external long-term warehouse storage from 2026 • Reduce in-house printing demand and the number of clinical letters sent via post year-on-year
Engage suppliers and hosting partners to reduce environmental impact	• Ensure all new digital contracts include sustainability requirements and carbon reduction plans • Improve contract management by incorporating sustainability-focused KPIs • Increase cloud hosting from suppliers with demonstrable progress in carbon impact reduction
Reduce environmental impact of digital infrastructure	• Work with our suppliers to track energy savings when changing devices/software • Introduce a targeted power down configuration and increase number of active devices annually • Evaluate managed power downs of ‘non-production’ servers outside of core hours • Move to Office 365 and SharePoint from shared drives to reduce file duplication
Make informed sustainable hardware decisions	• Evaluate a refurbished hardware programme • Transition ‘Computers On Wheels’ to low-power Linux devices by 2028 • Incorporate sustainability into hardware refreshes, considering maximising asset lifetime and appropriate disposal
Take advantage of emergent technologies in a safe and sustainable manner	• Develop an AI governance framework considering environmental impacts by 2027 • Evaluate the use of wearable technology to facilitate remote monitoring, e.g. integration of home-based diabetes monitoring

Medicines

Medicines are a crucial part of improving peoples' health, but some of the choices we make are an avoidable source of harm to the environment.

We can deliver best clinical practice and significant reductions in the NHS carbon footprint by making simple changes.

Medicines account for around 25% of NHS emissions overall. A few medicines account for a large portion of these emissions, for example anaesthetic gases and some inhalers. Waste from medicines, such as used inhalers or expired stock, leads to emissions from disposal and other environmental pressures.

We will continue to reduce nitrous oxide waste from inefficient piped systems, support patients to choose the most appropriate inhaler and help them to dispose of used inhalers in a more environmentally friendly way.

Please note that this section focuses on the 'point of use' emissions of medicines. Actions to reduce emissions from the medicines supply chain are set out in the 'Supply Chain and Procurement' focus area.

Progress so far

- Stopped using desflurane - the most environmentally harmful anaesthetic gas - in all clinical settings in 2023
- Significantly reduced emissions from nitrous oxide waste by decommissioning piped medical gas systems
- Halved our carbon footprint from anaesthetic gases over the past five years
- First site to participate in an innovative South East London inhaler recycling pilot
- Begun shift from intravenous (IV) to lower carbon oral paracetamol at King's College Hospital

Medicines

Our objectives are:	Examples of how we will achieve this:
Reduce medical gas wastage	• Decommission three remaining piped nitrous oxide systems by 2026 • Continue to move to portable cylinder supply only for all nitrous oxide and oxygen mixed (Entonox) usage areas • Decommission all nitrous oxide and oxygen mixed (Entonox) piped manifolds by 2028 • Ensure no new installations of either pure nitrous oxide or nitrous oxide and oxygen mixed (Entonox) systems from 2026
Support appropriate inhaler choice and technique	• Support implementation of the South East London Emergency Department Asthma and Chronic Obstructive Pulmonary Disease (COPD) guidance, including on low-carbon inhaler choice • Achieve a 10% year-on-year decrease in the proportion of non-SABA (short-acting beta-2 agonists) inhalers that are metered dose inhalers (MDIs) from 2027 • Achieve a 10% year-on-year decrease in SABA high-carbon MDIs issued in ED from 2027
Switch from IV to oral administration of medicines	• Achieve a reduction in IV versus oral administration of antibiotics, where clinically appropriate, by 2026; then achieve a subsequent 5% year-on-year reduction in 2027 and 2028 • Stop all routine use of IV paracetamol in perioperative settings unless oral medication is not clinically appropriate by 2027; roll out to other settings from 2027
Reduce the impact of waste from medicines	• Evaluate the South East London inhaler recycling pilot at Trust level and, subject to its outcome, continue the scheme

Travel and Transport

We can reduce the environmental impact of our travel and transport by championing cleaner, greener and more efficient ways of getting around.

The NHS fleet is the second largest in the country, and directly contributes to harmful air pollution. From staff commuting and business travel to patient transport and logistics, every journey matters.

We will support a shift towards zero-emission vehicles, active travel, and smarter journey planning by providing the right infrastructure, incentives and information. This includes expanding access to Electric Vehicle (EV) charging, promoting electric bikes (e-bikes) for business travel, and ensuring our fleet is increasingly zero emission.

We will embed sustainable travel into how we work, encouraging all staff to make greener choices and helping our travel and transport partners do the same. By rethinking how we travel, we can improve air quality, cut carbon emissions and support the health and wellbeing of our staff, patients and communities.

Progress so far

- Launched a Travel Plan for each major site
- Introduced NHS's first EV charger at an Emergency Department at King's College Hospital, Denmark Hill
- EVs now make up almost a quarter (23%) of our fleet
- Installed 41 EV chargers for patients and visitors at PRUH
- Developed a dedicated micro-mobility e-bike parking bay at King's College Hospital
- Provide cycling storage facilities, Cycle to Work Scheme and Dr Bike (free onsite bike maintenance service)

Travel and Transport

Our objectives are:	Examples of how we will achieve this:
Increase EV charging network across our estate	• Grow the number of EV chargers across the King's estate by 2028
Expand our zero emission fleet	• Increase the percentage of Zero Emission Vehicles (ZEV) in the Trust's and King's Facilities Management (KFM) vehicle fleets year-on-year • Only offer ZEVs in the Trust's salary sacrifice scheme from December 2026 • Only lease ZEVs from December 2027 (as per NHS England guidance)
Reduce vehicle idling across Trust and partner fleets	• Launch anti-idling campaigns with applicable contractors including patient transport providers, taxi contractors, waste collection providers and couriers
Use vehicles more efficiently and encourage the least polluting modes of transport	• Reduce the number of under-utilised vehicles in the Trust fleet by 2028 • Grow the number of Trust e-bikes by 2028 • Improve access to public micro-mobility schemes (e-bikes / scooters) annually from 2026
Support active travel at the Trust	• Maintain and improve Dr Bike sessions at King's College Hospital and explore options to extend to other sites • Improve active travel support by 2028 through initiatives such as improving cycling storage • Increase proportion of staff using active modes of travel for work from 2025 (as shown through staff travel survey)
Develop new sustainable travel frameworks	• Replace Green Travel Plan with a Sustainable Travel Strategy by December 2026 (as per NHS England guidance) • Adopt a Sustainable Business Travel Policy by 2027

Estates and Facilities

There are opportunities across our estate to reduce emissions and lower costs, while improving energy resilience and patient care.

The energy used in our buildings accounts for around 91% of our NHS Carbon Footprint (the emissions we directly control). In addition, fossil fuel heating and local power production contribute to air pollution in and around our sites, which impacts our patients, visitors and staff directly.

We will minimise emissions from new build projects and major refurbishments, as well as address their contribution to local air pollution. We will continue to reduce the waste we produce, reusing what we can and recycling what we can.

Our outdoor spaces offer an opportunity to support patient recovery as well as staff and visitor wellbeing by connecting with nature. We will further improve our green spaces to support preventative healthcare and explore innovative ways to green our grey spaces.

Progress so far

- Implemented renewable energy initiatives across King's College Hospital, PRUH, and Orpington
- Received £250,000 to deploy rooftop solar arrays at Orpington and PRUH
- Secured £216,000 from GLA Zero Carbon Accelerator for low-carbon heating feasibility study
- Working in partnership with the Lambeth GP Food Co-op to help connect patients with nature
- Transformed green spaces at King's College Hospital thanks to funding from the King's Charity

Estates and Facilities

**Subject to grant funding*

Our objectives are:	Examples of how we will achieve this:
Reduce the environmental impact of capital projects	• Ensure all new build projects and major refurbishments are compliant with the NHS Net Zero Building Standard • Achieve BREEAM 'excellent' and 'very good' respectively for 100% of new build projects and major refurbishments from 2026 *Where these are not agreed, Board-level sign-off is required at design stage*
Complete heat decarbonisation plans for all of our hospital sites	• Build on and deliver heat decarbonisation plans for King's College Hospital, Orpington and PRUH, with the aim to reduce our NHS Carbon Footprint from heat at Trust owned sites by at least 80% between 2030-35 against our 2018/19 baseline*
Continue to reduce energy usage and source low-carbon energy	• Ensure 70% of all lighting across our owned estate is LED by 2028* • Ensure 50% of suitable Trust owned spaces have solar panels installed by 2028* • Ensure all new building leases have an EPC rating of 'C' or above and are heated by low-carbon sources from 2026
Achieve NHS England targets for waste management	• Achieve 60:20:20 clinical waste segregation ratios (60% disposed of as offensive / non-infectious waste, 20% infectious waste and 20% high-temperature incineration waste) by 2026 • Achieve 70% non-clinical waste recycling rate by 2028
Support patients, staff and visitors to connect with nature at our sites	• Improve our outdoor spaces, with nature in mind, to enable the delivery of the Healthy by Nature Programme, from 2026 • From 2026, continue to support Lambeth GP Food Co-op to carry out sessions in nature with patients
Assure compliance with environmental legislation	• Maintain an environmental management system (EMS) certified to ISO14001 certification - the internationally recognised standard for environmental management

Supply Chain and Procurement

It is crucial that we reduce the environmental impact of the goods and services we buy and bring our suppliers with us on our Net Zero journey.

Our supply chain accounts for 73% of our emissions. We recognise that our supply chain is extremely complex. However, as one of the largest NHS Trusts, we are also in a position to drive lasting change.

We will embed sustainability and circularity into procurement in line with Public Procurement Regulations. This will involve avoiding purchases where possible, and shifting to reusable, remanufactured or recycled solutions when clinically appropriate, which are often cost-saving.

We will continue to collaborate with our suppliers to reduce our NHS Carbon Footprint Plus and align with the NHS Net Zero Supplier Roadmap. Our supply chains will become more resilient to climate risks and disruptions. Digital tools and data will be used to monitor carbon impact and enhance transparency and traceability across the supply chain. We will ensure ethical sourcing and labour standards are upheld.

Progress so far

- Introduced a walking aid return scheme for patients at King's College Hospital, Denmark Hill
- Set up a furniture and equipment reuse scheme for our staff
- Rolling out a Gloves Off campaign to reduce unnecessary glove usage
- Shifting away from single-use gowns in our theatres at King's College Hospital
- Integrated sustainability into our Procurement Policy

Supply Chain and Procurement

Our objectives are:	Examples of how we will achieve this:
Ensure sustainability is consistently considered in procurement	• Continue to ensure all new procurements include a minimum 10% Net Zero and Social Value weighting • Ensure all suppliers submit Carbon Reduction Plans (baseline emissions and published targets) from 2027 • Encourage all Tier 1 (Gold) suppliers (by spend) to achieve level 2 Evergreen Sustainable Supplier Assessment by 2028 • Encourage all Tier 2 (Silver) suppliers (by spend) to achieve level 1 Evergreen Sustainable Supplier Assessment by 2028 • Ensure all procurement contracts include mandated sustainability clauses by 2028
Improve circularity and phase out single-use items	• Develop at least one new opportunity a year to move away from single-use products Trust-wide (i.e. couch roll from clinical areas by 2027) • Collaborate with suppliers to reduce packaging waste on purchased goods in line with the NHS Packaging Programme from 2026 • Consider repurposed or recycled products in our equipment replacement and capital project contracts by default from 2027
Increase collaboration and training with our suppliers and partners	• Ensure best practice is shared across our regional partners and the Trust's supply chain from 2026 • Ensure all Procurement and Supply Chain commercial colleagues receive sustainability and Social Value training by 2027
Make our supply chain operation more efficient	• Identify and create waste reduction strategies for products with the highest inventory-related waste (i.e overstocked or expired) by 2027 • Improve efficiency of deliveries and stock handling through NHS Supply Chain optimisation programme by 2028

Food and Nutrition

We can support our patients and the planet by reducing food waste and reviewing our menu choices.

The food system produces more than 30% of global emissions and is the number one driver of nature loss. Half of these emissions come from food waste.

By making changes to our menus, we can significantly reduce the environmental impact of catering, while making dishes healthier and more nutritious. However, we must carefully balance this with patient choice.

We will place a focus on seasonal produce, high in fruit and vegetables supplemented by low-carbon proteins like wild venison and tofu. Placing plant-based options at the top of our menus will prompt greener, healthier choices.

Regular monitoring and reporting of our food waste volumes and emissions will enable us to reduce our costs and wider impacts on nature, including deforestation and pollution.

Progress so far

- Reduced food waste by 28% between 2023 and 2025
- Conducted a carbon assessment of food ordered at King's College Hospital
- Reduced the carbon intensity of our menu choices and put plant-based options at the top of menus

Food and Nutrition

Our objectives are:	Examples of how we will achieve this:
Measure and reduce waste and carbon emissions from our food	• Weigh all of patient and retail food waste at point of disposal (e.g. at ward level) • Reduce Trust-wide food waste by a further 20% by weight by 2028 • Donate food at risk of expiry to the local community and encourage our partners to do the same • Obtain carbon footprint figures for 85% of ordered patient and retail food by 2027
Put in place a digital meal ordering system for all patient food orders	• Order all patient meals through a digital ordering system by 2028
Sustainably source our food	• Ensure a minimum of 70% of annual food spend is certified to higher environmental standards by 2027 • Ensure a minimum 70% of food spend is for food grown, reared or produced in the UK by 2026
Incentivise plant-based meals and low-carbon meats	• Explore the 'greener by default' trial for suitable areas including retail, with approval from the Nutrition Steering Committee for any menu changes, by 2028 *(This approach makes plant-based food the standard option on menus, while allowing diners to choose meat/dairy options)*

Adaptation

Resilience to a changing climate is essential to meet increasing pressures on our services and avoid disruptions.

Our climate is changing. Forecasts by the Met Office predict that the frequency of climate impacts such as extreme weather events will continue to increase, which poses a risk to Trust operations.

Flooding and overheating has previously impacted our operations and demonstrated how climate change is already affecting healthcare.

We published our Climate Change Adaptation Plan in 2023 which outlines our approach to address this risk. Infrastructure upgrades, including new green spaces, will boost our resilience to extreme weather events.

We are also working with our partners to understand how climate change scenarios may affect our healthcare planning needs.

Progress so far

- Published a Climate Change Adaptation Plan in 2023 and launched a working group for delivery
- Put in place Emergency Preparedness, Resilience and Response (EPRR) plans to support business continuity during extreme weather events
- Trialling intelligent energy management software at Orpington and King's College Hospital
- Building on partnership and research opportunities to support healthcare planning in a changing climate

Adaptation

Our objectives are:

Our objectives are:	Examples of how we will achieve this:
Establish accountability for adaptation at the Trust	• Formalise appointment of a senior member of staff who is accountable for adaptation measures by 2026
Support business continuity during adverse weather events	• Integrate NHS adaptation recommendations into our EPRR processes by 2026 • Complete the NHS England Climate Change Risk Assessment for one Trust site by 2027
Assess and report on climate risk	• Ensure climate risk is reported in line with Taskforce on Climate-related Financial Disclosures (TCFD) annual reporting requirements by 2026 • Complete a deep dive review of climate change risk on the corporate risk register by 2026 • Build resilience into our Estates Strategy and capital project planning, including through green infrastructure

Air Quality

Air pollution remains the most important environmental threat to health.

Poor air quality affects every single organ in our bodies and throughout all life stages, causing and worsening long-term conditions. It is estimated to contribute to 30,000 early deaths in the UK a year.

Not everyone is affected equally. London boroughs had the highest proportion of deaths attributable to air pollution in 2023. The most deprived and most diverse communities of London are more likely to live in the most polluted areas.

The Trust plays a dual role: we contribute to air pollution through our own operations and also treat the people who suffer from poor air quality.

The Government's 10 Year Health Plan highlights air quality as a key element to achieving one of its three fundamental shifts: from sickness to prevention. We will continue to take action to reduce our own impact and raise awareness through our Clean Air Action Group, staff training and education, and knowledge sharing with other trusts.

Progress so far

- Published our first Clean Air Plan with Guy's and St Thomas' NHS Foundation Trust in 2023
- Installed air quality monitoring at pedestrian entrances at King's College Hospital and PRUH
- Send out air quality alerts to all staff on days of 'high' and 'very high' air pollution
- Integrated air quality data into Epic and MyChart
- Run a Clean Air Action Group as well as awareness raising events such as Clean Air Day

Air Quality

Our objectives are:	Examples of how we will achieve this:
Continue to carry out air quality monitoring and reporting	• Continue air quality monitoring at a minimum of two pedestrian entrances across the Trust • Regularly share monitoring data internally and externally where relevant
Further improve our understanding of the impact of air pollution at our sites	• Quantify the change in Emergency Department admissions on days of 'high' and 'very high' air pollution for conditions such as acute asthma and stroke by 2027 • Assess ways to link ED admissions data to population demographics and health inequity to support wider research
Continue to raise awareness of air pollution with our staff, patients and visitors	• Develop and implement a staff and patient engagement strategy by 2027 • Continue to send out air quality alerts to all staff on days of 'high' and 'very high' air pollution • Improve air quality messaging to patients and suppliers through digital display boards in loading bays, waiting rooms and air quality data in MyChart from 2026
Enable our clinicians to take action	• Evaluate use of air quality identifiers in Epic and increase usage year-on-year from 2027 • Widely communicate air quality training opportunities to staff and identify ways to measure uptake from 2026 • Co-develop damp and mould pathways and guidance for clinicians, working with regional partners, by 2027

Governance and accountability

The Trust Board has responsibility for oversight, assessment and management of climate-related issues and our commitments relating to environmental sustainability.

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

The GPDB is chaired by a nominated Board-level Net Zero lead, whose role is to drive forwards the sustainability agenda and promote environmental considerations through the GPDB and its members.

The Trust will appoint its first Net Zero Clinical Lead - a member of the GPDB - who will shape and drive the integration of sustainability into our clinical pathways, ensuring we deliver high-quality, preventative, low-carbon care across the Trust.

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

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

We will continue to embed environmental sustainability into existing policies, projects and processes, by committing to implement a Sustainability Impact Assessment for all business cases.

We will learn from best practice, share progress across the sector, and play an active role as an anchor institution by working with our partners, tenants and local organisations, contributing to and delivering against key local environmental strategies.

Please note some of the objectives and Key Performance Indicators (KPIs) outlined in this document are subject to grant funding.

Tracking and reporting

The Trust will report on progress against its Green Plan in line with the requirements set out in the ~~Department of Health and Social Care (DHSC) Group Accounting Manual~~, the ~~Foundation Trust Annual Reporting Manual~~ and the ~~NHS Standard Contract~~.

Annual reporting:

- Trust carbon footprint (NHS Carbon Footprint and NHS Carbon Footprint Plus) - this goes beyond NHS England reporting requirements. NHS Carbon Footprint Plus reporting, which includes indirect emissions through our supply chain, is an area of improving methodology.

- Trust Annual Report:

The 'sustainability' section includes:

- Narrative updates on progress and key achievements
- Delivery of key milestones
- Task Force on Climate-related Financial Disclosures (TCFD) which will be increased in scope from 2026 to enhance decision making, strategic planning and transparency

Going forward, this will also include an assessment of risks to future delivery.

- Estates Return Information Collection (ERIC)
- Premises Assurance Model (PAM)
- Environmental management system (EMS) certification and environmental compliance score

Bi-annual reporting to:

- King's Executive
- Trust Finance Board Committee

Quarterly and monthly reporting:

- Greener NHS Data Collection
- Reporting against all KPIs

Ad-hoc:

- Progress against the delivery of our Green Plan will also be reported on as part of the Care Quality Commission (CQC)'s Well-led single assessment framework.

As set out in NHS England's reporting guidance, we are adopting a phased approach to publishing sustainability disclosures and meeting reporting requirements.

We are working hard to ensure that we collect robust data across a wide range of environmental performance indicators, including our carbon footprint, which we have been able to report on across all Trust sites and activity at King's since 2019/20.

Work is ongoing to ensure environmental sustainability considerations are fully embedded into clinical and delivery group planning and reporting.

All clinical divisions and corporate teams will have KPIs for environmental sustainability which will be reviewed regularly and enable the Trust to track progress and escalate any issues.

We will develop an environmental sustainability dashboard to support reporting efforts and visualise progress as well as gaps in delivery.

To shape subsequent delivery windows, the Trust will commission a quantified gap analysis by 2028, which will compare progress to date to the system-wide Net Zero targets and identifying revised delivery milestones and timelines to 2040 and 2045.

Glossary

BREEAM (Building Research Establishment Environmental Assessment Model) - a method of assessing, rating and certifying the environmental, social and economic stability of buildings
Circularity - A system where materials are kept in circulation through processes like maintenance, reuse, refurbishment, remanufacture, recycling and composting
Climate change - A large-scale, long-term shift in the planet's weather patterns and average temperatures
CO2e (carbon dioxide equivalent) - A unit of measurement that is used to standardise the climate effects of various greenhouse gases
Consolidation centre – A facility where goods from multiple suppliers are combined into larger, more efficient loads for final delivery
Core vehicle fleet - The essential vehicles that a business or organisation uses through lease, ownership or hire to support its primary operations
Decarbonise - Reduce or eliminate carbon emissions being released by a process
Deforestation - The removal and destruction of a forest or stand of trees from land that is then converted to non-forest use
Desflurane - An anaesthetic gas which has been decommissioned for routine use by NHS England due to its high global warming potential (2,500 x that of carbon dioxide)
Emergency Preparedness, Resilience and Response (EPPR) - Planning for, and responding to, a wide range of incidents and emergencies that could affect health or patient care
Ethical sourcing - The process of sourcing products and services in a responsible way that considers the social, environmental and economic impacts of the supply chain
EMS (Environmental Management System) - a framework designed to help organisations monitor, control, and continuously improve their environmental performance.
Epic - An electronic patient record system used at King's College Hospital NHS Foundation Trust
Evergreen Sustainable Supplier Assessment - An online self-assessment tool which enables suppliers to engage with the NHS on their sustainability journey
Fossil fuels - A natural non-renewable fuel (e.g. coal or gas) formed from the buried remains of ancient living organisms
Greener by default - Making plant-based food the standard option on menus, while allowing diners to choose meat/dairy
IV (intravenous) - A medical process that administers fluids, medications or other substances directly into a person's vein for rapid delivery
LED - a light emitted diode (with low power consumption and longer lifetimes over incandescent light sources)
Low-carbon - Causing only small amounts of carbon dioxide added to the atmosphere
MyChart - An app and website which lets patients securely access parts of their health records (as part of Epic)
Net Zero - A state in which the greenhouse gas emissions going into the atmosphere are balanced by removal from the atmosphere
NHS England Climate Change Risk Assessment - A tool which helps NHS organizations identify, assess, and plan for climate-related risks to their operations, infrastructure, and service delivery
Nitrogen oxides - A family of gases which are toxic pollutants, formed mainly from burning fossil fuels
Non-SABA (short-acting beta-2 agonist) - Inhalers used for the long-term management of conditions like asthma and COPD
NEPTS (Non-emergency patient transport services) - Funded transport for patients who would struggle to safely attend their treatment independently
Particulate matter pollution - Harmful pollution from a mixture of solid particles and liquid droplets found in the air
NHS Supply Chain - A national body which supports the NHS by managing the sourcing, delivery and supply of healthcare products, services and food
Pollution - The introduction of substances into the natural environment that cause harm
Plant-based meal - A meal consisting mostly or entirely of foods from plants
Plate waste - Uneaten food that is left on plates after a meal
Quality Improvement - A systematic and continuous process for evaluation and improving systems, often focusing on patient experience, safety and efficiency
Remanufactured - The build of a product to its original specifications using a combination of reused, repaired and new parts
Renewable energy - Energy from naturally replenishing natural sources (e.g. sunlight, wind, water and heat)
SABA (short-acting beta-2 agonist) - quick-relief inhalers that open airways to treat asthma and COPD symptoms like wheezing and breathlessness
SusQI (Sustainability in Quality Improvement) - An approach to improving healthcare in a holistic way, measuring the health outcomes against its environmental, social and economic costs and impacts to determine its "sustainable value"
Task Force on Climate-related Financial Disclosures (TCFD) - A framework to support public sector bodies to disclose climate-related risks and opportunities
Under-utilised vehicles - Vehicles that have not been used as often as expected i.e. those being driven for less than 15 miles per day on average

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Next steps

Our plan is ambitious: designed to address the environmental challenges facing our healthcare systems to give us hope for the future. It will be delivered through the talent and dedication of our people and by harnessing the power of new technology and innovation to help us to meet the needs of the communities we serve.

We will continue to engage with patients, colleagues, our governors and a wide range of external partners as we implement our plan.

Our clinical divisions and corporate teams will drive delivery through local strategies that align with this overarching plan, and our Trust Strategy will guide this work.

Our Board will monitor progress, and we will review and adapt our plans in response to changing circumstances where necessary, holding true to our commitment to protect our patients, people and planet.

For further information about our Green Plan, please contact our Sustainability Team at kch-tr.sustainabilityteam@nhs.net.

King's College Hospital
NHS Foundation Trust

Innovation Strategy
2026 – 2031

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Foreword

Innovation is central to King's ambition to deliver world-class care. This supporting strategy sets out how we will embed innovation as a core organisational capability so that staff, patients and partners can contribute to and benefit from new ideas.

It matters now because we face increasing financial and operational pressures, alongside rising expectations for quality, productivity and digital maturity. While innovation is already happening, it is fragmented and inconsistently supported; a clear approach will provide pathways, governance and targeted resources to focus effort where it delivers greatest impact.

This strategy is for:

- Patients and communities – to improve outcomes, experience and equity through problem-led innovation.
- Staff – to make it easier to develop, test and adopt good ideas with the right support and governance.
- Partners – to enable trusted collaboration with academia, industry and system partners to co-develop and adopt effective solutions.

Success will look like a visible and accessible front door for innovation, clearer pathways and governance, a fellowship programme to accelerate the highest-value opportunities and improvements in patient outcomes, operational efficiency and financial sustainability.

Julie Lowe, Deputy Chief Executive, Kings College Hospital NHS Foundation Trust

Background

Case for change

Innovation in healthcare is the process of developing, testing and adopting new ideas, technologies or ways of working that deliver measurable improvements in outcomes, experience, productivity and/or sustainability.

There are three main types of innovation:

- Clinical innovation – new pathways, interventions or models of care.
- Technological innovation – digital tools, devices, diagnostics, AI and data-enabled solutions.
- Operational/organisational innovation – new processes, workforce models or systems that improve efficiency and value.

In practice, most NHS innovations span more than one category.

At King's, innovation is driven both by strategic intent and by creative responses to emerging challenges. Innovation activity operates across a broad and connecting ecosystem, including:

- Frontline innovation – ideas generated through day to day clinical, operational and support services.
- Research and academia – innovation emerging from research activity, academic partnerships and translational work.
- National programmes and funding – innovation enabled through participation in national initiatives, programmes and external funding opportunities.
- Partnerships and collaboration – working with public sector organisations and industry to co-develop, test and scale innovation.
- Data and technology as a driver for change – using data, digital capability and technology to identify challenges, evidence the need for change and target innovation where it can deliver the greatest impact.

Support for innovation across the Trust is currently fragmented and under-resourced, with unclear governance and variable routes for staff to access help. Without a supporting strategy, opportunities to improve care, productivity and sustainability may be missed and promising ideas may stall due to lack of support, funding or safe adoption pathways.

At present, staff and partners experience an innovation landscape that is difficult to navigate. Routes for support are inconsistent, with no clear front door, resulting in staff often not knowing where to take an idea, who can help, or what governance steps are required. Innovators can struggle to access the right expertise leading to delays, duplication of effort and frustration. There is also no clear entry point for external partners to engage with King's, impacting our ability to attract high-value collaborations.

This supporting strategy targets both sides of the innovation pipeline:

- Developing new ideas and concepts that can be commercialised (pre-NHS regulated research).
- Piloting and adopting innovation into business as usual (BAU) (post-NHS regulated research).

If we act, 'good' will look like:

- A visible and accessible innovation front door.
- A coordinated, outcome-focused innovation pipeline linked to Trust priorities.
- Structured support for King's innovators (training, signposting and targeted support through a fellowship programme).
- Clear pathways and governance providing oversight and prioritisation of innovation activities across the Trust and ensuring the safe delivery of innovation (patient safety, data and digital infrastructure).
- Innovation designed with Equity, Diversity and Inclusion (EDI) at its heart to ensure benefits are shared fairly.

Local context

King's delivers care within one of the most pressured health systems in the country, serving a large, diverse South London population with significant health inequalities. This creates high demand for services but also a strong imperative for innovation that improves outcomes and reduces unwarranted variation.

Feedback from patient and local communities highlights an expectation that King's will innovate, ensuring that local residents benefit directly from advances in care, technology and treatment. As a major teaching and research active Trust, innovation is not only a strategic necessity but a core part of how King's is perceived and trusted by the communities it serves.

Operationally, the Trust continues to face workforce shortages, financial constraints and high activity levels, all of which limit capacity for staff to engage in development and constrain investment. These pressures reinforce the need for innovations that can increase productivity, streamline pathways and support financial sustainability.

Digitally, King's has strong foundations through Epic and its Microsoft environment, enabling data-driven care and AI-enabled innovations. However, disciplined governance, particularly "Epic-first" and "Microsoft-first" principles, is essential to avoid increasing complexity or long-term support burden.

As an academic provider within King's Health Partners, the Trust benefits from world-class research expertise, strong clinical leadership and proximity to major academic and industry partners. These create opportunities for collaboration, evaluation and external funding, though the Trust's scale can limit access to large-profile partnerships compared with larger peers.

Overall, King's must balance significant operational and financial pressures with the opportunity to leverage its digital assets, partnerships and strong appetite for innovation. A coordinated, disciplined innovation approach is essential to delivering better outcomes, improved patient and staff experience and long-term financial sustainability.

National context

Across the UK, the NHS 10-Year Plan sets a decisive shift towards AI-enabled productivity, digital-first services and earlier intervention, with major reforms centred on moving care closer to communities, replacing analogue systems with end-to-end digital infrastructure and expanding precision, genomics and personalised medicine.

The NHS is also under pressure to address productivity, waiting time recovery and workforce constraints, with national reviews highlighting system inefficiency, rising illness burden and growing workforce shortages. This has led to an expectation that digital tools and AI will not simply automate tasks but act as catalysts for system-wide reform – a direction that aligns with King's ambition to streamline pathways, enhance capability and introduce innovations that deliver measurable operational and financial impact.

Environmental expectations are also rising at a national level. Through the NHS Net Zero ambitions, there is a clear expectation that innovation should contribute to sustainability and decarbonisation wherever possible, reducing environmental impact while improving efficiency and quality of care. As a result, innovation is increasingly expected to demonstrate both clinical and operational value alongside tangible environmental benefits.

Regionally, the Southeast London Integrated Care System (SEL ICS) has made innovation a clear strategic priority, committing to "drive innovation using emerging technologies and new ways of working" as part of its wider system-transformation approach. This direction of travel is supported by the Health Innovation Network South London (HIN SL), which acts as the regional innovation arm of the NHS.

Progress so far

Innovations developed by King's staff

There have been successes where King's clinicians have led innovation into clinical practice (Table 1).

Staff Member	Title & Role	Innovation / Study Summary
Professor Bu'Hussain Hayee	Professor of Gastroenterology	Artificial Intelligence in Gastroenterology – NAIAD Study: The largest CADe study to date, demonstrating an 8% increase in adenoma detection rate using AI-assisted colonoscopy. Link
Dr Sophie Harris	Consultant in Diabetes & Endocrinology	Hybrid Closed Loop (HCL) Automated Insulin Delivery: Implementation aligned with NICE TA943, improving glucose control and user experience for people with Type 1 diabetes. Link
Mr Jonathan Shapey	Consultant Neurosurgeon	Data-driven Intraoperative Hyperspectral Imaging: Real-time tumour visualisation to support more precise neurosurgical resections in neuro-oncology. Link
Professor Sharlene Greenwood	Professor of Exercise and Lifestyle Therapy; Consultant Physiotherapist	Kidney Beam – Digital Exercise and Wellbeing Platform: Co-designed with people living with kidney disease; improving physical and mental health; implemented in renal services nationally and endorsed by the UK Kidney Association. Link
Professor James Teo	Professor of Neurology	Cogstack – Clinical Data Platform: Can search and interpret any structured or unstructured clinical data in patient records (including free text) using a type of AI called natural language processing (NPL), to enable advanced analytics, clinical decision-making, research, service improvement and AI-enabled innovation. Link

Table 1: Examples of where King's staff have led innovation into clinical practice.

Figure 1: Innovation and collaboration partnership event with King's, the Association of British HealthTech Industries and the Shelford Group, held on 1 October 2025, showcasing clinical innovations developed at King's.

Strengthening innovation culture

King's has undertaken a range of activities to build a more consistent, system-wide approach to innovation, including:

Successfully joining the NHS InSites Programme, a national peer-led innovation network.

Impact: Provides funded support to help King's build an innovation culture, strengthen infrastructure and accelerate the piloting and adoption of innovations that benefit patients and staff.

Contributing to policy work through InSites, including work on the Innovation Passport (ongoing).
Impact: Ensures King's helps shape national policy and gains early insight into new pathways for adopting innovations.

Developing a Trust-wide innovation system, covering commercialisation, governance, and piloting/adoption (piloting).
Impact: Creates a clear, safe and repeatable route for innovations to move from idea to implementation.

Introducing a triage process for using InSites funding to support pilot projects.
Impact: Ensures resources are prioritised for innovations with the strongest potential clinical, operational or financial value.

Co-designing bitesize innovation training with InSites partners, produced by the Health Technology Enterprise (in progress).
Impact: Provides accessible learning to build capability across clinical and operational teams.

Developing an Innovation Fellowship programme (in progress).
Impact for staff: Access to mentorship, networking and microfunding to progress high-value ideas.

Impact for Small and Medium Sized Enterprises (SMEs): Supports development of innovations aligned to Trust needs.

Intellectual Property (IP) Guidance – Implementation and Evaluation (in progress).
Impact: A clearer, nationally informed approach to IP helps ensure that both staff and the Trust

receive fair recognition and benefit from innovations developed at King's, while creating a more supporting environment for generating and commercialising new ideas.

Tracking commercial innovation and value (In progress)

Impact: Improves oversight of commercial activity and strengthens value capture from innovation.

Pilots and funded projects

King's is progressing a portfolio of funded innovation projects aligned to key priorities such as patient experience, safety, efficiency and sustainability. This programme has been enhanced through external awards, including joint bids with Guy's and St Thomas' (GSTT) and Mid and South Essex (MSE), with support from Greener NHS, InSites and Rosetrees. The projects include:

XWatts – Energy optimisation System

Funding source: Greener NHS

Applied with: Joint bid with GSTT

Status: Live, 12-month pilot

Expected impact: £98k annual cost savings and 43.9 tCO_2e reduction.

oVRcome – VR Support for Patients with LD/Autism

Funding sources: Rosetrees and InSites

Applied with: Joint bid with Mid and South Essex (MSE)

Status: Planned

Intended impact: Improved patient experience, reduced anxiety and better access to care.

Improved Liver Disease Detection – ELF Testing

Funding source: InSites

Status: Live, 12-month pilot

Intended impact: Earlier diagnosis for alcohol dependence related liver disease; reduced impatient days; reduced readmissions; improved 12-month mortality.

Capillary Blood Gas Testing to Assess Sickle Cell Disease (SCD) Deterioration

Funding source: InSites

Status: Planned

Intended impact: Faster assessment of deterioration, reduced intensive care unit (ICU) admissions and shorter length of stay.

Raizer Lifting Chairs

Funding source: InSites

Status: Live, 8-month pilot

Intended impact: Reduction of 41 Princess Royal University Hospital (PRUH) Accident and Emergency (A&E) and £16.7k non-cash releasing savings.

Additional external funding: £25k from the Urgent and Emergency Care Learning and Improvement Network (UEC LIN) for additional chairs following successful early learning.

Supporting the organisational strategy

Alignment to the six strategic objectives

Innovation is a key enabler of the Research, Innovation and Education pillar of the Trust Strategy 2026–2031. By embedding innovation as a managed capability, this strategy supports delivery across organisational objectives through improved quality and safety, better patient experience, greater productivity, workforce empowerment and financial sustainability.

Summary of strategic impact

This supporting strategy contributes by:

- Delivering improvements through adoption of proven innovations into BAU.
- Enabling the pathways, governance, training and targeted support that allow innovation to flourish.
- Protecting patient safety, information governance and value through clear oversight, standards and decision routes.

Vision

Vision statement

To embed innovation as a core organisational capability at King's - enabling staff from all professional backgrounds, patients and partners to turn ideas into measurable improvements in

care, productivity and sustainability through a safe, coordinated and inclusive innovation system.

What will be different (future state)

Patients will experience:

- More access to effective innovations that are shaped by strong EDI principles.
- Safer, faster pathways and more personalised care enabled by digital and data-driven solutions.

Staff will experience:

- A single front door to submit ideas and get timely signposting and support.
- Clear routes for development, piloting and adoption, with training on innovation, IP and commercialisation.
- A fellowship programme that provides networking opportunities, mentorship, project support and micro-funding for the highest-impact ideas.

Partners will experience:

- A single front door to submit collaboration proposals.
- Clear governance and collaboration pathways for co-development, evaluation and adoption.

Strategic objectives and outcomes

Strategic objectives (what we will achieve)

1. Strengthen the Trust's innovation pipeline by attracting, identifying and progressing high-value opportunities with clear commercial and clinical impact potential.
2. Embed a systematic approach to improvement ensuring priority innovations aligned to Trust strategic pillars are consistently adopted and sustained across BAU.
3. Empower staff to confidently innovate through clear pathways, accessible support, capability-building and a visible innovation culture.
4. Establish a coordinated, well-governed innovation system that accelerates safe adoption into BAU.
5. Secure long-term financial sustainability through commercialisation and innovations that deliver demonstrable productivity and cost benefits.

How we will deliver the objectives

To achieve this, we will:

- Implement an Innovation Front Door where staff and partners can submit innovation queries and ideas supported by a standardised submission form, triage process and a knowledge base built from resolved queries to reduce repeat questions. For innovations intended for piloting or adoption into BAU, divisional and care group sign-off will be required as part of the front door process.
- Establish and maintain pathways for creators, collaborators and adopters, including criteria for progression and appropriate governance routes.
- Convene an Innovation Stakeholder Group, bringing together key innovation-enabling functions (CI&I, ICT, Commercial Legal, IG, KFM/Procurement, Transformation, R&D and others) to provide coordinated oversight, prioritisation and strategic direction for innovation activity across the Trust.
- Operate within defined 'lanes': Epic-first, Microsoft-first, and prioritisation of innovations that deliver against Trust objectives including AI-enabled opportunities where appropriate.
- Build capability through training (innovation basics, IP, commercialisation) and embedding innovation within Quality Improvement (QI) training aligned to the King's Improvement Method (KIM).
- Use the KIM to provide the operational framework for generating innovative ideas that can be adopted into BAU by:
    - Ensuring innovations are problem-led and aligned to organisational need.
    - Creating a unified improvement–innovation pipeline by connecting improvement activities (QI, audit, evaluation, research and transformation) into a single coherent system that feeds the innovation pipeline.
    - Supporting safe, effective piloting and adoption into BAU.
- Develop and deliver an Innovation Fellowship Programme to support both staff innovators and early-stage SMEs. For King's staff, the Fellowship is open to all professional backgrounds, ensuring a multi-professional approach and includes mentorship, networking opportunities and micro-funding to progress good ideas to a level where they are able to join a national programme and/or apply for funding. For SMEs, the programme aims to support Digital Health London (DHL) innovations, local startups and/or clinician–industry co-development, working with KFM to progress innovations that align with the Trust's strategic priorities.
- Strengthen funding and sustainability through partnership with charities and/or reinvestment of innovation-related income.

Delivering the strategy

Governance and accountability

Executive lead and reporting:

- Executive oversight via the Deputy Chief Executive, with formal reporting to the Executive Team.
- Quarterly Innovation Stakeholder Group (ISG) for strategic oversight and prioritisation, with representation from CI&I, ICT, KFM/Procurement, R&D, Commercial Legal, Strategy, Transformation and King's College Hospital Charity.
- Research, Innovation and Education objective embedded as strategic pillar within the King's 2026 – 2031 Strategy ensuring the innovation portfolio directly contributes to the Trust's strategic ambitions and organisational performance metrics.

Decision routes and specialist governance:

- Divisional and Care Group governance for approval of proposals within the relevant clinical or operational remit where an innovation is being piloted in clinical or operational services and creates and expectation of adoption, scaling or service change.
- Digital innovation routing via the ICT PMO governance process for technical assurance and alignment with the Trust's digital strategy.
- Clinical safety assurance via the Clinical Safety Officer, where required.
- Information Governance assurance for data driven innovations, including completion of a Data Protection Impact Assessment (DPIA) and review of data sharing proposals by the Data Collaboration Assurance Group (DCAG).
- Financial governance via the Investment Board for any innovation proposals requiring Trust investment, committing capital or revenue or with material financial implications.
- Specialist assurance via relevant committees – including the New Clinical Procedures Committee and the Clinical Products and Devices Standardisation Committee for proposals involving new clinical procedures, products or devices.
- Procurement oversight via KFM, applying NHS procurement regulations for innovations requiring commercial purchase or contracting.
- Commercial and contracting governance via Commercial Legal for review and approval of proposals requiring contractual agreements or commercial legal oversight.

The ISG will align with and coordinate across existing governance routes and ensure that innovations involving new clinical procedures, products or devices are reviewed and approved through the appropriate specialist committees.

Innovations will be prioritised based on their alignment to Trust strategic objectives, ensuring resources are focused on opportunities that deliver the greatest impact for patients, staff and organisational performance.

Enablers

Key enablers required include:

- People and capability: Innovation capability across the workforce through access to training and fellowship opportunities and protected time for staff to develop and progress innovative ideas, aligned to the Trust's People Strategy.
- Communications support: Ensures effective engagement, visibility and dissemination of innovation activities across the Trust.
- Cross-functional collaboration: A Trust wide approach to innovation with enabling functions working together providing coordinated oversight and streamlined, joined up support, underpinned by the KIM.
- Digital foundations: Strong digital infrastructure, including Epic EPR optimisation, aligned Microsoft platforms and robust cybersecurity and information governance, in line with the Trust's Digital Strategy, to enable safe, scalable and interoperable innovation.
- Partnership ecosystem: Effective collaboration with regional and national partners including the Health Innovation Network South London/Digital Health London, KFM, King's College London, King's Health Partners and the Association of British HealthTech Industries, to provide expertise, networks and delivery support.
- Funding and sustainability: Access to dedicated and sustained funding streams, including charitable and external funding and reinvestment of innovation-related income, to support development, piloting, adoption and ensure long term sustainability of the innovation programme.

High-level delivery plan

The strategy will be delivered in three phased stages, moving from foundation, to embedding and scale, to optimisation and sustainability. Each phase builds directly on the core deliverables set out earlier in this strategy; a single front door, clear pathways and governance, capability-building, a fellowship programme and safe adoption of innovation into BAU.

Year One (2026/27) – Establish the foundations

Focus: Create the core infrastructure, governance and capability required to support innovation consistently and safely.

Key deliverables:

Innovation Front Door established

- Launch a single, visible entry point for staff and partners, including standardised submission, triage and tracking.
- Introduce an innovation register and dashboard to provide transparency and oversight of activity.

Clear pathways and governance in place

- Agree Innovation Stakeholder Group (ISG) terms of reference and decision routes.
- Define creator, collaborator and adopter pathways, including escalation and assurance requirements.

Capability and culture building initiated

- Embed innovation principles within Quality Improvement training.
- Deliver bite-size innovation training (innovation basics, IP, commercialisation).

Innovation Fellowship launched

- Recruit and onboard the first cohort of staff innovators.
- Establish mentorship, microfunding and support offer for high value ideas.

Communications support established

- Provide appropriate communications support to ensure effective engagement, visibility and dissemination of innovation activities across the Trust.

Outcome by end of Year One:
A functioning innovation system with a clear front door, agreed governance and trained staff.

Years Two and Three (2027/28–2028/29) – Embed and scale

Focus: Strengthen the pipeline, increase adoption into BAU and grow partnerships and funding.

Key deliverables:

Innovation pipeline strengthened and embedded

- Increase volume of commercialisable ideas entering through the front door.

Fellowship and partnerships scaled

- Expand the Fellowship programme, growing the mentor network and external partners (e.g. HIN SL, DHL, academia, SMEs).
- Run regular innovation showcases to support spread and adoption.

Adoption into BAU accelerated

- Use KIM to systematically progress problem led innovations from idea to pilot and adoption.
- Support safe piloting, evaluation and transition of priority innovations into routine practice.
- Strengthen links between innovation, transformation and divisional delivery.

Sustainable funding model developed

- Explore and establish longer term funding mechanisms (e.g. charitable funding, reinvestment of innovation related income).

Outcome by end of Year Three:
A mature, managed innovation pipeline with multiple innovations adopted into BAU, stronger external partnerships, and more sustainable funding.

Years Four and Five (2029/30–2030/31) – Optimise and sustain

Focus: Maximise impact, refine the system based on learning and position King's as a recognised innovation leader.

Key deliverables:

Impact demonstrated and optimised

- Evidence measurable clinical, operational, workforce and financial benefits from adopted innovations.
- Refine KPIs, pathways and governance based on learning and performance.

Innovation embedded as business as usual

- Innovation fully integrated with QI, transformation and operational delivery as part of KIM.

Outcome by end of Year Five:
Innovation is embedded as a core organisational capability, delivering sustained improvements in care, productivity and financial sustainability.

Thank you

Innovation relies on the collective efforts of multiple functions and partners across the Trust and beyond. Thank you to all who have contributed to the development of this strategy.

King's College Hospital
NHS Foundation Trust

Making King's A Great Place To Work

Our People & Culture Strategy

2026 – 2031

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Foreword

At King's, our people are at the heart of everything we do. Every day, colleagues across our hospitals, community services and corporate functions bring skill, commitment and compassion to caring for our patients and communities.

We know that working in the NHS is demanding. Staff have told us about the pride they feel in what they do, but also about the pressures they face and the differences in experience between teams, sites and staff groups. They have told us what is working well and where we need to do better, including leadership, wellbeing, development, inclusion, staff voice and the everyday systems and conditions that enable people to do their jobs well.

This strategy sets out how we will respond. Our ambition is to make King's a great place to work, a place where people feel valued and included, are well led and supported, can learn and develop, feel safe to speak up and can contribute to improving and transforming healthcare.

Achieving this ambition requires us to consider both the workforce we need and the environment in which our people work. We need to plan for the skills, roles and capacity required to meet changing demand, while creating the leadership, culture and organisational conditions that enable people and teams to thrive. These are closely connected to our ability to deliver safe, high-quality care, improve productivity, retain our people and remain financially sustainable.

Our values of Caring, Collaborative, Inclusive and Innovative provide the foundation for how we will work. They must be more than words. They should be visible in how we lead, make decisions, treat one another, develop our people and respond when things are not working as they should.

Over the next five years, we will build on the progress already being made at King's. We will focus on getting the foundations right, reducing variation in staff experience, strengthening leadership and management, developing our workforce and building the capability to lead and sustain change.

This is an engagement draft. We want staff to help shape how these priorities are delivered and what should happen first. We will publish what we heard, what changed as a result and what will happen next.

Our shared commitment is to lead compassionately, listen openly and act visibly.

Our ambition is simple: to create a sustainable workforce and a culture in which our people can thrive, so that together we can deliver the best possible care for our patients and communities.

The most important measure of this strategy is simple, it must make a real and meaningful difference to the experience of working at King's.

Matthew Trainer, Chief Executive, King's College Hospital NHS Foundation Trust

Damian McGuinness, Chief People Officer, King's College Hospital NHS Foundation Trust

Background

Local Context

King's provides local services to the diverse communities of Southwark, Lambeth and Bromley, alongside highly specialised services for patients from across the UK and internationally. We deliver care across five hospital sites, through community-based services and in people's homes. The scale and complexity of our services create significant opportunities to develop specialist expertise, build strong training pipelines and grow our own talent. This scale also brings significant financial and operational pressures as demand for care continues to grow.

In 2025/26, King's incurred approximately £1.17 billion in employee costs, representing more than half of the Trust's operating expenditure. This reflects the size and complexity of the multidisciplinary workforce needed to deliver our services. Rising demand across urgent, elective and specialist care continues to place pressure on staffing capacity and our ability to deliver timely care. There is also a significant opportunity to improve productivity and make better use of our workforce and resources while maintaining safe, high-quality care.

During 2025/26, King's delivered more than 2.35 million patient contacts across outpatient, emergency, elective, non-elective and maternity services. This scale of activity demonstrates both the contribution of our people and the importance of planning our workforce sustainably.

Certain areas continue to experience persistent vacancies and skills shortages because workforce supply does not consistently meet demand. Hard to fill roles occur across nursing, medical, healthcare science and allied health professional groups. Maintaining safe service delivery can therefore require a combination of temporary staffing, recruitment and retention premia, and international recruitment.

Bank and agency staff provide important flexibility and resilience. However, where they are relied upon to address persistent supply gaps, turnover or the impact of less than full time working, this can mask wider workforce and organisational risks that need to be understood and addressed.

Alongside these workforce pressures, King's has a workforce characterised by pride, skill, commitment and a strong sense of purpose. There are also areas of effective practice and evidence of improving staff experience. However, the day-to-day experience of working at King's is not yet consistent. Staff continue to describe pressure and emotional strain, variation in leadership behaviours, uneven access to development, inequitable experiences and frustration when basic working conditions or systems make it harder to do a good job.

Taken together, the local context requires King's to consider workforce capacity alongside the organisational conditions in which people work. Ensuring we have the right workforce, skills and roles to meet changing demand needs to go hand in hand with effective leadership, culture, learning, wellbeing, engagement and organisational development. These are complementary parts of the same challenge, creating the workforce and organisational conditions that enable our people to thrive, adapt and deliver safe, effective and sustainable care.

National context

King's is operating in a challenging national environment in which the NHS is expected to increase productivity, transform services and improve access while managing constrained resources. The 2025 Spending Review provides average annual real terms growth of 3.0% for NHS day to day spending between 2023/24 and 2028/29. Much of this growth will be required to meet rising demand and costs, maintaining a continued focus on affordability, productivity, service redesign and making the best use of existing skills and capacity.

The 10 Year Health Plan sets out three major shifts in how care will be delivered: from hospital to community, from analogue to digital and from sickness to prevention. Delivering these shifts will require changes to workforce models, roles, skills and ways of working. Further changes will emerge over the lifetime of this strategy, and King's will need to adapt while maintaining safe, high-quality care.

Recent and planned changes to immigration routes may also affect workforce supply, particularly for some lower paid and hard to fill roles. They may create additional pressures through their impact on the wider health and social care labour market. This reinforces the need to strengthen local recruitment, retention, career pathways and internal workforce pipelines alongside ethical international recruitment.

The workforce is also changing, with increasing expectations around flexibility, work life balance, career development, autonomy and working patterns. Growth in less than full time training and working, particularly among resident doctors, alongside an ageing workforce and the need for more effective succession planning, will require King's to think differently about how roles, careers and working arrangements are designed. These expectations have implications for workforce supply, retention, engagement, wellbeing and our ability to attract future talent.

Taken together, the national context reinforces the need for an integrated approach to workforce, culture and organisational development. King's must manage affordability and productivity while creating the conditions in which people can adapt to new roles, develop new skills, work differently and remain engaged. Workforce redesign cannot be separated from leadership, culture, learning, wellbeing, inclusion, staff voice and change capability. These will be critical to delivering transformation safely, sustainably and with staff rather than simply to them.

Case for change

The workforce challenge is not simply one of numbers. King's needs the right workforce capacity, skills, roles and deployment to meet changing demand while improving productivity, quality and financial sustainability.

Shortages in some clinical and specialist roles, reliance on temporary staffing in parts of the organisation, changing expectations about work and careers, and national policy changes requiring service and workforce redesign all increase the need for a more sustainable approach. Without intervention, there is a risk of repeated cycles of reactive workforce growth and contraction, with consequences for morale, financial stability, retention and patient care.

At the same time, the organisational conditions in which people work matter. King's has a workforce characterised by pride, skill, commitment and a strong sense of purpose and there is evidence of improving staff experience. However, experience is not yet consistent across teams, sites and staff groups. Staff continue to describe workload pressure and emotional strain, variation in leadership behaviours, uneven access to development, inequitable experiences, barriers to speaking up and frustration when basic working conditions or systems make it harder to do a good job.

What staff have told us: progress is being made, but people still experience too much variation in leadership, workload, opportunity, inclusion, speaking up and the everyday systems they rely on.

The message from our staff is not that King's needs to start again. It is that we need to build on progress, reduce variation and make good practice more consistent.

The 2025 NHS Staff Survey provides encouraging evidence of improvement. King's improved across all seven NHS People Promise themes and in 98 of 110 survey questions. The Trust also achieved the greatest improvement among London acute trusts in its overall staff experience score. This provides a strong platform on which to build.

However, progress is not yet experienced consistently. King's remains below its comparator position across the People Promise themes, and staff experience continues to vary by team, site, profession, staff group, background and manager. The next step is to convert improvement into sustained progress and reduce inequity and local variation.

Staff have told us that leadership and management are not consistently experienced as compassionate, inclusive, visible or enabling. People want King's values to be lived through everyday interactions, decisions, people processes and team cultures. They want wellbeing to be addressed through workload, team climate, psychological safety and practical working conditions, not only through support offered once people are already struggling.

Staff also want learning and development to be easier to access and more clearly connected to their role, career stage and future opportunities. Managers need clear expectations, practical support and effective tools to lead teams in a pressured environment. Equity, diversity and inclusion must be embedded into leadership, talent, workforce planning and governance, while organisational development support should be targeted where it can make the greatest difference.

There is also an important opportunity to build on the strengths already present at King's. The Trust has a stable and experienced core workforce, effective training pipelines, significant specialist expertise and a strong sense of purpose. King's also has established improvement capability and partnerships through King's Health Partners, whose strategy emphasises personalised health, digital health, population health and greater workforce and financial stability through partnership. These assets provide a strong foundation for developing new roles, skills and ways of working rather than relying solely on external recruitment.

The challenge is therefore to move from reactive workforce management and pockets of good organisational practice, towards a more integrated and sustainable approach. Workforce redesign will not succeed without trust, engagement and effective change leadership.

Retention will not improve through recruitment and vacancy management alone if staff experience, leadership, wellbeing and development remain inconsistent. Productivity will not be sustained through workforce controls in isolation if teams do not have the skills, leadership, systems and culture needed to work differently. Equally, culture improvement cannot be separated from the practical realities of workload, workforce capacity, role design and financial sustainability.

The case for change is therefore about creating the workforce and organisational conditions for King's to deliver its strategy. This means having the right people, skills and roles, alongside effective leadership, inclusive and compassionate culture, learning and development, wellbeing, engagement, psychological safety and organisational development. Together, these will enable King's to adapt to changing demand, improve retention and productivity, support safe and high-quality care and make King's a great place to work.

Our Aspiration

To make King's a great place to work by building a compassionate, inclusive and high performing culture where our people feel safe, valued, well led, supported to learn and able to contribute to improving and transforming healthcare.

By 2031, King's will have a sustainable, skilled and engaged workforce, supported by the culture, leadership and organisational conditions needed to deliver the Trust strategy.

We aim to be in the top quartile of comparable NHS organisations for People Promise outcomes and to demonstrate sustained improvement in staff experience, leadership, wellbeing, inclusion, learning, retention and organisational performance.

Success is more than a survey score. Staff experience and patient experience are closely connected. Teams that are well led, psychologically safe, inclusive and supported to learn are better able to raise concerns, improve care, work across boundaries and sustain high standards under pressure.

This strategy therefore supports King's ambitions for quality, safety, patient experience, productivity and financial sustainability.

What success will look like by 2031

- King's is in the top quartile of comparable NHS organisations for People Promise outcomes and demonstrates year on year improvement in the areas that matter most to staff.
- King's has the right workforce capacity, skills and roles to meet changing demand, with stronger internal pipelines, improved retention and reduced reliance on reactive workforce solutions.
- Staff describe King's as a place where values are lived consistently and poor behaviours are addressed fairly and promptly.

- Leaders and teams are more confident and capable in leading change, with staff involved earlier, impacts understood more clearly and change delivered in a way that builds trust rather than fatigue.
- Managers have a clear, practical and supported role in creating good staff experience, developing their teams and delivering effective services, not just delivering operational tasks.
- Leadership expectations are embedded in recruitment, induction, appraisal, talent, development and performance conversations.
- Staff feel safer, healthier and more able to speak up, with clearer evidence of action and learning from feedback.
- Inequities in experience, opportunity and outcomes are reducing, with transparent data and visible leadership accountability.
- Learning, core skills, development and talent pathways are easier to navigate and more fairly accessed, supporting both individual careers and future workforce needs.
- OD and workforce transformation support is targeted, evidence informed and valued by Care Groups, divisions and corporate functions as a route to better team effectiveness, workforce sustainability and change delivery.
- Culture, workforce and staff experience are routinely considered alongside quality, finance, productivity, patient experience and operational performance.

Our Strategic Priorities

This strategy is delivered through two connected strategic pillars: Workforce Sustainability and Transformation and Culture, Leadership and Organisational Development. Inclusion is a core design principle across both.

The Workforce Sustainability and Transformation pillar describes what King's needs to build: the right workforce capacity, skills, roles and pipelines to deliver changing models of care sustainably.

The Culture, Leadership and Organisational Development pillar describes the conditions that will enable delivery: values led leadership, inclusion, healthy teams, staff voice, learning, talent and the capability to lead change well.

Inclusion is not a standalone workstream. It is one of King's values and a fundamental part of how we will achieve our goals. Improvement in People Promise outcomes will only be meaningful if it is experienced across staff groups, sites and every stage of the employee lifecycle.

Each priority will therefore be designed and measured through an equity lens. We will use insight from the NHS Staff Survey, the Workforce Race Equality Standard, the Workforce Disability Equality Standard, employee relations, recruitment and progression data, staff networks, Freedom to Speak Up and local engagement to identify differences in experience and

outcomes. This insight will be used to target action and address inequalities, rather than simply report variation.

Together, the two pillars address both the workforce King's needs and the organisational conditions in which people work. Having the right people, skills and roles must go hand in hand with a culture in which everyone can thrive, contribute and deliver their best for patients.

One strategy to deliver a sustainable workforce through a values-led staff experience.

Workforce Sustainability and Transformation

Workforce Priority 1: Develop a Flexible, Multiskilled and Inclusive Workforce

As care increasingly moves into community and virtual settings, roles and skills will need to evolve. We will develop broader capabilities alongside specialist expertise, enabling staff to respond more holistically to patient needs and strengthening multidisciplinary working across professional boundaries. We will redesign, train and deploy our workforce in ways that support changing models of care while maintaining safe staffing, professional standards and equitable access to opportunity. Key actions include:

- Generalist Skills: Develop and test a generalist skills programme for appropriate clinical groups, including doctors, nurses and allied health professionals. This will begin with small, clinically led cohorts and will include appropriate professional, educational and patient safety assurance before wider implementation.
- Outpatient and Virtual Care Redesign: Support specialties to develop new workforce models for outpatient care, including additional Advanced Clinical Practitioner (ACP) roles for experienced nurses, AHPs and pharmacists.
- Multidisciplinary Team (MDT) Working: Explore pilots such as Integrated Neighbourhood Teams, bringing community nurses, therapists, pharmacists, medical, social care and mental health professionals together around defined populations.
- Flexible Deployment: Review and strengthen our internal bank and deployment arrangements so that appropriately skilled staff can work across departments or sites more easily when demand changes, while maintaining continuity, competence and staff choice.
- Workforce Redesign: Use data from the Model Health System and local workforce intelligence to identify opportunities to redesign roles, skill mix and ways of working. Directorates will have access to practical workforce planning tools and support to understand service need, productivity, affordability and future workforce requirements. Proposed changes will be assessed against safe staffing, quality, equality and professional standards before implementation.

Expected outcomes: By 2031, King's will have a more agile, multiskilled workforce able to work across care settings and professional boundaries. Patients will experience more coordinated care, while staff benefit from broader roles and less siloed working. We will increase our capacity to deliver care in community and virtual settings while maintaining safe staffing and improving workforce productivity.

Workforce Priority 2: Enhance Staff Engagement, Wellbeing and Retention

Supporting our staff to feel valued, included, healthy and able to develop is fundamental to providing great care. Delivering changes to care models will depend on a motivated and stable workforce. This priority focuses on improving the employment experience, strengthening retention and making King's a place where people choose to build their careers. Key actions include:

- Wellbeing and Mental Health: Review and strengthen our trust wide wellbeing offer, creating clearer and more accessible routes into occupational health, psychological support, trauma informed support and workplace adjustments. We will explore how support can be made more visible and accessible across our main sites and for staff working remotely or across community settings.
- Supportive Management: Equip managers to support staff effectively, including through regular conversations about wellbeing, workload, development and work life balance.
- Flexible and Inclusive Work Options: Embed flexible working options from recruitment onwards, including compressed hours, part time working, job shares and remote working where feasible, alongside approaches such as self-rostering and annualised hours.
- Access to nutritious food and drink: Review staff access to healthy, nutritious and sustainable food and drink against the National Standards for Healthcare Food and Drink and relevant NHS staff standards, including access for colleagues working overnight and outside usual opening hours.
- Career Development and Progression: Support the national ambition for every member of staff to have meaningful career and development planning. During this strategy period, we will improve the quality of career conversations, make development routes easier to navigate and establish a phased approach to personalised career planning and coaching.
- Recognition and Reward: Strengthen recognition at King's through timely local appreciation, inclusive opportunities to celebrate individual and team contributions and an annual staff awards programme. We will ensure that clinical, non-clinical, corporate and support roles are all visible within our recognition activity.

Expected outcomes: By 2031, staff should report a stronger sense of being valued, supported and able to develop at King's. We will improve retention, reduce avoidable turnover and strengthen Staff Survey outcomes relating to wellbeing, recognition, flexible working, voice and intention to stay. Measures and targets will be agreed once Year 1 baselines have been confirmed.

King's should be increasingly recognised by its people as a place where those who care for patients are themselves supported, valued and cared for.

Workforce Priority 3: Embrace Digital Innovation and New Ways of Working

This priority focuses on giving our people modern, reliable tools and the skills to use them confidently. We will use digital technology, data and AI to redesign work responsibly, reduce

avoidable administrative burden and support safer, more flexible and productive ways of working. Key actions include:

- Digital Skills and Confidence: Develop a phased digital skills offer for staff, including continued support for Epic, data literacy, responsible AI use and the practical skills needed to use emerging analytics and digital tools.
- Reduce administrative burden: Work with staff to identify high-volume, repetitive or frustrating processes and use technology, automation and process redesign to simplify them. Baselines will be established before setting targets, with benefits measured through time released, staff experience, safety and productivity.
- Responsible AI and Decision Support: Pilot AI enabled tools where there is a clear clinical, operational or staff benefit. Staff will be involved in the design and evaluation of these pilots. Implementation will include appropriate clinical, information governance, equality, safety and ethical oversight, alongside training on the capabilities and limitations of AI. Human judgement and accountability will remain central.
- Digital Champions: Build a network of clinical and non-clinical digital champions who can help colleagues use new tools, share learning and identify where technology could improve care or working lives.
- Empower Mobility and Remote Work: We will consider extending remote working options for appropriate roles. We would expect this to improve retention and it could also extend workforce reach.
- Interoperability and access to information: Work with digital teams and system partners to reduce the need for staff to navigate multiple disconnected systems or repeatedly seek the same information. This work will align with the Trust's digital strategy and relevant information governance requirements.

Expected outcomes: Staff will be more confident using digital tools and AI, experience fewer avoidable administrative barriers and have more time for patient care and higher-value work. Digital improvement will contribute to the wider NHS requirement for annual productivity improvement, while maintaining safety, quality, equity and appropriate human oversight.

Workforce Priority 4: Invest in Leadership, Talent and Culture Change

Sustainable workforce transformation depends on effective leadership, visible career opportunities and a culture in which people feel able to contribute and improve. We will connect workforce planning with leadership development, talent, succession and culture change so that King's builds the capability needed for future services. Key actions include:

- Align leadership and management development with workforce transformation priorities and the NHS Leadership and Management Framework.
- Strengthen succession planning for critical clinical, operational, professional and specialist roles.
- Create clearer and fairer routes for internal development, progression and mobility.

- Build change leadership, improvement and workforce planning capability among clinical and operational leaders.
- Use King's values and Behavioural Framework to shape leadership expectations, talent decisions and accountability.
- Improve the diversity of leadership and specialist pipelines through transparent talent processes, positive action, sponsorship and targeted development.

Expected outcomes: King's will have stronger leadership and specialist pipelines, clearer succession for critical roles and a more diverse group of people ready to take on future opportunities. Leaders will be better equipped to transform services, develop their teams and create the conditions for people to thrive.

Detailed delivery is set out in the Culture, Leadership and Organisational Development priorities on leadership, values and behaviours, learning, talent and change capability.

Workforce Priority 5: Workforce Planning, Recruitment and Partnerships

To secure our workforce for the future, we must excel in planning and collaboration. This means accurately forecasting staffing needs in a changing care landscape and working closely with education providers and regional partners to ensure a robust pipeline of talent. It also involves smart recruitment - targeting the right skills and areas, attracting high quality candidates to priority roles and reducing dependency on short term fixes. We also need to take a proactive approach to identifying fragile services within King's and responding to national and local challenges around small and vulnerable professions. By planning ahead and partnering widely, we can better mitigate workforce risks such as shortages in critical roles and build a sustainable workforce supply for King's. Key actions include:

- Demand and Capacity Modelling: We will review our approach to modelling demand and capacity. This will enable us to better understand the bottlenecks within our system, improve organisational flow and reduce delays. It will also give us a better understanding of the capacity we require to deliver our services which will inform and improve our workforce planning processes.
- Workforce Planning: Strengthen workforce planning by working with services and professional leads to understand current capacity, risks and future requirements. This will be supported through training, practical tools, workforce intelligence and access to specialist advice. We will use consistent planning approaches across the Trust while allowing for the different needs of services and professions.
- Fragile Services and workforce risks: Establish a consistent approach to identifying services where workforce supply, specialist expertise, succession or staffing models create a risk to sustainable delivery. Higher risk services will be reviewed at least every six months, with clear escalation, ownership and mitigating action.
- Local Recruitment and pipelines: Develop targeted recruitment activity for hard to fill roles and strengthen King's reputation as an inclusive employer offering meaningful work, development and flexibility. We will expand apprenticeship and local training partnerships

and create clearer routes into suitable King's vacancies following successful completion, subject to workforce need and normal recruitment requirements.

- Graduate and Trainee Partnerships: We will deepen partnerships with local universities with the aim of forecasting changing demand and securing appropriate additional training posts in a timely manner.
- International Recruitment: While we cannot exclude applicants on the basis of nationality, we will only actively recruit internationally for specific high need roles where appropriate alternatives are not available. International recruitment will follow the national Code of Practice, with effective support for recruits and a continued focus on strengthening local workforce pipelines and self-sufficiency.
- Regional Collaboration: We will continue to collaborate on workforce matters with our system partners, King's Health Partners and neighbouring Trusts. We will consider shared recruitment efforts for hard to recruit specialties and create joint posts with partners. Cooperative approaches like these increase each organisation's resilience and fulfil the vision of a devolved, diverse NHS where local systems support each other.
- Service delivery models: Where changes to delivery models, partnerships, shared services or external provision are considered, decisions will be based on quality, safety, workforce impact, equality, value and service resilience. Staff and trade unions will be involved at an early stage, in line with relevant policies and consultation requirements.
- Pay and reward: Review how national and local pay flexibilities, including recruitment and retention premia, are used to support hard to fill and highly competitive roles. Any approach will be evidence based, affordable, equitable and aligned with national terms and Trust governance.

Expected outcomes*:* King's will have a clearer understanding of current and future workforce need, with workforce risks identified and acted on earlier. We will improve fill rates in hard to fill roles, strengthen internal and local pipelines, reduce avoidable agency reliance and increase the number of people progressing into King's roles through apprenticeships, education partnerships, return to practice and internal development.

Key Outcomes

The delivery of these strategic workforce priorities will fundamentally reshape and strengthen our workforce by:

- Shifting care delivery models by moving more staff and services into community and virtual settings, enabling our hospitals to focus on complex and specialist care, while growing and modernising roles to support this transition.
- Redesigning roles and skill mix by expanding advanced and new roles, ensuring teams are configured to better meet patient needs and improve service delivery.
- Retaining and supporting our people by strengthening staff engagement, wellbeing, flexible working, career development, and inclusion, to improve morale and retain our talented workforce.

- Embracing digital innovation by equipping staff with modern tools and training, maximising the use of our digital systems, and introducing AI enabled workflows to release time for patient care and higher value activity.
- Strengthening leadership, planning, and partnerships by empowering managers with the skills for compassionate and inclusive leadership, enhancing workforce planning through data driven approaches, and working more collaboratively across the Trust and wider health and care system

This establishes a productivity led and quality focused approach to workforce growth. It recognises that demand will continue to increase while financial growth remains constrained. Workforce plans will therefore balance activity, affordability, productivity, safe staffing and quality, while strengthening supply and retention and reducing reliance on reactive workforce expansion.

Culture, Leadership and Organisational Development

Culture/OD Priority 1: Living our Values and Behaviours

We will co-design and embed a trust wide Behavioural Framework that describes what Caring, Collaborative, Inclusive and Innovative look like in practice. This will give staff and managers a shared language for the behaviours we expect, encourage and hold each other accountable for. Key actions include:

- Co-design the Behavioural Framework with staff, patients, staff networks, trade unions and leaders.
- Ensure the Behavioural Framework reflects both staff and patient expectations, including how we demonstrate compassion, respect, inclusion and professionalism in every interaction.
- Embed the framework into recruitment, induction, appraisal, leadership development, recognition, talent and team interventions.
- Use the framework to support constructive conversations about behaviours, including when behaviours fall short.
- Create practical tools for teams to discuss values, civility, respect, psychological safety and decision making.
- Align values and behaviours with staff survey action planning and local culture improvement work.
- Ensure the framework describes inclusive behaviours clearly, including how we challenge discrimination, incivility and exclusion when they occur.
- Align the Behavioural Framework with recruitment, induction, appraisal, recognition, leadership expectations, talent decisions and performance conversations, so that values-based behaviour is recognised and reinforced and behaviours that undermine safety, dignity or inclusion are addressed fairly and consistently.

Expected Outcomes: Staff experience greater consistency in how people behave, how concerns are handled and how the values show up in everyday decisions. Managers have clearer expectations and a practical route for reinforcing good culture.

Culture/OD Priority 2: Inclusion, Equity and Belonging

Inclusion is central to culture and organisational performance. We will strengthen belonging and tackle inequity through mainstream leadership accountability, transparent data, targeted interventions and continued investment in staff voice and staff networks. Key actions include:

- Use WRES, WDES, staff survey, employee relations, recruitment, progression, pay gap and lived experience data to identify and address inequity.
- Set clear EDI priorities and improvement targets, with visible executive and divisional accountability.
- Strengthen anti-racism, disability inclusion, gender equity, LGBTQ+ inclusion, social mobility and support for parents and carers through targeted action.
- Embed inclusive recruitment, appraisal, talent and succession practice so progression is fairer and more transparent.
- Establish clearer partnership arrangements with staff networks, including early involvement in relevant work, visible executive sponsorship, timely organisational responses and feedback on how network insight has influenced policies, decisions and improvement.
- Ensure EDI is built into leadership development, OD interventions, staff engagement, learning and governance rather than delivered as a standalone programme.
- Engagement routes will actively include staff who are less likely to attend formal forums or access digital channels.

Expected Outcomes: Staff are more likely to feel they belong and have equal opportunities. Managers use data and lived experience to identify inequity and improve fairness. King's reduces disparities in recruitment, development, progression, disciplinary experience and staff survey outcomes.

Culture/OD Priority 3: Compassionate, Inclusive and Effective Leadership

Leadership is one of the strongest levers for improving staff experience and organisational performance at scale. We will develop a phased leadership and management offer aligned with the published NHS Leadership and Management Framework, King's values, King's Improvement Method and the practical realities of leading in a large acute and specialist provider. Key actions include:

- Prioritise development in year one for team and service leaders (including Bands 5 to 7 and 8a to 8c), where the day-to-day impact on staff experience will be greatest.
- Create clearer leadership pathways for line managers, service leaders, clinical directors, matrons, corporate leaders and senior teams.

- Support leaders and managers to use the NHS Leadership and Management Framework self-assessment as part of appraisal and development conversations, with appropriate development plans and access to learning.
- Build practical capability in core management skills, inclusive leadership, wellbeing conversations, appraisal, team climate, change leadership, finance, workforce and productivity.
- Embed coaching, mentoring, action learning and peer support so managers are not expected to lead complex teams without support.
- Strengthen executive and senior leadership development through the King's Improvement Method, A3 thinking, purpose walks, improvement huddles, sponsorship and visible improvement leadership.
- Connect leadership accountability to staff experience, patient experience, quality, EDI outcomes and organisational performance.
- Ensure inclusive leadership is a core expectation for all managers, not an optional module.

Expected Outcomes: Managers feel more confident and better equipped. Staff experience more consistent, visible and compassionate leadership. King's sees stronger engagement, improved team climate, better change delivery and clearer succession for critical roles.

Culture/OD Priority 4: Change Capability, OD and High Performing Teams

King's cannot deliver the workforce transformation it needs unless we become better at leading, supporting and sustaining change. Change capability is not simply about project delivery. It is about how leaders involve staff, explain decisions, understand impact, manage transition, respond to concerns, learn as they go and create the conditions for high performing teams. This priority will build the skills, routines and OD support needed for leaders and teams to deliver change well, rather than experiencing change as something done to them. Key actions include:

- Develop a King's approach to people centred change, aligned to Kings Improvement Method and the wider workforce transformation agenda.
- Build change capability into the leadership and management offer, including engagement, communication, impact assessment, co-design, transition, change readiness, responding to concerns, learning and sustaining change.
- Strengthen how teams work together by clarifying their purpose and roles, improving decision making and information sharing, creating a safe environment to speak up, strengthening accountability and supporting teams to solve problems locally.
- Prioritise OD support for major workforce and service redesign programmes, staff survey hotspots, areas of concern, senior teams and services under pressure.
- Equip leaders to understand the impact of change on workload, wellbeing, inclusion, staff voice and trust.

- Use team diagnostics, change readiness assessments and engagement insight to target support where change risk is highest.
- Embed King's Improvement Method principles so teams use inquiry, testing, learning and improvement to make change sustainable.

Expected Outcomes: Staff experience change as more honest, joined up and well supported. Managers and leaders feel more confident to lead change. Teams have clearer purpose, roles and ways of working. King's builds stronger organisational capability to deliver workforce redesign, service transformation, productivity improvement and cultural change

Culture / OD Priority 5: Wellbeing, Psychological Safety and Healthy Teams

This priority describes the leadership, team and organisational conditions needed to support wellbeing, while Workforce Priority 2 focuses on the wider employment, retention and workforce outcomes. Wellbeing at King's must move beyond a menu of support offers. It needs to be built into the way teams are led, workload is discussed, risks are escalated and staff are supported after difficult experiences. The emotional load of healthcare work must be recognised and addressed as part of safe, high-quality care. Key actions include:

- Strengthen the trust wide wellbeing approach, with clearer and more accessible routes into occupational health, psychological support, trauma informed support, workplace adjustments and local wellbeing resources.
- Use sickness absence, staff survey, FTSU, employee relations, violence and aggression and EDI data to identify wellbeing hotspots.
- Support managers to have better wellbeing, workload and adjustment conversations.
- Strengthen manager capability to identify early signs of stress, support reasonable adjustments and escalate concerns before issues become formal, unsafe or harder to resolve.
- Embed team-based wellbeing resources into OD interventions and local culture action plans.
- Strengthen violence prevention, sexual safety, civility and respect work as part of a coherent staff safety approach.
- Ensure wellbeing actions are linked to practical working conditions, including rest, hydration, access to equipment, workspaces and reliable people processes.
- Wellbeing support will recognise that staff experience is shaped by role, background, site, working pattern and exposure to discrimination or trauma.

Expected Outcomes: Staff feel safer, healthier and better supported. Managers are more confident in identifying and responding to risk. King's reduces avoidable sickness absence, improves retention and strengthens performance under the People Promise theme "We are safe and healthy". Wellbeing will be treated as a shared responsibility, with King's improving the conditions for wellbeing and staff supported to access help early.

Culture / OD Priority 6: Learning and Future Skills

Learning is essential to statutory and professional assurance and is also a wider commitment to developing our people. Core skills compliance will be treated as an enabler of safe care, statutory assurance and professional accountability. Our wider learning offer will build the capabilities King's needs for future care models, digital working, improvement, inclusive leadership and organisational change. Key actions include:

- Stabilise core skills governance and assurance, with clear ownership between central teams, Care Groups and managers.
- Clarify the role of mandatory, role specific and locally required learning, ensuring reporting is proportionate, risk based and meaningful.
- Strengthen access to development through LEAP, apprenticeships, digital learning, leadership pathways, coaching, mentoring, action learning and experiential learning.
- Build future skills in digital, data, AI enabled practice, improvement, population health, inclusive practice and change leadership.
- Improve induction and onboarding so staff understand King's strategy, values, support routes, inclusion, safety and expectations from the start.
- Use learning evaluation to understand impact on staff experience, patient care, safety, productivity and service improvement.
- Monitor access to development to identify and address inequity by staff group, grade, protected characteristic and site.

Expected Outcomes: Staff find it easier to access the learning they need. Managers understand their role in core skills and development. King's improves assurance, reduces compliance risk and builds the capabilities needed for future models of care.

Culture / OD Priority 7: Talent, Careers and Succession

King's has a wealth of talent within its existing workforce, with significant potential to develop and grow our people. Our next step is to ensure everyone can see and access meaningful opportunities to learn, develop and progress, with a particular focus on supporting colleagues who face barriers to career progression. Talent management must support retention, internal mobility, succession for critical roles and a stronger sense that people can build their career at King's. Key actions include:

- Develop a trust wide talent and succession framework aligned to values, workforce planning and the NHS Management and Leadership Framework.
- Link talent and succession planning to workforce planning, hard to fill roles, service redesign and future skills so development activity supports both individual progression and workforce sustainability.
- Build on the talent pilot in Care Groups and use evidence to scale what works.

- Create transparent career pathways, including for clinical, operational, corporate and specialist roles.
- Use positive action, sponsorship, mentoring and stretch opportunities to improve progression for under-represented groups.
- Develop succession plans for critical leadership and specialist roles, including clinical directors, matrons, service managers and corporate leaders.
- Increase internal development, mobility and progression through secondments, acting up opportunities, project roles, job shadowing and cross system placements. Talent processes will actively support fair progression and improve representation in leadership pipelines.
- Strengthen fairness in talent and succession decisions through clearer criteria, transparent moderation and active challenge of bias, recognising that informal access to opportunity can reinforce existing inequalities.

Expected Outcomes: Staff see clearer routes to progress. Managers hold better career conversations and identify talent fairly. King's strengthens internal pipelines, reduces reliance on external recruitment and improves retention of skilled people.

Culture / OD Priority 8: Staff Voice and Trust

Staff voice must be central to how King's designs, delivers and improves its people and culture work. Engagement means listening early, involving staff in changes that affect them and showing how their feedback has influenced decisions. It is not simply consultation after decisions have been made.

We will bring together insight from the NHS Staff Survey, free text comments, local listening, staff networks, Freedom to Speak Up, trade unions, pulse surveys, OD work and team conversations. This will help leaders understand what is improving, where variation remains and where trust is being affected.

Key actions include:

- Develop the King's Engagement Approach, setting out clear principles for listening, involving, sense making, responding and closing the loop.
- Strengthen how staff survey results and free text themes are analysed, shared and acted on at Trust, Care Group, divisional and team level.
- Introduce clearer "you said, we did, we are still working on" reporting so staff can see what has changed, what has not changed yet and why.
- Build engagement into the way change is led, so staff are involved earlier in decisions that affect their roles, teams, services and working lives.
- Support managers and leaders to have better local listening conversations, including how to make sense of feedback, respond honestly and turn insight into practical action.
- Ensure staff voice routes include colleagues who are less likely to attend formal forums, work across different sites and shifts, or have limited access to digital channels.

- Use staff networks and trade unions as strategic partners in understanding lived experience, testing proposals and shaping improvement.
- Triangulate staff voice with workforce, wellbeing, EDI, FTSU, ER, OD and patient experience insight through the culture dashboard.
- Use engagement insight to identify hotspots, inform OD support, improve team climate and strengthen local culture action plans.
- Build trust by being honest about what can change quickly, what will take longer, and where there are constraints or trade-offs.

Expected Outcomes: Staff feel better heard and can see how their feedback influences decisions and improvement. Managers have clearer routines for listening, sense making, responding and closing the loop. Leaders have better insight into the lived experience of staff and use that insight to shape decisions, change and local improvement. King's builds trust by showing what has changed, what has not changed yet and why.

The test of this priority will be whether staff can see and describe what changed because they spoke up, contributed or gave feedback.

Our values led delivery approach

Our values provide the bridge between our aspiration and how we deliver it.

The People Strategy priorities describe what King's needs to achieve. Our values of Caring, Collaborative, Inclusive and Innovative describe how we will work and the experience we want our people, patients and partners to have along the way.

Our values are therefore not simply statements of intent. They are a practical guide to the culture, behaviours and ways of working needed to make King's a great place to work.

This means:

- **Caring** will guide how we improve wellbeing, psychological safety, recognition, flexible working and the practical conditions that enable people to do their best work.
- **Collaborative** will guide how we strengthen teamwork, engagement, communication, system working and shared problem solving across Sites, Care Groups, Divisions and corporate functions.
- **Inclusive** will guide how we tackle inequity, improve belonging, strengthen staff networks, improve representation and make development, progression and voice fairer.
- **Innovative** will guide how we build learning, improvement, digital confidence, talent, OD capability and new ways of working**.**

In practice, our strategic priorities and values work together. The People Strategy's priorities give King's the workforce direction, the values ensure the delivery feels coherent, human and consistent with the culture we are trying to build.

Our system levers for culture change

Culture will not change through programmes alone. It will change when the systems that shape everyday experiences are aligned with our values. Over the next 5 years, King's will focus on the organisational levers that have the greatest influence on culture:

- **Leadership and management practice:** clear expectations for how people are led, supported, developed and held to account.
- **Equity and access:** data used to identify where opportunity, experience or outcomes differ, with targeted action to reduce variation.
- **Employee centred People services:** accessible, responsive and reliable People services that use technology effectively, resolve issues as early as possible and make it easier for staff and managers to obtain the support they need.
- **Trust and voice:** staff feedback listened to, acted on and closed through visible 'you said, we did, we are still working on' reporting.
- **Team conditions:** stronger psychological safety, clearer communication, better information flow and more consistent support for teams under pressure.
- **People processes:** recruitment, induction, appraisal, talent, learning, recognition and employee relations aligned to our values and inclusion ambitions.
- **Accountability and consequences:** behaviours that reflect our values recognised and reinforced; behaviours that undermine safety, dignity or inclusion addressed fairly and consistently.

Together, these levers will help King's move from pockets of good practice to a more reliable, values led culture across teams, sites and staff groups.

How we will measure progress

Progress will be monitored through one integrated People Strategy evidence framework, combining workforce metrics, culture and staff experience measures, staff voice, qualitative insight and evidence of changed practice. The aim is not to create additional reporting burden, but to give King's a clear view of progress, identify where variation remains and inform where further action is needed.

Baselines will be established in Year 1 for each outcome area. Each headline measure will have a named owner, reporting frequency, trajectory and agreed level of analysis.

Measures will be benchmarked against national and peer organisations where appropriate and analysed by Care Group, division, staff group, site and protected characteristic where data quality allows. This will help us identify variation and target improvement where it is most needed.

The integrated dashboard will include two connected views:

- workforce sustainability and transformation;

- culture, leadership and staff experience.

Together, these views will show both whether King's has the workforce it needs and whether we are creating the conditions in which people can thrive and deliver their best.

Workforce Dashboard

A comprehensive Workforce Dashboard will track key workforce and operational metrics, including:

- **Vacancy rate** – tracked monthly, Trust wide and by staff group.
- **Staff turnover** – monitored quarterly, with a focus on hotspots and areas of concern.
- **Sickness absence** – reviewed monthly, including breakdowns by reason to understand trends and the impact of wellbeing interventions.
- **Agency spend** – monitored through monthly finance reporting.
- **Staff engagement and voice** – annual NHS Staff Survey outcomes, supported by targeted pulse activity and local engagement where there are a clear question, purpose and route to action.
- **Training and development uptake** – including participation in leadership programmes, personal development plans and apprenticeships.
- **Productivity** – using measures and benchmarks such as Model Hospital/Model Health System.
- **Hard to fill roles** – monitored through the Trust's hard to fill roles directory.
- **Fragile services** – informed by the Workforce Diagnostic Tool.
- **Workforce demographics** – using HR data to understand workforce composition and trends.
- **Regional workforce risks** – including issues emerging from higher-risk staffing models across the system and London region.

The Workforce Dashboard will be reviewed through the appropriate governance arrangements to identify trends, risks and areas requiring action.

People Strategy Dashboard: Culture, Leadership and Staff Experience View

This dashboard will be used to identify where culture and staff experience are improving, where variation remains and were targeted leadership, OD or organisational support may be required. It will draw on staff survey findings, staff networks, Freedom to Speak Up, employee relations, patient experience, OD insight and local engagement alongside quantitative measures.

Outcome area	Indicative measures
People Promise and staff experience	Top quartile position by 2031; annual movement in all 7 People Promise themes; staff engagement score; morale; recommendation as a place to work; addressing local variation across Care Groups and sites.
Leadership and management	Leadership and management staff survey questions; appraisal quality and completion; 1:1 uptake where measured; leadership programme participation and evaluation; manager confidence measures.
Wellbeing and safety	Sickness absence; stress and anxiety absence; Occupational Health and wellbeing access; violence and aggression reporting; sexual safety and civility insight; psychological safety measures through surveys and OD diagnostics.
Inclusion and equity	WRES and WDES indicators; discrimination, bullying and harassment scores; equality of opportunity; recruitment, progression, disciplinary and employee relations disparity; pay gap reporting; staff network insight.
Learning and development	Core skills compliance and risk; role specific compliance; LEAP utilisation; development uptake; apprenticeship starts and completions; programme evaluation and impact.
Talent and careers	Internal appointment rates; succession coverage for critical roles; diversity of talent pools; participation in positive action and development programmes; retention of participants.
Change capability, OD and high performing teams	OD intervention outcomes, team climate measures, change readiness, change experience, high performing team diagnostics, change adoption, King's Improvement Method alignment and feedback from supported change programmes
Engagement, staff voice and trust	"You said, we did" evidence, staff survey action plan quality, confidence that feedback leads to action, speaking up confidence, free text themes translated into action, and evidence that staff voice has shaped decisions

Together, the two dashboards will provide complementary oversight of the strategy, tracking both whether we have the workforce we need and whether we are creating the culture and organisational conditions in which our people can thrive and deliver their best.

Delivering the strategy

Delivering this strategy requires leaders, managers, staff and our People and Organisational Development functions to work together. Clear accountability, effective governance and regular oversight will support delivery and ensure the strategy remains aligned with King's wider priorities for quality, patient experience, productivity and financial sustainability.

Leadership and accountability

Overall executive accountability will sit with the Chief People Officer, supported by the Deputy Chief People Officer, Director of Culture and Organisational Development and Divisional People Directors.

Delivery is not the responsibility of the People function alone. Executive, clinical and operational leaders will be accountable for translating the strategy into action within their areas. Divisions, Care Groups and corporate functions will own local workforce plans, staff experience priorities and delivery actions, supported by People Business Partners and Culture and OD expertise.

The Board and Executive Team will provide visible leadership, challenge and assurance. Managers will be responsible for creating the day-to-day conditions in which staff feel safe, included, supported, developed and able to deliver effective services. Every member of staff has a role in living our values and contributing to improvement.

Governance and reporting

Culture and OD

Delivery will be supported by an integrated operating rhythm through established People governance. The Culture and OD portfolio will provide expertise, programmes, tools, organisational development support and insight, while divisions, Care Groups and corporate functions remain accountable for local implementation.

Progress will be reviewed quarterly through the appropriate People governance route and King's Executive. Strategic assurance will be provided to the Board through the People, Inclusion, Education and Research committee. A fuller progress review will be provided to the Board at least twice each year, aligned where appropriate with the NHS Staff Survey, workforce planning cycle and annual strategy review.

Workforce

A Workforce Steering Group, chaired by the Chief People Officer, will oversee delivery of the workforce strategy, ensuring alignment with organisational priorities and providing regular oversight of progress, risks and performance. Delivery will be supported through:

- Divisional level workforce plans aligned to Care Group and service needs.
- Strengthened workforce planning capability and tools.
- Active People Business Partnering support.
- Robust vacancy control processes to maintain oversight and grip.

Progress will be reported through established governance routes, including King's Executive and the People, Education and Inclusion Committee, providing regular oversight of delivery, risks and performance.

High level delivery plan

This strategy will be delivered over 5 years, recognising that culture change requires a clear sequence: building the foundations, embedding consistent practice, scaling what works and sustaining improvement.

Year	Main Focus	What We Will Deliver
Year 1	Build the foundations	Confirm governance, ownership and the integrated dashboard; establish workforce and culture baselines; co-design the Behavioural Framework; launch the King's Engagement Approach; begin implementation of the NHS Leadership and Management Framework; agree EDI and wellbeing priorities; assess fragile services and workforce risks; strengthen workforce planning capability; map learning, talent and career routes; identify priority digital, AI and workforce redesign pilots; and establish the OD consultancy and prioritisation model.
Year 2	Embed core practice	Embed values and behaviours into recruitment, induction, appraisal, leadership, talent and recognition; implement divisional workforce plans; launch the talent and succession framework; strengthen manager capability; begin multi-skilled workforce and digital redesign pilots; and improve local recruitment and development pipelines.
Year 3	Scale and reduce variation	Scale effective workforce redesign, team development, coaching, mentoring, talent and OD support; expand career pathways and internal mobility; use workforce, Staff Survey, WRES, WDES, retention and sickness data to reduce variation; and embed King's Improvement Method into workforce and service change.
Year 4	Mature and integrate	Demonstrate measurable improvement in workforce sustainability, People Promise outcomes, leadership confidence, wellbeing, inclusion and retention; evaluate benefits from digital and workforce redesign; and strengthen succession and representation across critical roles.

Year 5	Sustain top quartile performance	Achieve and sustain top quartile People Promise performance; demonstrate reduced variation; strengthen workforce pipelines and leadership diversity; reduce avoidable turnover and temporary staffing reliance; and provide clear evidence that workforce and culture improvements are supporting quality, productivity and patient care.

Immediate year 1 priorities

Year 1 will create the foundations for the five-year ambition. It must be focused, visible and deliverable, with enough early action for staff to see that the strategy is more than a statement of intent.

Our immediate priorities are to:

- confirm governance, ownership, delivery plans and reporting routes for the full People Strategy;
- establish an integrated People Strategy Dashboard, with workforce and culture baselines;
- co-design the trust wide Behavioural Framework and agree how it will be embedded into core people processes;
- launch the King's Engagement Approach, including clear principles for listening, involvement, sense making, responding and closing the loop;
- begin implementing the NHS Leadership and Management Framework and confirm priority leadership cohorts;
- strengthen manager support for appraisal, one to ones, wellbeing conversations, inclusive practice, performance and team climate;
- agree the EDI delivery plan, including transparent data, staff network partnership and visible leadership accountability;
- clarify the wellbeing offer and introduce more proactive identification and support for hotspots;
- stabilise core skills governance and clarify central, divisional and managerial responsibilities;
- map learning, talent and career routes so staff and managers can navigate development more easily;
- establish a consistent approach to workforce planning, fragile services and critical workforce risks;
- identify priority workforce redesign, digital and AI pilots with appropriate quality, safety, equality and staff involvement;

- strengthen local recruitment, apprenticeship, return to practice and internal workforce pipelines;
- establish the OD consultancy and prioritisation model for major change, Staff Survey hotspots, senior teams and services under pressure;
- identify practical action on the basic conditions that affect staff experience, including equipment, digital systems, rest, food, workspaces and reliable People services;
- agree a small number of visible Year 1 measures through which staff can see progress.

Next steps

The next step is to translate this strategy into a focused and integrated programme of delivery. During Year 1, we will confirm ownership, milestones, measures, resources and reporting arrangements for each workforce and Culture and OD priority.

We will begin the first priority actions, including the Behavioural Framework, King's Engagement Approach, leadership and management offer, workforce planning baselines, fragile service assessment, wellbeing and EDI plans, learning and talent mapping, and priority workforce redesign and digital pilots.

We will also publish what we heard through engagement, what changed as a result and what will happen next. Progress will be made visible through regular updates, including what has been delivered, what is still in progress and where there are constraints or trade-offs.

Delivery will not be static. We will use staff feedback, workforce data, patient experience and evidence of impact to refine priorities over the five years. Our aim is to maintain accountability and focus on the actions that will make the greatest difference to our people and the care we provide.

Thank you

This strategy has been shaped by the commitment, experience and insight of our people. We thank everyone who has contributed through the NHS Staff Survey, staff networks, Freedom to Speak Up, trade unions, workshops, team discussions and day to day feedback.

We are particularly grateful to colleagues who have shared their experiences openly, including where things are not yet working as they should. Their insight has helped us understand both the strengths we can build on and the areas where we need to improve.

The strategy provides a clear direction for the next five years, while recognising that delivery must continue to respond to staff feedback, workforce need and the wider environment in which King's operates. We will continue to listen, learn, act and explain.

King's College Hospital
NHS Foundation Trust

Population Health Management and Healthcare Equity Strategy

2026 - 31

King's College Hospital NHS Foundation Trust

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Foreword

Population health management (PHM) and healthcare equity are key pillars of high-value care and critical enablers of improvement, supporting delivery in line with King's College Hospital NHS Foundation Trust's (King's) strategy and the NHS 10 Year Plan for our communities.

There are clear national and local system imperatives for this work. The PHM and healthcare equity function will provide clear executive leadership, accountability and coordination across a complex and interdependent agenda. It will enable King's to meet national and local system expectations on prevention, healthcare equity and PHM, in line with the Health and Care Act 2022, NHS Long Term Plan, Core20PLUS5 and the CQC Single Assessment Framework.

By integrating population health intelligence, prevention, and healthcare equity into clinical and operational decision-making, the function will improve outcomes, reduce avoidable demand and enhance operational and financial sustainability. It is the engine that will release essential bed capacity, supporting elective recovery. It will do so by identifying high-need cohorts, designing targeted interventions, leveraging advances in digital technologies and evaluating impact through rapid-cycle learning. It will reduce low-value interventions.

Evidence from PHM programmes suggests that these approaches can deliver significant return on investment through reductions in avoidable activity and improved outcomes. While published evidence indicates that many benefits accrue at a system level, this programme will prioritise interventions that deliver measurable impact for King's, including reductions in admissions, length of stay, and avoidable activity.

This function will position King's as a health-promoting hospital, aligning with SEL ICS ambitions for integrated neighbourhood health and high-value care. It will embed healthcare equity as a core strategic objective, supporting King's to respond effectively to the concerns and expectations we have heard from the community we serve.

Delivering on this agenda positions King's as a forward-looking organisation, aligned with national policy, patient empowerment and community-focused prevention, improving outcomes not just for those who access care easily, but for those who need us most.

This is a strategy for all: patients, staff, partners, communities and it supports delivery across the 6 pillars of the King's Strategy 2026-2031.

It is a strategic investment in the future of King's and for the health of our community. It will deliver a healthier population, improved patient experience, improved healthcare equity, a more sustainable hospital and improved value for the taxpayer: high-value care.

Background

Case for change:

The 10 Year Health Plan for England[1] sets out a commitment to seize the opportunities provided by new technologies, medicines, and innovations to deliver better care and outcomes for all patients – wherever they live and whatever they earn – while ensuring better value for taxpayers.

Improving the population's health and preventing illness and disease are fundamental to reducing unwarranted health inequalities and remain central to the ambitions of the NHS Long Term Plan[2] and to sustainable service delivery.

Population health management (PHM), healthcare equity, a patient-centred outcomes-focus and resource management are the key pillars of high-value care and are the critical enablers to ensure delivery of improvement in line with King's strategy and the NHS 10 Year Plan for our communities.

Summary of Potential Benefits

Intervention Theme	Patient Benefit	Operational & Financial Impact
Frailty and high-risk cohorts	Reduced admissions, improved outcomes and independence	Reduced bed days, improved flow, and lower non-elective costs
Long-term conditions (e.g. cardio-renal-metabolic)	Improved disease control and reduced complications	Fewer emergency attendances and admissions, reduced high-cost activity
Prevention and inequalities (Core20PLUS5, Vital 5)	Improved population health and reduced inequities in access and outcomes	Reduced future demand and improved value through targeted intervention
Digital and self-management	Improved access, engagement, and patient self-management	Reduced outpatient and unplanned activity, improved efficiency
Integrated care (physical & mental health, community interface)	More coordinated, holistic care and improved experience	Reduced duplication, length of stay, and system cost pressures
Data, insight and evaluation	Earlier identification of need and continuous improvement in care	More effective targeting of resources and improved return on investment

Definitions

High-value care: the equitable, sustainable and transparent use of the available resources to achieve better outcomes and experiences for every person.
Health inequalities: these are what we see - measurable variations in access, experience or outcomes between groups. **Healthcare equity** is what we do (at King's within the context of an acute provider) - identifying which variations are unwarranted and taking action to correct them. This can be through three interconnected lenses:

- Patients – equitable access, experience and outcomes
- Communities – equitable partnership and representation in service design and research

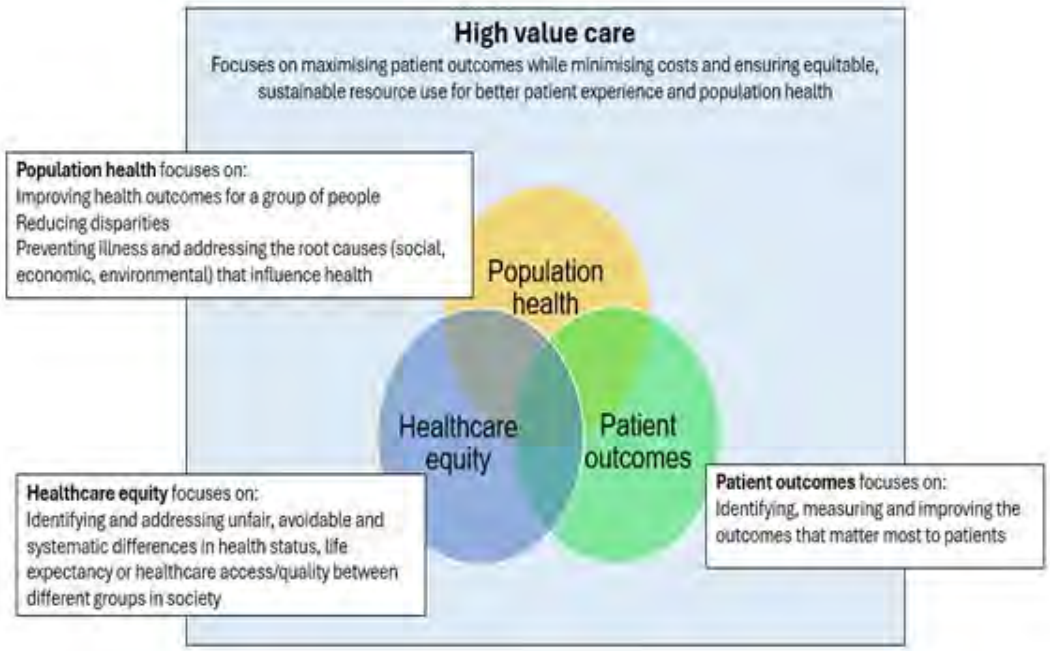
[1] **HM Government** (n.d.) *10-Year Health Plan for England: Fit for the Future*. 10 Year Health Plan for England: fit for the future - GOV.UK
[2] **NHS England** (n.d.) *The NHS Long Term Plan*. Available at: https://www.longtermplan.nhs.uk/

- Staff - healthcare initiatives that support staff health and wellbeing, such as access to Vital 5 checks

Population health management (PHM): a way of working that aims to improve the health of entire populations not just individuals. This can be done by preventing illnesses, managing long term conditions that affect many people, like heart disease or frailty, or improving other factors that affect a populations health such as housing, instability, homelessness or severe deprivation.[3]

PHM is a tool to support the outcomes of improved healthcare equity and high-value care (Figure 1 below).

Figure 1: relationship between high-value care, PHM and healthcare equity



Progress to Date

[3] **King's Health Partners** (n.d.) *Our Strategy to 2030: Improving Population Health*. Available at: https://www.kingshealthpartners.org/about-us/our-strategy-to-2030#improving-population-health

Kings launched its Health Inequalities Strategy in 2022, with an initial focus on the **Vital 5 priorities: healthy blood pressure, stop smoking, drinking less, healthy mind and healthy weight.**

Achievements to date include:

- Installation of the Staff Vital 5 health machine, improving access to preventive health checks for staff
- Production of community-centric reports on research and the Vital 5 highlighting how King's contributes to local health improvement
- Hosting the Southeast London Vital 5 Workshop to align system priorities.
- Development of an EDI programme in Maternity in response to the local EDS delivering better infrastructure for tackling inequities for birthing people
- Advancing inclusive research through *"The King's Model for minority-ethnic research participant recruitment"* (Chaudhuri et al., 2023), demonstrating significant improvement in diverse research participation
- Writing a Health Advocacy Course for Staff from Minorities background to support in understanding around vaccine hesitancy
- Delivery of Care Navigator programme for long waiting patients
- Strong work is already happening across Care Groups, with examples recognised under the *CQC Well-Led* framework – including inclusive maternity improvement, haemoglobinopathy care, dental outreach for vulnerable groups and community partnerships on screening and early diagnosis. Some of this work is aligned with the national Core20PLUS5 priorities for both adults and children (Figures 2 and 3)

***Figure 2: NHS* Core20PLUS5 Adults**

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***Figure 3: NHS* Core20PLUS5 Children**

Despite these strengths, a 2025 Evaluation and Gap Analysis against Core20PLUS5 and Vital 5 found that equity work remains fragmented, inconsistently reported, and not yet fully embedded within governance or resource frameworks (Appendix 1).

The population across the boroughs we serve are diverse, each with significant healthcare challenges. (Figures 4-6).

Inequalities and unmet needs remain visible in feedback from public engagement sessions for the revised King's strategy 2026 (Table 1), in addition to unplanned admissions, length of stay, and outcomes across ethnicity and deprivation quintiles.

Table 1.

Key themes: Patient and Public engagement (King's Strategy session 2026)
-Access is inconsistent and often difficult to navigate
-Inclusion, dignity and cultural competence require strengthening
-Digital exclusion is a significant equity issue
-Staff wellbeing directly affects patient experience

Digital inequality is not theoretical. At King's and GSTT there is evidence of in our MyChart roll out data, which shows differential activation and use across age, sex, ethnicity and deprivation, strongly influenced by access to a valid email address. This reflects wider evidence that digital healthcare, if not actively designed and managed for equity, can manifest, reproduce or sometimes even widen inequalities through uneven benefit. The NHS England framework for inclusive digital healthcare highlights five domains—access, accessibility, skills, trust and leadership—and the need for complementary non-digital routes. Within this strategy, digital care is therefore both an opportunity

and a risk. We will begin to understand how and where we need to monitor digital uptake and outcomes, identify unwarranted variation, and look to implement targeted interventions to ensure digital transformation reduces, rather than reinforces, healthcare inequity.

As pressures on acute care rise, King's must lead the shift from reactive treatment to preventative, proactive models.

Figure 4. The population we serve – London Borough of Bromley

Figure 5. The population we serve – London Borough of Lambeth

Figure 6. The population we serve – London Borough of Southwark

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To date, King's lacks a dedicated PHM function with dedicated capability to translate rich clinical and system data into population-level insights and action. Examples of the potential power of the local data to identify high-risk populations, support targeted interventions and evaluation frameworks was demonstrated at a recent Board Development Meeting (Feb 2026), highlighting risk stratification analysis evaluating the impact of frailty in Bromley and secondary care service utilisation at the PRUH is one local example (Figure 7, Appendix 2).

Figure 7.

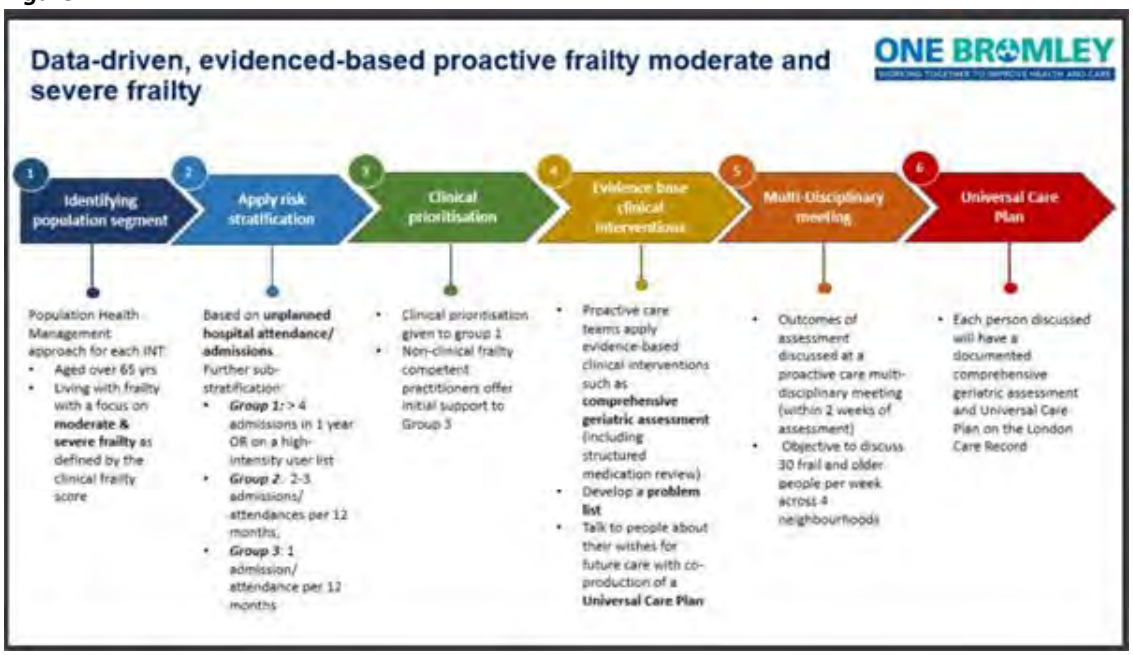


Table 2 (below) summarises other initiatives and external examples of potential patient and organisational benefits from a PHM and Healthcare equity function. More information can be found in Appendix 3.

Table 2.

Intervention area	Patient benefit	Organisational benefit	Indicative financial impact
Frailty / proactive care for older adults	Improved independence; slower frailty progression	Reduced admissions; reduced future care costs	~£740 per patient (external case study) – indicative; local modelling required
Hypertension detection & optimisation	Reduced stroke/MI/HF risk	Reduced future acute events; reduced primary care burden	External model: £850m/10y system-wide; acute share to be modelled for KCH
High-risk heart failure cohort management	Fewer crises; improved QoL	Reduced non-elective admissions; reduced bed occupancy	Circa. £7,500 per patient/year (external)
Early CKD optimisation	Slower progression; reduction in incident dialysis	Reduced incident dialysis demand; capacity release	165 dialysis slots by year 5 (external model)
Shared decision-making for arthroplasty	Better informed choices; satisfaction	Avoid unwarranted surgery; theatre capacity	Not quantified in source
Post-PCI care coordination	Reduced anxiety/ complications	Reduced readmissions; outpatient efficiency	Not quantified in source
High-intensity A&E/GP users (holistic support)	Improved wellbeing; better access	Reduced A&E attendances; reduced GP use	A&E -70%, GP -30% (external)
COPD risk-stratified proactive support	Fewer exacerbations; better self-management	Reduced unplanned respiratory admissions; improved specialist capacity	External evidence; quantify locally
Multi-generational household outreach	Improved uptake of prevention; reduced burden	Reduced A&E/admissions/bed days; improved QOF	A&E -16%, admissions −13%, bed days -40 to 50% (external)
MSK patient engagement / co-production	Improved experience; alignment with needs	Reduced unnecessary referrals/imaging/procedures	Not quantified in source

For King's to play an active role in PHM and be a functioning, relevant part of our integrated care system, King's will need to be involved in the data engineering, risk prediction and intelligence capabilities, as well as clinical service design and response - through embedding within the emerging integrated neighbourhood teams, in addition to acute provider clinical service reviews and innovations.

King's is the host organisation in the Bromley Integrator function but to prioritise the intelligence behind how to intervene and who to intervene on, will require a PHM and Healthcare equity function with integrated data foundations.

Data infrastructure- background

PHM relies on two pillars:

- Population Scale Data and Analytics
- Intervention

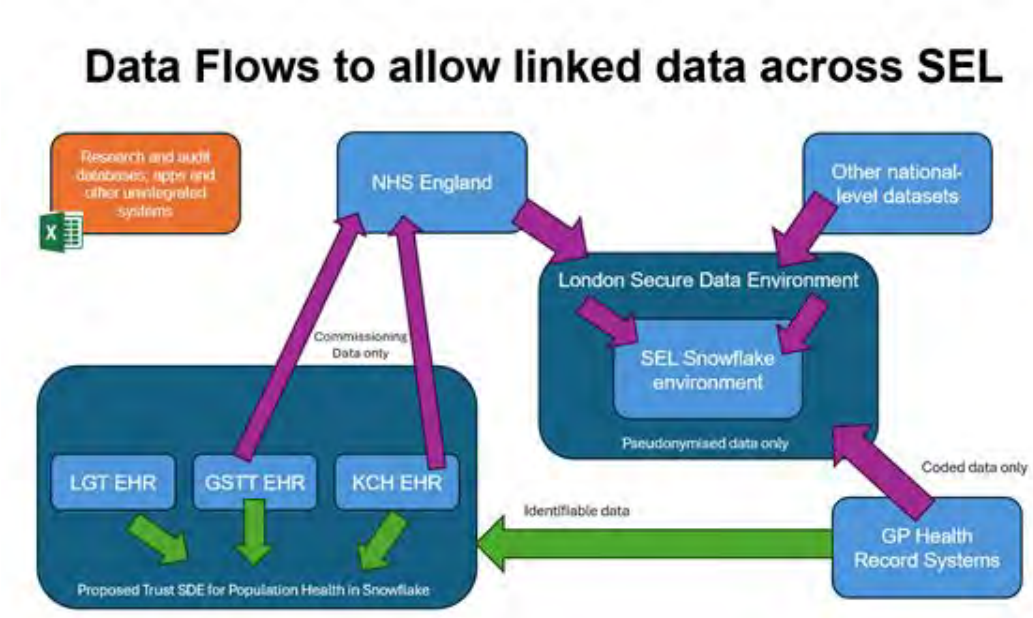
PHM is dependent on the availability of datasets that cover all aspects of patients' health and care.

The SEL Integrated Care Board has been building these capabilities over several years in an ultra-fast big-data cloud database (Snowflake) together with the OneLondon Secure Data Environment.[1] The data here is used by commissioners for reporting and has real-time pseudonymous Primary Care Data joined with Commissioning Datasets from SEL providers like KCH, with the data controllership of SEL GP providers and NHS England.

More recently, GSTT have decided to use Snowflake as their environment for storing and accessing data from "legacy systems" (such as their old EPR and PAS). The previous data warehouse (Long Term Archive, LTA) stores all the pre-Epic archived data Lewisham and Greenwich will also host their legacy data in Snowflake and KCH have been invited to do the same.

GSTT plans to use this new environment for PHM – This is now being called the South-East London Secure Data Environment for PHM (SEL SDE for PHM). Its key distinguishing feature is that this multi-source, close to real-time, longitudinal data allows **identification of individuals**. This enables the **intervention** arm of PHM. Permissions have just been gained in the SEL Data Usage Committee, to make the Primary Care Data available in this environment for PHM only (Figure 8).

Figure 8.



Current work on is ongoing to extend the SEL SDE for PHM to become a SEL-wide asset, expanding its scope to include:

- Secondary care data engineering and analytics for KCH, Lewisham and Greenwich NHS Trust (LGT), in addition to GSTT
- Ingestion of available datasets from the London Data Service relating to SEL residents:
    - initially primary care data for all boroughs in the SEL Integrated Care System

  - and the NHSE Commissioning Data Sets covering all statutory health and care providers in the country
- Linkage and engineering of London Data Service and locally derived datasets to support PHM activities
- Support to nominated SEL Integrators, to support PHM activities and the development of Integrated Neighbourhood Based Care and Teams (INTs).

The central rationale for this approach is efficiency through consolidation. A single engineering and system management team - serving multiple organisations avoids duplicated capabilities across each partner, promotes cultivation of expertise, and enables richer cross-organisational data linkage. While strengthening each organisation's analytics capabilities to utilise the platform and tooling available.

Within KCH work linking PLICS to Epic is almost complete, enabling near-real-time costings and cost-effectiveness analysis for PHM interventions. Current PLICS data requires validation due to post-Epic transition issues; BIU and Finance are addressing quality gaps.

A small number of technical KCH staff are already contributing to the ICB environments, on ICS-determined use-cases, through honorary contracts. The technical skillset to produce data-driven intelligence for population health exists in KCH and KCL as many clinicians have data science skills as well as basic medical statistics. This allows tracking outcomes, measurement of inequalities, predicting risk of unplanned admissions, risk of frailty and avoidable complications. All these real-time analytics allow new models of care to be constructed through Integrated Neighbourhood Teams.

Additionally having KCH embedded in system leadership has been crucial to success to date and is essential going forward in the emerging data and PHM landscape- for example existing crosscutting roles including KCH site CCIO /SEL CCIO, MD London AI Centre, as well as expertise from our BIU team, operational leads and clinical and academic expertise.

National and Local Context: Policy and System Expectations

- **Alignment with NHS 10-Year Plan** and to a focus on delivering improved outcomes for patients and value for the taxpayer (High-Value Care) and prepares King's for new financial models described which will reward outcome rather than activity, ensuring we are strategically positioned for the transition.
- **Alignment with national and SEL ICS priorities**, facilitating joined up working with partner organisations, particularly SEL ICB, KHP, GSTT and SLAM. Nationally, NHS England requires acute providers to embed population health and prevention into service delivery and decision-making. We will align with, and compliment KHP PHM strategic priorities, collaborate with the GSTT Population Health Hub and any future developments at SLAM and other local partner organisations (e.g. HIN/other local Trusts).
- **Delivering integrated, preventative care** -through a PHM function under the CMO, King's will use data-driven insights to identify high-risk cohorts, target interventions, and reduce avoidable admissions - directly supporting elective recovery and urgent care flow.
- **Improving health equity** with a focus on key national and local population health priorities as set out in the Core20Plus5 and Vital 5 and alignment with the National Outcomes

Framework.[4] The transition to a Healthcare Equity model reflects both a strategic opportunity and a regulatory necessity. This work represents a significant and positive opportunity for King's. By placing equity at the heart of how we deliver care, we will strengthen our reputation as a leader in inclusive quality improvement, motivate and inspire our staff, and deliver greater pride and connection with the diverse communities we serve. This is an opportunity for King's to lead on an agenda of growing national and system significance.

- **System leadership and partnership/s**: our strategic position at the interface. King's population profile is characterised by high deprivation, multimorbidity, and ethnic diversity; this requires a data-driven, equity-informed response. We have a responsibility and an opportunity to shape how care is designed and delivered across the system. It is vital we have capability and capacity in the PHM sphere to remain relevant and be able to respond and deliver health care to meet the needs of our population. The SEL healthcare system increasingly depends on shared accountability for outcomes. King's scale, analytics capability, and specialist expertise uniquely position it to convene partners across primary care, community services, and local authorities, ensuring consistent pathways, clearer accountability, and joined-up improvement.
- **Operational and Financial Sustainability** - Strengthening prevention and interface performance is not just the right thing to do to enhance health benefits to individuals through interventions, it is essential to sustainability. Improved discharge processes, fewer readmissions, and better-managed long-term conditions will help release inpatient beds, improve flow, reduce avoidable admissions, and generate income.
- **Improving patient and staff experience** - The SEL Interface Framework[5] identifies national priorities around waiting experience, access to the right advice, and information continuity. King's leadership in improving referral, discharge, and advice processes can directly enhance patient safety and outcomes, while reducing work and friction across care boundaries. An outcomes-focus is motivating for clinicians and will improve clinical engagement.
- **Outcomes: What Matters Most to Patients**: There is currently a limited and inconsistent understanding of the outcomes that matter most to our patients, which can contribute to unwarranted variation and in some cases, over-treatment. A core component of the King's PHM and Healthcare equity strategy will be to use data to empower patients, support shared decision-making and improve our knowledge of the outcomes that matter most to patients. The strategy will therefore interface closely with the work of the Patient Experience and Patient Outcomes Teams, to ensure:
    - Alignment of outcome measures and intelligence
    - Consistent use of patient-reported outcome and experience measures
    - Translation of insight into service improvement, pathway redesign and clinical decision-making
    - Clear assurance that patient voice and outcomes are driving value-based care

[4] **NHS England** (2025) *NHS Oversight Framework 2025/26*. Table 6: Health Inequalities. Available at: https://www.england.nhs.uk/nhs-oversight-framework/ (Accessed: March 2026).
[5] **Southeast London ICS** (2025) *Primary and Secondary Care Interface Consensus*. July 2025. https://www.selondonics.org/wp-content/uploads/dlm_uploads/SEL-Primary-and-secondary-care-interface-consensus-July-2025.pdf

- The Trust must provide clear assurance that it is meeting its **statutory *must-do* and *should-do* requirements** and align with the national direction set out in the 10-Year Health Plan for England (2025).[6] The establishment of a PHM and Healthcare Equity function provides a clear governance mechanism to evidence delivery, impact and compliance.

Strategic Alignment

The PHM and Healthcare Equity function will **deliver** on "High quality patient care" and "Strong, successful partnerships," **enable** "Timely and efficient care," "Pioneering research, innovation and education" and "A great place to work," and **protect** "Financial sustainability".

Strategic Objective	Delivers/enables /protects	Example
High quality care for patients ***(Chief Nurse and Executive Director of Midwifery)***	DELIVERS	- Utilise PHM tools to identify high risk cohorts and implement system change -e.g. frailty/CVRM - Reduce unwarranted variation in clinical outcomes and patient safety (e.g. deteriorating patient). - Embed equity within harm-reduction and safety improvement work, ensuring outcomes are analysed and acted on by key inequality markers
Strong, successful partnerships ***(Deputy Chief Executive Officer)***	DELIVERS	- Alignment of healthcare equity and PHM priority areas including Vital 5 and Core20PLUS5 across SEL - Strengthen partnerships with SEL/KHP/GSTT/other partner Trusts/community providers to address shared equity priorities and prevention at the interface e.g. via the developing INT programmes
Pioneering research, innovation and education ***(Chief Medical Officer)***	ENABLES	- Harness strength of collaboration with KHP-PHM/analytics/evaluation - Strengthen inclusive research practice by building on *The King's Model* / NIHR themes for diverse researchers and participant recruitment and engagement. - Lead on innovation ideas that embed and focus on equity gaps e.g. measuring of saturation in sickle cell patients
Timely and efficient patient care ***(Chief Delivery Officer)***	ENABLES	- Address inequities occupied bed days, cancer and elective pathways through equity-informed A3 projects and improved ethnicity data quality - Use data to identify delays and variation across protected characteristics
An inclusive and inspiring place to work ***(Chief People Officer)***	ENABLES	- Support staff as part of our patient population through access to health-promoting initiatives such as the Vital 5 programme. - Strengthen staff awareness of healthcare equity through leadership development, improvement training and wellbeing offers

[6] **HM Government** (2025) *10-Year Health Plan for England*.

Financial sustainability *(Chief Finance Officer)*	PROTECTS	- By focusing on early intervention and preventing high-cost, unplanned hospitalisations - Ensure business cases have clear equity lens

Vision

Our vision aligns with that of SEL ICB- one that builds our PHM capacity and capability resulting in improved outcomes and health care equity for our population (Population health - South East London ICS).[7]

We will take a system-wide PHM approach which is data-driven, evidence based, embeds digitally enabled interventions across the life course to achieve equitable, high-value care.

We will align and integrate King's PHM priorities with SEL ICB priorities to achieve the best possible outcomes for our patients and local population within existing resources

We will embed Healthcare equity as a routine part of decision-making both at micro (clinical and services) and macro (strategic and organisational) levels, providing visible assurance to the Board and enabling teams to deliver equitable care every day.

We will Embed Core20PLUS5 delivery for adults and children.

A programme of this scale and complexity requires a clear theory of change to articulate how intended activities will lead to measurable improvements in outcomes, experience, and value. A theory of change sets out the causal pathway from inputs and actions through to outputs and outcomes, providing a shared understanding of how impact will be achieved and how it will be evaluated over time.

In this programme, the theory of change is based on a structured improvement cycle: using population health data and intelligence to identify high-risk cohorts and unmet need; delivering targeted, equity-informed interventions through clinical pathways and system partnerships; evaluating outcomes, activity and cost to understand impact; and scaling effective models across services and populations. By embedding this cycle within routine decision-making and governance, the programme will translate insight into sustained improvements in patient outcomes, reductions in unwarranted variation, and more efficient use of resources across the Trust

Strategy objectives and outcomes (what we will achieve)

Our core objectives are built around three main pillars—**Know, Connect, and Prevent**—aligned with the aims of improving population health, enhancing patient experience, advancing equity, and increasing workforce well-being, and improve system sustainability and efficiency.

We will work with partners across the sector to help achieve the goals.

Objectives

- Improved identification of high-risk population cohorts through data-driven segmentation
- Increased delivery of targeted interventions for priority adult and children's populations

[7] Southeast London Integrated Care System. *Population Health Management.* Available at: https://www.selondonics.org/who-we-are/our-work/population-health/population-health-management/ (Accessed March 2026)

- Reduced health inequalities through consistent delivery of Core20PLUS5 and prevention within pathways
- Improved integration of physical and mental health care for patients with long-term conditions
- Increased use of digitally enabled care, with reduced digital exclusion
- Embedded evaluation, learning, and continuous improvement across all PHM programmes

To achieve this, we will

- Generate actionable insights through risk stratification and segmentation
- Design, deliver, and scale programmes for priority cohorts in adult and children's services
- Lead the Trust's Core20PLUS5 (Adults and CYP) delivery and embed prevention in pathways
- Champion integrated models of care that address mental health needs within long-term conditions
- Drive the adoption of patient-facing digital tools for self-management and remote monitoring, ensuring a focus on digital inclusion
- Embed rapid-cycle evaluation, robust benefits tracking (including health economics), and academic partnership to drive continuous improvement

Priority conditions, population groups and programmes:

- Frailty
- Multiple long-term conditions (e.g. cardio-renal-metabolic, respiratory)
- Vital 5
- Children and young people

Delivering the strategy

Governance and accountability

The Programme Board will:

- Provide leadership for the PHM and Healthcare Equity work programme, including delivery of appropriate Trust strategic objectives, meeting relevant external regulatory requirements (such as those set out in Appendix 4) establishing priorities, ensuring appropriate involvement of key stakeholders, establishing work groups to deliver pieces of work as required.

- Ensure robust governance of the PHM and Healthcare Equity work programme, including managing an action tracker, escalating issues, ensuring communications to Trust decision-makers and ensuring appropriate dovetailing with other Trust workstreams.

The Programme Board will include Trust leaders for:

- Population health management
- Healthcare equity
- Patient outcomes
- Patient experience
- Digital strategy
- Costings & income

- Business intelligence.

In addition, it will include members from KHP and the ICB to ensure coordination and collaboration across care boundaries, patient/public representation as well as subject-matter experts as needed.

The Programme Board will initially meet at least monthly to ensure the establishment of the work programme.

Programme Management

Reporting to the CMO a Programme Office will be established to include Programme Management, population management and data analyst expertise. Evaluation and benefits realisation will be embedded from the outset of the programme. All priority workstreams will include defined outcome, activity and cost measures, enabling continuous assessment of impact and value, and informing scale-up of effective interventions.

Enablers

People and Data

- Core roles to deliver the programme require a combination of technical and subject matter expertise to enable programme design, delivery, and evaluation, including health economic impact. This includes programme management, health informatics and analytics, clinical leadership, digital leadership (including at system level), and evaluation and research expertise.
- A core function of the PHM and Healthcare Equity programme is to bring together existing teams and individuals with relevant expertise across King's and its wider network under a coordinated structure. This will strengthen alignment, reduce duplication, and enable high-impact delivery with clear governance across the scope of work.
- To deliver the programme at an appropriate pace, a small core delivery capacity would be required, comprising programme leadership, dedicated analytical resource, clinical leadership, and programme management support. The current approach is to draw on existing resource across the organisation and through system partnerships; however, it is important to note that the pace and scale of delivery will be constrained without this core capacity. In particular, dedicated analytical and programme coordination capability are critical enablers to translate insight into targeted interventions and measurable impact.

Programme management

- Dedicated programme coordination capacity is required to ensure effective delivery, including joining up workstreams, maintaining momentum, and coordinating assurance to the Board.
- Much of the activity will be delivered through existing Strategy, Quality Improvement, Analytics, and divisional teams. The priority is to align and coordinate this work more effectively, ensuring that existing capability is directed towards areas of greatest population and system impact. This will reduce duplication, avoid silo working, and enable stronger cross-organisational collaboration across functions including Patient Outcomes, Patient Experience, Quality Improvement, Costings, and BIU.
- An initial review of existing programme management structures and posts will be undertaken to identify capacity within current corporate resources to support this function.

Data Analytics

- Dedicated analytical capacity is essential to deliver PHM and Healthcare Equity. Without this capability, the Trust will not be able to undertake the data management, risk stratification,

evaluation, and insight generation required, and risks being unable to operate effectively within the evolving system PHM landscape.

- In the first instance, the programme will draw on existing analytical capability within King's and through system partnerships, including collaboration with the AI Centre, KHP population health teams, and wider ICS data infrastructure. This will support initial delivery while longer-term sustainable capacity is developed.

Sustainability

- The programme will take a phased approach to building sustainable capacity. Initial delivery will focus on demonstrating impact and value through early programmes, with a view to securing longer-term investment where there is clear return.
- Opportunities to support sustainability will be actively explored, including internal reprioritisation, system partnership funding, and external sources such as King's Charity, innovation grants, and collaborative opportunities with KHP and other partners.

High level delivery plan

This an evolving programme. A preliminary 3-year road map is presented; this will be reviewed within 2 years to determine the 5-year programme plan aligning with Trust strategy timeframe, 2026-2031.

Community -Secondary care Integration/partnership working is a fundamental and cross cutting action across all 3 years of the starter roadmap: embedding and collaboration with the integrator functions across SEL.

PHM Programme Phasing and Delivery Plan

Year	Focus	Key Activities
Year 1: 2026-2027	**Foundations & Data Sharing**	Recruit core PHM team. Establish programme governance and oversight arrangements. Finalise data sharing and IG agreements.
	Adult Priority Programmes - Mobilisation	Initiate dedicated workstreams for priority adult programmes: • Vital 5 / Core20PLUS5 • Frailty • Multiple long-term conditions (mLTC)
	Children & Young People (CYP)	Initiate a dedicated CYP workstream, focusing on high-impact areas aligned to Core20PLUS5 for CYP.
Year 2 (2027–2028)	**Insight & Initial Interventions**	Implement pilot interventions for identified high-risk cohorts, informed by population insight and segmentation.
	Adult Priority Programmes – Delivery	Deliver and test interventions across: • Vital 5 / Core20PLUS5 • Frailty • mLTC
	Children & Young People (CYP)	Deliver targeted CYP interventions aligned to Core20PLUS5 priorities.
	Workforce Health & Wellbeing	Launch workforce health and wellbeing initiatives, including:

		• Healthcare Equity Toolkit • Vital 5 workforce initiative
Year 3 (2028–2029)	**Scaling & Sustainable System Transformation**	Evaluate core programmes and scale interventions demonstrating sustainable system transformation and impact.
	Digital Deployment	Roll out and evaluate patient-facing digital technologies (e.g. remote monitoring, self-management apps) for priority cohorts, with a clear digital inclusion strategy

Risks and Mitigations

Risk	Potential Impact	Mitigation
Data availability and IG dependencies (e.g. SEL SDE)	Delays in accessing linked data may limit ability to identify and target cohorts	Work in partnership with SEL ICB and existing data environments; prioritise use cases that can be delivered with available data
Workforce capacity (analytics and programme management)	Limited ability to translate insight into delivery and sustain momentum	Prioritise use of existing internal resource; identify targeted additional capacity where required
Benefits realisation (system vs Trust)	Financial benefits may accrue across the system rather than directly to King's	Align programmes with Trust priorities (flow, LOS, admissions); track both system and provider-level impact
Clinical engagement and capacity	Risk of limited uptake due to competing priorities and initiative fatigue	Embed work within existing clinical priorities and improvement programmes; ensure clinical leadership and co-design
System dependency (e.g. reliance on partner organisations/platforms)	Delays or changes in partner plans may impact delivery timelines	Maintain active system partnerships and representation; ensure local capability where critical

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 13.

BOARD/COMMITTEE REPORT COVER PAPER

Report to:	Trust Board
Date of meeting:	16 of September 2026
Subject:	Trust Winter Plan
Author(s):	Lesley Powls and Paul Larrisey- Hospital Directors
Sponsor:	Angela Helleur- Chief Delivery Officer
History:	Final Approval
Status:	

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

Purpose

Each year the Trust details its operating arrangements for the management of winter across its sites. This year the overarching strategic principles are contained within the Trust wide winter plan. This plan also details the internal management arrangements for the winter period. The Trust plan is attached as Appendix One. Each site with an ED holds separate local plans and these are appended to the main plan.

Plans reflect agreements across the Southeast London ICS with key priorities for the system identified and reference the actions to be taken across the system at times of extreme pressure.

Risks for winter have been identified and placed onto the risk register. No risk scores higher than 16, with this highest scoring list related to overcrowding within the Emergency Departments (ED).

The plan is informed by a debrief of the previous year's response to winter and the requirements laid out in the NHSE winter planning expectations. All arrangements within the plan have been agreed following meetings with Divisions and the care group triumvirates.

The plan will be shared widely across the organisation and uploaded onto the Resilience hub within the intranet.

Recommendations:

The Board are asked to approve the Seasonal Pressures Plan and submit for board Assurance alongside the Board Assurance Framework.

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	*None identified*
King's Improvement Impact (KIM):	*KIM methodology is in use to drive actions within the flow programme that are referenced within both the model acute and model discharge pathways.*
Quality Impact	*The plan supports a set of actions and escalations to ensure that patient access to services in maintained.*
Health Equity Impact	*An EqIA has been completed*
Workforce Impact	*The impact to workforce and actions taken to support them over the winter period is described in the plan.*
Research/Innovation Impact	*Not applicable*
Digital Impact	*EPIC is used to drive actions within the plan*
Financial Impact	*There are no financial impacts described within the plan and an assumption that all winter actions are delivered within baseline.*
Legal/ regulatory compliance	*NHSE requires each organisation to have a board assured winter plan.*
Communications and Engagement	*All stakeholders from within the organisation are involved with planning and the plan has been tested outside of the organisation.*
Use of Artificial Intelligence Tools	*Not used.*
Committee that will provide relevant oversight Kings Executive.	

Main Report

Winter Landscape

Across the NHS, winter generally leads to a rise in pressures across the entire system. The increase in pressure is related to an increase in attendances related to seasonal illness (typically flu and respiratory illness), and the impact of cold weather.

Children's health is particularly affected by respiratory illness and there is a separate plan for the management of paediatric seasonal pressures.

King's College Hospital NHS Foundation Trust

Modelling for Winter 2026/2027

The plan is based on the response to formal bed modelling across the winter period.

Trust wide Operational Plan

The focus of the plan is to detail the Trust's arrangements for the mitigation and management of consequences associated with winter pressures. Specific areas of focus include:

- Detailing what will be done differently during the winter months to mitigate pressures and describing actions to manage issues.
- Ensuring that the Trust can manage a response to emergency winter pressures in a way that does not compromise safe and effective elective services.
- An assessment of the site's maturity to the model ED, model acute and model discharge pathways
- Staff and patient vaccination plans
- Arrangements for management of infection

The Winter Plan operates alongside existing and separate arrangements for managing day-to-day capacity pressures such as the Corridor Care Policy, Local site escalation policies and maternity policies.

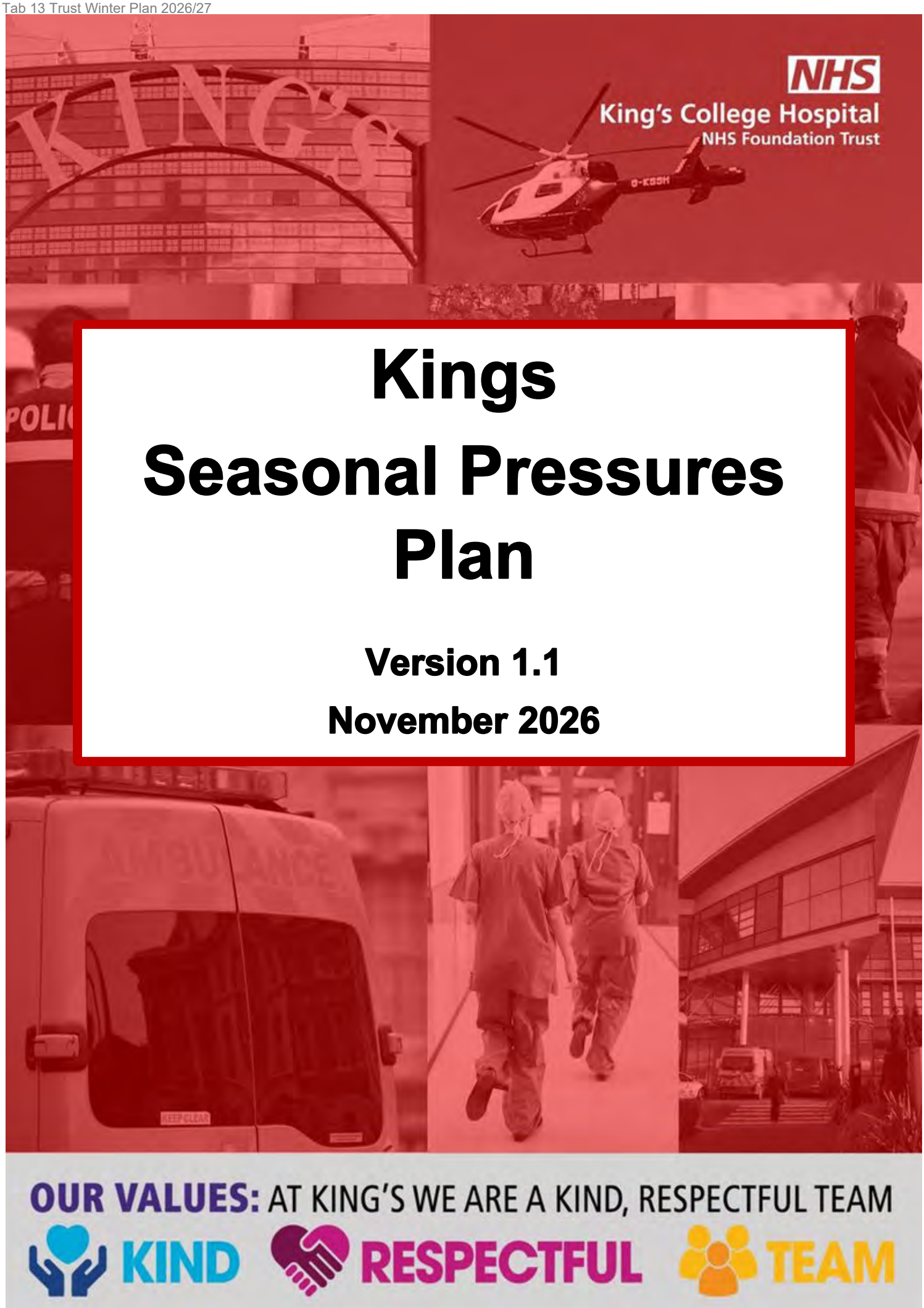
Additional Assurance

This year the Trust is asked to submit the plan to board and complete a Board Assurance statement following this - attached as Appendix Two.

Recommendations

The Board are asked to:

- Approve the final plan previously reviewed by PTIC



Kings Seasonal Pressures Plan

Version 1.1

November 2026

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

KIND RESPECTFUL TEAM

Document Control

Title:	Kings Seasonal Pressures Plan
Version:	1.1
Approved by:	Kings Executive
Date approved:	
Date when plan comes into effect:	
Author(s):	Lesley Powls and Paul Larrisey Hospital Directors and the Emergency Planning Team
Owner:	Angela Helleur- Chief Delivery officer
Committee:	EPRR Working Group
Review date:	April 2027
Target audience:	All Trust Staff
External standards addressed by this policy:	NHS Constitutional Standards
Location of document:	Trust Intranet- Resilience Hub

Version	Date	Amendment(s)	Author(s)
1.0	July 2026	New Document	PRUH and DH Hospital Director

Target audience(s)	Method	Person responsible
Executive Directors	King's Executive meeting	Chief Delivery officer
All staff	Trust Intranet	EPRR Team

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1 Introduction and Strategic Context

1.1 Purpose

The Trust is preparing for another challenging winter, where we are likely to experience a combination of pressures from seasonal viruses and influenza above the usual challenges of winter. This document describes the Trust's arrangements which will operate in addition to 'business as usual' arrangements between 1 November 2026 and 31 March 2027 to manage Winter 2026/27.

King's College Hospital has an outstanding reputation for excellent patient care, world-class teaching, and cutting-edge research. However winter periods on the site are particularly challenging, and our response will be critical in maintaining the health and wellbeing of our communities in Southeast London and beyond.

Urgent and Emergency Care pathways are placed under significant pressure in winter, and it is anticipated that this pattern will be repeated this year. Staff have already faced one of their busiest summers ever with high numbers of A&E attendances and increased urgent ambulance call outs.

Thanks to the professionalism and commitment of staff, the NHS continues to provide care to over 100,000 urgent and emergency care patients each week. Despite best efforts, pressures have meant that there have been too many occasions when staff have not been able to provide timely access for our patients in the way they would have wanted.

This plan has been informed by NHS England's Key Performance and Access Standards, learning from previous winter responses and previous winter readiness exercise, and NHS England's Core objectives and key action for operational resilience this winter.

1.2 Aim

The aim of the *Trust's Seasonal Pressures Plan* is to describe the Phased Operating Model which will enable King's College Hospital NHS Foundation Trust Denmark Hill and PRUH sites to effectively manage additional demand and other challenges associated with seasonal pressures whilst continuing to deliver excellent patient care and maintaining business as usual between 1 November 2026 and 31 March 2027.

The plan has been assessed against an equality impact assessment.

Within the plan are separate documents outlining the sites responses to seasonal pressures. Local Plans are held for each site for ease of use for local teams, the Trust plan incorporates both plans.

1.3 Objectives

NHSE released its winter planning priorities in a letter on the 17th of July 2026.

Providers were asked to have a robust, clinically led and deliverable winter plan with the following core expectations

- Draft winter plans to be completed by the end of August
- A named executive winter lead accountable for preparedness and response
- Plans tested through the regional stress test exercise in September
- Trust board to sign off plan by the end of September

In addition, The Trust must

- Ensure the winter plan describes the staff flu vaccination plan
    - Implement the model Emergency Pathway, Model Acute pathway and Model discharge pathway, with the elimination of corridor care treated as a patient safety priority
    - Maintain elective capacity throughout winter

- Assure tested arrangements are in place for escalation, infection prevention and control, on call leadership and staff welfare
- Protect delivery of agreed 2026/27 trajectories

The winter operating function within NHSE is stood up from the 1st of November.

1.4 Scope

The focus of this plan is to detail the Trust's arrangements for the mitigation and management of consequences associated with seasonal pressures. Therefore, detailing what will be done differently during these months to mitigate those pressures and escalating phases of arrangements to manage issues and/or sustained pressures on the Trust's services.

This Plan will operate alongside existing and separate arrangements for managing day-to-day capacity pressures such as the Capacity Management Patient Flow SOP. For incidents and emergencies, the Trust's existing Emergency Preparedness, Resilience and Response arrangements will be utilised under the leadership of the Trust's Gold Commander.

1.5 Strategic Context

The below diagram shows the hierarchy of EPRR legislation, guidance and both Trust and Site Level Incident Response Plans.

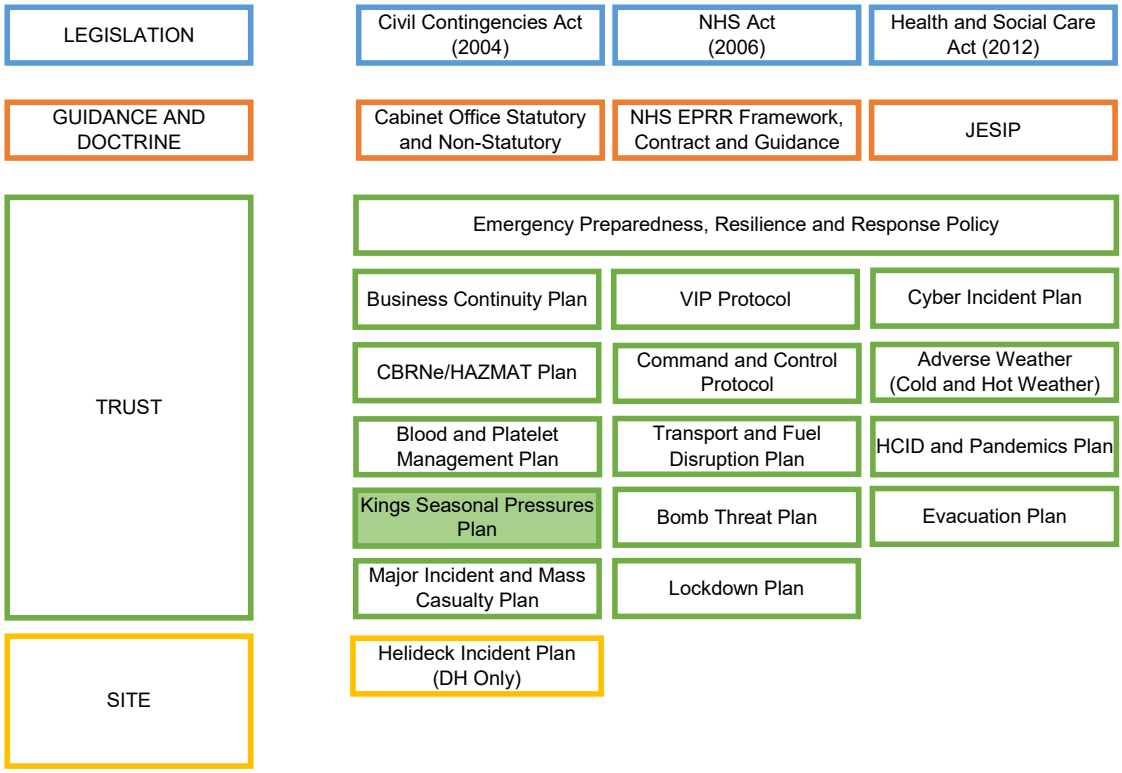


Figure 1 - EPRR Legislation, Guidance and Trust and Site Level Incident Response Plans

1.6 Risk, Historical Trends, Lessons, and Modelling

1.6.1 Risk Landscape this winter

As part of the planning for winter, specific risks and challenges have been identified which will be mitigated through specific plans and actions. Each winter the NHS is put under significant pressure due

to the possibility of prolonged cold weather and severe weather such as snow and low temperatures. Many health conditions (respiratory illnesses) can be caused or worsened by cold weather. In addition, higher incidences of 'seasonal illnesses' including flu and norovirus also places an additional burden on the NHS.

The risk of severe winter weather is assessed as a priority risk from an emergency planning and business continuity perspective. Prolonged cold weather and heavy snow increase the risk of heart attacks, strokes, lung illnesses, flu, and other diseases. Some groups, such as older people, very young children, and people with serious medical conditions are particularly vulnerable to the effects of cold weather. On average, there are around 25,000 excess winter deaths each year in England.

Winter 2026/27 is likely to present its own unique challenges as we may see pressures from seasonal influenza and illness which will place additional pressures on the Health and Social Care system including the potential need for a high number of beds for respiratory patients.

The following main risks have been identified ahead of Winter:

External Risks reflected in risks on the risk register

- Respiratory challenges (risk of a combination of COVID, Influenza and RSV Infections) including the impacts on beds, patient management and workforce absences.
- Impacts associated with extreme winter weather resulting in increased patient demand and transport disruption affecting the workforce.
- Demand, capacity, and discharge pressures because of winter generally and cost of living crisis; impacting upon the general health of the population making them more vulnerable to seasonal illness or exacerbating pre-existing conditions or requiring increased social and financial support to ensure they can be discharged safely.

Risks to Operational Delivery that might increase winter pressures

- The potential for EPIC business continuity incidents with KCH- the move even temporarily to paper increases overall time to deliver care and may impact upon length of stay
- The potential that KCH could be impacted by business continuity incidents related to cyber security affecting either the sites or third-party providers
- Maintaining elective and outpatient activity; the current backlog of activity means there is no flexibility to reduce outpatient sessions to deploy additional resource, and the elective programme of work needs to be maintained in priority order throughout winter removing the ability to utilise elective beds
- Workforce challenges such as burnout rates combined with seasonal absences due to illness, leave and vacancy levels.
- Reduction in capacity within ED due to long stay mental health patients- each mental health patient who remains in ED over 4 hours reduces the cubicle capacity to treat physical health patients, leading to delays in creating space to offload LAS vehicles, increasing the risk of treating the undifferentiated patient
- The non-availability of additional funds to support enhanced working and escalation beds to support the sites at times of extreme pressure (the arrangements for risk assessment at times of pressure and therefore decision making around unfunded measures will be described later). In previous years escalation space has been opened to reduce pressure in the ED but this cost is not built into the baseline funding nor is additional winter pressure additional funds available to support this.

It is assumed COVID-19 will continue to circulate for the foreseeable future and that new variants will emerge consistently. The UK Government identified four scenarios, but these are not the only

plausible courses the pandemic could take. Each scenario assumes a relatively stable and repeating pattern is reached overtime 2-10 years (with the UK currently at year 6 post modelling), but the transition to this will be highly dynamic and unpredictable. Factors considered include:

- Viral evolution and immunity.
- Interaction with other viruses; and
- Countermeasures.

The 4 scenarios include:

1. **Reasonable best-case** – relatively small resurgence with low levels of severe disease as seen in two past winters.
2. **Central optimistic** – seasonal wave of infections with comparable size to Omicron wave
3. **Central pessimistic** – new variant with large wave of infections, potential short notice however limited to certain high-risk groups (i.e., unvaccinated, vulnerable, and elderly);
4. **Reasonable worst-case** – very large wave affecting general population, although most severe health outcomes affecting groups with no immunity.

Mitigation for the management of Covid-19:

- Ensure strong and effective campaign for vaccination for eligible groups
- Vaccination promotion amongst vulnerable patient groups
- The use of rapid lateral flow testing within ED and admission pathways to minimise outbreaks
- Enforce adherence to IPC practices
- Daily IPC site meetings to review patients of concern

1.6.2 Historical Bed Usage Trends

- G&A bed use for non-elective activity has been gradually increasing since 2015, with elective use increasing since the Covid pandemic in line with elective recovery.
- We can see that historically each H2 period shows increased levels of non-elective demand from summer months.
- 2025/26 saw lower levels of bed occupancy at Denmark Hill and PRUH sites than previous years. This is reflected in the H2 forecasts.

However, there are notable differences between our hospital sites:

PRUH has higher proportions of non-elective bed use than DH and frequently operates closer to its capacity. The 2026/27 plan includes a requirement for 20 additional elective beds to deliver the required performance improvements. This means PRUH will be operating over capacity without reductions in non-elective length of stay.

Orpington bed occupancy has been stable since November 2023 and shows little seasonal variation. It is expected that this will continue into 2026/27 H2.

Denmark Hill bed occupancy has become less predictable over the last year, with more peaks and troughs. Overall bed occupancy is down, but this is accompanied by more days with very high occupancy levels.

Chart 1. Trust wide available beds

Site	Adult CC	Adult G&A	Paeds CC	Paeds G&A	Total
PRUH	10	415	0	12	437
ORP		116			116
Denmark Hill	109	715	16	60	900
Total	119	1,246	16	72	1,453

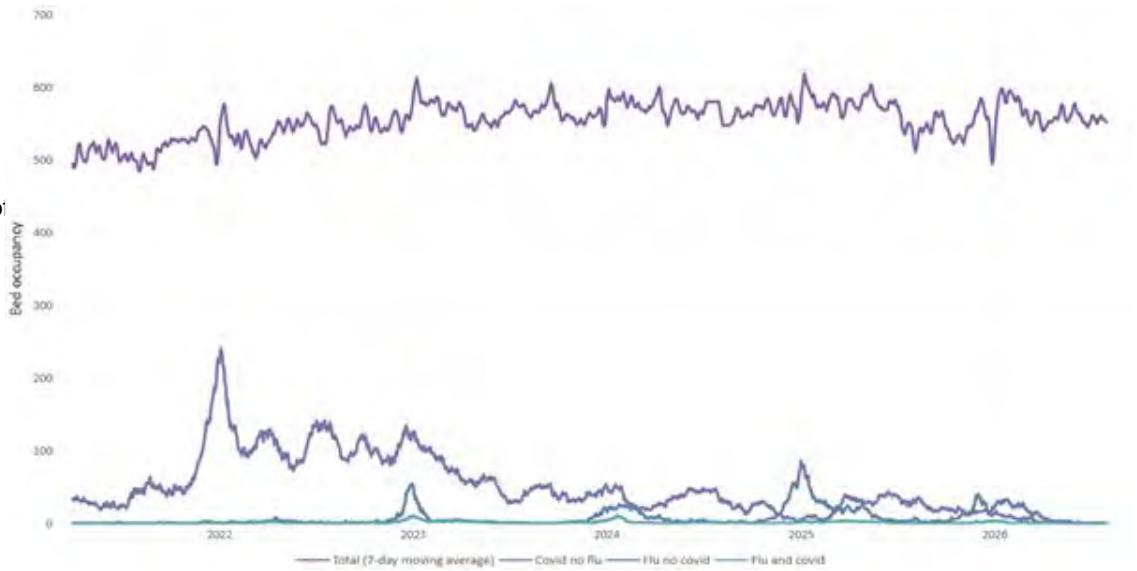
This represents core bed stock and does not consider any plans for closures

Denmark Hill

- G&A bed use for non-elective activity reduced significantly in July 2025, before tracking back up over the rest of the year. The first week of January consistently sees the highest bed occupancy.
- Overall bed occupancy reduced during 2025/26 for the first time in 10 years (excluding Covid). However, variation and the number of very high occupancy days increased. These patterns have continued into 2026/27.
- 2026/27 H1 has seen lower levels of G&A bed use for non-elective than in previous years so our modelling reflects this change.
- Reduction in non-elective bed use are less than the reductions in capacity, in effect creating a pressure on elective resources.
- In the scenarios we have modelled, current elective capacity and the delivery of the additional capacity required to meet plan (39 elective beds) could not be met without achieving the flow programme goals.

Forecasting winter 26/27 Denmark Hill

Non-Elective G&A bed use over time - DH

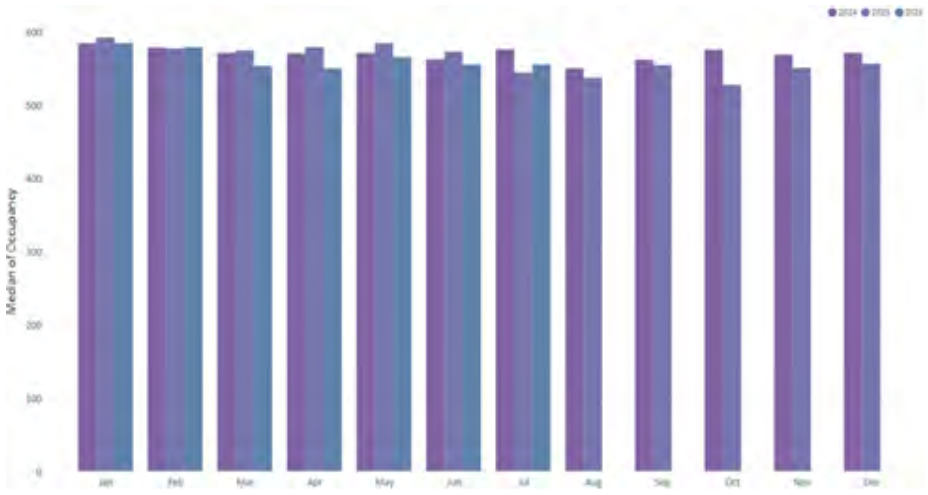


- The chart above shows non elective G&A bed use from April 2021 to July 2026
- Graph shows a gradual but consistent increase in use over time withclear chnages that relate to covid spikes or winter with a sustained high period of occupancy in January 2026
- Non-elective bed use has stabilised around 550 in the first part of 2026. However, the volatility seen last winter will increase the uncertainty around future bed occupancy forecasts.

Median weekly bed use 2021-2026 non- elective adult G&A

- The above chart shows average monthly non-elective bed use up for the H2 plan period (Oct-Mar) for the last five years.
- Analysis showed that non-elective bed use dropped significantly in July 2025 from new highs seen in April-June 2025. These numbers picked up again in September, in line with patterns seen in previous year.
- In conjunction within the next table this indicates that total bed use for non-elective patients at DH has been lower in H1 than previous years but has **not r**educed proportionally in line with reductions in G&A beds.

All years have been adjusted to account for incidents and events (e.g. cyber-attacks and industrial action.



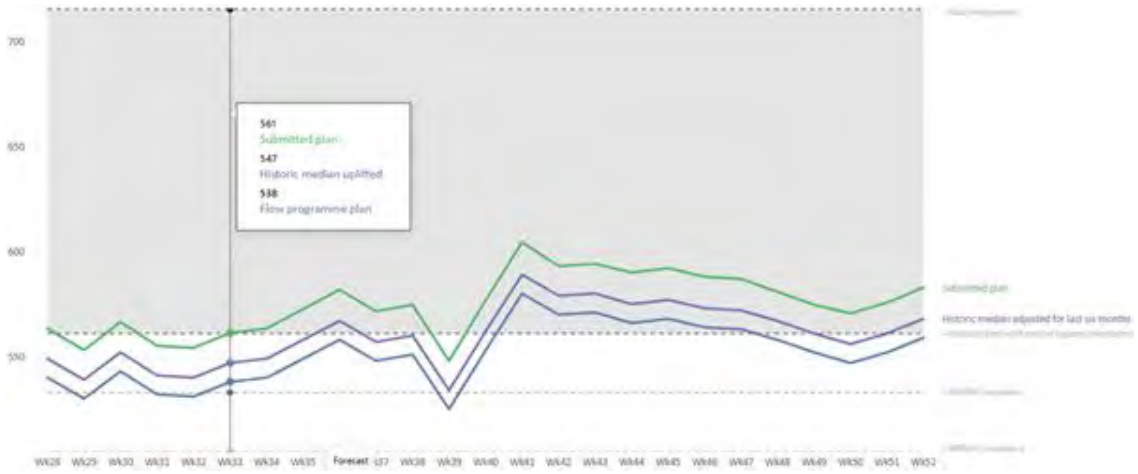
Average Historic demand for non-elective G&A beds

Denmark Hill has seen lower levels of bed occupancy from April to July 2026.

However, this bed occupancy is still higher in July 2026 than it was in July 2025. The average daily bed use has dropped by 2.5%, but the actual available bed stock has dropped by 3.6% therefore the bed position is one of squeeze rather than excess beds.

The reduction in demand equates to 14 beds but the total beds closed with escalation beds in play was 39.

Bed Demand Scenarios winter 26/27



The grey block at the top of the above chart shows the capacity required to maintain the planned elective activity levels (this plan assumes an additional 39 beds are available to deliver elective performance- these beds have not been realised).

Flow programme benefits have been estimated and account for part of the shortfall in elective beds.

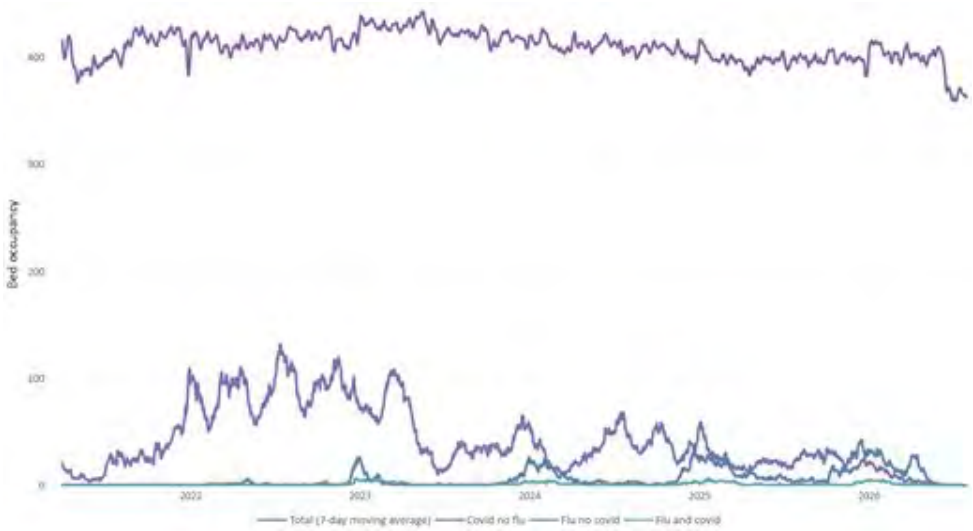
Unless reductions in length of stay are seen and sustained throughout winter the site will not be able to maintain elective performance and will not have available G&A beds for the January peak of winter pressures.

<u>PRUH and Orpington</u>

- Beds at Orpington continue to be used flexibly over the years to relieve pressure and respond to operational priorities at PRUH. Non-elective bed use at Orpington has increased during H1 2026/27.
- Non-elective G&A bed use at PRUH in total increased during H1 2026/27 compared to the same period in 2024/25. There has been a drop in bed occupancy during H1 2026/27 directly linked to the closure of 12 beds which impacts on winter modelling.
- Due to its lower bed numbers and high proportion of non-elective bed use, bed modelling suggests that PRUH remains at risk of reduced elective capacity in G&A beds and reaching overall Critical Care capacity in all scenarios other than the best case.
- To Note the submitted elective activity plan will require an additional 20 elective beds to deliver expected performance. Please note, submitted plan will require an additional 20 beds to deliver the expected

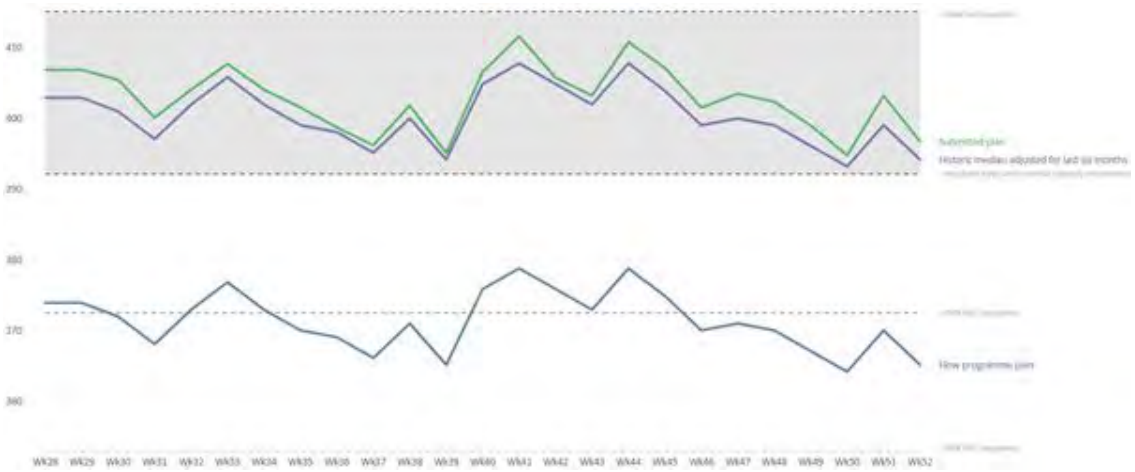
Chart Forecasting PRUH

Non-elective G&A bed use over time - PRUH



- The Chart shows non-elective G&A bed use at PRUH from April 2021 to July 2026 inclusive.
- After a gradual downward trend in bed occupancy between February 2023 and April 2025, bed occupancy has increased over winter 2025/26. This level has not materially changed over summer.

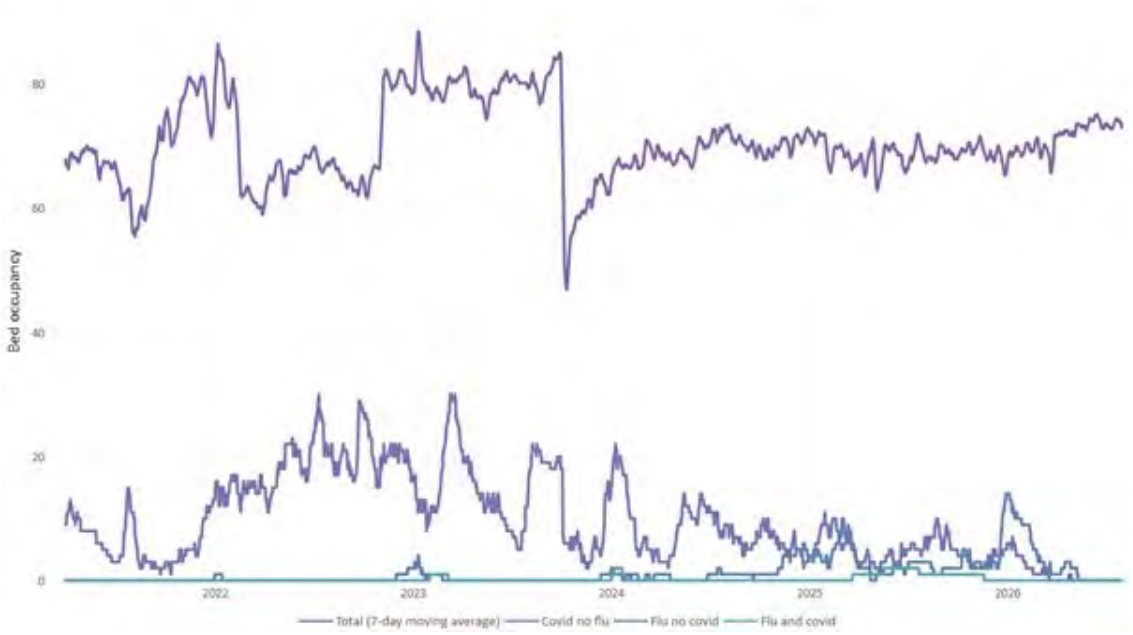
PRUH Scenario modelling winter 2026/27 non-elective G&A



- The chart above shows the three forecast scenarios for the PRUH. The dotted lines show different bed capacity thresholds for non-electives.
- The grey block at the top of the chart shows the capacity required to maintain current elective activity levels. Please note, submitted plan will require an additional 20 beds to deliver the expected performance improvements.
- Flow programme benefits have been estimated based on current delivery expectations and account for the additional elective activity required.
- Submitted plan includes a growth uplift based on demographically driven activity increases.
- PRUH is dependent on improvements to managing patient flow to avoid significant bed pressures during H2.

Orpington

Non-elective G&A bed usage over time



- Non-elective bed use has increased at Orpington during H1 2026/27,
- Using data from H2 2025/26 we can determine how bed use during H1 differs from the previous year. Orpington average daily bed use for non-electives has increased by 5.8% in General & Acute beds.

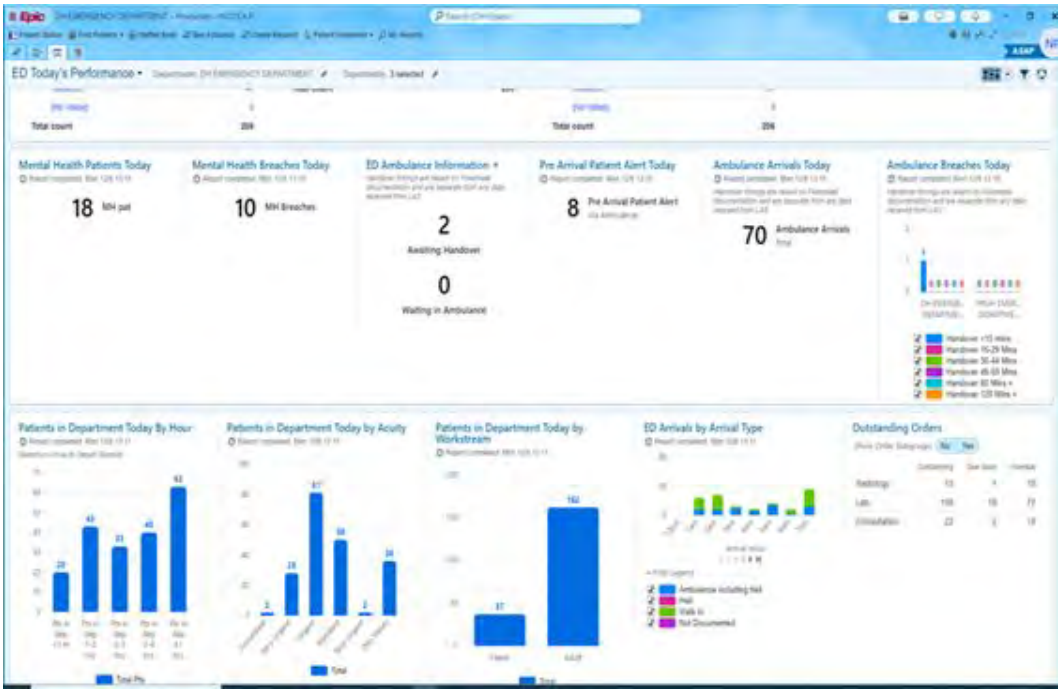
1.6.3 Review of Learning

Winter de-briefs and a table top exercise to test the local business continuity were undertaken in May 2026.
Trust and site plans reflect learning from the previous winter.

1.6.4 OPEL Framework

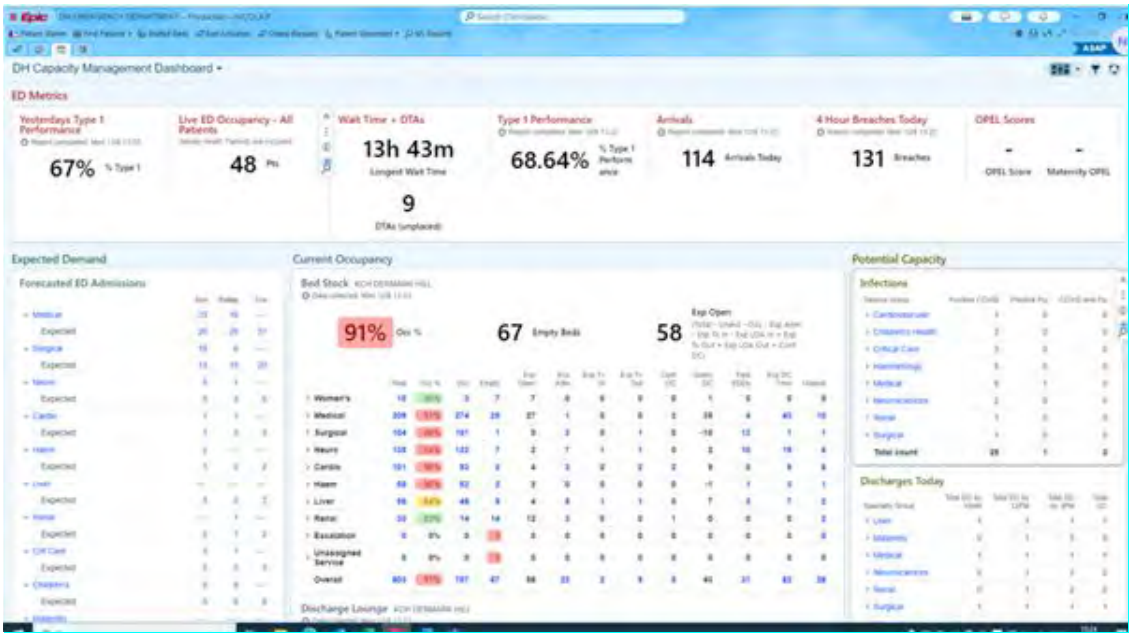
The available data for internal monitoring of the ED and the site in general is available in several live reports on Epic.

- ED Todays performance - including arrivals/ departures/ type 1 performance (as the type 3 performance is held on the UTC standalone system called Adastra this data is only available retrospectively.



- Capacity Management dashboards- showing actual available beds plus predicted demand for the day. This is the “live bed state”

Site operational meetings are run using the information within the live bed state and have been refreshed and training provided to operational bronze roles prior to winter.



National guidance was issued in 2024, updating the national OPEL framework. Within Southeast London, an OPEL awareness system called RAIDAR was put in place to manage the OPEL scores within the system providing a regular feed of live OPEL scores into NHSE London.

The system is not linked with Epic so requires a manual input of data three times a day from the clinical site teams. A calculation of the submitted OPEL score is sent via email within the Trust and is available on the live bed state alongside OPEL scores for maternity and the critical care status known as CritCon levels.

The live updated OPEL score is available on both the Capacity dashboards and within Power BI.

To support enhanced levels of response and in recognition that both sites will usually trigger at Opel 3 or above on RAIDAR even when the site is not under pressure, the PRUH led on the development of an internal scoring system to aid daily site to divisional discussions- this has now been adopted across the sites alongside a SOP for the role of the care groups within the daily operational calls and a standardised approach to the site meetings.

Chart 18. OPEL Parameters

Indicator	New
Total number of unplaced DTAs	
Total number of unplaced Peadiatric DTAs	
Total number of unplaced Mental Health DTAs	
All type attendances since midnight	
All type 4 hour breaches since midnight	
Total Number of patients in ED	
Total Number of adult patients in ED	
Total Number of peadiatric patients in ED	
Total Number of patients in ED longer than 12 hours	
Total Number of patients in ED longer than 24 hours	
Total Number of patients in ED longer than 48 hours	
Total Number of patients in ED longer than 72 hours	
Longest wait to be seen by 1st clinician (hours)	
(Time until) First 12 hour Breach Risk without a plan (hours)	
Resus space available	
Current number of empty beds available	
Total number of beds closed due to IPC issues	
ITU space	
HDU space	
CCU	
Paeds space	
Mortuary space	
Bed Predictor (Best Case)	
Bed Predictor (Worse Case)	
PICU	
NICU	
Predicted Emergency Admissions	
Planned Elective Admissions	
Predicted Discharges	
Actual Discharges completed since midnight	
Actual Admissions completed since midnight	
Medically optimised total	
Medically optimised patients awaiting MH bed	

1.7 Trust Overarching Approach to Managing Winter 2024/25

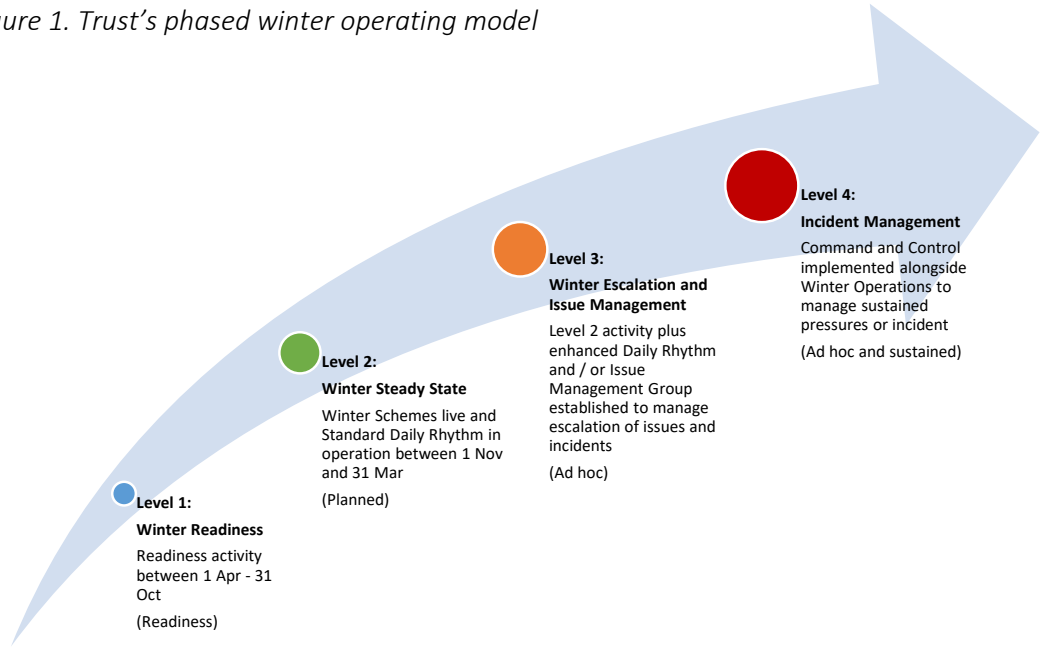
The following table defines the key terms used within this document:

Definition of key terms

Term	Definition
Steady state	used to describe the activities that organisations respond to and manage as part of their everyday responsibilities. Steady state may also be known as business as usual or normality. Here this refers to agreed planned activity as part of the Seasonal Pressures Plan for the duration this plan is live (1 Nov – 31 March).
Rising tide	an event or situation with a lead in time in days, weeks or even months, the final impact of which may not be apparent early on.
Rapid onset / Sudden impact	an event or situation which develops quickly and usually with immediate effects, thereby limiting the time available to consider its management options.
Incident	Business Continuity, Critical or Major Incident declared by the Trust or Site using established EPRR arrangements.
Command	exercise of vested authority, that is associated with role or rank within an organisation, to give direction to achieve defined objectives.
Coordination	the integration of effort and available capabilities to achieve defined objectives.

The following diagram illustrates the Trust's phased winter operating model and outlines the escalating levels of management activity that may be required to manage seasonal pressures, issues, and incidents:

Figure 1. Trust's phased winter operating model



The decision to escalate or de-escalate through the levels will be taken by the Hospital Director for each site in discussion with the Deputy CDO, or the CDO or equivalent from a Trust-wide perspective

if required. In addition, escalation or de-escalation through the levels does not need to occur sequentially and will be driven by the scale, severity and duration of the pressure(s), issue(s) and/or incident occurring at the time.

2. Winter Readiness & Management - System Level

The Trusts seasonal plan is closely aligned with the key priorities and actions within the SEL ICB plan.

Working within the pre-agreed 2026/7 financial plan where it is agreed that there is no additional system funding for winter- but several previous winter schemes exist within the sites baseline- examples of which are detailed below.

- Frailty SDEC
- Multi-Speciality SDEC
- Provision of Transfer of Care assessment seven days a week

Daily site rhythms and how this aligns to the system are described within this document

2.1 System Plan

1. Improve ED waiting times with a minimum of 84% of patients seen within 4 hours by March 2027
2. Improvement of category 2 ambulance response times to an average of 30 minutes
3. Reduce the proportion of waits in ED that are over 12 hours (both physical and mental health)

Additionally, the system through the UEC delivery boards agreed upon the following to focus their winter improvement and receive dedicated system support for this.

- **Whole system flow** with a reduction in delays across the pathway from ambulance arrival to discharge
- **Provision of care closer to home** by maximising the sue of the UCR, support to virtual wards, community pathways, SDEC and UTCs
- **Right service, first time**- improvements in NHS 111, clinical navigation, SPoA and direct access pathways
- **Frailty and complex care**- strengthen the front door frailty offer, increase care home support and proactive care
- **Mental Health crisis care-** improve alternatives to ED and reduce long waits
- **Health inequalities**- target groups with poorer access, outcomes or higher demand
- **Digital and Data**- use shared records, dashboards and digital navigation to improve flow

2.2 Continuing to Deliver on the UEC Recovery Plan

Same Day Emergency Care

Providing robust Same Day Emergency Care (SDEC) pathways across a variety of specialties is a key priority and a critical enabler in meeting the 4-hour Emergency Care Safety Standard performance trajectory. Increasing SDEC capacity to improve the stream of patients from ED and reduce unnecessary admissions is a high priority to support flow through emergency pathways. The Trust has completed a review of SDEC services with the national GIRFT team.

Following assessment by the UEC GIRFT team the site is working to:

- Increase the use of Hospital at Home/ UCR for all patients- this service is delivering a virtual ward environment. Frailty SDEC facilities were implemented in 23/24 and will continue to run across the winter period.

- Review the higher-than-average volume of care home admissions from the acute service- this is a long-term review of work within social care to enable patients to be discharged home sooner and supported rather than becoming de-conditioned within the hospital environment.

The ambition of winter 26/27 is to establish an SDEC by default model that reduces unnecessary admissions and improves ambulatory patient flow.

Sustaining Improvements in ED performance

UEC all types of performance dipped over quarter 2 with an increase in attendances and ambulance arrivals.

The Trust has implemented the following actions that phase into winter to improve ED performance.

- Admission avoidance linked to CTA audits with a trial of pre conveyance SPOA model for older people at the PRUH
- Prehospital stroke triage
- Continuation of performance management with the DH UTC provider
- Governance forums to review and reduce non admitted referred breaches

2.3 Actions to support the EDs

A full set of internal triggers and escalation cards have been developed specifically to support the EDs - these have been reviewed and are supported by the patient flow group.

A full set of internal triggers have been developed for both acute sites.

To support the response to ED at times of sustained pressure within the department- a complete set of action cards have been developed for care groups and divisional response.

All local site plans and the supporting documents for opening and closing areas are available within the appendices.

2.4 Mental Health Pressures

The pressure placed on the ED and acute bed base by mental health patients is significant, causing cubicle block within the ED leading to delays to offload LAS vehicles, bed occupancy within the acute bed base becomes blocked leading to delays in placement of physical health patients within the admitting areas.

Whilst both sites work across the ICS to improve flow within the mental health trust- it is recognised that outflow within MH and times of increased demand require additional internal trust support.

On average 23% of ED MH attends are seen and treated within 4 hours- with all others staying in ED past this time.

All ED and inpatient mental health patients are discussed with the ICS and MH Trust(s) twice a day seven days a week - with the site (including on site MH teams) having the ability to identify patients who are particularly resource intensive or high risk.

The sites works alongside the ICS to implement the local MH 5-point action plan with recommendations from the Carnall Farrar Report:

1. Increasing bed capacity

2. Bed Management and patient flow - daily COO/SD bed calls, weekly and monthly MADE, Robust 24/7 crisis offer, Reinforcing CMHT – Crisis – Inpatient interface, Strengthening ED Breach escalation, Demand and capacity review in PCNs and community caseload reduction
3. Reducing the length of stay - streamlining discharge processes: DCCM standard work embedded, Home by Lunch, Morning admissions where discharges are planned, Enhanced CRFD Meetings. Weekly Trust meeting, daily borough meetings and LLOS: Borough led meetings to review >32 LoS
4. Ensuring core quality and safety standards across our ED liaison services
5. Increasing non-medical senior decision makers - in October 2024 due to increasing pressure we agreed additional review of patients every shift as part of ICS MH work stream

As part of work across the ICS- a protocol has been developed and tested through 4 cycles of PDSA that allows ED to identify patients within the department who require rapid access to MH admission beds.

All long stay MH patients within ED are escalated daily through either the Hospital Directors or Senior Manager on call through to respective COO or SMOC- additionally notification of long waits is issued to London region through the ICS.

Through the ICS continue to work to improve the attendance of those requiring primary care support only (whilst this does not reduce admissions it supports a reduction of overcrowding within the UEC pathway).

2.4.1 Clinical Site Management Teams

Clinical Site Management Teams operate 24/7 to provide clinical site management support and co-ordinate and facilitate patient flow at both sites. In addition, the Clinical Site Team provide senior nursing support and advice to all clinical areas and are the first point of escalation in the event of an incident or emergency. The Clinical Site Management Teams work from an Operations Centre and lead all Bed and Flow Meetings.

During Winter the Clinical Site Management Teams will operate as normal and lead the Site's Operational Management of Winter unless Level 4 (purple) – Incident Management is enacted.

2.4.2 Daily Site Meetings

The Site will continue running scheduled Daily Site meetings (Bed and Flow Meetings) in accordance with each site's daily rhythm. These meetings will review the site's individual status and conclude with actions and issues to be mitigated. Representation from each of the Trust's Care Groups is required at these meetings to deliver and receive any escalations (care group bronze role).

All site meetings were refreshed over the summer months, and revised terms of reference were developed.

2.4.3 Inpatient Flow and Length of Stay

The Flow Programme includes several trust-wide interventions designed to reduce length of stay and, through admission avoidance, decrease inpatient bed days and improve time of discharge.

Alongside these corporate programmes, care groups and site teams are delivering a range of locally

focused workstreams aimed at improving patient flow and reducing delays in care. Examples include the fractured neck of femur pathway redesign at PRUH, Right Patient Right Bed at PRUH, optimized handovers within therapies, the early mobilization pilot in therapies, the frailty single point of access at PRUH, and stroke video triage across both Denmark Hill and PRUH sites.

2.4.4 Clinical Operational Standards – Specialty-Led Admissions

A key priority is ensuring that patients are admitted directly under the most appropriate specialty team rather than remaining under generalist teams while awaiting specialist review. The Clinical Operational Standards (COS) programme launched in July 2026 and is intended to reduce length of stay by enabling patients to receive earlier specialty-led assessment and management.

2.4.5 Criteria-Led Discharge

Criteria-Led Discharge (CLD) is now in place across 40% of eligible ward areas with plans in place to improve this coverage. Its aim is to provide earlier discharges and an associated reduction in length of stay.

2.4.6 Reducing Long Lengths of Stay

The long length of stay (LLOS) programme aims to reduce the number of patients staying in hospital for more than 21 days. The programme has started on the general medical wards introducing twice-weekly multidisciplinary team reviews for patients with prolonged length of stay to accelerate discharge planning and reduce stranded patients.

2.5 Management of Elective Patients

The management and placement of elective (planned) admissions is of equal importance to the management of unplanned care; therefore, best efforts must be made to ensure that those patients planned for elective admissions are not adversely impacted by pressures within the site over winter. However, at times of extreme pressure a risk assessment of site capacity must be undertaken, and it may be felt the risk to cancellations of electives, and the loss of planned theatre time is outweighed by the risk to patient safety within the ED. This decision must be made by the site Hospital directors in full and open discussion with the divisional Chiefs of Service.

The dedicated elective bed base can therefore only be used to support non-elective care within the specific care group if:

- It is written into the local action card for escalation for the care group, and all other actions reviewing LoS, no CTR etc have been completed
- The use of the bed base has been agreed with the care group triumvirate
- There are patients within the ED footprint that can be cared for within that bed base- that have been reviewed by a senior clinician within surgery and are not suitable for either day case surgery or SDEC
- That all electives planned for admission have been reviewed by a clinical director, a member of the theatre triumvirate and an assessment of harm/impact has been made
- All options for alternative admission routes have been explored - use of recovery, 23 hours stay etc
- The final decision will be made following this risk assessment by members will be made as described above

2.6 Maintaining Patient Flow

The NHSE 'Acute Hospital 100 Day Challenge' discharge guidance sets out ten initiatives to engage in collaboration with community and system partners optimising discharge management and enhancing senior oversight. The following principles have been adopted to manage flow through the winter period, in line with ongoing planned local initiatives:

1. Identify patients needing complex discharge support early
2. Ensure multidisciplinary engagement in early discharge plan
3. Set expected date of discharge (EDD), and discharge within 48 hours of admission
4. Ensuring consistency of process, personnel, and documentation in ward rounds
5. Apply seven-day working to enable discharge of patients during weekends
6. Treat delayed discharge as a potential harm event
7. Streamline operation of transfer of care hubs
8. Develop demand/capacity modelling for local and community systems
9. Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges
10. Revise intermediate care strategies to optimise recovery and rehabilitation

Additionally, the sites have completed both the model acute and model discharge pathway assessments and any vulnerabilities within those pathways are detailed in section three.

2.7 Surge Planning/ Escalation

The Trust has planned for the opening of formal escalation space only when either site would declare Purple as escalation. constraints do not support escalation space.

All care groups have reviewed the use of corridor care spaces within wards and have provided plans, locations and risk assessments for the opening of these spaces. These have been reviewed and approved and form part of the action cards held locally as a response to internal OPEL triggers.

Decompression/ escalation/corridor care will only be opened in response to crowding within the ED and will not be used to support planned care. They may however be opened to support the decompression of ED when specialities have competing priorities for long wait electives or cancer care.

The need for and the site management of overcrowding in ED and overall response to rising OPEL triggers is outlined within section 4.

- **Assessment of Risk**
- **Escalation**
- **Quality of Care**
- **Raising concerns and reporting incidents**
- **Data collection and measuring harm**
- **De- escalation**

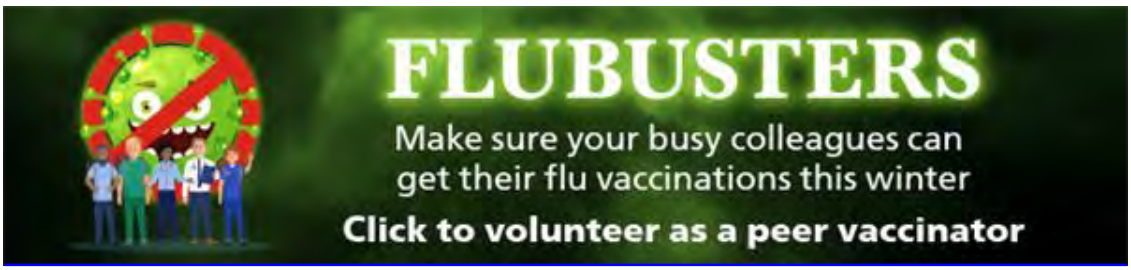
2.8 Keeping Staff Well - Flu

SEL ICB as part of their winter workshops committed to ensure they focus on preventing illness within staff and improving system resilience.

This includes making every possible effort to maximise vaccination uptake in patient-facing staff - in particular Trusts were asked to

This includes making every possible effort to maximise vaccination uptake in patient-facing staff; in particular, Trusts were asked to:

- The national frontline healthcare worker target for flu vaccination uptake is set at 60%-65% this year. The success will be added to the National Outcome Framework.
- Ensure eligible staff have easy access to relevant vaccinations from October 2026
- Record vaccinations in a timely and accurate way, linking with ESR and RAVS, as the lead systems
- Monitor uptake rates and act accordingly, with most vaccinations being delivered by 30 November 2026
- Ensure staff promote vaccination uptake to members of the public and patients who are eligible



The Trust is committed to providing an accessible staff and patient flu delivery service that builds on our previous years of staff vaccination growth, with King's leading as the best performing large Trust in London in 25/26 with 46.85% uptake.

The Trust's annual Autumn/Winter flu vaccination campaign will start on 1st October 2026, with full support from the Divisions and the Trust Operational Influenza (Flu) Group, working in partnership to reach vaccine-hesitant staff groups, and supported by the Caribbean and African Health Network (Homepage new - CAHN), to undertake a listening and informing change high-impact project for our global majority staff.

Boardroom launch events have been booked at both our Denmark Hill and PRUH sites for early October, accompanied by a focused and bespoke Trust-wide communications campaign.

Accessibility: there will be static locations, pop-up locations and roving peer vaccinators to ensure full coverage for all staff who wish to uptake the vaccine across all sites and across a range of hours, nights and weekends.

At Denmark Hill- static locations will rotate through the Boardroom, Golden Jubilee Foyer and Hambleden Wing Reception.

At the PRUH main reception and intermittent space within the staff canteen will be used.

Vaccinations will also be offered from our new permanent Occupational Health clinic space at Orpington in between clinics, and in the main waiting room area.

This will be supplemented by drop-in clinics at other Trust sites, attendance at large events and vaccinations within the Occupational Health Department.

Staff have been encouraged to volunteer as peer vaccinators, and as an incentive, small value vouchers will be awarded to three monthly winning peer vaccinators who are eligible to enter the monthly prize draw.

As in 25/26 the Clinical Site Teams are trained peer vaccinators with access to vaccinations in dedicated fridges out of hours. This allows staff to receive vaccinations whilst at work overnight and at weekends.

The Trust has committed to Big Week in November, where a 24-hour jabathon will be hosted at the PRUH and DH sites.

A Communications plan is in place that is both clinically relevant and inclusive with posters, messaging, badges/stickers and weekly invite letters to attend a vaccination clinic.

Regular messaging will be sent to all staff with access to LOOP and KingsBank

Vaccinations will continue to be recorded using the Vaccination Track system, alongside what is essentially double entry into RAVS (the replacement for NIVS).

The former allows the Trust to get accurate and real time uptake information which will be monitored through the vaccination steering group.

2.9 Protecting Vulnerable Patients- Flu

From the 1st of October 2026 the Trust has committed to provide the vaccination as an offer for vulnerable patients- this will be offered to all patients who have been in hospital for 21 days and all discharges to care and nursing homes.

Additionally maternity patients and some vulnerable groups will be offered the vaccine as outpatients. All vaccines administered will be recorded on RAVs reducing the risk of double vaccine within the community.

3 Winter Readiness & Management – Overarching Site Principles

The Hospital Directors alongside the Divisional Teams will use the live bed state and capacity dashboard to make three formal submissions of OPEL status each day and the level of response to the pressures is contained by care group within escalation cards to support actions to ease pressure.

Each care group has a determined set of actions at all OPEL levels and are monitored against these actions through regular flow meetings to determine if actions have been successful in mitigating pressures. As each care group has been given triggers based upon demand, predicted flow, volume of stranded patients to aid actions- it is hoped that actions within escalation cards whilst not alleviating pressure should allow the site to remain within OPEL 3.

The opening of escalation beds will only be considered when all actions have been implemented, and the site is at OPEL 4 and system support has been requested- and despite all efforts the site in question has remained on OPEL 4 for over 36 hours.

The pressure needs to have been sustained for over 24 hours with ED having remained at OPEL 4 for the duration of that time. It is possible that if the site sees a significant infection outbreak OPEL 4 will be declared and due to bed losses opening escalation beds to support non-surge admissions may be

the only option- however the principles outlined below and the SOP for the opening of escalation areas must still be followed.

The Hospital Directors or deputies must have taken responsibility for the escalation both internally and externally of any blocks to patient flow.

If the site has not been able to reduce its OPEL score at 24 hours, then an internal incident should be declared, and the site formally step into Level 4 of its winter operational management as described in figure 7.

3.1 Model Emergency Department

Both sites formally assessed their ED's against the model ED standards and the submission of this maturity was reviewed by the Chief Delivery Officer.

Denmark Hill Site

Four areas of the submission were answered as not in place

- Single point of access is not available in Lambeth and Southwark
- The Criteria to Admit Decision Tool is not in place and not routinely used
- All patients are not reviewed by the mental health liaison team within an hour of presentation
- There is not a Mental Health Emergency Centre co-located within the ED

PRUH Site

Six areas of the submission were answered as not in place

- Single point of access - currently being piloted and only for frailty.
- No digital tool to support front door streaming, triage and redirection.
- The Criteria to Admit Decision tool is not regularly used.
- No Streaming direct to Paediatric SDEC
- All patients are not reviewed by the mental health liaison team within an hour of presentation
- There is not a Mental Health Emergency Centre co-located within the ED

3.2 Corridor Care

Corridor care forms part of our escalation winter plans, to support safety across all areas when the hospital is at capacity, used when demand is greater than standard capacity and when areas must be used to ensure we can deliver safe care for our patients, whether in ED or our wards. It is used when other operational management tools fail to release the pressure. Enactment and patient safety of this practice will be utilised as per our Trust policy and site escalation plans.

Corridor Care is an umbrella term used to describe the process for increasing the number of patients in each setting over and above the established capacity. Its aim is to decompress the Emergency Department (ED), and in doing so support improved operational flow and risk sharing to decompress

overcrowding in ED departments across the organisation, and to support a sector wide response to ambulance response and offload times.

The use of corridor care is monitored daily via a Power BI report and review of any potential harm is described within the policy.

Any care group requiring the use of corridor carea s part of the Sites response to escalation has reviewed the space and the detailed requirements for the space to be used.

All plans have been designed to reflect the Care Quality Commission's (CQC) fundamental standards and reflect the core principles outlined by NHSE.

For the ward are plans include:

- An assessment of the clinical, psychological and functional suitability of the patient. Mental Health patients requiring admission are excluded.
- The need for a clear clinical plan for the patient.
- Allocation of named staff to ensure ongoing care for the duration of their stay
- Appropriate equipment to ensure on-going monitoring
- The ability to admit the patient into a boarding bed on EPIC allowing for recording of care, identification of deterioration and the ability to undertake subsequent harm reviews should they be required.
- Full environmental assessment in advance of the space to be used
- The ability of the patient to be able to call for assistance of required

A dashboard is held within EPIC to reflect any patients being cared for within boarding spaces to ensure that appropriate monitoring, recognition of numbers and reporting requirements can be delivered.

3.3 Model Acute Pathway

To try and minimise the need for corridor care both sites have assessed their maturity against the model acute pathway with the assessment and actions to support improvement outlined below.

- **Early clinical decision making**- there are no barriers to early clinical decision making with the use of EPIC supporting the ability to review remotely if required and communicate amongst clinical teams. Use of frailty scoring and frailty practitioners at each ED to ensure this pathway can be maintained.
- **Care Navigation**- length of stay within the acute medical units is monitored within EPIC but patients will stay longer than 72 hours is suitable downstream beds cannot be found. Both sites flow programme actions should address this, but we are unlikely to see the benefits of this for the winter plan
- **Care on the acute receiving area and continuity of care-** the daily rhythms within the acute medical units are well established- but the timeliness of board and ward rounds and the decision making could be more robust. Speciality engagement into the non- elective pathway can be variable and this is not always a senior decision maker. Within the medical specialities senior decision makers are present across the 7-day working week. Patients are moved to downstream beds when beds become available, but this is not always within 12 hours of that bed request. The Trust is working on right patient right bed as an initiative which will address this is part.

- **Support services and 7- day working**- there is good support across the 7-day week following the modernising medicine programme, but over holiday periods the Trust needs more rigid rota management to ensure senior decision makers are available.
- **Patients, families and carers**- there are well embedded mechanisms for acting upon feedback and the roll out of Marthas Law supports urgent escalations 24 hours a day
- **Data Recording and Metrics**- EPIC dashboards support full tracking of any delays, length of stay and the PSIRF process is firmly embedded for harm/ patient safety events
- **Internal Professional Standards**- were launched in July 2026 and are monitored.

3.4 Communications

The King's Communications Team is working with the Southeast London integrated care system communications team - plus neighbouring hospitals - to deliver a joined-up winter communications campaign. This will focus on reducing pressure on our services, mainly by pointing people to services more appropriate for their needs.

3.5 Discharge Planning

Both sites have assessed their discharge maturity in line with the Model Discharge Pathway.

The Seven key discharge principles within that pathway are in place within the Trust.

7 principles of discharge

1. Discharge is a clinical decision, not an administrative one

It is planned from the point of admission and enabled by efficient, consistent operational processes that are everyone's responsibility. ADT functionality used in EPIC for all site meetings supports this.

2. Staying in hospital longer than necessary causes harm. Long length of stay reviews as part of the flow programme are in place for this winter.

3. Timely discharge is essential for patient flow and safety across the urgent and emergency pathway. All care groups and support teams provide daily Bronzes to escalate and resolve blockages to discharge patients, and both sites have discharge's lounges that use EPIC to pull patients proactively.

The whole urgent and emergency care pathway depends on patients leaving hospital when they are ready. Maintaining a daily oversight of discharge flow, aligned to admission demand, reduces the risk of prolonged waits for admission in emergency departments and corridor care.

4. Discharge home or to the usual place of residence is the default

5. Discharge is everyone's business, every day – with empowerment and clear decision rights

Multidisciplinary working is essential, with clear roles and accountability so everyone can act confidently within their role to support discharge.

6. Patients and carers (including parents of children and young people) are partners in achieving high-quality discharge

Discharge planning involves patients and carers early and meaningfully, in line with statutory duties (Health and Care Act 2022 s.91).

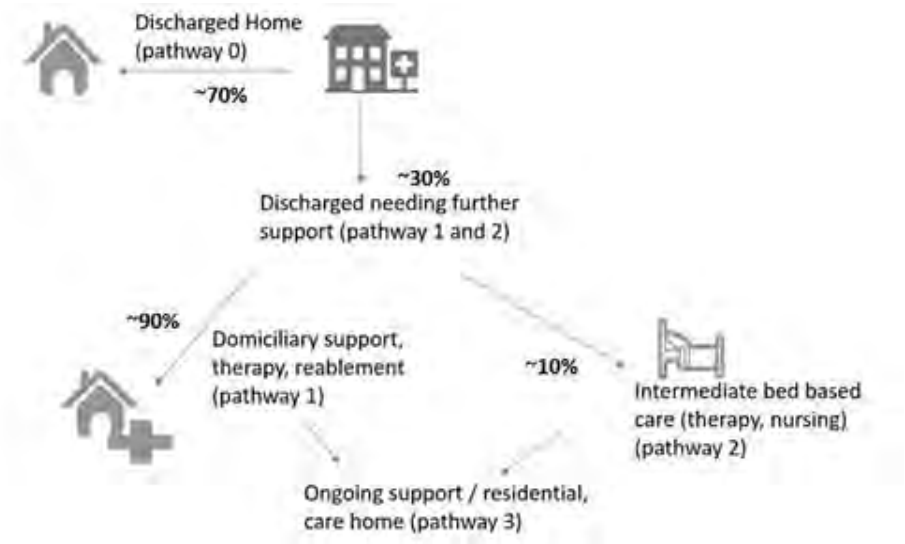
7. Decisions are informed by timely, high-quality data and transparency

In line with NHS national policy and guidance Hospital discharge and community support guidance (March 2022) a Discharge to Assess (D2A) operating model will be utilised by partners across both acute hospital sites to community interface. The model intends for integrated partnership working, which results in patients being able to leave hospital when medically optimised for discharge (MOFD) with any required community support is in place, without the need for protracted assessment in hospital.

To maintain capacity throughout the winter, the transfer of care teams will operate a 7-day service providing a smooth transition between hospital and home. With ToC leads now substantiated for both sites.

The below figure provides an illustration of the discharge pathway for planning purposes:

Figure 2. Discharge Pathways



Patients can often experience delay in accessing services, such as maintenance tasks, transportation, cleaning and assistive aids that can lead to a delayed transfer of care by patients who are well enough to be discharged but are unable to return home. These overstays significantly impact patient experience and effect patient flow throughout the NHS. The Trust has invested in the following services to improve the health outcomes of vulnerable patients:

- Red Cross service assists frail and vulnerable Lambeth and Southwark residents to get home following an inpatient stay and prevents unnecessary admissions from A&E, over winter this will include a dedicated discharge transport service to aid transfers out of hospital
- Safely Home Trust initiatives to support patient flow across the organisation.
    - Crisis Fund (supported by King's Charity) available for all patients and to be spent on reasonable items and services which would enable a safe discharge to take place, examples of £10 electricity top up, locksmith, food shopping, supermarket vouchers, replacement duvet and pillows, item of furniture, train ticket etc.
    - Pest control
    - Cleaning services (including blitz and deep cleans) - This service reduces risk of infection from harmful surface bacteria and free the home from unnecessary clutter
    - Handyman services - to facilitate a safer home environment, offering services such as fitting handrails and steps
    - Hotel4Homeless (Provided by the London Hotel Group Ltd)

- Bromley Well service assists frail and vulnerable Bromley residents to get home following an inpatient stay and prevents unnecessary admissions from A&E. Bromley Well offers:
  (a) General advice like assistance with cost-of-living concerns, benefits, housing issues and more.
  (b) Emotional support for older people (65+) like friendship groups, companionship and signposting to appropriate local services and therapies.
  (c) Practical support like Handyperson Service for minor repairs.
  (d) Transport service to support discharge from hospital and settling in at home.

- Safely Home Trust initiatives to support patient flow across the organisation. The Safe to go Home service offers support with:
  (a) Furniture moves
  (b) Deep Cleaning
  (c) Clearing space for microenvironment and moving equipment
  (d) Wait in for equipment deliveries
  (e) Turn on heating
  (f) Unblock sinks, toilets
  (g) Keys cut and put into key safes
  (h) Environment review (measure, take pictures, video call with OTs to review space)

- Assistive Technology enables patients to return and remain home by maximising independence and safety. The team offers personalised assessments in people's homes following discharge.

- Enhanced Care a short-term intervention of 24/7 care to support adults to safely transition back home and aims to reduce to pre-admission levels of functioning and support. It is typically used for up to 2 weeks to maintain an individual's safety in their own home or care home.

- Virtual ward and H@H to provide continued care in own homes

3.6 Infection Prevention and Control

The Infection prevention and control (IPC) team support the Trust in organisation-wide infection prevention and control measures across our health and care systems to minimise nosocomial infection and lead on outbreak management.

The team have reviewed all relevant IPC policies ahead of winter and held separate planning workshops with the Hospital directors.

The IPC nurses work alongside the clinical site teams during winter ensuring that outbreak management minimises bed closures.

All symptomatic and respiratory pathway emergency admissions are tested with a combined Flu/COVID Lateral flow test in ED. All positive patients are admitted to single room source isolation or to a cohort bay (with other patients positive for the same virus). If symptomatic and negative LFT, and if being admitted, patients are tested with a respiratory viral PCR once on the ward.

3.7 Horizon scanning

Keep abreast of UKHSA notifications and guidance as regards novel infections and epidemics/pandemics.

- Monitor national guidance and ensure KCH policies are updated accordingly and disseminated in a timely way.
- Ensure the Trust intranet is up to date with the latest national guidance.
- Liaise with Communications accordingly.

3.8 Screening

- Ensure prompt identification of people who have, or are at risk of, developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other patients.
- Help evaluate and implement new microbiology testing platforms where appropriate.
- Ensure compliance with Trust guidelines for infection screening.
- Testing of patients being discharged into the community or into care homes for relevant infections, as per current national IPC guidelines.

3.9 Infection Prevention & Control practice

- Adequate training in, and use of personal protective equipment (PPE), hand hygiene, and other infection prevention and control measures.
- Ensure prompt isolation or cohorting of suspected or confirmed infection.
- Where applicable, contact tracing of patients and support Occupational Health and the clinical teams to undertake staff contact tracing.
- In collaboration with Medirest and ISS, ensure enhanced cleaning is instigated where appropriate.
- Support the Fit testing team to ensure that all staff have access to fit testing with local records of FIT testing compliance held.
- Support the risk assessment of single rooms to ensure optimal use of isolation facilities in the Trust.

3.10 Outbreak Management

- Timely reporting, investigation, and outbreak management of infection in patients.
- Provide early notifications and updates on outbreaks both internally and to external stakeholders e.g., ICS and UKHSA, via established reporting systems.
- Daily updates and outbreak management for all active outbreaks.
- Support the Trust to minimise agency/multi-site staffing and staff movements between wards.
- Support the Trust to minimise frequent movements of patients within the Trust.
- Consider ways in which to improve the bed spacing to promote social distancing where necessary.
- Work with the Estates team to ensure adequate numbers of mobile HEPA filtration units are available, in wards with inadequate ventilation.

The IPC team will ensure regular communication between the ICS and UKHSA, as regards the management of outbreaks and potential ward closures. We will share messages via the trust communications team as regards preventative measures, and updated guidelines.

3.11 IPC cover

A daily (Monday-Friday) IPC huddle supports the understanding of infection control needs across the site, and this will be stepped up to a seven day a week huddle if another pandemic is declared. Out of hours cover is provided by the on-call Consultant Microbiologist. The IPC Nurses have a rota to provide additional daytime cover during the festive period, including Public Holidays.

3.12 Mortuary

The Trusts mortuaries are far more resilient than in previous years.

DH Site now has an additional 20 fridge spaces giving a capacity of 102 adult spaces and the mortuary at PRUH has the capacity of 201 spaces.

In the event of demand exceeding capacity, the first step will be for each site to support each other. Working with the cross-site mortuary team to move appropriate bodies between sites.

Beyond internal support, a mutual aid position has been agreed with Guys and St Thomas', with the potential to access Funeral Director capacity if required should the Trust be required to implement surge arrangements.

For the duration of winter, the mortuary team will provide daily capacity figures to the Clinical Site Management and Emergency Planning Teams, allowing for Operational decision making through the site meetings if demand exceeds capacity.

3.13 Pharmacy

The rapid access to medication and the ability to rapidly dispense medications to take home are critical to maintaining flow over winter. The winter plans for pharmacy aim to improve patient flow and have a greater impact on efficient discharges with a 7-day service:

- Ensuring fewer stock deliveries at weekends and out of hours by better stock procurement.
- Improve patient flow and have an impact on discharges by extending the use of pharmacists and ward level dispensing to reduce the wait for discharge medications.
- Enhanced procurement stock tracking cross site to ensure consistency in supply of particularly high use items
- Proactive service provision to speciality SDEC care areas/ discharge areas and the assessment units.

3.14 Procurement and Supply Chain – KFM

KFM, the King's Facilities Management provider has taken additional steps in preparing for the winter, including:

- External offsite storage location (to support winter, and COVID-19 surge planning demand requirements.
- Increased stock holding of PPE at both a local (via onsite store and off-site warehouse run by King's Facilities Management) and national level to support winter and the Management of High Consequence Infectious Diseases, New and Emerging Pandemics Plan demand requirements.
- Additional temporary resource within Supply chain (to support winter and the Management of High Consequence Infectious Diseases, New and Emerging Pandemics Plan planning demand requirements).

- Annual leave planning to safeguard service provisions.
- Continuation of agile working practices to reduce the risk of sickness absence of non-frontline staff.
- Capability to increase service desk capacity (from 6 to 7 days a week) to support clinical staff should it be required.
- Daily attendance at the operational meetings to allow for resource to be deployed/ increased as site pressures change.

3.15 Soft Facilities Management

The soft FM provider at both sites will attend all of the daily site meetings and prioritise cleans and portering resource based upon instruction from either the operational or site team.

Additional resource for deep cleans can be requested through this mechanism and resource intensive cleans is approved through a member of the site leadership team.

A senior manager is available 7 days a week to respond to site escalations/ delays/ engage with planning for opening decompression spaces and re-allocate resource as required.

The opening and closing a ward area checklist will be used to support resource and a level of clean.

This checklist has been amended to reflect the changes within the organisation post the implementation of EPIC.

3.16 Workforce and Wellbeing

As far as reasonably possible Care Groups have developed robust plans to mitigate staffing shortages on delivery of care across all settings and sites and are committed to ensuring that there are no gaps in senior decision makers over the Christmas / New Year period and this will be managed on a continuous basis during winter. All rotas to cover the winter period and critically, the Christmas period, are created and signed off as complete by Care Group teams six weeks in advance.

Additionally, staffing for all clinical areas is reviewed through the twice daily staffing meetings and staff are reallocated according to need.

Staff will be relocated as required, prioritising safe staffing levels across the Trust. Where necessary, the Trust will also move staff between departments and where possible between sites and different employing organisations across South East London.

The Trust has an established process to contract with bank and/or agency staff when required. There is a clear process for in and out of hour's requests for bank and agency staff. Service levels and Care Group levels via the Bank are in place. There is a pool on which to draw staff working across the Trust.

Health and Well-being:

- Individual psychological support available via OH.
- Targeted team support available on request.
- Critical Incident Staff Support in response to serious incidents.
- Continuation of the Health & Wellbeing hubs
- Continuation of the Schwartz rounds programme
- On-going promotion of Employee Assistance Programme service
- Support from Keeping Well South East London
- A broad range of financial well-being support

Further support can be extended in the event of widespread staff shortages and / or surges in demand, e.g., regular check-ins with challenged wards.

The on-call rota for the Christmas and New Year period for the GOLD rota will be managed by the Deputy Group Chief Executive ensuring that appropriate levels of cover are provided. The on-call SILVER rota will be managed by the Hospital Directors.

The daily on site SILVER presence will be provided throughout the duration of winter by either one or both Hospital Directors with the exception to this being bank holidays and weekends.

4 Winter 2026/27 Phased Operating Model

The Trust's overarching approach to managing Winter 2025/26 is outlined in Section 1.7. The following table describes in more detail each of phase of the Trust's Winter 2025/26 Phased Operating Model including level, activity, timing, and lead:

LEVEL	ACTIVITY	TIMING	LEAD
Level 1: Winter Readiness (1 April – 31 Oct)	Winter Readiness activity	1 April – 31 Oct 2026	All Services
	Winter Readiness Exercise	28 April 2026	EPRR Team
	Seasonal Pressures Plan Approval Kings Executive	14 Sept 2026	
	Seasonal Pressures Plan Sign-off Board	16 Sept 2026	King's Exec
	Launch of Trust Seasonal Pressures Plan and Senior Management Briefings	End of Oct	EPRR Team
	Post Winter Debrief	April 2027	EPRR Team
Level 2: Winter Steady State – pre-planned activity (1 Nov – 31 Mar)	DH Site Bed Meeting	0830hrs	Clinical Site Management
	DH Site Operations Meeting and Command Briefing	0900hrs (Monday – Friday)	Director of Ops / Clinical Site Management
	PRUH Site Flow Meeting	0900hrs	Clinical Site Management
	DH Nursing Staff Call	0845hrs and 1600hrs (Mon-Fri)	Site Exec Nursing / Clinical Site Management
	Trust Executive Briefing	0930hrs (Monday – Friday)	CEO's and Director of Ops
	Mental Health Pressures Call	10.15 and 15.00 hrs	Clinical Site Management/ Silver

	SEL Director of Ops Call	1000hrs (Monday – Friday)	Director of Ops
	Trust National SITREP	1100hrs	BIU
	DH Site Meeting	1230hrs	Clinical Site Management
	DH Site Meeting	1630hrs	Clinical Site Management
	Trust Cross-site Gold Call	1700hrs	On-call Gold
Level 3: Issue and Escalation Management (sudden impact, rising tide issue or situation requiring ad hoc enhanced management and coordination)	Level 2: Winter Steady State continues	As soon as issue or escalation is identified	Hospital Directors
	Consider additional: • Site Bed and Flow Meetings • DH Site Operations Meetings • Trust Executive Briefings • Establishing an Issue Management Group • External escalation where appropriate (i.e., Divert)	As required	Hospital Directors
Level 4: Incident Management (Sustained pressures / incident declared)	Review and continue as appropriate with Level 2 and 3 activity.	Upon incident declaration	Site Silver Commander
	Activate an appropriate Command and Control Structure to manage the situation safely and effectively alongside Winter Operations.		
	Consideration should be given to existing Business Continuity, Incident Response arrangements and other existing Trust Policies.		
	External escalation and notification as appropriate.		Trust Gold Commander
	Site Silver or site leadership teams		

4.1 Escalation

Escalation and de-escalation through the Trust's phased winter operating model will be informed by dynamic risk assessment based on activity at the time to ensure a precautionary, proportionate, and flexible approach. This plan must be used, in conjunction with the site local plan and triggers and Patient Flow arrangements; plus Seasonal Incident Response Plans; and other Incident Response Plans all of which will operate alongside the winter operating model.

4.2 Associated Plans

The following existing plans and policies should be used to support the management of capacity and patient flow.

Plan and Policy	Summary
Corridor Care Policy	This policy sets out the daily operational management processes to effectively manage patient flow and bed

Corridor Care Policy - Version 2_KE Paper	capacity. It includes triggers for escalation and actions to be undertaken at times of increased operational pressure on bed capacity.
Site Escalation Policies Insert two links	This protocol describes the 'process and priorities' for balancing and sharing risk across the site when ED has more patients than it can safely care for.
Policy and Procedure for Closure and Opening of Wards or Clinical Areas (DH and PRUH) Opening and Closure of Wards ar	This policy and procedure details how the Trust responds to the need to open or close wards or departments in a coordinated manner to ensure the safety of patients, visitors, staff and contractors.
Operational Pressures Escalation Levels Maternity Framework and escalation policy for London PanLondonDivertPolicy Final.pdf	This policy will ensure a standardised approach to communicating changes in an operational capacity to improve consistency, reduce variation in practice across the region and improve coordination between London Maternity Services and the London Ambulance Service (LAS) within the Integrated Care Systems (ICSs) and across the region.
Safe Transfer of Care (Discharge) Policy & Summary Safe Transfer of Care (Discharge) Pol Safe Transfer of Care (Discharge) Pol	This policy aims to provide guidance and to ensure a standardised approach to staff across King's College Hospitals including the Princess Royal University Hospital on how to achieve the safe and timely transfer of hospital inpatients to an appropriate setting in the community.

4.3 Seasonal Incident Response Plans

The following existing Incident Response Plans are most likely to be enacted during the winter period / risk profile and if required will operate alongside this Seasonal Pressures Plan:

Plan and Policy	Summary
Management of High Consequence Infectious Diseases, New and Emerging Pandemics Plan	The aim of the Trust's management of High Consequence Infectious Diseases and new and emerging Pandemics Plan is to enable King's College Hospital NHS Foundation Trust to effectively manage the consequences of human infectious disease incidents and emergencies while continuing to deliver appropriate patient care and maintain business as usual as far as reasonably possible.
Trustwide Adverse Weather Plan	Outlines the general procedures to be taken in the event of extreme weather disruption affecting the Trust's critical priorities, including disruption affecting large numbers of staff getting to or leaving the Trust.

Copies of these EPRR Plans can be found online via: Kwiki - Emergency Planning

4.4 Other Incident Response Plans

The following other existing Incident Response Plans could also be enacted at any time in response to an incident and if required will operate alongside this Seasonal Pressures Plan:

Plan and Policy	Summary
Command and Control	Command and Control is essential to the effective management of any incident or emergency. This document describes the Trust's Command and Control arrangements for responding to and recovering from Business Continuity, Critical and Major Incidents.
Business Continuity management System Policy	Ensures that the Trust is capable of responding to an interruption of activities, and to also ensure critical services across the Trust can be restored within a defined timeframe. This plan provides guidance for Trust personnel in the event of loss or disruption of IT systems, telephone systems or utilities (electricity, gas, water). It also covers localised flooding and chemical spills.
Major Incident and Mass Casualty Plan	The Major Incident plan describes the Site's response to a Major Incident or mass casualty Incident.
CBRNe/HAZMAT Plan	This plan is intended to provide guidance for the management of any incident involving Chemical, Biological, Radiological Nuclear or Explosive materials CBRN(e). This plan covers a number of scenarios and is intended to mitigate any disruption to the Emergency Department and hospital as a whole. All casualties are to be decontaminated before entering the hospital via ED
Trustwide Evacuation and Shelter Plan	This is not undertaken lightly but may be required in the event of a fire, breakdown of utilities, major equipment failure, hospital-acquired infections or violent crime. In addition to evacuations caused by natural disasters, hospitals need to be prepared to evacuate patients due to terrorist incidents and industrial accidents.
Trustwide Lockdown Plan	Lockdown is intended to restrict site access for the public, staff, patients and others in a safe and co-ordinated manner and enable any relevant checks on people accessing the site to be completed in the event of an incident.
Trustwide Bomb Threat Plan	The Bomb Threat Plan details how employees and the Trust respond to a bomb threat, it assists the organisation's response in a coordinated manner to ensure the safety of staff, the public and patients.
Trustwide Vehicle Fuel Disruption Plan	Provides guidance on the management of Trust operational delivery when fuel supplies are threatened due to any cause e.g. tanker strike, delivery problems, inclement weather or pandemic flu.
Emergency Blood and Platelet Shortage Management Plan	This plan has been structured to provide a framework of actions for the Trust at three phases of differing blood availability, as they are defined by the Contingency Plan document: Green - Normal circumstances where supply meets demand Amber - Reduced availability of blood for a short or prolonged period Red - Severe, prolonged shortages

Copies of these EPRR Plans can be found online via: Kwiki - Emergency Planning

5 Appendices

5.1 Supporting Documents

Category	Title	Document
Bereavement	Cruse Support Bereavement Care Leaflet	Cruse-Understandi ng-Grief-Leaflet.pdf
Community Support	Lambeth Larder Directory	Lambeth-Larder-Dir ectory-Issue-10-202(
Community Support	Telephone & Neighbour Befriending Service Flyer	Befriending-CCL-Fa ctsheet-Nov-25.docx
Cost of Living	Cost of Living - Guide to Support in Lewisham and Southwark	Financial-Hardship- CCL-Factsheet-Dece
Mental Health	Information Service Lambeth and Southwark	Mental-Health-Sup port-CCL-Factsheet-
Transport	Community Connections Lewisham Factsheets - Community Transport	Transport-CCL-Facts heet-January-2026-u

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Internal Flow and Escalation Policy with Full capacity Protocol

Document Control

Field	Detail
Document Title	Internal Flow and Escalation Policy
Version	Draft v1.0
Authors	Lesley Powls – Hospital Director (Denmark Hill) Pau Larrisey – Hospital Director (PRUH and South Sites) Greg Jackson - Head of Site Operations (PRUH and South Sites) Laura George – Deputy General Manager (Denmark Hill) Sally Salter – Lead Nurse, Patient Flow and Discharge Unit (Denmark Hill)
Directorate	Corporate
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Glossary

KCH	King's College Hospital NHS Foundation Trust
OPEL	Operational Pressures Escalation Level
DH	Denmark Hill
PRUH	Princess Royal University Hospital
CSP	Clinical Site Practitioners
ED	Emergency Department
DMR	Duty management report
I/P	Inpatient
SOP	Standard operating procedure
G&A	General and adult
PW	Pathway
EDD	Estimated discharge date
TDS	Ter die sumendum (three time a day)
AMU	Acute medical unit
AGU	Acute gerontology unit
SAAU	Surgical ambulatory assessment unit
DSU	Day surgery unit
RSU	Respiratory support unit
SDEC	Same day emergency care
AFAU	Acute frailty assessment unit
MDT	Multidisciplinary Team

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King's College Hospital NHS Foundation Trust

1. Introduction

This policy sets out the daily operational management processes for the safe and effective management of patient flow, bed capacity and operational escalation across King's College Hospital NHS Foundation Trust. It defines the principles, governance arrangements, escalation thresholds and actions required to support patient safety and operational effectiveness during periods of increased demand.

The policy is informed by NHS England guidance, the National Operational Pressures Escalation Levels (OPEL) framework and the Southeast London Operational Pressures Escalation Framework. The national OPEL framework provides a standardised methodology for the declaration, communication and management of operational pressure across the NHS.

This document provides a Trust-wide framework applicable to both the Denmark Hill site and the Princess Royal University Hospital (PRUH) and South Sites. Whilst the overarching principles of escalation, governance and decision-making are consistent across the organisation, the operational characteristics, service configurations and capacity pressures of individual hospital sites differ. Consequently, local escalation processes, operational triggers, response actions and capacity plans may vary and are described within the relevant site-specific appendices.

The primary focus of this policy is the management of adult general and acute (G&A) patient flow and bed capacity. Where specialist services require alternative escalation arrangements, these are outlined within supporting appendices. These may include paediatric services, maternity services, critical care services and other specialty-specific escalation plans.

Where developed and approved, site-specific escalation frameworks may incorporate local operational indicators, capacity assessments and escalation methodologies to support proactive management of patient flow and bed capacity. These arrangements supplement, rather than replace, the Trust-wide escalation principles set out within this policy.

This policy sets out the governance arrangements, escalation responses and required actions to ensure a consistent, proportionate and safe organisational response to operational pressure across King's College Hospital NHS Foundation Trust.

1.1. Purpose

The purpose of this policy is to:

- Establish a consistent Trust-wide framework for the management of patient flow, bed capacity and operational escalation.
- Support the delivery of safe, timely and effective patient care during periods of normal activity and operational pressure.

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- Define the governance arrangements, escalation thresholds and decision-making responsibilities required to manage capacity pressures across the organisation.
- Provide a structured and proportionate approach to escalation, ensuring actions are implemented in a safe, timely and coordinated manner.
- Set out the Trust's Full Capacity Protocol, including the principles, authorisation processes and controls required when additional capacity measures are required.
- Enable operational teams to identify, communicate and respond to emerging capacity risks at the earliest opportunity.
- Support compliance with national operational escalation requirements, including the NHS England Operational Pressures Escalation Levels (OPEL) framework.
- Provide a framework within which site-specific and specialty-specific escalation arrangements can be developed and implemented in support of local operational requirements.

1.2. Scope

This policy applies to all King's College Hospital NHS Foundation Trust hospital sites and provides the overarching framework for the management of patient flow, bed capacity, operational escalation and full capacity responses.

The policy applies to all staff involved in the admission, placement, transfer, discharge and operational management of patients, including:

- Clinical Site Management Teams and Clinical Site Practitioners (CSPs)
- Hospital Directors and Heads of Site Operations
- Divisional and Specialty Triumvirates
- Clinical Directors, General Managers and Heads of Nursing
- Consultants and senior clinical decision-makers
- Discharge, therapy and patient flow teams
- Operational managers and on-call teams (in-hours and out-of-hours)
- Executive and Gold Command teams during periods of escalation or incident response

The primary focus of this policy is the management of adult general and acute (G&A) patient flow and bed capacity. The policy establishes the governance arrangements, escalation principles, decision-making responsibilities and authorisation requirements that apply across the Trust.

Where specialist services require alternative escalation arrangements, these will be described within approved site-specific or specialty-specific appendices. This may include, but is not limited to:

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- Paediatric services
- Maternity services
- Critical care services
- Emergency Department escalation processes
- Site-specific operational escalation frameworks
- Other specialty escalation plans approved by the Trust

This policy should be read in conjunction with associated Trust policies, procedures and operational plans, including:

- Full Capacity Protocol
- In-patient Corridor Care SOP
- Seasonal Pressures Plan
- Major Incident Plan
- Site-specific escalation plans and specialty escalation appendices

2. Governance

- The management of patient flow, bed capacity and operational escalation is a shared organisational responsibility. Effective management of operational pressure requires coordinated action across clinical, operational and corporate teams to ensure patient safety, quality of care and efficient use of available resources.
- This policy establishes the governance framework through which escalation decisions are made, communicated and implemented across King's College Hospital NHS Foundation Trust. All escalation actions undertaken under this policy must be proportionate, risk assessed where required, appropriately authorised and recorded through established operational reporting arrangements.

2.1 Accountability

- Overall accountability for the implementation and oversight of this policy rests with the Hospital Directors and Executive Team. Day-to-day operational management of patient flow and capacity is delegated to operational and clinical leaders in accordance with the authorisation levels defined within this policy.

2.2 Escalation Decision-Making

- Escalation decisions should be made at the earliest appropriate opportunity, using available operational intelligence, capacity information and clinical risk assessments. Where operational pressures require actions outside normal operating arrangements, authorisation must be obtained in accordance with the escalation levels defined within this policy and any associated site-specific appendices.

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2.3 Site-Specific Escalation Arrangements

- This policy provides a Trust-wide governance framework. Individual hospital sites may operate approved local escalation frameworks, response tools or specialty escalation plans to support operational decision-making. Any such arrangements must align with the principles, authorisation requirements and governance standards described within this policy.

2.4 Full Capacity Responses

- The implementation of any full capacity measure, including the opening of escalation capacity, use of approved corridor care arrangements or any other authorised capacity intervention, must be undertaken in accordance with this policy and any associated standard operating procedures. Decisions must consider patient safety, workforce availability, clinical risk and operational necessity.

2.5 Monitoring and Assurance

- Compliance with this policy will be monitored through routine operational oversight, escalation reviews, incident reporting processes and periodic policy review. Learning identified through operational incidents, internal reviews or external guidance will be incorporated into future revisions of the policy.

3 Roles and Responsibilities

3.1 Executive Team

The Executive Team is responsible for:

- Providing strategic oversight of patient flow, capacity management and operational escalation across the Trust.
- Ensuring appropriate organisational arrangements are in place to manage periods of operational pressure.
- Authorising strategic actions associated with major incidents, sustained capacity incidents and other exceptional circumstances.
- Receiving assurance regarding compliance with this policy and associated escalation arrangements.

3.2 Hospital Directors

Hospital Directors are responsible for:

- Providing overall site leadership during periods of operational pressure.
- Ensuring local escalation arrangements are implemented in accordance with this policy.
- Supporting the coordination of site-wide responses to operational pressures.

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- Authorising escalation actions in accordance with the escalation framework and site-specific escalation plans.
- Escalating significant operational risks through the appropriate management and on-call structures.

3.3 Site Operational Flow Leadership

Whilst operational leadership structures differ between hospital sites, all sites must maintain clearly defined arrangements for the management of patient flow, bed capacity and escalation. Local leadership arrangements are described within relevant site-specific escalation appendices.

The designated site operational flow leadership team is responsible for:

- Providing operational leadership for patient flow, capacity management and escalation.
- Coordinating the site response to periods of operational pressure.
- Reviewing capacity intelligence, flow metrics and escalation indicators.
- Ensuring appropriate escalation actions are considered, enacted, communicated and documented.
- Supporting implementation of site-specific escalation plans and full capacity responses.
- Providing operational advice and recommendations to senior decision-makers and on-call teams.

At PRUH and South Sites, these responsibilities may be discharged through the Head of Site Operations, Clinical Site Management Team and other nominated operational leaders. At Denmark Hill, these responsibilities may be discharged through the Deputy General Manager for Patient Flow, Lead Nurse for Patient Flow, Lead Nurses for Site Management and other nominated operational leaders.

3.4 Divisional and Specialty Triumvirates

Divisional and Specialty Triumvirates are responsible for:

- Maintaining oversight of capacity, patient flow and operational performance within their services.
- Supporting the delivery of timely discharges, patient placement and flow initiatives.
- Implementing escalation actions within their areas of responsibility.
- Participating in operational flow meetings and escalation reviews.
- Identifying and mitigating clinical and operational risks associated with capacity pressures.

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3.5 Clinical Site Management and Patient Flow Teams

Clinical Site Management, Patient Flow and Bed Management teams are responsible for:

- Monitoring patient flow and bed capacity.
- Coordinating patient placement decisions.
- Escalating operational concerns through appropriate governance arrangements.
- Supporting implementation of approved escalation actions.
- Maintaining situational awareness of operational pressures.
- Recording and communicating escalation decisions and actions.
- Supporting operational flow meetings and capacity reviews.

3.6 Clinical Teams

Consultants, senior clinicians, ward leaders and multidisciplinary teams are responsible for:

- Supporting timely clinical decision-making to facilitate patient flow.
- Undertaking regular board rounds and discharge planning activities.
- Contributing to specialty escalation actions when operational pressures arise.
- Identifying and escalating clinical risks associated with delayed patient flow.
- Supporting implementation of approved capacity and escalation measures.

3.7 On-Call Teams

Operational, nursing, medical and executive on-call teams are responsible for:

- Providing leadership and decision-making support outside normal working hours.
- Authorising escalation actions in accordance with delegated authority arrangements.
- Ensuring operational risks are appropriately assessed and managed.
- Supporting coordination of the organisational response to significant capacity pressures and incidents.

3.8 All Staff

All staff have a responsibility to:

- Comply with the requirements of this policy.
- Support actions that promote safe and effective patient flow.
- Escalate operational concerns through the appropriate management structure.

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- Act in a manner that prioritises patient safety and quality of care.

4. Escalation Framework

4.1 Principles

The Trust will maintain arrangements to identify, assess and respond to operational pressures that may impact patient flow, bed capacity, patient safety or the timely delivery of care.

Escalation arrangements must:

- Support proactive management of emerging operational pressures.
- Promote timely decision-making and intervention.
- Ensure escalation actions are proportionate to the level of operational risk.
- Support effective communication between clinical, operational and executive teams.
- Prioritise patient safety, quality of care and workforce wellbeing.
- Facilitate a coordinated organisational response to periods of increased demand and reduced capacity.

4.2 Escalation Levels

Operational pressures should be assessed using approved escalation arrangements designed to provide an accurate representation of demand, capacity, flow and organisational risk.

The Trust will continue to utilise the NHS England Operational Pressures Escalation Levels (OPEL) framework for external reporting and communication of operational pressure.

In addition, hospital sites may operate approved local escalation frameworks to support operational decision-making and internal escalation of capacity pressures. Site-specific escalation methodologies, thresholds and response arrangements will be described within relevant local appendices.

4.3 Escalation Responses

Escalation responses should be progressive, proportionate and cumulative, with actions implemented in accordance with the severity and duration of operational pressures.

Responses may include:

- Enhanced operational oversight and monitoring.
- Additional discharge and patient flow interventions.
- Service-level escalation actions.
- Opening of approved escalation capacity.
- Full Capacity Protocol measures.
- Internal capacity incident arrangements.

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- Major incident escalation where appropriate.

All escalation actions must be undertaken in accordance with approved governance arrangements and authorisation processes.

4.4 Site-Specific Escalation Arrangements

Hospital sites may develop local escalation frameworks to support effective management of operational pressures, patient flow and bed capacity.

Where implemented, local frameworks should:

- Align to the governance principles described within this policy.
- Support consistent and objective assessment of operational pressures.
- Clearly define escalation thresholds, actions and decision-makers.
- Include arrangements for escalation, de-escalation and communication.
- Be approved through appropriate Trust governance processes.

Site-specific escalation arrangements and specialty escalation plans form part of the supporting appendices to this policy.

4.5 Escalation and De-escalation

Escalation measures should be implemented at the earliest appropriate opportunity when operational pressures are identified.

Once pressures have reduced and risks have been mitigated, services should safely de-escalate and return to normal operating arrangements as soon as reasonably practicable.

Any de-escalation must consider:

- Patient safety.
- Clinical risk.
- Workforce availability.
- Capacity and demand.
- Sustainability of service delivery.

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Appendix A – Operational Escalation Response Framework

Green Bed Escalation - Response Level 1 All Specialities at all KCH Acute sites			
Actions			**Responsibilities**
	Points =	**DH - <7 PRUH 0 - 4**	
Emergency Department / SDEC's			
Action appropriate to ED escalation triggers and response			As per ED internal escalation plan
SDEC's BAU			SDEC teams
Discharge and Ward Activity			
MDT engagement in Board rounds and discharge planning. Shared ownership of EDD, discharge pathway clarity, and patient progression. EPIC compliance to reflect this inclusive of medically ready status and live discharge confirmation orders.			Ward MDT
Timely specialty review of outliers. Ward or specialty teams to ensure ADT 7 order is completed on EPIC, requesting the correct bed and providing information on bed specific e.g. side room, enhanced care			Specialty process with ward team support
Attendance to flow / bed / operational meetings in support of patient flow according to ToR's.			Specialty Triumvirate - Site operations
All patients to be discharged via discharge lounge. Only exclusions are IPC requiring isolation, unstable mental health, Patients requiring 1 to 1 enhanced care and acute transfers.			Ward teams and discharge lounge
Timely completion of supported discharge referrals			MDT's and discharge team
BAU for supported discharge, Repatriation and Mental health placement waits.			Discharge team, Therapy team, Clinical site management
BAU patient placement, maintaining focus on right patient, right bed first time.			Clinical Site Team
Maintain good IPC practices in line with policy.			IPC and clinical site team
Prioritisation			
Elective, CEPOD and Trauma list BAU			Theatre co-ordinator with surgical speciality CD.
Staffing			
Local staffing and mitigation processes			Relevant staffing leads
Specialty Activity			
BAU			specialty Consultants with support from Clinical Site Management

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Amber Bed Escalation - Response Level 2
All Specialities at all KCH Acute sites

Actions			Responsibilities
	Points =	**DH – 7 – 11 PRUH 5 - 10**	
Emergency Department Emergency Department / SDEC's			
Action appropriate to ED escalation triggers and response			As per ED internal escalation plan
SDEC BAU			SDEC Teams
Discharge and Ward Activity			
Twice daily Consultant led board / ward rounds to identify discharges. Ward approach to board round should support review and action of the sickest, those for discharge and then other patients. Each in- patient ward to discharge a patient or transfer to discharge lounge by 10:00. Active escalations of discharge barriers to appropriate teams and services			Medical Team, led by consultant, supported by Nurse in charge
Review and rounding of outliers out of speciality. Enhanced oversight of support.			Specialty Team, led by consultant, supported by specialty bronze and Nurse in charge of impacted ward
Discharge lounge to be utilised in line with local SOP			HoN, Matron, Discharge lounge Manager
Ensure processes support scrutiny on clinical criteria to reside. Supporting timely referrals to Community capacity/@Home Services to bridge POC.			Specialty triumvirate and Discharge Team lead
Escalate supported discharge, Repatriation and Mental health placement delays			Discharge team, Therapy team, Clinical site management
Appropriate capacity escalation step in line with response level escalation			All clinical, nursing and operational teams.
Proactive patient placement to support reducing LOS in key areas i.e. AMU, SAU, embedding right patient first time on all pathways			Clinical Site Team
Review of any closed beds.			IPC and clinical site team
Prioritisation			
Elective, CEPOD and Trauma list must be prioritised to ensure patients in inpatient beds are operated on first (excluding clinical emergency)			Theatre co-ordinator with surgical speciality CD.
Specialty CD and GM to ensure all elective lists for day case procedures are supported in appropriate day case setting. No pre op bed requests for patients with no criteria to admit			Specialty CD and GM
Staffing			
Staffing to be reviewed to support step 3 of inpatient corridor care SOP in readiness of deterioation to escalation response level 2. Staffing in areas of high acuity and / or enhanced care to be adjusted to maximise required impact of boarding on patient safety			Matron/HoN, with support from Divisional DoN
Specialty Activity			
Prioritisation of referral for out of area repatriation			specialty Consultants with support from Clinical Site Management

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Red Bed Escalation - Response Level 3
All Specialities at all KCH Acute Sites

Actions			Responsibilities
	Points =	DH 12 – 17 PRUH - 11 to 17	
! All response level 2 actions, plus.. !			
Emergency Department Emergency Department / SDEC's			
Action appropriate to ED escalation triggers and response			As per ED internal escalation plan
SEDC's to consider review of returns and TCI demand reduction if ED demand available			SDEC team
Discharge and Ward Activity			
Consultant decision to admit only.			Specialty Consultants
Senior MDT involvement in discharge acceleration activity			Medical Team, led by consultant, supported by Nurse in charge - Clinical director oversight
Clear specialty recovery plans communicated through operational flow / bed meetings			Specialty reps./ bronze
Discharge lounge to be utilised in line with Local SOP. Discharge lounge team to review if criteria can be flexed to accommodate identified excluded patients			HoN, Matron, Discharge lounge Manager
COO Escalation on supported discharge delays from Discharge Acceleration meeting updates			TOC lead, Therapy Lead, Hospital director
Escalate supported discharge, Repatriation and Mental health placement delays to service leads. COO to COO escalations on delays exceeding 48hrs			Lead CSP, Heads of site operations and Hospital Director
Consider cancelation of non-urgent meetings for key staff who could provide additional support in expediting discharge.			Specialty triumvirate with support from Divisional leads
Follow capacity escalation steps appropriate to internal trigger enactment			All
Review of any closed beds.			IPC and clinical site team
Prioritisation			
Elective, CEPOD and Trauma list must be prioritised to ensure patients in inpatient beds already, are operated on first.			Specialty GM and CD
Staffing			
Staffing to be reviewed and mitigated to support indicated escalation step requirement to its full potential. Divisional A, B and C to coordinate to support shortfalls for the site.			Matron/HoN, CD, CL's with support from Divisional DoNs and Chiefs
Specialty Activity			
Prioritisation of referral for out of area repatriation. Delays escalated			Specialty Consultants with support from Clinical Site Management

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Purple Bed Escalation - Response Level 4
All Specialities at all KCH Acute Sites

Actions			Responsibilities
	Points =	**PRUH & DH - >18 >21 Capacity incident**	
! All response level 2 and 3 actions, plus !			
Operational incident command centre to be set up at level 4 when >21 points (internal incident)			Site operations
Specialty demands and discharge requirements to be shared with admitting and ward-based teams			Site operations for demands and requirements.
Mandatory cancellation of non-essential meetings to release relevant Clinical, Nursing and Operational personnel to support specialty Ward Response Team.			Divisional triumvirates and Site operations
Emergency Department Emergency Department / SDEC's			
Action appropriate to ED escalation triggers and response			As per ED internal escalation plan
Enhance pull of patients from ED to SEDC's. SDEC's to review all planned and return activity and reschedule patients where safe to do so.			SDEC team with specialty triumvirate oversight and support.
Based on demand, wait time and any compromise to IPS, allocate specialty Consultant in reach to ED.			Clinical Directors
Consultant decision to admit only.			Clinical Directors
Discharge and Ward Activity			
Senior attendance / oversight to board rounds in AMU (CL, Matron,). Senior oversight of all board round outputs			Medical Team, led by consultant, supported by Nurse in charge - Clinical Director / HoN oversight
Repatriation and Mental health placement delays to COO and ICB			Lead CSP, Heads of site operations, Hospital; Director. CDO oversight.
Specialty and divisional triumvirate reps at all operational flow / bed meetings for duration of level 4 response.			Specialty triumvirate
Escalation beds to be staffed and escalation areas opened, as per escalation steps			Divisional triumvirate
Escalation steps in line with response level requirement			Supported by divisional triumvirate.
Prioritisation			
Elective activity review of next 48hrs. Specialty to present plans to accommodate without further compromise to emergency pathways.			Specialty triumvirate and Divisional leads
Placement of elective patients to be held until emergency pathway recovery commenced			
Staffing			
Staffing to be reviewed to support optimal escalation actions area use.			Matron/HoN, with support from Divisional DoNs
Ensure staffing of appropriate escalation action for next 36 hours.			Matron/HoN, with support from Divisional DoNs
Study leave to be reviewed to staff beds across sites.			

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Appendix B – PRUH & South Sites Escalation Framework

Internal Calculator

Internal Response Calculator

Date	dd/mm/yy
Time of assessment	hh:mm

	Range
G	<5
A	≤11
R	≤17
P	18+

	G	A	R	P
	0	1	2	3
ED Internal RAG	G	A	R	P
Number receiving corridor care	0	1 to 4	5 to 10	>10
OPEL score	1	2	3	4
Critical Care	Critcon 0	Critcon 1	Critcon 2	Critcon 3
SDEC RAG	G	A	R	P
Staffing RAG (Dr + Nursing)	G	A	R	P
Expected Physical Bed allocation (next hr)	8+	5 to 7	1 to 4	0

	11
Enter Value	Score
A	1
A	1
3	3
Critcon 0	0
P	3
A	1
6	2

Trigger	Score Range
ED Internal R.A.G.	0 to 3
Corridor Care	0 to 3
O.P.E.L. Score	0 to 6
Critcon level	0 to 3
SDEC R.A.G	0 to 3
Staffing R.A.G	0 to 3
Bed allocation	0 to 6

SDEC RAG Calculator

Area	Space available	Individual RAG	RAG Score
AFAU	5	Green	1
MSDEC	3	Amber	2
SAAU	2	Red	3
Combined SDEC RAG		Amber	

Response Level 1-4

Internal Response Required	Score
Level 1	0 to 4
Level 2	5-10
Level 3	11 to 17
Level 4	18 to 21
Level 4 internal incident	>21

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Escalation Steps 1-4

Escalation Step 1: Flex beds and step 1 & 2 In-patient corridor care.

Purpose: Flex beds - To close and open beds within the established bed base of PRUH and SS.
Response 1 & 2 In-patient corridor care – to maintain consistent flow in the absence of effective discharge timings.

Enactment Criteria: Flex beds - Response level 1 and 2, in the presence of a positive bed position of >10 beds.
In-patient corridor care response 1&2 internal response levels 1 & 2.

Authorisation required: Head of Site Operations.

Division	Capacity Impact
Division B	Dynamic assessment with specialty agreement for flex
Division C	Dynamic assessment with specialty agreement for flex

Escalation Step 2: In-patient corridor care. Response level 3

Purpose: This represents step 3 of the PRUH and SS in-patient corridor care S.O.P. and is the addition of 1 -2 beds to the specified risk assessed area, described within the SOP.

Enactment Criteria: embedded within the Local SOP and will only be present in response level 3 or more.

Authorisation required: Hospital Director or equivalent. Out of hours Gold on call.

Division	Capacity Impact
Division B	Up to 20 beds
Division C	Up to 8 beds

Escalation Step 3: Mandated Double in-patient corridor care (plus 2 all Group 1 &2 areas)

Purpose: To optimise in-patient corridor care in support of patient safety compromise within the emergency pathway.

Enactment Criteria: Response level 4 at >21 points, internal capacity incident declared.

Authorisation required: Hospital Director or equivalent. Out of hours Gold on call.

Division	Capacity Impact
Division B	20 beds
Division C	8 beds

Escalation Step 4: Capacity Incident Escalation Capacity

Purpose: Planned (24hr notice) expansion to capacity in the event of a sustained capacity incident.

Enactment Criteria: Sustained capacity incident – Bed position remains at ≥ minus 40 after escalation step 3.

Authorisation required: Divisional triumvirate rep and or Hospital Director.

Division	Capacity Impact
Division B	M1 - Step 1 x6beds Step 2 x12beds
Division C	S3 - 4 beds DSU - up to 10 beds

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	Enactment trigger	Authorisation Level	Action and Areas
Step 1 - Flex beds and step 1 & 2 In-patient corridor care.	From level 1, in the presence of a positive bed position >10.	Head of Site Operations. Senior Manager on call (OOH)	• Specialty capacity demands and bed position will be documented within the duty management report • If a specialty is in a positive bed position, a request can be made to reduce bed base via flow meeting • Step 1& 2 of inpatient corridor care policy S.O.P. Step 1 – patient flow against confirmed discharges. Step 2 – patient flow against potential discharges. • See S.O.P. for inpatient corridor care actions and R&R's
Step 2 – In-patient corridor care	From level 3	Divisional Triumvirate member or Hospital Director. Gold OOH	• In-patient corridor care can be initiated 24/7, but proactive decision making during the day should be the aim to avoid patient disruption out of hours. • Risk assessed areas come in 3 groups. Group 1 are the lower risk and group 3 the highest. Clarity should be provided when authorising on which groups are included. • All areas provide 1 additional bed. • Group 1 – Farnborough Ward • Group 2 – AMU 1, AGU, M2, M3, M4, M6, M7, M8, D2, FW, HASU, S3, S4, S5, S6, • Group 3 – D1, SAU, S7, Chartwell (Group 3 spaces are for 23hr Trolleys and may not be in patient bays)
Step 3 - Mandated Double in-patient corridor care (plus 2 all Group 1&2 areas)	>21 – Response level 4 at >21 points, internal capacity incident declared.	Hospital Director or equivalent. Out of hours Gold on call.	• As above with the exception that only Group 1 and 2 should be utilised out of hours. • Any exclusions must be escalated by specialty triumvirate rep (in hours) SCSP (OOH) for sign of by Hospital Director or equivalent (in hours) or Gold (OOH – SMOC to support)
Step 4 – Sustained Capacity Incident	Capacity Incident - Bed position remains at ≥ -ve 40 after impact of escalation step 3	Hospital Director or equivalent. Out of hours Gold on call.	• Escalation areas require additional resources to open. • In the presence of enactment triggers; escalation location will be determined by individual specialty bed deficits as per DMR. • 24hrs notice to support the safe opening of areas required. • Medical ward 1 – Phased approach to opening (Step 1 = 6 beds. Step 2 = 12) beds. • Surgical 3 - 4 Beds • RSU – 2 Beds (Critical Care escalation / flex plan) • DSU - 10 beds • See policy for patient inclusion criteria for escalation areas. • Opening / Closing Ward policy

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Appendix C – Denmark Hill site escalation Framework

Internal Escalation Trigger Framework

Date	11/03/2026
Time of assessment	11:00

aticallg.

	G	A	R	P	Level 3	14
	0	1	2	3	Enter Value	Score
ED Internal RAG	G	A	R	P	A	1
Number receiving corridor care	0	1 to 4	5 to 10	>10	13	3
OPEL score	0	1	2	6	Opel 4	6
Critical Care Flow	G	A	R	P	G	0
Staffing RAG (Dr + Nursing)	G	A	R	P	A	1
Emergency Pathway flow	G	A	R	P	G	0
HASU Pathway flow	G	A	R	P	R	2
PAMI Pathway flow	G	A	R	P	A	1

	Range
G	<7
A	7-11
R	12-17
P	18+

Trigger	Score Range
ED Internal R.A.G.	0 to 3
Corridor Care	0 to 3
O.P.E.L. Score	0 to 6
Critcon level	0 to 3
Staffing R.A.G.	0 to 3
Emergency flow	0 to 6
HASU Pathway	0 to 3
PAMI Pathway	0 to 3

Internal Response Required	Score
Level 1	<7
Level 2	7 - 11
Level 3	12 - 17
Level 4	+!8
Level 4 internal incident	Sustained

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	Enactment trigger	Authorisation Level	Action and Areas
Step 1 - Flex beds	Level 1 & 2. In the presence of a positive specialty bed position. On request from Specialty Triumvirate to site	Head of Site Operations. Senior Manager on call (OOH)	• Review EPIC for specialty specific bed position • If a specialty is in a positive bed position, a request can be made to reduce bed base via flow meeting • Specialty Triumvirate agreement attained and request to site via bed meeting.
Step 2 – Next patient step against a confirmed discharge	From level 1	Lead / SCSM	• Hours of operation 08:00 – 17:30 in line with Discharge unit.. • Confirmed discharge to discharge lounge or to defined plus one space. • Alternative capacity that can support. Additional patient spaces Marjory Warren 2 beds, Kinnear Warren 1 bed, Twinning 1 bed, Lister 1 bed. Plus x2 chairs Frank Stansil, 2 chairs Frailty.
Step 3 – Next patient step against potential discharge	From Level 3	Hospital Director or equivalent. Out of hours Gold on call.	• Hours of operation 08:00 – 17:30. • Potential discharge to discharge lounge or to defined plus one space. • Defined spaces to support - Marjory Warren 2 beds, Kinnear Warren 1 bed, Twinning 1 bed, Lister 1 bed. Plus x2 chairs Frank Stansil, 2 chairs Frailty • Areas defined in plus 1 document. • Action to facilitate conversion to definite is prioritised. Bronze action owner.
Step 4 – Elective wards to support emergency flow.	From Level 4 or from specialty triumvirate directive	Hospital Director or equivalent. Out of hours Gold on call.	• Use of In the presence of enactment triggers; escalation ownership will be determined by individual specialty bed deficits. • Site operations to present number of beds to be used in support of emergency flow up to total capacity.. (total capacity - Murary Falconer – 31 beds, Coptcoat – 16 beds) • Specialty triumvirates to lead coordination of opening with Site operations support?
Step 5 – Additional patient	From Level 4	Hospital Director or equivalent. Out of hours Gold on call.	• Inpatient corridor support required. • Area to support – RDL 1 space, Frailty 1 space, Donne 1 space, Byron 1 space, Fisk and Cheer 1 space, Cotton 1 space, Sam Oram 1 space, V&A ward 1 space, David Marsden 1 space, Howard 1 space, Lister 1 space, Trundle 1 space, Elf and libra 1 space, Davidson 1 space, • Specialty teams to identify clinically safe patients for these areas in support of urgent flow and patient risk balance.
****Opening of Seasonal Pressure Escalation****	Sustained Internal triggers between red and purple	Hospital Director or equivalent. Out of hours Gold on call.	• Site Operations and divisional triumvirates to define area. • Site Operations to identify specialty to lead based on specialty bed deficits • Actions in line with opening and closing ward policy.

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Appendix D – TOR for Operational flow meetings with roles and responsibilities

Daily Operational Meeting Terms of Re

Bronze Action Card.docx

Appendix E – PRUH Site: Critical Care Escalation Plan

PRUH Critical Care Escalation Plan -Rev

Appendix F – Paediatric Escalation

Appendix G Maternity Escalation

Escalation Policy for Midwifery Services (3

Appendix H – Opening Closing ward policy

Opening and Closure of Wards ar

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Winter Planning 26/27
Board Assurance Statement (BAS)

1. Purpose
The purpose of the Board Assurance Statement is to ensure the Trust Boards has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement
Please include the Trust / Provider name at the top of the tab.
This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist
This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026.**

Winter Planning 26/27
Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down):	King's College Hospital Foundation Trust
If Other, write Provider/Trust Name:	
Contact details (email, phone number):	angela.helleur@nhs.net
Date:	

Please complete these sections

		Assurance statement	Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes		
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes		
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes		
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes		
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes		
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes		

Winter Planning 26/27
Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

				Please complete these sections	
Section B: 26/27 Winter Plan checklist			**Confirm (Y/N)**	**Additional comments or qualifications (optional)**	**Blockers/Support requirements (optional)**
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: •the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; •that both walk-in and bookable appointments are available; •that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and •the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes		
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes		
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes		
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes		
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes		
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: • coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. •executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. •targeted operational actions to reduce long discharge delays. •Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	Yes		
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes		
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes		
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes		
Capacity					
	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes		

3	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes		
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes		
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes		
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes		
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes		
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes		
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes		
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes		
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes		
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes		
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes		
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes		
Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes		
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes		
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes		
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes		

	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes		
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes		
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes		
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	Yes		
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	Yes		
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.	Yes		

BAS Self-Assessment Dashboard

Trust

Overall Assessment Rating: 5 - Full assurance

		Rating
Section B	Prevention	5 - Full assurance
	Flow, occupancy and discharge	5 - Full assurance
	Capacity and community	5 - Full assurance
	UEC Flow	5 - Full assurance
	Infection Prevention and Control (IPC)	5 - Full assurance
	Leadership and operational grip	5 - Full assurance
	Specific actions for Mental Health Trusts	5 - Full assurance

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 14

BOARD OF DIRECTORS COVER PAPER

Report to:	Board of Directors
Date of meeting:	16 September 2026
Subject:	Provider Capability Assessment
Author(s):	Siobhan Coldwell, Director of Corporate Affairs
Sponsor:	Matthew Trainer, Chief Executive Officer
History:	Annual exercise
Status:	

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

Purpose

To seek comment, feedback and approval for the attached Provider Capability Self-Assessment before its submission NHS England London Region.

Recommendations:

- The Board of Directors is asked to provide feedback on the attached self-assessment and support its submission to NHS England London Region.
- The Board of Directors is asked to provide delegated authority to the Director of Corporate Affairs to make any necessary changes ahead of submission, for sign-off by the Chair and Chief Executive.

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

Key implications

Strategic risk - Link to Board Assurance Framework	*BAF is a key support document to the self-assessment submission*
King's Improvement Impact (KIM):	
Quality Impact	*Considered in the main report.*
Health Equity Impact	*Considered in the main report.*
Workforce Impact	*Describe the implications for staffing, workforce capacity, skills, wellbeing, engagement, recruitment, retention, training or organisational culture.*
Research/Innovation Impact	*Considered in the main report.*
Digital Impact	*Considered in the main report.*
Financial Impact	*n//a*
Legal/ regulatory compliance	*This submission is a core part of NHS England's oversight framework.*
Communications and Engagement	*n/a*
Use of Artificial Intelligence Tools	*n/a*
Committee that will provide relevant oversight Board of Directors	

Main Report

As part of its approach to oversight, NHS England assesses NHS Trusts' capability. This is done using several sources of information including a self-assessment, NOF segmentation and other regulatory information e.g. CQC inspections. The self-assessment is based on the key domains highlighted in The Insightful Board document and include strategy and planning, quality of care, people and culture, access and delivery of services, productivity and value for money and financial performance and oversight.

The first provider capability assessment was carried out in 2025 and in the final assessment, the Trust was rated amber-red overall. It should be noted that the ratings used for the self-assessment have changed since last year, so it is not possible to do a direct comparison.

The document has been compiled with support from colleagues across the Trust and using evidence from external sources including CQC and internal and external audit. Although we are not required to submit evidence as part of the process, we may be required to provide it at a later date. Relevant sources of evidence are identified in each section.

Appendix 1 attached provides a detailed assessment against the domains, including proposed domain ratings, summarised as follows:

	Proposed 2026/27	**2025/26**
Strategy, Leadership and Planning	Amber Green	Compliant
Quality	Amber Green	Compliant
People and Culture	Amber Red	Partially compliant
Access and Delivery of Services	Amber Green	Partially compliant
Productivity and Value for Money	Amber-Green	Partially compliant
Financial Performance and Oversight	Amber-Green	Partially compliant

Appendix 2 provides a summary of the framework and how the ratings should be applied.

Appendix 1 Provider capability self-assessment template 2026 – King's College Hospital NHS Foundation Trust

Providers should use the form and the supporting annex to rate themselves across each domain and, following Chair and CEO sign-off, submit to their regional oversight lead by **5pm Friday October 2**.

I. Strategy, leadership and planning

Capability statements	Proposed domain rating
	Amber-Green
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners 2. **If in breach of licence:** The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE 3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan. 4. The trust is working effectively and collaboratively with its system partners and provider	**Strategy:** The Trust published its new 5-year Trust Strategy, which identifies clear strategic objectives. The development of the strategy was underpinned by extensive internal and external consultation. A core strand within the strategy is a commitment to 'strong successful partnerships, with system partners. The Trust is the Integrator for Bromley and working closely with One Bromley to develop a neighbourhood model that will support the 'left shift' outlined in the 10-year Plan. In Southwark and Lambeth, the Trust is committed to working with the integrators to support people with multiple long-term conditions at home and in their neighbourhood to reduce admissions to hospital. A framework for overseeing delivery of the strategy has been agreed, which recognises arrangements may need to be adapted in response to internal and external events. The delivery of the strategy is also underpinned by a quality improvement framework. The Board has refreshed its BAF, in line with the new strategy and is working to ensure that all risks to delivery are fully mitigated. *(supporting evidence: Trust strategy and reports to Board including partnership updates, KIM, BAF, CQC Well-Led)* **Licence:** The Trust was notified on 2nd September that all enforcement undertakings against the foundation trust licence have been removed. *(supporting evidence: Letter from NHS London)* **Board Skills and Expertise** The Board has a wide range of skills and expertise and has been strengthened with the addition of three new non-executive directors in the past 12 months. A new chief executive joined the organisation in July 2026, and recruitment is underway to replace the Chief Delivery Officer who retires later in the year. All board-level posts are substantively filled. All board members have clear objectives and have received appraisals over the past 12 months. Further work is needed to ensure succession plans are in place and that accountabilities are clear. Regular board development sessions have been delivered (5 per year). *(supporting evidence: CQC Well-Led)* **Collaboration with system partners** The Board is able to demonstrate a commitment to partnership working at system level. As above this is a core strand of the Trust strategy. There are named leads for Place partnerships and the Trust CEO and Chair are actively involved in the

collaborative for the overall good of the system(s) and population served	Acute Provider Partnership. The Board is committed to ensuring system sustainability. *(supporting evidence: CQC Well-Led, Board Reports, APC papers, Acute Services Review)*
5. The trust has an effective cyber security strategy and uses digital technology to support organisational improvement	**Cyber Security and Digital Transformation** The Board can demonstrate a clear commitment to digital transformation. In the past year the board has agreed a digital strategy and has had several board sessions aimed at ensuring there is a shared (and high) level of understand of the opportunity digital transformation offers. This includes a commitment to ensuring the full optimisation of Epic, the Trust's EPR. The Trust implemented EPIC jointly with GSTT and by the end of 2027 all acute and community providers in SE London will be on the same system. The Board recognises the threat posed by poor cyber security in its Board Assurance Framework and risk register, and there is regular consideration of the risk at Audit and Risk Committee. The Board of Directors undertakes annual information governance training and had a bespoke externally facilitated cyber security training session on 16 September 2026. (*supporting evidence: Board development material, ARC papers, BAF and risk register).*

II. Quality of care

Capability statements	Proposed domain rating **Amber-Green**
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt). 7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients 8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Regard to relevant NHSE/CQC Guidance:** The Board receives assurance through a comprehensive governance structure including Board committees, the Outstanding Care Board (OCB), Risk & Governance Committee, Divisional Quality and Governance arrangements, Integrated Quality Reports (IQR) and quality dashboards. Weekly and monthly quality audits undertaken through MEG, Quality Assurance Visits (a component of the Quality Assurance Framework (QAF)), patient feedback, complaints, outcomes data and performance metrics are triangulated to identify concerns at an early stage and support timely escalation and intervention. This enables the Board to identify and respond to areas of concern, manage quality risks and drive continuous improvement across the organisation aligned to King's Improvement Method (KIM). The Trust has established arrangements for translating national guidance, regulatory requirements and internal intelligence into quality oversight and improvement. Relevant sources include NHS England guidance and Patient Safety Alerts, CQC findings, clinical audit, PSIRF learning responses, complaints and PALS themes, patient experience information, quality visits, divisional governance and corporate risk reporting. The Integrated Quality Report (IQR) offers the Trust Board an oversight of all key metrics pertaining to the Trust's performance and ensures oversight and assurance for safety and quality. The Board recognises the weaknesses identified in the 2026 CQC Well-led assessment including inconsistency in the effectiveness of quality governance, risk management, learning and ward to Board information flows and has action plans in place to address these. (*supporting evidence: IQR, OCB and QRC papers, CQC inspections, risk register, BAF, revised quality assurance framework).* **Effective arrangements for monitoring and continually improving the quality of healthcare** The Board maintains oversight of quality through the Board Quality Committee, Integrated Quality Report, Board Assurance Framework, corporate risk reporting and escalation from the Outstanding Care Board and divisional quality and governance meetings. The Board receives patient or staff stories and Executive and Non-Executive Directors undertake clinical visits, providing qualitative intelligence alongside performance and safety information. The Trust uses clinical audit, confidential enquiries, CQC and other external reviews, incident and complaints learning, patient experience information and benchmarking to identify priorities. Divisional governance reviews actions and barriers, with escalation to Trust-level committees where delivery is off track. The Outstanding Care Board provides executive challenge on improvement, action implementation and quality risks.

	The Trust has a well-established and increasingly mature approach to risk management, underpinned by a comprehensive governance framework that provides oversight from care group through to Board level. The Trust's approach is supported by a programme of continuous improvement and external assurance. *(supporting evidence: board and quality committee papers, IQR, harm reviews, board clinical visits, OCB papers, QAF, PSIRF framework.)* **Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board** The Trust monitors patient experience through the Quality Patient Experience at King's dashboard, which brings together Friends and Family Test (FFT), complaints, PALS, involvement, demographic and other experience information. This is reported through IQR. Formal complaints and PALS concerns are reviewed for themes, timeliness and escalation. Patient and service-user involvement supports quality assessment and improvement through a range of mechanisms including Patient Expert Partners, Patient Safety Partners and Patient Outcome Partners, who contribute to selected governance meetings and improvement activities. The Board receives CQC inspection findings, survey results and associated action plans through formal governance structures. Progress against regulatory actions is monitored through divisional governance arrangements and Trust committees. While action plans are developed in response to inspection findings and national survey outcomes, there is an opportunity to strengthen Board visibility of how improvements are translated into measurable changes in patient care. The Trust also recognises the need to improve the routine presentation of information relating to inequalities in patient experience and access for people with protected characteristics and local communities, as well as enhancing triangulation of patient experience, staffing, risks, incidents and complaints to provide a more comprehensive view of quality. These areas form part of the Trust's ongoing work to strengthen quality governance, patient experience oversight and Board assurance. The Board of Directors recognises the CQC finding that patient voice is not consistently embedded in Trust wide improvement and that complaint management requires improvement. (*Supporting evidence: Annual patient experience report, CQC inspection reports and action plans, IQR, OCB and QRC papers)*

III. People and culture

Capability statements	Proposed domain rating
	Amber-Red
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience 10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels 11. Staff can express concerns in an open and constructive environment	**Staff experience and skills development** The Board has a People, Education and Inclusion Committee which regularly receives a range of information that allows it to monitor staff experience. This includes NHS staff survey data, quarterly pulse surveys, reports from the FtSU Guardian and the Guardians of Safe Working. Employee relations and EDI data is reviewed at each meeting and staff networks are invited to present to the committee. There is a staff story at 3 out of 6 board meetings per year. The Board of Directors has responded to the Government's 10 point plan to improve the lives of resident doctors. Whilst the Trust NSS scores improved significantly in 2025, the data shows the Trust is below average in many areas, and Board recognises this is an area for improvement. This was reinforced by the findings of the CQC Well-led inspection, published in July 2026. Addressing staff experience and is a key strategic priority in the new Trust Strategy. This is underpinned by a People and Culture strategy with clear strategic objectives and a 5-year delivery plan. The Board is committed to learning and development and has a wide-ranging offer in place. Statutory and Mandatory training compliance is monitored at board level, and compliance is generally good. Through the People and Culture strategy, the Board is committed to ensuring the workforce is flexible and multi-skilled and this is reflected in the BAF. **Staff can express concerns in an open and constructive manner:** The Trust has mature Freedom to Speak Up arrangements, supported by a dedicated Lead Guardian and Deputy Guardian, with clear Executive and Non-Executive leadership oversight, Board reporting and annual assurance processes. A revised Freedom to Speak Up Policy was introduced in line with national requirements and provides multiple routes through which staff, volunteers, students, contractors and agency workers can raise concerns openly, confidentially or anonymously. The policy emphasises openness, learning and psychological safety and is supported by clear escalation routes and protections for individuals raising concerns. Despite this, multiple data sources including the staff survey and the recent CQC Well-Led inspection highlighted cultural concerns. Addressing this is a core strand of the Trust's People and Culture Strategy. *(supporting evidence: PEIRC and Board papers, workforce metrics, FSUG annual report, report from the Guardian of Safe Working, People and Culture strategy and engagement plan)*

IV. Access and delivery of services

Capability statements	Proposed domain rating
	Amber-Green
12. Plans are in place to improve performance against the relevant access and waiting times standards	**Performance against relevant access and waiting times standards** A detailed demand and capacity plan is in place to ensure agreed access targets are met. This is supported by robust governance, including a newly established board-level Performance, Transformation and Improvement Committee. This committee meets monthly and reviews a wide range of operational data and commissions deep-dives into areas of concern. Supporting governance is in place within the divisions, including monthly accountability meetings at care group and divisional level. Performance is generally improving across key domains. Improvement plans are in place where necessary. The Trust has a population health strategy in place and works in partnership with system partners to address health inequalities. Improving data remains a priority. (*supporting evidence: IPR, PTI papers, Board papers, Regional oversight engagement, LMS Maternity Voices work, Southwark Maternity Commission, Population Health Strategy.*
13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients	
14. Appropriate population health targets have been agreed with the ICB	

V. Productivity and value for money

Capability statements	Proposed domain rating
	Amber-Green
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	The Board is confident that plans are in place to drive productivity improvements, aiming to reach the top 25% of most productive providers by 2029/30. The evidence supporting this assessment is: • The external auditors' review of value for money arrangements for 2025/26 highlighted that the Trust has resolved the weakness identified in 2024/25 and "has continued to demonstrate improved financial governance" and "has reduced its underlying deficit from £161m to £131.2m, representing a significant improvement". • The external auditor also noted in their report that "The Trust has arrangements in place to support improvement, including Board-level performance oversight and active engagement in system working. This includes financial governance and operational performance." • The Trust's implied productivity has been reported to the Board since 2025. It has recently added implied productivity reporting, aligned to NHS England's methodology, to care group and divisional reporting to support local identification of savings opportunities. • The Trust has achieved higher levels of implied productivity (compared with previous year) than regional peers or the provider average since March 2025. In March 2026, the Trust's corrected year to date implied productivity had improved by 3.3% relative to 2024/25, in line with London providers and above all provider (2.6%) medians. • The Trust has a 15-year financial strategy including annual CIP requirements, which is based on a comprehensive diagnostic drawing on a longitudinal study, national benchmarking, and more detailed local 'deep dives'. The initial financial strategy was approved by Trust Board in May 2025, the version updated for 2026/27 planning guidance was approved by Trust Board in May 2026. • CIP targets for each financial year are initially agreed by the Board as part of the 15-year financial strategy. They are refined as required as part of a multi-disciplinary, five-cycle annual planning process across operations, clinical, workforce and finance teams. • The diagnostic was refreshed for 2026/27 planning and is in process of being refreshed again for 2027/28. The latest version updates the financial strategy diagnostic as well as including key results from the NHSE productivity pack released to support 2026/27 planning, and the latest corporate benchmarking. • CIP is required to be recurrent, with proposed CIP projects reviewed and approved for service quality, operations, workforce and finance impact before they are approved through a gateway process, overseen by the Trust's Improvement Programme Delivery Unit, and transacted. • Progress in identifying and delivering the Trust's CIP plans is included in specific weekly reporting to the Trust Executive, and monthly finance reporting both at Trust level to the Board and at divisional and care group level. • The fortnightly King's Improvement Programme Board, chaired by the Deputy CEO, provides a forum for senior, multi-disciplinary Trust leadership to consider CIP delivery, key risks and mitigations. • The Trust delivered £50.8m recurrent CIP in 2024/25 (against £50m plan, 2.6% of opex) in 2024/25 and £71.3m in 2025/26 (against £82.4m plan, 3.5% opex), compared with 0%-1.6% opex CIP delivery from 2020/21 to 2023/24.

	• The Board is concerned about the level of CIP target which has not yet been identified and transacted in 2026/27 (£65.1m against £84.9m target as at July 2026 reporting). In order to manage the risk to the financial position all three divisions have agreed recovery plans to reduce their run-rate and control costs until additional CIP can be identified. The Trust is also taking a Financial Improvement Plan for consideration at its September 2026 Board meeting.

VI. Financial performance and oversight

Capability statements	Proposed domain rating
	Amber-Green
16. The trust has a robust financial governance framework and appropriate contract management arrangements	The Board is confident in the Trust's financial governance and oversight framework, including the management of contracts. The evidence for the Board's confidence is: • Based on significant improvements in financial governance and delivery. NHS England confirmed in May 2026 that King's had exited the Recovery Support Programme and is now in NHS Oversight Framework segment 3. • The Trust commissioned an external review of its financial governance in April 2024, which assessed the Trust's maturity as 'basic / sustainable (levels 1 and 2 out of 5 on the maturity scale). Following a comprehensive programme of improvements the external reviewers assessed the Trust level of maturity as 'integrated / advanced' in October 2025 (levels 4 and 5 out of 5 on the maturity scale). • The external auditor's report on value for money arrangements in 2025/26 confirmed that "The Trust has appropriate governance arrangements in place, with clearer financial oversight and evidence of strengthened control assurance" and gave green ratings for "ensures effective processes and systems are in place to ensure budgetary control", "ensure it makes properly informed decisions, supported by appropriate evidence and allowing for challenge", "monitors and ensures appropriate standards", and "commissions or procures services, assessing whether it is realising the expected benefits". • The internal auditor's conclusion for 2025/26 for financial reporting and management was: "Overall findings on design showed controls are effectively designed and our testing showed controls are operating effectively." with an overall rating of 'green'. • The Trust has established an ongoing quarterly financial governance and improvement programme as a 'first line of defence' and commissions an annual Internal Audit to provide external scrutiny and assurance. The programme has reported through to Risk and Governance Committee and onwards to Audit and Risk Committee from April 2025. • The Trust delivered to its financial plans in 2024/25 and 2025/26. • Monthly financial reporting includes detail of the pay run rate, including bank and agency spend and WTE, and activity to enable triangulation and focussed action where required. This has included enhanced controls on temporary staffing bookings, currently in place, with a fortnightly temporary workforce delivery group focussing on approvals for short-term bookings, retrospective bookings and annual leave management. • During the past 12 months, three minor contract disputes have been resolved, one of which related to a contract entered into by the Trust's procurement subsidiary on its behalf, and a commercial dispute relating to a major contract is close to settlement. These matters have been managed
17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes	
18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	

	through appropriate contract management, engagement and escalation routes in line with Trust delegations. • The Trust has a 5-year finance function strategy underpinned by annual objectives to drive the development of a strategic, high-performing finance team to enable strong financial management across the Trust. The team are currently seeking to obtain the highest Future Focused Finance (FFF) accreditation (Level 3) through One NHS Finance's scheme with decision due in September 2026. The Board is confident that financial risk is managed effectively and that financial considerations do not adversely affect patient care and outcomes, because: • The external auditor's value for money opinion for 2025/26 rated the Trust green (no significant weaknesses or improvement recommendations) for identifying and managing risk to financial resilience. • The Trust developed a 15-year financial strategy to return to break-even which the Board approved in May 2025, setting out the savings required to reach and maintain breakeven. This strategy was updated in 2026 to reflect the outcomes of the medium term planning round and included assessment of financial risk, with Board approval in May 2026. • The Trust's operational plans align to the financial strategy and are developed through a multi-disciplinary 4-cycle process which ensures that risks are considered across quality, performance, workforce and finance and that plans are triangulated. • Financial performance and risk is updated and considered by through the Trust's monthly financial reporting from Board to Care Group. Reporting includes detail of the pay run rate, including bank and agency spend and WTE, and activity to enable triangulation and focussed action where required. • Finance risks are also taken through the Trust's 'risk deep dive' review through Risk and Governance Committee (part one in June 2026, part 2 due October 2026), and on to Audit and Risk Committee. • Key actions in place to respond to financial risk, including: o Financial Performance Framework in place, supporting oversight of financial performance, monitored through monthly Executive-led multi-disciplinary Divisional Strategic Deployment Reviews (SDRs). o All CIP must be recurrent with proposed CIP projects reviewed for service quality, operations, workforce and finance impact before approval through a gateway process and then transaction. o Efficiency development and delivery is reported weekly to Trust Executive as well as in monthly financial reporting at Trust, Divisional and Care Group level. o Fortnightly King's Improvement Programme Board, chaired by the Deputy CEO, provides a forum for senior, multi-disciplinary Trust leadership to consider CIP delivery, key risks and mitigations. o Divisional recovery plans including financial run rate intervention in place across all divisions (phase 1 approved April 2026, phase 2 approved May 2026), responding to financial risk. • The Trust commissioned an independent review of its relationships with its subsidiaries, particularly King's Facilities

	Management, which reported in 2024. By December 2025 all of the actions had been delivered successfully and the review moved into ongoing monitoring. The Board is confident that the trust engages with its system partners well and helps to deliver the system outcome, based on the evidence below: • The external auditor's report for 2025/26 gave the Trust a 'green' rating for "ensures it delivers its role within significant partnerships and engages with stakeholders it has identified, in order to assess whether it is meeting its objectives" • The Trust is an active participant in system and wider national networks including working with other providers in SE London through the Acute Provider Collaborative: o Actively engaged in SEL ICB finance community, including membership of SEL CFOs and SEL Deputy CFOs meetings (forum to enable oversight of and system-wide response to financial risk), CFO chair of Acute Provider Collaborative Finance and Estates Group (May 2025 to July 2026) and DCFO Chair of SEL System Capital Group (from July 2026). o Increased SEL CFO oversight (move from monthly to fortnightly meetings) from January to May to support system-wide financial oversight of operational planning. o Sharing learning on King's financial recovery, including presentations to London Region CFOs (December 2024) and sharing approach directly with CFOs who have requested further information. o Active participation with One NHS Finance, including sharing of good practice developed through financial recovery, particularly related to financial governance and control (including financial reporting and financial improvement approach). o Active engagement in SEL ICB Acute Services Review (Q4 2025/26 / Q1 2026/27) to support consideration of system-wide sustainability for acute services. o CEO and CFO members of SEL System Sustainability Group. • The Trust agreed and delivered its financial plan within system envelope in 2024/25 and 2025/26. • The Board is concerned that only a minority of the CIP target for the year has been identified and transacted at this point in the year. This is being managed through divisional recovery plans to reduce the run rate, improving controls on temporary workforce and sustained focus on CIP identification.

Signed on behalf of the Board of Directors

Chair: _____

Signature: _____ Date: _____

Signed on behalf of the Board of Directors

Chief Executive: _____

Signature: _____ Date: _____

Appendix 2: Using a RAG-rating approach to derive the rating – guidance for providers

The table below sets out the approach providers should take to assess themselves across the six domains. Providers should set out, in their return template, a commentary covering the rationale behind each domain's rating, the evidence referenced in their return and improvements made since the last submission in 2025.

Note that regions will take their own views of capability across the board and will not have the level of detail that providers have – while the evidence here supports the rating it should not be considered automatic or algorithmic in every instance, rather it sets a general benchmark around different levels of capability taking account of the statements.

<table>
<tr><td colspan="2">Leadership and strategy</td></tr>
<tr><td colspan="2">Overarching expectation: the trust's board is working well as a unit to oversee the provider and has effective relationships with system partners and stakeholders. The board demonstrates the skills to oversee the delivery of safe, sustainable services, plans effectively and receives the right information to oversee performance and plan delivery as well as monitoring internal and external risk factors.</td></tr>
<tr><td>Capability statements</td><td>Indicative evidence</td></tr>
<tr><td>1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners

2. If in breach: The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE
3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan.

4. The trust is working effectively and collaboratively with its system partners and provider collaborative for</td><td>The following are indicative aspects of each level of capability but should not be seen as exhaustive

Green
• Strategy is coherent, measurable, aligned with provider's objectives and system priorities.
• If in breach: all undertakings being delivered; regulatory confidence restored and trust on track to compliance
• Board has requisite range of skills; development plans active; succession plans in place; no vacancies > 3 months; no interims > 6 months.
• Strong collaboration with local partners; joint planning; shared outcomes delivered.
• Regular board reporting on cybersecurity matters, cyber built into Board Assurance Frameworks; digital strategy embedded.
Amber-Green
• Strategy mostly aligned with the provider's objectives but lacks depth or consistent delivery.</td></tr>
</table>

the overall good of the system(s) and population served 5. The trust has an effective cyber security strategy and uses digital technology to support improvement	• **If in breach:** On track to compliance with credible plans; minor slippage only. • Skills mostly adequate; some gaps recognised and being addressed. • Good relationships with system partners but inconsistent joint delivery. • Cybersecurity is mostly well-managed, but some areas lack maturity or consistency. • Concerns from independent board governance reviews or CQC well-led findings in past 6 months that are in hand **Amber-Red** • Strategy unclear, outdated, or inconsistently applied. • **If in breach:** Behind trajectory on return to compliance; repeated slippage; weak assurance. • Significant capability gaps at board level; weak development; over-reliance on individuals. • CQC well-led 'requires improvement' • Patchy collaboration; strained relationships; siloed behaviour. • Outdated systems; weak cyber assurance; limited digital use. **Red** • No credible strategy; board direction fragmented. • **If in breach:** persistent non-compliance; enforcement actions escalating; board grip absent. • Board lacks a number of core skills; no development; unsafe capability. • CQC well-led 'Inadequate' • Board isolated; system relationships dysfunctional. • No credible cyber strategy; repeated material incidents.
Quality oversight	
Overarching expectation: the trust's board is set up for effective oversight of the quality of care it provides, monitoring safety, patient experience and using insights from third parties as appropriate. This is evidenced by robust information going to boards, a track record of high-quality care and an open, curious and enquiring approach on quality issues from executives and non-executives alike.	
Capability statements	**Indicative evidence**

6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt). 7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients 8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green** • Guidance is used effectively to drive improvements in quality of care. • Established quality governance arrangements in place; confidence in early warning systems; systems of triangulation identify issues before they become critical • Patient experience embedded in discussions around quality; concerns reach board quickly. **Amber-Green** • Mostly compliant with guidance and it is generally used to improve care; • Some gaps in the effectiveness of quality oversight e.g. escalation approaches or learning from close calls. Triangulation is used in places. • Systems in place to monitor patient experience but aren't always used consistently to escalate. **Amber-Red** • Guidance applied inconsistently • Board tends to be reactive to quality issues and actions to address issues are not consistently effective. • Limited insight into patient experience; slow escalation; weak or non-existent triangulation. **Red** • No regard for guidance; blind spots in safety and complaints. • Quality governance failing; evidence from third parties that serious risks are unmanaged. • No reliable patient experience monitoring.
People and culture	
Overarching expectation: the board has an accurate, evidence-based view of the trust's culture and improves the organisation as a place to work. This is evidenced by: staff input being collected, valued and used in board decisions; staff being able to speak up where they have concerns; and staff have access to training and other opportunities to carry out their roles as well as possible.	
Capability statements	**Indicative evidence**

9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience 10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels 11. Staff can express concerns in an open and constructive environment	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green:** • Evidence that staff feedback drives improvement; strong culture indicated by high scores in staff survey, and Staff Standards measures. • Workforce plans credible; training embedded across the organisation; safe staffing levels in place and reviewed regularly. • Strong speaking-up culture. **Amber-Green** • Feedback collected but not consistently acted on. • Staff skills are mostly adequate but there may be gaps/insufficient depth in key areas. • Generally open culture; some pockets of concern in specific areas of the staff survey. **Amber-Red** • Feedback intermittently collected or when reported is out of date; limited impact on care or management actions. • Persistent gaps in skill levels in key areas; weak/ineffective training; • Evidence that staff groups indicate fear of speaking up; insufficient insights at board level. • Persistently lowest quartile in NHS staff survey **Red** • Persistent lowest 10% in NHS staff survey • Staff feedback ignored; culture deteriorating. • Unsafe staffing; no development in staff. • Evidence of a toxic culture; concerns suppressed.
Access and delivery of services	
Overarching expectation: the board understands the drivers of delivery of core national access standards and uses this to optimise the trust's performance. The Board has extracted the maximum reasonable performance from the resources, workforce and authority available to it, and does all it can to mitigate the impact of external factors.	
Capability statements	**Indicative evidence**
12. Plans are in place to improve performance against the relevant	*The following are indicative aspects of each level of capability but should not be seen as exhaustive*

access and waiting times standards 13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients 14. Appropriate population health targets have been agreed with the ICB	**Green** • Generally delivering on trajectory vs plans. • Clear knowledge/awareness of access and care levels across local geography and demographics in order to identify and address inequalities; can demonstrate measurable improvement. • Targets aligned with system partners; joint delivery plans in place where necessary (e.g. with provider collaborative partners). **Amber-Green** • Plans credible but inconsistent delivery. • Inequalities in access/care identified; actions underway but not yet fully addressing issues. • Targets aligned with system partners; joint delivery plans in place as necessary (e.g. provider collaborative) but not fully implemented or delivering desired outcomes. **Amber-Red** • Under-delivery or deterioration in performance but board cannot demonstrate a credible plan to address it; • Underperforming local peers with no evidence of mitigating factors • Known variation in the quality of and access to services but little or no evidence of addressing them. • Limited engagement across system partners to deliver access standards. **Red** • Behind trajectory on multiple access measures with no credible plan to address. • No insights into inequalities by demographic. • No engagement with rest of system
Productivity and value for money	
Overarching expectation: the board understands how workforce, estate, asset utilisation, activity and provision of care interact at the trust to drive productivity. This is evidenced by a track record of improvements in productivity that are delivered within the wider context of quality of care and patient experience.	
Capability statement	**Indicative evidence**

15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green** • Board understands drivers of productivity and can use them to improve use of resources; provider in top 25% vs peers • Productivity improvements are discussed in the context of quality of care, patient experience and staff wellbeing **Amber-green** • Board has good insights and credible plans but has not fully extracted efficiencies • Performance vs peers flat/declining <12 months **Amber-red** • Board is aware of poor productivity and associated symptoms but has been unable to address them • Declining productivity vs peers >12 months **Red** • Board cannot explain the drivers behind poor productivity, quantify the upside or deliver improvement • Persistent bottom quartile in benchmarks vs peers
Financial performance and oversight	
Overarching expectation: the trust's board demonstrates a good financial understanding and literacy, leads the forecasting and risk management process and has a track record of overseeing the delivery of financial plans and efficiencies and offers strong challenge and insight. There is effective triangulation of workforce, activity and finance in both forward planning and in-year oversight.	
Capability statements	**Indicative evidence**
16. The trust has a robust financial governance framework and appropriate contract	*The following are indicative aspects of each level of capability but should not be seen as exhaustive:* **Green**

management arrangements 17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes 18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	• Track record of delivering financial plans 'without surprises'; cost improvement programmes are generally delivered • Executives and Non-Executives understand the drivers of the trust's financial position and the board links finance discussions to quality of care, operational demand and workforce • Financial risks are reviewed regularly at board level; • Strong links between trust and system planning functions; supports system outturn. Impact of external factors outside the board's control are minimised **Amber-Green** • Occasionally off-plan, but generally returns to plan over time and by year-end • Cost improvement programs are delivered, but below forecast • Minimal reliance on one-off mitigations to hit plans **Amber-Red** • Understands headline numbers but struggles to explain or control how underlying drivers affect financial performance. • Unplanned reliance on agency/bank staff • Has recurring forecasting inaccuracies and missing planned performance – may rely on one-off mitigations to ameliorate under-performance • Shows weak linkage between workforce, activity levels, quality of care and financial performance. **Red** • Persistent plan under-delivery, with frequent unexpected in-year deterioration in performance vs plan, and little confidence in forecasts. Consistently misses savings targets. • Unplanned reliance on agency/bank staff • Board cannot clearly articulate factors behind the organisation's financial position; weak board-level financial governance, poor scrutiny of financial information and the factors behind performance • Track record of reliance on external support, regulatory intervention or year-end bailouts; little connection with system partners on financial planning and investment

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 15.

BOARD/COMMITTEE REPORT COVER PAPER

Report to:	Public Board
Date of meeting:	16 September 2026
Subject:	Annual Review of Standing Financial Instructions
Author(s):	Mairi Bell, Director of Financial Operations
Sponsor:	Roy Clarke, Chief Financial Officer
History:	Presented to and approved by King's Executive on 24 August 2026. Presented to and approved by Audit and Risk Committee on 10 September 2026.
Status:	

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

Purpose

This paper presents the Trust's Standing Financial Instructions, updated following annual review.

Recommendations:

The Board is asked to review and approve the proposed draft of the Standing Financial Instructions.

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

Key implications

Strategic risk - Link to Board Assurance Framework	*Supports robust financial governance required to support financial performance.*
King's Improvement Impact (KIM):	*Not applicable*
Quality Impact	*Not applicable*
Health Equity Impact	*Not applicable*
Workforce Impact	*Not applicable*
Research/Innovation Impact	*Financial instructions are applicable to research areas – this is detailed within the document.*
Digital Impact	*No digital impact*
Financial Impact	*Failure to put appropriate governance in place puts the Trust's financial resources at risk.*
Legal/ regulatory compliance	*The Trust is required to have a robust set of financial instructions in place governing use of resources.*
Communications and Engagement	*Discussion with key stakeholders in Finance and Procurement teams.*
Use of Artificial Intelligence Tools	*AI has not been used*
Committee that will provide relevant oversight Audit and Risk Committee	

NHS
King's College Hospital
NHS Foundation Trust

Annual Review of Standing Financial Instructions – 2026/27

Public Board, 16th September 2026

Presentation of the updated Standing Financial Instructions following annual review.

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Annual Review of Standing Financial Instructions (SFIs)

The Trust's Standing Financial Instructions (SFIs) have undergone their annual review. The updated document is attached here as Appendix 1, and requires approval from Trust Board, following review of King's Executive / King's Management Committee and Audit Committee.

Changes made at this time are focussed on procurement areas, enhancing clarity and ensuring compliance with procurement regulation. A separate exercise has also been undertaken to more closely align SFIs of King's Facilities Management LLP (KFM) to the Trust SFIs.

Summary of Key Changes

Key changes are as follows:

- Responsibilities relating to procurement activity which are delegated to the Chief Financial Officer (section 5.10 and 5.11) have been updated, with procedures strengthened to ensure compliance with current procurement regulations.

- The Scheme of Delegation has been updated to reflect the enhanced procurement information, with specific reference to waiver processes removed and replaced with instruction on compliant procurement.

- References to King's Executive have been updated to refer to King's Management Committee. No change to the powers delegated to individuals within this group have been made.

STANDING FINANCIAL INSTRUCTIONS

King's College Hospital NHS
NHS Foundation Trust

Standing Financial Instructions August 2026

Main Document Information	
Version:	2.0
Publication Date:	
Approval Body:	Board of Directors
Approval Date:	
Document Author:	Director of Financial Operations
Responsible Executive Director:	Chief Financial Officer
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Document Change from Previous:	Standing Financial Instructions July 2025
Related Documents:	Trust Standing orders, Standards of Business Conduct Policy
Readership (Target Audience):	All Staff
Relevant External Requirements (CQC / NHSLA / HSE / IGT etc.)**:**	NHS Model Standing Financial Instructions DHSC Group Accounting Manual

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

Document Authors	
Document Owner:	Director of Financial Operations
Other Contributing Authors:	Not applicable

Consultation Distribution		
Sent To		**Date**
Group:	King's Executive Audit Committee	Sept 2024

Version Control History				
Version		**Date**	**Summary of Changes**	**Author**
		Sept 204		**Mairi Bell** **Siobhan Coldwell**
		July 2025	Updated to reflect new organisational structure	Nikki Greenwood
		July 2026	Annual review and procurement updates	Mairi Bell

Dissemination Schedule (Following Ratification)				
Target Audience	**Method of Distribution**	**Person Responsible**	**Confirmation Receipt Required?**	**Method of Replacement for Previous Version**
All staff	Kingsdocs	Finance Dept.	N/A	N/A

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

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King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

Introduction

1.1. Purpose

1.1.1. These Standing Financial Instructions (Instructions) are issued for the regulation of the conduct of the Trust, its Directors, officers, employees and agents in relation to all financial matters. The Instructions will also apply to the Trust's consolidating subsidiaries when acting on behalf of the Trust. The Board expects Trust subsidiaries to have their own documented financial governance arrangements in place for use when conducting their own business.

1.1.2. These Instructions explain the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law, Government policy and best practice to achieve probity, accuracy, economy, efficiency and effectiveness in the way in which the Trust manages public resources.

1.1.3. They identify the financial responsibilities which apply to everyone working for, and on behalf of, the Trust. They do not provide detailed procedural guidance. These statements should therefore be read in conjunction with relevant detailed departmental and financial policies and procedure notes. All policies and procedures with a financial impact must be approved by the Chief Financial Officer.

1.1.4. These instructions should be read in conjunction with the Finance pages on the Trust's Intranet which contain guidance for Trust officers on financial matters.

1.2. Authority and Compliance

1.2.1. These Standing Financial Instructions have been compiled under the authority of the Board of Directors of the Trust. They have been reviewed and approved by the Trust's Audit Committee and by the Board of Directors.

1.2.2. These Standing Financial Instructions apply to all staff, including those within hosted organisations, interim appointments and temporary contractors. The Instructions will also apply to the Trust's subsidiaries when acting on behalf of the Trust. Failure to comply may result in disciplinary action, up to and including dismissal, for Trust employees and immediate termination, without notice, of engagement for contractors.

1.2.3. Management must ensure that all employees are aware of and understand their individual financial responsibilities and the rules contained within these instructions. All employees are required to seek clarification from management where they are unsure as to the most appropriate course of action and should do so in advance of making any financial commitment on behalf of the Trust.

1.2.4. Where existing departmental rules and procedures appear to offer conflicting advice to that contained in these Instructions, it is expected that these Instructions will take precedence. However, staff are urged to bring such conflicts to the attention of the Chief Financial Officer.

1.3. Terminology

1.3.1. Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

1.3.2. "Trust" means the King's College Hospital NHS Foundation Trust;

1.3.3. "Board" means the Board of Directors of the Trust and/or relevant Board Committees.:

1.3.4. "Budget" means a resource, expressed in financial terms, approved by the Trust for the purpose of carrying out, for a specific period, any or all the functions of the Trust;

1.3.5. "Chief Executive" means the most senior executive with overall responsibility for the Trust's activities and is accountable to the Board of Directors;

1.3.6. "Chief Financial Officer" means the senior executive responsible for managing the financial actions of the Trust;

1.3.7. "Funds held on trust" shall mean monies held by the Trust, received on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

1.3.8. "Group" means King's College Hospital NHS Foundation Trust and its subsidiaries including King's Interventional Facilities Management LLP (KFM), King's Commercial Services Ltd (KCS) and King's College Hospital Management Ltd (KCH Ltd).

1.3.9. "Legal Adviser" means the properly qualified person appointed by the Trust to provide legal advice.

1.3.10. **"**NHS England (NHSE) is an arm of the Department of Health which oversees the financial performance of NHS Trusts and Foundation Trusts.

1.3.11. Wherever the title Chief Executive, Chief Financial Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.3.12. Wherever the term "employee" is used, and where the context permits, it shall be deemed to refer to all staff of the Trust including nursing and medical staff, consultants practising upon Trust premises as well as employees of third parties contracted to the Trust when acting on behalf of the Trust (i.e. temporary or contract workers). This will include KFM, when applying the Trust's procurement policy.

2. Powers of Authority and Delegation

2.1. Principles of delegated powers of authority and Schemes of Delegation

2.1.1. The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation Document adopted by the Trust. The Board of Directors have determined that they shall reserve, for their sole approval, certain financial transactions based around types or values as set out in the Scheme of Delegation. Those aside, all executive powers are invested in the Chief Executive, who in turn will provide delegated powers to relevant officers. The Chief Executive and Chief Financial Officer may, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

2.1.2. The Scheme of Delegation is a collection of schedules setting out various powers of authority by post holder. The first schedule sets out Board of Directors powers and the extent to which they are delegated to the Chief Executive and members of the King's Management Committee. Separate schedules are to be retained by each member of the King's Management Committee setting out the powers

they have themselves delegated to identified post holders within their own organisational control.

2.1.3. The Trust Executive Directors shall be responsible for ensuring that Schemes of Delegation are kept current. A full record of each Scheme of Delegation must be retained within each Executive Directorate with evidence of proper authorisation and acceptance. Copies, including amendments, must be given to the Chief Financial Officer to enable him/her to keep a record of all Schemes of Delegation for each Directorate within the Trust.

2.1.4. No officer nor employee of the Trust may delegate to anyone who is outside their organisational control.

2.2. Board of Directors

2.2.1. The Board of Directors have retained sole rights to approve all financial transactions with a value in excess of the level specified in the Scheme of Delegation (appendix 1 of this document), subject to any exclusions covered by specific delegated authority. This applies to individual transactions and to term contracts for the provision of goods, proposals to spend or generate income, procurement decisions and issuing of contracts for services or capital works over a period of time (unless the contract is such that the Trust may terminate it without financial penalty after the first year).

2.2.2. There are no exceptions to this instruction other than through the exercise of the Chairman of the Board of Directors' action. This may occur where the Chairman instructs the Chief Executive to approve such transactions where time is a critical factor in the interest of the Trust and it is not possible to consult all members of the Board of Directors. In such circumstances, the Chief Executive must provide a full report to the Board of Directors at the next available opportunity.

2.3. Chief Executive

2.3.1. The Chief Executive is the accounting officer for the Trust. This means they are accountable to Parliament for the funds administered by the Trust. The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board of Directors for ensuring that its financial obligations and targets are met. Further, the Chief Executive is recognised by Statute as the Accountable Officer of the Trust and as such is accountable to Parliament for all actions undertaken by the Trust.

2.3.2. Save for the requirements under Board of Directors powers, the Chief Executive is provided with full operational powers to approve financial transactions within the Trust and to delegate such powers to individual members of the Trust Management Executive as per the Scheme of Delegation.

2.3.3. It is the duty of the Chief Executive to ensure that existing members of the Board of Directors, officers, and all new appointees are notified of, and put in a position to understand, their responsibilities within these Instructions. The Chief Executive's duty encompasses both financial and non-financial roles.

2.4. King's Management Committee

2.4.1. Individual members of the King's Management Committee are identified as Executive Directors for the purposes of these Instructions and the associated Schemes of Delegation. The Chief Executive delegates powers to them in accordance with the relevant Scheme of Delegation to enable the efficient management of individual directorates.

2.4.2. Each Executive Director must produce, update, formally approve and retain their own Schemes of Delegation for officers within their organisational control. The list of approvers will be identified through this document and retained in Oracle, the Trust's financial system for purchasing and payment approvals.

2.5. Chief Financial Officer

2.5.1. The Chief Executive delegates powers to the Chief Financial Officer in his/her role as the Executive Director responsible for the Finance Directorate. In addition to these, the Chief Financial Officer is provided with further powers to manage the approval of financial transactions initiated by other directorates across the Trust.

2.5.2. The Chief Financial Officer is required to implement the Trust's financial policies, ensure that detailed financial procedures and systems are established and ensure that sufficient records are maintained to show and explain the Trust's transactions, to disclose the financial position of the Trust at any time.

2.5.3. The Chief Financial Officer shall prepare, document and maintain detailed financial procedures and systems incorporating the principles of separation of duties and internal checks to supplement these instructions. The Chief Financial Officer shall require in relation to any officer who carries out a financial function, that the form in which the records are kept and the way the officer discharges his/her duties shall be to the satisfaction of the Chief Financial Officer.

2.5.4. The Chief Financial Officer shall ensure that such systems and procedures are implemented to protect the Trust's assets from fraud.

3. Corporate Responsibilities of all Trust employees

3.1.1. All directors and employees, severally and collectively, are responsible for:

- the security of the property of the Trust;
- avoiding loss;
- exercising economy and efficiency in the use of resources; and
- conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

3.2. Compliance with principles of Public Sector Values

3.2.1. All employees, including directors and senior management, of the Trust must be committed to the highest standards of corporate and personal conduct in all aspects of their work within

the Trust, based on a recognition of public service values. These cannot be ignored.

3.2.2. The crucial public service values which must be understood, accepted and applied are:

- **Accountability -** everything done by those who work in the Trust must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- **Probity -** there should be an absolute standard of honesty in dealing with the assets of the Trust. Integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of Trust duties.
- **Openness -** there should be sufficient transparency about Trust activities to promote confidence between the Trust, its staff, patients and the public.
- **Selflessness** - Holders of public office should act solely in terms of the public interest.
- **Objectivity** - Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
- **Leadership** - Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

3.2.3. All employees, but particularly the Board of Directors, King's Management Committee and senior management, have a constant duty to ensure that public funds are properly safeguarded and Trust business is conducted as efficiently and effectively as possible.

3.2.4. Proper stewardship of public monies requires Value for Money to be achieved. The Board of Directors and employees must strive for this at all times.

3.2.5. Accounting, tendering and employment practices within the Trust must reflect the highest professional standards.

3.3. Compliance with rules on Gifts and Hospitality

3.3.1. Employees are required to exercise caution in all matters relating to the offering and receipt of gifts and hospitality to and from third parties. Employees must be aware of the potential risks and the public perception, however unjustified, that may arise in such circumstances.

3.3.2. The Trust's Conflict of Interest Policy and Section *8.1* of these Instructions set out the Trust's policies regarding gifts and hospitality. It is vital that employees of the Trust fully understand these policies and reflect them in their conduct at all times. It is essential that gifts and hospitality must not be offered or received in any situation or manner which may be prejudicial to the interests or reputation of the Trust.

3.3.3. Where an employee is uncertain as to the most appropriate course of action involving a gift or hospitality, the matter should be referred to the immediate line manager for guidance, consideration or approval before taking any further action. If this is not possible, there should be a refusal to make or accept any offer of a gift or hospitality which cannot be fully justified. A material breach of these instructions will be regarded as a significant disciplinary offence.

3.3.4. All staff must comply with the Trust's Anti-Bribery Policy.

3.4. Compliance with rules of delegated powers of authority

3.4.1. While the Board of Directors retain absolute authority for the conduct of the financial affairs of the Trust, it is necessary to establish a system of delegated powers to enable appropriate officers of the Trust to manage the day-to-day activities. This system of delegated powers is referred to throughout these Instructions as Schemes of Delegation. The high-level Scheme of Delegation is included as APPENDIX A – SCHEME OF DELEGATION to these Instructions. The lower-level Schemes of Delegation must be maintained by each Division/Department and copies provided to the Chief Financial Officer after each amendment.

3.4.2. It is critical that employees of the Trust understand these fundamental principles and apply them at all times. These are:

- Financial or approval powers cannot be delegated to a subordinate officer(s) in excess of the powers as set out in the Scheme of Delegation for the delegating officer.
- Powers may only be delegated to officer(s) within the organisational control of the delegating officer; in circumstances where there is no practicable alternative, the term 'officers' in this context may include individuals who are not directly employed by the Trust, such as temporary contractors.
- All powers of delegation must be provided in writing, duly authorised by the delegating officer and accepted by the receiving officer. Any variations to such delegated powers must also be in writing.
- All applications for short term powers of delegation, such as holiday cover, which are not intended to be permanent must be provided in writing by the delegating officer, with start and end dates prior to the period for which approval is sought. In the event of an anticipated event such as long-term illness or an extended period away from the office, the maximum time limit for temporary delegation is 6 months.
- Any officer wishing to approve a transaction outside their written delegated powers must in all cases refer the matter to the relevant line manager with adequate delegated powers, before any financial commitment(s) is made in respect of that transaction.
- Powers may be delegated onwards unless this is specifically prohibited by the delegator.
- Conditions or restrictions on delegated powers, e.g. not allowing onward delegation of those powers, should be reasonable in the circumstances and stated in writing.

3.4.3. Failure to comply with these principles, or a material breach thereof, will be recognised as a disciplinary offence. Where such a breach results in clear financial loss, the employee may be personally liable to compensate the Trust.

3.5. Compliance with Trust policies and procedures

3.5.1. Employees are reminded that absolute authority governing all actions within the Trust rests with the Board of Directors and that this authority is exercised through Schemes of Delegation. All employees are bound through their contracts of employment to follow the instructions of the Board of Directors and to comply with the policies and procedures that are developed and

authorised by the Trust.

3.5.2. These Standing Financial Instructions set out specific Trust policies and procedures across a number of areas. Employees must comply with these requirements at all times. Where exceptions are deemed necessary, prior approval from the relevant Executive Director must be obtained, as set out in these Instructions. Compliance will be monitored through systems controls, management review, and by audit processes. It is the responsibility of management to ensure that all employees are aware of and understand their individual responsibilities deriving from these Instructions.

3.5.3. It is neither possible nor desirable to govern all the financial affairs of the entire Trust through a single set of instructions. Therefore, these Instructions make reference in a number of areas where it is considered appropriate for the Chief Executive or the Chief Financial Officer to develop a series of detailed policies and procedures. In these instances, it is the responsibility of all employees of the Trust to ensure they understand fully the existence, contents and requirements of such policies and procedures and to comply with them on the basis that they have received full authority from the Board of Directors.

3.5.4. Guidance on the existence and relevance of policies and procedures to specific situations are available from either the Chief Executive or Chief Financial Officer. All employees are required to consult with one of these Executive Directors in situations where they are unsure as to the most appropriate course of action. Such consultation must be sought in advance of making any financial commitment on behalf of the Trust. The Board of Directors will expect all employees of the Trust to comply with these requirements and will regard a material breach as a disciplinary offence.

3.6. Safeguarding Trust resources

3.6.1. Employees of the Trust have an individual and collective responsibility for safeguarding the interests of the Trust at all times. Section *3.2* and *3.3* of these Instructions explain the general requirement for all staff to protect the reputation of the Trust as a public service organisation. This section is intended to remind Trust employees of the requirement to safeguard the financial resources of the Trust. These resources may take the obvious tangible form of fixed assets, cash or negotiable instruments, as well as less clear, or possibly intangible items such as lost or foregone income through failure to notify income sources or opportunities to earn or recover income due to the Trust.

3.6.2. Employees are directed to section *5.2* of these Instructions, which describe the responsibilities of the Chief Financial Officer with regard to income management. Employees are expected to comply with these Instructions and report all income sources promptly to the Chief Financial Officer.

3.6.3. The Chief Executive, in consultation with the Chief Financial Officer and Security personnel, will develop, maintain and monitor detailed policies, procedures and instructions covering all aspects of the security of money, assets and other Trust resources. Employees of the Trust are expected to comply fully with these requirements and to take any and all corrective action as necessary or instructed by appropriate officers of the Trust.

3.6.4. Further to this requirement, each employee has an individual and collective responsibility for the security of property and other resources of the Trust. All issues of concern or potential risk must be reported immediately to the Security department, including any concerns employees have where existing practices may represent a risk to the assets or other resources of the

Trust.

3.6.5. Any damage, beyond ordinary business, to the Trust's premises, assets, supplies or other resources must be reported immediately in accordance with the procedures for Losses and Special Payments, which shall be established by the Chief Financial Officer. These procedures must comply with guidance set out in the Department of Health and Social Care Group Accounting Manual (DHSC GAM) and the Treasury's Managing Public Money guidelines. Any employee discovering or suspecting a loss of any kind must immediately inform their Director, who must immediately inform the Chief Executive and the Chief Financial Officer.

3.6.6. In the case of suspected fraud, it must be reported to the Local Counter Fraud Specialist. This officer will then appropriately inform the Chief Financial Officer and/or Chief Executive. The Chief Financial Officer must also ensure that procedures are in place that specify the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. (These are set out in the Local Counter Fraud and Corruption policy.)

3.6.7. Where a criminal offence is suspected, the Chief Financial Officer must immediately inform the police if theft (not involving deception) or arson is involved. For losses apparently caused by theft (not involving deception), arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must notify the Board of Directors and the External Auditor.

3.6.8. The Board of Directors recognise that in extreme cases financial loss may be the result of fraud (i.e. intentional deception to secure unlawful advantage) or corruption. While the Board of Directors has every confidence in the integrity of Trust employees, it has a duty to put in place controls to minimise the opportunity for illegal appropriation of Trust resources. Accordingly, the Chief Financial Officer shall ensure that appropriate counter-fraud measures are in place, which are referred to in section 5.14 of these instructions.

3.6.9. All employees of the Trust are required to ensure they fully understand the Trust's Local Counter Fraud and Corruption Policy and the procedures for reporting suspicions or matters of possible concern. (This policy can be found on the intranet).

3.7. Patient Property

3.7.1. The Trust has a responsibility to provide safe custody for money and other personal property handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

3.7.2. Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients, and must refer to and comply with the Safe Management of Patient Property policy for detailed guidance.

4. Responsibilities of the Chief Executive

4.1. Business Plans and Estimates

4.1.1. The Chief Executive, with the assistance of the Chief Financial Officer, shall compile and submit to the Board of Directors, the Integrated Care System and NHSE strategic plans and

operational plans in accordance with the guidance issued about timing and Trust financial duties. The operational plan shall be reconcilable to an annual update of the financial pro-formas, which the Chief Financial Officer will prepare and submit to the Board of Directors and NHSE. The plan will contain:

- a statement of the significant assumptions on which it is based;
- details of major changes in workload, delivery of services or resources required to achieve the plan.
- Prior to the start of the financial year the Chief Executive will require the Chief Financial Officer to prepare and submit financial estimates and forecasts, on both revenue and capital account, for approval by the Board. As a consequence, the Chief Financial Officer shall have right of access to all budget holders on budgetary related matters. Such budgets will:
- Be in accordance with the aims and objectives set out in the service development strategy and annual business plan;
- Be in accordance with workload and manpower plans;
- Be produced following discussion with appropriate budget holders;
- Be prepared within the limits of available funds; and
- identify potential risks.

4.1.2. All budget holders must provide the Chief Financial Officer with all financial, statistical and other relevant information as necessary for the compilation of such business plans, estimates and forecasts.

4.1.3. The Chief Executive shall require the Chief Financial Officer to report to the Board of Directors any significant in-year variance from the business plan and to advise the Board of Directors on action to be taken.

4.1.4. The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them to manage their budgets successfully.

4.1.5. The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

- the amount of the budget;
- the purpose(s) of each budget heading;
- individual and group responsibilities;
- authority to exercise virement;
- achievement of planned levels of service; and

- the provision of regular reports.

4.1.6. The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

4.1.7. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

4.1.8. Non-recurring budgets should not be used against annual recurring finance expenditure without the written authority of the Chief Financial Officer.

4.2. Budgets

4.2.1. The Chief Financial Officer shall, on behalf of the Chief Executive, and in advance of the financial year to which they refer, prepare and submit budgets within the forecast limits of available resources and planning policies to the Board of Directors for approval. Budgets will be in accordance with the aims and objectives set out in the Trust's service strategy and business plan.

4.2.2. The Chief Executive shall require the Chief Financial Officer to devise and maintain systems of budgetary control. All officers whom the Board of Directors may empower to engage staff, to otherwise incur expenditure, or to collect or generate income, shall comply with the requirements of those systems. The systems of budgetary control shall incorporate the reporting of, and investigation into, financial, activity or workforce variances from budget. The Chief Financial Officer shall be responsible for providing budgetary information and advice to enable the Chief Executive and other officers to carry out their budgetary responsibilities.

4.2.3. The Chief Executive may delegate management of a budget or part of a budget to officers to permit the performance of defined activities. The Schemes of Delegation shall include a clear definition of individual and group responsibilities for control of expenditure, exercise of virement, achievement of planned levels of services and the provision of regular reports upon the discharge of those delegated functions to the Chief Executive.

4.2.4. The Chief Executive shall not exceed the budgetary or virement limits set by the Board of Directors, and officers shall not exceed the budgetary limits set for them by the Chief Executive. The Chief Executive may vary the budgetary limit of an officer within the Chief Executive's own budgetary limit.

4.2.5. Except where otherwise approved by the Chief Executive, taking account of advice of the Chief Financial Officer, budgets shall be used only for the purpose for which they were provided and any budgeted funds not required for their designated purpose shall revert to the immediate control of the Chief Executive, unless covered by delegated powers of virement.

4.2.6. Expenditure for which no provision has been made in an approved budget, and which is not subject to funding under the delegated powers of virement shall only be incurred after authorization of an approved business case.

4.2.7. The Chief Financial Officer shall keep the Chief Executive and the Board of Directors informed of the financial consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

4.2.8. The Investment Board, made up of members of the King's Management Committee, will be the forum to agree business cases for all new capital investments and increases to operating budgets for revenue spend. The Investment Board will seek Board approval for business cases that are beyond the Investment Board authority level.

4.3. Contracts for the provision of Healthcare Services

4.3.1. The Board of Directors will approve standard terms and conditions for legally binding contracts, on the basis of which the Trust will provide healthcare services. Any variations to the standard terms and conditions will be approved in accordance with the Scheme of Delegation. The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan. In carrying out these functions, the Chief Executive should take into account the advice of the Chief Financial Officer regarding:

- costing and pricing of services;
- payment terms and conditions;
- amendments to NHS service agreements and out of area arrangements.

4.3.2. NHS service agreements should be devised to minimise risk whilst maximising the Trust's opportunity to generate income, achieve activity and performance targets. The Trust will utilise the National Tariff and, subject to approval from NHSE, will engage with commissioners to agree a tariff for any services in respect of which the Trust believes that a local tariff should apply.

4.3.3. The Chief Financial Officer shall ensure that a summary of the Trust's contracts is reported annually to the Board of Directors. The Chief Financial Officer shall also produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income.

4.3.4. Any pricing of non-NHS Tariff services should be undertaken by the Chief Financial Officer in accordance with a policy and the tariff reported to the Board of Directors. In respect of non-NHS tariff income, the Council of Governors will be asked to satisfy itself that the services from which such income is derived do not interfere with the Trust's fulfilment of its principal purpose.

4.4. Capital Expenditure

4.4.1. The Chief Executive is ultimately responsible for all capital expenditure of the Trust, including expenditure on assets under construction. To discharge this duty, the Chief Executive will issue Schemes of Delegation for approval of capital commitments and will arrange for the development of detailed policies and procedures covering all aspects of capital investment management, including scheme appraisals, contract awarding, contract management and financial control.

4.4.2. The Chief Executive shall provide executive delegation to a named Senior Responsible Officer, who must be an Executive Director to manage programmes for capital works expenditure, including assets under construction, within the restrictions of the Schemes of

Delegation. The Executive Director should not be the Chief Financial Officer, in order to maintain appropriate separation of duties.

4.4.3. All expenditure on capital assets will be authorised in line with Schemes of Delegation. Any commitment in excess of the limits currently specified shall be referred firstly to the Chief Executive and then to the Board of Directors, dependent on approval required, before such commitment is made.

4.5. Tendering and Contracting

4.5.1. The Chief Executive has overall responsibility to ensure that the Trust applies the principles of Value for Money in the procurement of goods, services and capital programmes. The Chief Executive shall liaise with the Chief Financial Officer and the Director of Procurement (KFM) to develop procedures for competitive selection wherever possible in procurement exercises. The Chief Executive shall ensure that these procedures are open and clearly demonstrate fair and adequate competition wherever possible. In particular, the procedures will incorporate NHS and Trust requirements for disclosure of any commercial sponsorship offered by or received from actual or potential suppliers to the Trust.

4.5.2. The Chief Executive has delegated procedures covering the receipt, safe custody and formal opening of tenders received and appropriate records to be maintained in connection with the full tender exercise to the Chief Financial Officer and the Director of Procurement (KFM). These are set out in the Procurement Policy.

4.6. Risk Management and Insurance

4.6.1. The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board of Directors.

4.6.2. The programme of risk management shall include:

- a process for identifying and quantifying risks and potential liabilities;
- engendering among all levels of staff a positive attitude towards the control of risk;
- management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
- contingency plans to offset the impact of adverse events;
- audit arrangements including internal audit, clinical audit and health and safety review;
- arrangements to review the risk management programme.

4.6.3. The existence, integration and evaluation of the above elements will provide a basis to make statements on the effectiveness of internal control within the Annual Report and Accounts.

4.6.4. The Chief Financial Officer shall ensure that insurance arrangements exist in accordance with the risk management programme, and that documented procedures cover these arrangements.

4.7. Retention of Documents (Corporate and Financial)

4.7.1. The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with the NHS Code of Practice on Records Management. Annex D2 to the Code of Practice sets out the retention periods for Business and Corporate (Non-Health) Records. APPENDIX B summarises the retention periods for key documents and records.

4.7.2. The documents held in archives shall be capable of retrieval by authorised persons.

4.7.3. Documents held under Annex in accordance with the procedures set out in the Code of Practice and at the express instigation of the Chief Executive. Records shall be maintained of documents so destroyed.

4.7.4. The Chief Financial Officer shall provide advice on the retention of financial records.

4.8. Patients' Property

4.8.1. The Chief Executive shall ensure that there are procedures in place for informing patients or their guardians, as appropriate, before or at admission, that the Trust will not accept responsibility or liability for patients' property brought into the Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

4.8.2. The Trust has a responsibility to provide safe custody for money and other personal items (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

4.8.3. The Chief Executive is responsible for ensuring that patients or their guardians, where appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

4.8.4. The Chief Executive shall require the Chief Financial Officer, in conjunction with the Chief Nurse and Chiefs of Divisions, to provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including

instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

4.8.5. In cases where the property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

4.8.6. Where patients' property or income is received for specific purposes and held for safekeeping, the property or income shall be used only for that purpose unless any variation is approved by the donor or patient in writing.

4.9. Annual Report and Accounts

4.9.1. The Chief Executive will prepare and certify annual accounts, submit together with any report of the auditor to NHSE and for laying before Parliament.

5. Responsibilities of the Chief Financial Officer

5.1. General

5.1.1. The Chief Financial Officer is responsible for:

- implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;
- maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
- ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;
- the design, implementation and supervision of systems of internal financial control; and
- the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

All such arrangements shall comply with the NHS Provider Licence and all other relevant statutory requirements.

5.1.2. The Chief Financial Officer is responsible to ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is

authorised to obtain income are covered by these instructions.

5.1.3. The Chief Financial Officer shall require in relation to any officer who carries out a financial function, that the form in which the records are kept and the manner in which the officer discharges his/her duties shall be to the satisfaction of the Chief Financial Officer.

5.1.4. The Chief Financial Officer shall ensure appropriate arrangements are in place to pay and recover tax and shall be responsible for seeking professional advice in this regard as necessary.

5.2. Income

5.2.1. General

5.2.1.1. The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due, including from other NHS bodies. All such arrangements shall comply with the NHS Provider Licence. Systems should be in place to ensure the prompt banking of all monies received.

5.2.2. Fees and charges

5.2.2.1. The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges in line with Section 10.1 of the Scheme of Delegation other than those determined by the NHS Executive or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

5.2.2.2. All employees must inform the Chief Financial Officer promptly of monies due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

5.2.3. Debt recovery

5.2.3.1. The Chief Financial Officer is responsible for ensuring an effective credit control policy is in place across the Trust, incorporating consistent procedures for recovery of all outstanding debts due to the Trust.

5.2.3.2. Income not received and which is irrecoverable should be dealt with in accordance with write off procedures.

5.2.3.3. Procedures should be in place to minimise overpayments, but where these do occur recovery action should be initiated, subject to such action being cost effective.

5.2.4. Security of cash, cheques and other negotiable instruments

5.2.4.1. The Chief Financial Officer is responsible for:

- approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
- ordering and securely controlling any such accountable stationery;
- providing adequate facilities, procedures and systems for employees whose duties include collecting and holding cash by making available safes or lockable cash boxes, dealing with keys and coin operated machines;
- prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust. The opening of incoming post shall be performed by staff other than those responsible for cash or bank reconciliations, and financial instruments received through the post shall be entered immediately in an approved register. All cheques shall be crossed immediately and passed to the cashier, from whom a signature shall be obtained.

5.2.4.2. Trust monies shall not under any circumstances be used for the encashment of private cheques or IOU notes.

5.2.4.3. All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

5.2.4.4. The holders of safe keys shall not accept unofficial funds for depositing in Trust safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

5.3. Annual Accounts and Reports

5.3.1. The Chief Financial Officer, on behalf of the Trust, will prepare financial returns in accordance with the requirements of NHSE and the Treasury, the Trust's accounting policies and generally accepted accounting principles.

5.3.2. The Chief Financial Officer, as delegated by the Chief Executive on behalf of the Trust, will prepare and certify annual accounts and submit them together with any report from the auditor for laying before Parliament and submission to NHSE.

5.3.3. The Trust's annual accounts must be audited by an auditor appointed by the Council of Governors in accordance with the appointment process as set out in the Audit Code for NHS Foundation Trusts issued by NHSE.

5.3.4. The Trust will publish an Annual Report, in accordance with guidelines issued by NHSE. This will be presented to the Council of Governors at a general meeting and (by at least one member of the Board of Directors) to the members at the annual members' meeting. The document will include inter alia the Audited Annual Accounts of the Trust. The annual report and audited accounts will be sent to NHSE.

5.4. Bank and Government Banking Services (GBS) Accounts

5.4.1. The Chief Financial Officer is responsible for managing the Trust's banking arrangements in accordance with the policy approved by the Board of Directors and for advising the Trust on the provision of banking services and operation of accounts. This advice will reflect any guidance and directions issued from time to time by NHSE.

5.4.2. The Chief Financial Officer is responsible for all bank and GBS accounts and for establishing separate bank accounts for the Trust's non-exchequer funds.

5.4.3. The Chief Financial Officer is responsible for:

- ensuring payments made from a bank or GBS account do not exceed the credit balance on that individual account except where prior arrangements have been made;
- applying solely for an overdraft subject to another employee acting on his/her behalf within the Scheme of Delegation;
- reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

5.5. Banking Procedures

5.5.1. The Chief Financial Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

- conditions under which each bank and GBS account is to be operated;
- the limit to be applied to any overdraft; and
- those authorised to sign cheques or other orders drawn on the Trust's bank accounts

5.5.2. The Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.5.3. The Chief Financial Officer will review the banking arrangements of the Trust at regular intervals not exceeding 5 years to ensure they reflect best practice and represent best value for money. Following such reviews, the Chief Financial Officer shall determine whether or not to seek competitive tenders for the Trust's banking business.

5.5.4. Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board of Directors.

5.6. External Investments, including Joint Ventures

5.6.1. The Chief Financial Officer will produce an investment policy, in accordance with any guidance received from NHSE, for approval by the Board of Directors. The investment may

include investment of cash in approved institutions, by forming or participating in forming bodies corporate and/or otherwise acquiring membership of bodies corporate. All new external investment will require approval by the Board of Directors.

5.6.2. The policy will set out the Chief Financial Officer's responsibilities for advising the Board of Directors on investments and reporting periodically to the Board of Directors concerning the performance of investments held. It should also confirm, how the Trust will protect its interests when forming and/or acquiring membership of bodies corporate.

5.6.3. The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and the records to be maintained.

5.7. External Borrowing and Public Dividend Capital (PDC)

5.7.1. The Chief Financial Officer will advise the Board of Directors of the Trust's ability to pay interest on, the repayment of the Public Dividend Capital and any commercial borrowing within the limits set by the Trust's NHS Provider Licence and reviewed annually by NHSE. The Chief Financial Officer is also responsible for reporting periodically to the Board of Directors on the Public Dividend Capital and all loans and overdrafts.

5.7.2. Any application for a loan or overdraft will only be made by the Chief Financial Officer or by an employee acting on his/her behalf, and in accordance with the Scheme of Delegation, as appropriate. All loans and overdrafts excluding PDC will require the approval of the Board of Directors.

5.7.3. The Chief Financial Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

5.7.4. All short-term borrowings should be kept to the minimum period possible, consistent with the overall cash flow position. Any short-term borrowing requirement in excess of one month must be authorised by the Chief Financial Officer.

5.7.5. All long-term borrowing must be consistent with the plans outlined in the current Business Plan.

5.7.6. Assets protected under the NHS Provider Licence with NHSE shall not be used as collateral for borrowing. Non-protected assets will be eligible as security for a loan.

5.8. Capital Expenditure and Assets

5.8.1. The Chief Financial Officer, in conjunction with other directors as appropriate, shall be responsible for preparing detailed procedural guides for the financial management and control of expenditure on capital assets, including the maintenance of an asset register in accordance with the minimum data set as specified in the Department of Health and Social Care Group Accounting Manual (DHSC GAM) and the requirements of the NHS Provider Licence.

5.8.2. The Chief Financial Officer, shall implement procedures to comply with guidance on valuation contained within the DHSC GAM, including rules on indexation, depreciation and revaluation.

5.8.3. The Chief Financial Officer shall establish procedures covering the identification and

recording of capital additions. The financial cost of capital additions, including expenditure on assets under construction, must be clearly identified to the appropriate budget holder and be validated by reference to appropriate supporting documentation. The Chief Financial Officer shall also develop procedures covering the physical verification of assets on a periodic basis.

5.8.4. The Chief Financial Officer, in conjunction with other directors as appropriate, shall develop policies and procedures for the management and documentation of asset disposals, whether by sale, part exchange, scrap, theft or other loss. Such procedures shall include the rules on evidence and supporting documentation, the application of sales proceeds and the amendment of financial records including the asset register.

5.9. Payment of Accounts

5.9.1. The Chief Financial Officer shall be responsible for the proper payment of all accounts and claims. The Chief Financial Officer shall establish and communicate procedures to ensure that all officers provide prompt notification of all monies payable by the Trust arising from transactions which are initiated including contracts, leases, tenancy agreements and other duly authorised processes.

5.9.2. The Chief Financial Officer shall establish detailed procedures covering the approval of accounts for payment. These shall include rules on verification of invoices including confirmation of prior receipt of goods or service delivery and confirmation of prices charged and discounts offered. Where required, these procedures shall include rules for proper approval from budget holders where goods or services are obtained outside the normal ordering procedures.

5.9.3. The Chief Financial Officer shall develop procedures for the prompt payment of accounts once verified for settlement. Such procedures will include the taking of settlement discounts where offered, and rules covering independent check and security of payment transactions.

5.9.4. The Chief Financial Officer will implement procedures to retain approval of all payments made in advance of receipt of the related goods or services.

5.10. Purchasing

5.10.1. The Chief Financial Officer shall ensure the existence of detailed procedures governing the purchasing process, including the requirement to have valid purchase orders in place for all goods and services purchased.

5.10.2. The Chief Financial Officer shall advise the Board of Directors regarding the setting of thresholds above which quotations or formal tenders, ensuring compliance with the Procurement Act 2023, the Provider Selection Regime (where applicable), and all applicable UK procurement laws and regulations. These shall be set out within Schemes of Delegation.

5.10.3. The Chief Financial Officer ensure that appropriate procedural instructions are in place for the procurement of goods, services and works, incorporating the thresholds approved by the Trust and ensuring compliance with all applicable procurement legislation and regulatory requirements. Responsibility for maintaining the Trust's Procurement Policy, Procurement Procedures and associated guidance is delegated to KFM, which shall act on behalf of and under the direction of the Chief Financial Officer.

5.10.4. All procurement activity exceeding thresholds determined by the Chief Financial Officer shall be recorded within the Trust's approved procurement and contract management system. Directorates shall maintain forward procurement plans and engage with KFM sufficiently in advance to enable compliant procurement activity to be undertaken.

5.10.5. The Chief Financial Officer shall determine that no goods, services or works, other than works and services executed in accordance with a contract and purchases from petty cash, shall be ordered except by the use of the Trust's agreed requisitioning and ordering procedures, including online procedures

5.10.6. Suppliers/contractors shall be notified that orders should not be accepted unless on an official form with an authorised unique reference number (a purchase order number (PO Number)) or by agreed electronic means where this has been established. The unique reference number should be quoted on all invoices and correspondence with the Trust.

5.10.7. Official orders shall be consecutively numbered, in a form approved by the Chief Financial Officer and include such information as to description, quantity, prices or costs as may be required. The order shall incorporate the standard NHS terms and conditions.

5.10.8. Order requisitions shall be authorised only by officers with the appropriate delegated authority as set out in the Schemes of Delegation. Lists of authorised officers shall be maintained with a copy of such lists to be supplied to the Chief Financial Officer.

5.10.9. The Chief Financial Officer shall ensure that no order shall be issued for any item or items for which there is no budget provision, unless authorised by the Chief Financial Officer on behalf of the Chief Executive.

5.10.10. Where a Trust contract is in place, goods and services shall be purchased through that contract. Off-contract procurement shall only be undertaken with the prior approval from the Director of Procurement (KFM) and in accordance with the Trust's Procurement Policy. The Director of Procurement shall maintain a register of off-contract expenditure, waivers and exemptions, and shall report material matters to the Audit Committee regularly.

5.11. Tendering and Contracting – Goods and Services

5.11.1. The instructions in this section concern purchasing decisions for goods and services required where the Trust needs to enter into formal tendering and contractual arrangements.

5.11.2. This section does not cover instructions in connection with capital expenditure on works programmes, which are subject to separate instructions.

5.11.3. The Chief Financial Officer shall advise the Board of Directors on g the thresholds above which quotations or formal tenders must be obtained. Such thresholds shall comply with the Procurement Act 2023, the Provider Selection Regime (where applicable), and all other applicable statutory procurement requirements in force at the time. These shall be set out within the Scheme of Delegation.

5.11.4. The Chief Financial Officer shall establish and maintain procedures for the competitive procurement of goods, services and works where appropriate and proportionate. Such procedures shall include arrangement for the tendering of in-house services that require members of any in-house bidding team are excluded from the evaluation process. The Chief Financial Officer shall ensure that tenders are evaluated by suitably constituted panels, supported independent advice where appropriate. Procurement procedures shall promote

transparency, equal treatment, non-discrimination and value for money, in accordance with applicable legislation and regulatory requirements.

5.11.5. Where procurement services are delivered by a third party on behalf of the Trust, including KFM, such services shall be undertaken in accordance with the Trust's Standing Financial Instructions, Procurement Policy, Scheme of Delegation and any relevant procedures approved by the Chief Financial Officer.

5.11.6. The Trust has delegated procurement and contract management responsibilities to KFM or may delegate to another organisation to act on its behalf. Reference in the Scheme of Delegation to KFM officers shall be deemed to include officers exercising authority delegated by the Trust under approved contractual and governance arrangements.

5.11.7. Tenders and quotations shall be invited only from financially sound and technically competent firms. In this regard, the Chief Financial Officer shall establish and maintain procedures for the assessment of financial standing and technical capability to ensure contracts are awarded only where appropriate assurance has been obtained.

5.11.8. All procurement activity above thresholds determined by the Chief Financial Officer shall be recorded within the Trust's approved procurement and contract management system. Sufficient records shall be maintained to demonstrate compliance with applicable legislation, governance requirements and the basis for contract award decisions.

5.11.9. All procurement requirements goods, services or works shall be referred to the Trust's procurement function in accordance with the Procurement Policy. The procurement function shall determine the appropriate procurement route, taking account of applicable legislation, value, risk, urgency and the nature of the requirement.

5.11.10. Competitive procurement shall be the default approach. A non-competitive procurement route may be used only where permitted by applicable legislation and the Procurement Policy. In all cases, the rational shall be documented on the recommendation of the Procurement Board or Director of Procurement and approved in accordance with the Scheme of Delegation. Where a procurement requirement can only reasonably be supplied by a particular supplier, the justification for the procurement route selected shall be documented and approved in accordance with the Scheme of Delegation.

5.11.11. The extent to which officers may exercise procurement authority is set out in the Scheme of Delegation. The procurement function shall maintain records of direct awards, exemptions and other non-competitive procurement activity and shall report significant matters periodically to the Audit Committee.

5.11.12. The Trust shall maintain a central contract register and procurement pipeline within its approved procurement and contract management system. Contracts above thresholds determined by the Chief Financial Officer shall be recorded together with such information as may be required to support effective governance, contract management and statutory reporting obligations.

5.12. Stores

5.12.1. Subject to the responsibility of the Chief Financial Officer for approving the systems of control, the management and control of stores maintained at a departmental level shall be the responsibility of the respective Executive or Clinical Director. The day-to-day responsibility may be further delegated to departmental employees and stores managers/ keepers, subject to such delegation being authorised and recorded with a copy sent to the Chief Financial Officer. The control of Pharmaceutical stocks shall be the responsibility of a designated

Pharmaceutical Officer.

5.12.2. The Director of Supply Chain (KFM) shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, returns to stores, and losses, these procedures and systems to be approved by the Chief Financial Officer.

5.12.3. Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items, wherever held (e.g. ward or departmental cabinets) at least once a year. The Chief Financial Officer shall establish procedures for the management and control of stores held in ward and departmental cabinets, including procedures for an annual stocktake. This includes stock areas controlled by the Trust's subsidiary, KFM.

5.12.4. Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer.

5.12.5. The responsible Director/Pharmaceutical Officer shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. These officers shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

5.12.6. For goods supplied via the NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods from the distribution centre. Procedures should be in place for the Chief Financial Officer to gain assurance that the goods have been received before accepting the recharge.

5.12.7. Subject to the responsibility of the Chief Financial Officer for approving the systems of control, the management and control of goods received at and distributed from the loading bays shall be the responsibility of the Director of Supply Chain and Clinical Procurement.

5.13. Information Technology

5.13.1. The Chief Financial Officer shall be responsible for the accuracy and security of the computerised financial data of the Trust. The Chief Financial Officer shall devise and implement any necessary procedures to ensure appropriate protection of the Trust's financial data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018.

5.13.2. In terms of the Trust's financial systems, the Chief Financial Officer shall ensure that:

- appropriate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system.

- adequate controls exist such that the computer operation is separated from development, maintenance and amendment.

- adequate management (audit) trail exists through the computerised system and that computer audit reviews are carried out as considered necessary.

5.13.3. The Chief Financial Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained prior to implementation.

5.13.4. The Chief Financial Officer shall ensure that contracts for computer services for financial applications with another health organisation or other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

5.13.5. Where another health organisation or other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

5.13.6. Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall be satisfied that:

- systems acquisition, development and maintenance are in line with corporate policies including the Trust's Information Technology Strategy;
- data produced for use with the financial systems is adequate, accurate, complete and timely, and that there is a management (audit) trail;
- Chief Financial Officer's staff have access to such data;
- computer audit reviews are carried out as considered necessary.

5.14. Audit and Counter Fraud

5.14.1. Audit Committee

5.14.1.1. The Board of Directors shall establish an Audit Committee of Non-Executive Directors which will provide an independent and objective view of internal control by overseeing Internal and External Audit services, counter fraud services, reviewing financial systems, ensuring compliance with the Standing Orders and Standing Financial Instructions, and making recommendations to the Board of Directors. The Audit Committee will have appropriate terms of reference as advised by regulators, statute and good practice.

5.14.1.2. The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

5.14.1.3. Where the Audit Committee is of the opinion that there is evidence of ultra vires transactions, improper acts or if there are other important matters which the Committee wish to raise, the Chairman of the Audit Committee should do so at a full meeting of the Board of Directors. Such matters may also need to be reported to the Council of Governors and, exceptionally, to NHSE.

5.14.2. External Audit

5.14.2.1. An external auditor will be appointed and operate in accordance with current audit

regulations and has the right:

- Of access at all reasonable times to every document relating to the NHS foundation trust which appears to them necessary for the purposes of their functions.

- To require a person holding, or accountable for, any such document to give them such information and explanation as they think necessary for the purposes of their functions. If they think it necessary, they may also require the person to attend before them in person to give the information or explanation or to produce the document.

- To require any director or officer of the NHS foundation trust to give them such information or explanation as they think necessary for the purposes of their functions. If they think it necessary, they may also require the director or officer to attend before them in person to give the information or explanation.

- To examine documents held by a contractor in respect of contracts with the Trust for the purposes of examination and certification of Trust accounts.

- In respect of services contracted out by the NHS foundation trust to third parties, all contracts between the NHS foundation trust and third parties shall include a clause whereby the third party shall grant access to the auditor for the purpose of audit and certification of the NHS foundation trust accounts. The said clause shall be in the following or similar terms.

5.14.2.2. The Audit Committee shall assess annually the quality of the external audit work and the level of fees and make a recommendation to the Council of Governors about the auditors' re-appointment.

5.14.3. Internal Audit

5.14.3.1. The Chief Financial Officer will ensure that there is an adequate and effective internal audit of the Trust's systems and controls in accordance with the requirements of NHSE, including the provision of an annual opinion on the effectiveness of internal controls as set out in the current public sector internal audit regulation and guidance.

5.14.3.2. The terms of reference for the Internal Audit function will be approved by the Audit Committee and its operation will be in accordance with current public sector internal audit regulation and guidance.

5.14.3.3. A representative of the Internal Audit service provider will normally attend Audit Committee meetings and has a right of access to all Audit Committee Members, the Chairman and Chief Executive of the Trust.

5.14.3.4. The Chief Financial Officer is responsible for:

- ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control by the establishment of an internal audit function;

- ensuring that the internal audit is adequate and meets the Public Sector Internal Audit Standards;

5.14.4. Counter Fraud

5.14.4.1. The Chief Executive and Chief Financial Officer shall ensure that effective counter fraud arrangements are in place.

5.14.4.2. The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as set out in the NHS standard contract requirements and NHS Counter Fraud Authority standards for providers.

5.14.4.3. The Local Counter Fraud Specialist shall report to the Chief Financial Officer and shall work as appropriate with staff in the NHS Counter Fraud Authority.

5.14.4.4. The Chief Financial Officer is responsible for:

- deciding at what stage to involve the police in cases of misappropriation and other irregularities (subject to sections *3.6.5* and *3.5.7* of these Instructions);
- ensuring that an annual audit report is prepared for the consideration of the Audit Committee and the Board of Directors.

5.14.4.5. The report must cover:

- progress against plan for the previous year,
- all major internal financial control weaknesses discovered,
- progress on the implementation of internal audit recommendations,
- strategic audit plan covering the coming three years,
- a detailed plan for the coming year.

5.14.4.6. The Chief Financial Officer, designated auditors and counter fraud staff are entitled, without necessarily giving prior notice, to require and receive:

- access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- access at all reasonable times to any land, premises or employee of the Trust;
- the production of any cash, stores or other property of the Trust under an employee's control;
- explanations concerning any matter under investigation.

5.14.4.7. Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately.

5.15. Joint Finance Arrangements with Local Authorities

5.15.1. Payments to and arrangements with local authorities made under the powers of section 75f the NHS Act 2006 shall comply with procedures laid down by the Chief Financial Officer which shall be in accordance with the Act.

5.16. New Business Enterprise Activities and Other Significant Transactions

5.16.1. In the case of any new business enterprise activities, including significant capital expenditure, acquisitions, joint ventures, equity stakes, major property transactions, loans to external organisations, mergers and alliances, reference should be made to the guidance issued by NHSE, including but not limited to the Risk Evaluation of Investment Decisions.

5.16.2. The Chief Financial Officer shall ensure that the approval of the Board of Directors is obtained where required.

5.16.3. The Board Secretary shall ensure that NHSE is notified and that approval is obtained as required in the guidance NHSE shall issue from time to time.

6. Responsibilities of Executive Directors Regarding Capital Programmes

6.1. Control of Capital

6.1.1. The Chief Executive delegates authority to the Executive Directors to control all works capital programmes, including ad hoc purchases and capital schemes over extended periods of time. These powers and the associated financial restrictions are set out in the Schemes of Delegation.

6.1.2. All capital schemes, including estates, IT and equipment, will be subject to the procedures as set out governing control of capital programmes in the NHS and enacted through the Investment Board process at the Trust. Where appropriate, alternative measures of control deemed may be adopted by the Trust on the advice of the Chief Financial Officer, following discussion with the Chief Executive. Where material, these will be brought to the attention of the Board of Directors.

6.1.3. All capital schemes undertaken must have a fully compliant and approved business case in place prior to commencement of any works or procurement activity in connection with the scheme.

6.2. Tendering and Contracting (Capital Works)

6.2.1. Capital works procurement shall be undertaken in accordance with these Standing Financial Instructions, the Procurement Policy, applicable procurement legislation and the Scheme of Delegation. Executive Directors shall ensure that procurement activity is planned and referred to the procurement function at the earliest opportunity are required to manage capital programmes under the general procurement rules (sections *4.4*, *4.5*, *5.8* & *5.11*) contained in these instructions

6.2.2. The Chief Financial Officer shall ensure that appropriate arrangements are in place for the procurement of capital works, including assessment of supplier suitability, financial standing and technical capability. Executive Directors must comply with general requirements under these Instructions in all regards. All policies, procedures and systems established to manage capital expenditure programmes, including procurement decisions and financial transactions, must be to the satisfaction of the Chief Financial Officer who is accountable to the Chief Executive and the Board of Directors for all financial systems, records and procedures.

6.2.3. The procurement function shall maintain records of direct awards, exemptions and other non-competitive procurement activity relating to capital works and shall report significant matters periodically to the Audit Committee.

6.2.4. The Executive Director must demonstrate effective and efficient use of resources in awarding contracts, with the use of competitive selection as the default procurement route.

7. Responsibilities of the Chief People Officer

7.1. Payment of Staff

7.1.1. The Chief People Officer shall make arrangements for the provision of payroll services to the Trust, to ensure the accurate determination of pay entitlement and to enable prompt and accurate payment to employees.

7.1.2. The Chief People Officer is responsible for ensuring that the Trust meets all its obligations to HMRC in respect of income tax, national insurance and other deductions when employing individuals directly or those who may be considered as employees.

7.1.3. All pay and conditions are determined by the NHS national terms and conditions, except those for Very Senior Managers, (VSM), whose pay is agreed by the Trust's Remuneration and Appointments Committee. Managers are not permitted to deviate from these conditions, including but not limited to pay rates, enhancements or allowances otherwise than in accordance with national agreements unless the approval of the Chief Executive or Chief People Officer has been given.

7.1.4. The Chief People Officer shall be responsible for establishing procedures covering advice to managers on the prompt and accurate submission of payroll data to support the determination of pay including, where appropriate, timetables and specifications for submission of properly authorised notification of new employees, amendments to standing pay data and terminations.

7.1.5. Managers are responsible for the accuracy, completeness and timeliness of manpower or e-roster returns to the Workforce directorate. As soon as a manager becomes aware of the effective date of an employee leaving or a change in circumstances affecting pay, they must notify payroll of details immediately.

7.1.6. Recruitment must be undertaken in accordance with the Trust's recruitment policy and no positions may be filled unless there is adequate budgetary provision. Provisions for the grading of posts are set out within the relevant HR policies and must be complied with.

7.1.7. Where contractors, agency or other form of interim staff are engaged, the booking must be made using the staff bank recording system. No payment shall be made directly to an individual for services without first ensuring that their self-employment status has been verified

and evidence of the check retained.

7.1.8. For individuals providing direct services through their own limited companies, known as personal service companies, the engaging manager must liaise with the Workforce Directorate to ensure that the relevant tax compliance checks have been undertaken prior to engagement.

7.1.9. The Chief Financial Officer will issue detailed procedures covering payments to staff including rules on handling and security of bank credit payments.

7.2. Staff Expenses

7.2.1. The Chief People Officer shall be responsible for establishing procedures for the management of expense claims submitted by Trust employees. The Chief People Officer shall arrange in most cases for duly approved expense claims to be processed through the Trust payroll system, having made appropriate journal entries to the relevant budget holder cost centres. Expense claims shall be authorised in accordance with the Trust's Expenses Policy and the Trust's Scheme of Delegation.

7.2.2. Expenditure on business travel and subsistence will be managed in accordance with the Trust's Expenses Policy.

7.2.3. The Chief People Officer shall refer to the Trust's general policies on staff expenses and may reject expense claims, in whole or in part, where there are material breaches of Trust policies. In this regard, the Chief People Officer shall liaise with the Chief Executive where appropriate.

8. Specific areas of concern

8.1. Hospitality

8.1.1. The Trust's Board of Directors recognise the integrity of all Trust employees in the manner in which they carry out their duties on behalf of the Trust. The Trust policy on Hospitality, which forms part of the Conflict of Interest Policy, should be referred to.

8.1.2. These notes cover instances where employees of the Trust wish to offer *hospitality to third parties* and cases where Trust employees are offered *hospitality by third parties*.

8.1.3. All Trust employees are reminded that they are responsible for public funds. Where hospitality is offered to third parties, this shall be approved in accordance with the Schemes of Delegation having given due regard to materiality and intention. In all cases offers of hospitality to third parties must be *incidental* to bona fide meetings or seminars and must be capable of justification from critical reviews. The Chief Executive shall be responsible for ensuring all Executive Directors and Trust Management retain full records of hospitality provided, with clear explanations of the hospitality offered, the names of all Trust employees and third parties involved and the financial costs incurred by the Trust. Where the costs exceed limits set out in the Conflict of Interest Policy, the record shall also provide a justification of hospitality offered and an assessment of the benefits accruing to the Trust.

8.1.4. English Law prohibits staff from soliciting or receiving any gift, hospitality or consideration of any kind from contractors or their agents, from any organisation, firm or individual as an inducement or reward for doing or refraining from doing something in their official capacity, or showing favour or disfavour to any person in their official capacity. It shall be understood that a breach of these requirements renders employees liable not only to dismissal but to prosecution under English Law.

8.1.5. All employees must be aware of the potential risks in accepting hospitality even when in good faith. Generally, all offers of hospitality should be reported to senior management.

8.1.6. Prior approval must be obtained from a relevant line manager in accordance with Schemes of Delegation where third parties will incur travel and related costs for Trust personnel to visit their premises or attend any third party organised event.

8.1.7. In general, Executive Directors are responsible for approving applications from employees under their organisational control and in turn individual Executive Directors must obtain prior approval from the Chief Executive. In both instances, these records are maintained by the Trust Secretary and Head of Corporate Governance.

8.1.8. The Chief Executive is accountable to the Board of Directors for any applications on their own behalf.

8.1.9. The Chief Executive shall be responsible for maintaining comprehensive records of all offers of hospitality, both accepted and rejected. The record shall be in a form designed by the Trust Secretary and Head of Corporate Governance. Completed records shall be available for inspection by the Chief Financial Officer, or designated auditors, at all reasonable times.

8.2. Credit Finance arrangements including leasing commitments

8.2.1. There are no grounds where any employee of the Trust can approve any contract or transaction which binds the Trust to credit finance commitments without the clear prior authority of the Chief Financial Officer.

8.2.2. The Board of Directors has provided the Chief Financial Officer with sole authority to enter into such commitments, although these powers can be delegated to appropriate officers under his/her organisational control. Any credit finance arrangements including lease commitments above the threshold laid out in appendix 1, must be reported to the Board.

8.2.3. This Instruction applies to leasing agreements and hire purchase undertakings which must be sent to the Chief Financial Officer for prior approval. No officer of the Trust outside the organisational control of the Chief Financial Officer has any powers to approve such commitments. Failure to comply with this instruction shall be a prima facie breach of an officer's contract of employment.

8.3. Bank Accounts

8.3.1. The Chief Financial Officer has sole authority to open, operate and close accounts with banks, building societies, PayPal (or any similar organisation) and the Government Banking Service

where Trust funds are received or expended. It shall be a disciplinary offence for any officer of the Trust outside the organisational control of the Chief Financial Officer to create or operate any such account.

8.3.2. Where officers of the Trust wish to manage non-Trust funds such as ward funds or funds from donated sources, they are required to liaise with the King's College Hospital Charity who will operate the accounts on their behalf. It is not appropriate for any officer of the Trust to hold any such account in their own names as it creates a lack of openness in the handling of such funds and may allow that officer's integrity to be called into question, however unjustified that may be.

8.3.3. The only exception to the above will be where the Chief Financial Officer has authorised officers to maintain accounts which have been deemed acceptable, such as accounts for social or sports clubs. The Chief Financial Officer will maintain a register of such accounts.

8.4. Credit Cards

8.4.1. The Chief Financial Officer has sole authority to open, operate and close credit cards or corporate purchase cards held in the Trust's name. It shall be a disciplinary offence for any officer of the Trust outside the organisational control of the Chief Financial Officer to operate any such account without the direct permission of the Chief Financial Officer.

8.4.2. The Chief Financial Officer shall maintain a register of authorised credit card users.

8.4.3. The Chief Financial Officer shall put in place measures to ensure any spend on Trust credit cards has appropriate authorisation and is accurately recorded.

8.5. Financial commitments to third parties

8.5.1. These Instructions set out the rules on general purchasing and contract tendering. The above also notes the requirements with regard to credit finance commitments. The Board of Directors require that all such commitments and transactions are managed under the authority of the Chief Financial Officer for all expenditure. Within these rules are clear requirements to ensure the Trust obtains value for money and to ensure that legal commitments are properly authorised.

8.5.2. In principle, the Trust will not allow officers to operate outside these delegated powers and commit the Trust to financial obligations with third parties. Applications to do so must be passed to relevant officers as set out in the Schemes of Delegation prior to any commitment being offered to any third party.

8.6. Direct Ordering

8.6.1. In general, no officer of the Trust can order goods or services directly from suppliers. These Instructions provide clear guidance on purchasing and contract tendering which must be followed. Where officers of the Trust wish to deal directly with suppliers for the procurement

of goods and services, the prior approval of the Chief Financial Officer must be obtained on a case by case basis.

8.6.2. In exceptional circumstances, where senior officers of the Trust wish to operate direct ordering procedures, the approval of the Chief Executive must be gained. This shall include procurement of goods and services where there are legal requirements for specialist approval outside the Finance Directorate, for example the procurement of certain pharmaceutical products. All applications must be made to the Chief Financial Officer who shall pass approved applications to the Chief Executive for ratification.

8.7. Non mainstream contracts with individuals

8.7.1. Where activity is undertaken in the Trust that does not fall within mainstream responsibilities, it may be necessary to contract with individuals for these services to be supplied. In order to ensure that the correct form of contractual relationship is established, the type of contract (i.e. payable gross or subject to statutory deduction through PAYE) must be considered. This requires that the type of activity, reporting responsibilities, place of work and ability to substitute another individual to perform the duties, should all be reviewed prior to engaging or contracting for services to be delivered.

8.7.2. Hence, the contractual arrangements and the estimated expenditure must be authorised in advance at an appropriate level, in accordance with the Scheme of Delegation.

8.7.3. The Chief Financial Officer shall be responsible for establishing detailed procedures, specifying the form of contractual arrangements which will apply, covering the terms and conditions, rates of pay, and method of payment, and the monitoring and reporting arrangements.

9. Research and Development

9.1 The principles and rules contained in this document (together with other relevant polices such as those concerning gifts and hospitality) apply equally to all research and development activity at, or administered by, the Trust.

9.2 Financial probity and compliance with external requirements for the use of public funds are as applicable to R&D activities as to any other activities being undertaken within the Trust.

9.3 There are two types of R&D activity as follows; both of which are covered by this document.

(a) "Commercial R&D" - where R&D is primarily conducted for commercial purposes and funded by an external company, for example a drug trial prior to licensing

(b) "Non – Commercial R&D" – where R&D is funded by a charitable organisation, a Research Council, the Department of Health and Social Care or other government agencies.

9.4 All research and development activities within the Trust shall be notified to the relevant Medical Director. The Chief Financial Officer shall ensure that procedures are put in place to ensure that all such activities are properly accounted for and that funding is utilised appropriately.

9.5 With regards to commercial research, all dealings with industry must be authorised by the Trust's R&D Office. Under no circumstances should an individual employee enter into a contract with industry in a personal capacity to undertake research involving NHS patients. Only protocols registered with the R&D Office will be covered by the NHS indemnity arrangements. The Trust will not accept liability for any activity that has not been properly registered and managerially approved.

9.6 Researchers, supported by finance managers, should ensure that any commercial partner is financially stable, (particularly if the company is small or new) and thus in a position to fulfil their financial obligations; all contracts should include termination clauses unless specifically agreed by the relevant Medical Director.

9.7 Trust employees must follow the agreed current Trust procedures for the financial management of all applications for research funding. No application should be submitted without having been properly costed and being subject to these processes. Standard Trust processes for capital investment and business case approval should also be followed, comprehensively assessing the likely resources required (including other areas of the Trust impacted by the proposed project, such as clinical support or corporate services). These must not wholly rely upon partner organisation estimates of costs. It is important that any commitment to R&D expenditure has a funding source, and that recurrent commitments are matched with recurrent funding. This applies to all expenditure including depreciation on R&D assets that are owned by the Trust.

9.8 For commercially funded R&D, at least the full cost of the activity must be recovered for research in which the intellectual property rests entirely with the company). Where intellectual property is shared, the level of cost recovery can be reduced in line with the potential benefits, subject to the general principles within the SFIs and SoD. For commercial clinical trials the sponsoring company is expected to supply free of charge the medicine that is the subject of the trial

9.9 All proposed R&D applications must be approved in line with the normal management arrangements within the Trust.

10. USE OF FUNDING GAINED THROUGH R&D ACTIVITIES

10.1.1. Researchers do not have the authority to use the funding for other purposes other than that specifically authorised. The use of any surpluses that occur must comply with the contractual terms of the research grant/contract.

10.1.2. In some cases, if the research activity is not fully delivered, under the contractual obligations, an element of the funding will need to be returned to the external funding body and will not be retained by the Trust. Researchers must ensure that this risk is appropriately understood, underwritten and authorised by the relevant Director in the Trust before entering into the contract.

10.1.3. Payments to employees for research activities must be in line with Trust payroll procedures and no arrangements to avoid taxation liabilities should be entered into.

10.1.4. Research leads supported by finance managers must ensure that there is ongoing monitoring and control of income and costs for a grant/contract and should any income not be forthcoming, appropriate action taken.

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APPENDIX A – SCHEME OF DELEGATION

RESERVATION OF POWERS TO THE BOARD OF DIRECTORS AND DELEGATION OF POWERS

INTRODUCTION

This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation, together with tables of financial limits and approval thresholds. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Board Committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed should the need arise.

The Scheme of Delegation shows only the 'top level' of delegation within the Trust. The Scheme of Delegation is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

Nothing in this Scheme shall allow the delegation of the powers of the Board of Directors where not permitted by Statute.

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POWERS RESERVED FOR THE BOARD OF DIRECTORS

1. General Enabling Provision

1.1 The Board of Directors may determine any matter it wishes in full session within its standing orders and statutory powers.

2. Regulation and Control

2.1 Approval, suspension, variation or amendment of Standing Orders, Standing Financial Instructions, Schedule of Matters reserved to the Board of Directors, Scheme of Delegation of powers from the Board of Directors to officers, and other arrangements relating to standards of business conduct.

2.2 Specification of financial and performance reporting arrangements.

2.3 Approval of the Group's Investment and Treasury Management Policies and authorisation of institutions with which temporary cash surpluses may be held and investments made.

2.4 Requiring and receiving the declaration of Directors' Interests which may conflict with those of the Trust and determining the extent to which that Director may remain involved with the matter under consideration.

3. Appointments

Subject to the Foundation Trust Constitution:

3.1 The appointment and agreement of the terms of reference of Board Committees.

3.2 The appointment of the Deputy Chair.

3.3 Through its Remuneration Committee, the appointment, appraisal, disciplining and dismissal of Executive Directors.

4. Policy Determination

4.1 The approval of personnel policies providing for the appointment, removal and remuneration of staff, including arrangements relating to standards of business conduct (specifically, disclosure of interests, hospitality, gifts and expenses). The approval of all other policies is delegated to the King's Management Committee.

5. Direct Operational Decisions

5.1 The approval of the acquisition, disposal or change of use of land and/or buildings (subject to NHSE approval in the event that NHSE invokes the relevant provisions in the NHS Provider Licence, and any other statutory restrictions). This includes entering into leases with a capital impact above £5m (i.e. above the level delegated to the Chief Executive Officer).

5.2 The approval of transactions with a value in excess of that currently specified in the table of financial limits as requiring Board of Directors approval, and which are not covered by any specific delegated authority. Such transactions may be subject to notification and approval

from NHSE.

5.3 The approval of loans with repayment periods in excess of one year.

5.4 The agreement of action on litigation on behalf of the Trust and against the Trust, except that the authorisation of clinical negligence payments is delegated to the Chief Financial Officer.

6. Financial and Performance Planning and Reporting Arrangements

6.1 The approval of strategy, business plans and budgets.

6.2 The approval of the Trust's Annual Plan prior to submission to the Integrated Care System and NHSE.

6.3 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees and officers of the Trust.

6.4 Approval of the Trust's Annual Report, including the annual accounts, prior to submission to NHSE and the Council of Governors.

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STANDING FINANCIAL INSTRUCTIONS

Table 1: Scheme of Delegation of Powers from the Board of Directors to Officers of the Trust

REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
1	**CAPITAL PROJECTS AND ASSETS**		
1.1	Approval of capital business cases and PFI schemes, including approval of variations, (subject to recommendation by Investment Board):	Executive Directors (sponsorship of bids) Investment Board above £5m NHSE – as per regulatory thresholds	This includes bids to the Charitable Foundation. These powers may not be further delegated; in the absence of the appropriate officer authorisation must be obtained from the level above. The external referral limit will depend on the regulations currently in force.
1.2	Management of capital expenditure and assets under construction	Executive Director (Senior Responsible Officer)	All third-party expenditure, procurement activity, contract variations and contractual commitments relating to capital schemes shall be undertaken in accordance with the Trust's Procurement Policy and Standing Financial Instructions and managed through KFM acting as the Trust's procurement function. Appropriate procurement records shall be maintained within the Trust's approved procurement and contract management system.
1.3	Maintenance of the asset register	Chief Financial Officer	Day-to-day responsibility delegated to the Director of Financial Operations. The Chief Financial Officer shall obtain appropriate assurance from third parties, including Group subsidiaries and managed service providers, that asset registers are maintained, reconciled and operated in accordance with Trust policies and accounting requirements.
1.4	Approval of asset disposals: Disposal of Land and Buildings	Board of Directors – No Delegation	Finance must be informed to enable the asset register to be updated. Disposal shall be supported by appropriate records demonstrating the rationale for disposal and compliance with
	Disposal of Assets (excluding Land and Buildings) with a book value below £100,000	Chief Financial Officer	

			Trust policies.

2	**PROCUREMENT & CONTRACTS**

REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
2.1	**Procurement Procedures and Thresholds** (Estimated Total Contract Value, inclusive of VAT)	**Procurement function (KFM acting on behalf of the Chief Financial Officer)**	**Other essential requirements:** All procurement activity shall comply with the Procurement Policy, Standing Financial Instructions and Scheme of Delegation. Contract values shall be based on the total estimated value over the full term of the contract, including extensions and options. Procurement shall determine the appropriate route to market and ensure compliance with applicable procurement legislation. Contract values shall not be artificially divided or disaggregated to avoid procurement thresholds, approval requirements or governance processes.
2.1.1	**Goods, Services and Works** **Under £10,000**	Budget Holder in accordance with Table 2 Authorisation Limits, subject to compliance with the Procurement Policy	A proportionate assessment of value for money shall be undertaken. This may include a written quotation, catalogue pricing, framework pricing, benchmarking, market testing or other evidence deemed appropriate by the procurement function. Any capital expenditure exceeding £5,000 must be supported by an approved business case.
2.1.2	**Goods, Services and Works** **greater than £10,000 and below the relevant statutory procurement threshold in force at the time.**	Budget Holder in accordance with Table 2 Authorisation Limits. Procurement route to be determined by KFM Procurement.	KFM shall undertake a proportionate procurement process having regard to value, risk, complexity and applicable legislation. This may include quotations, competitive tendering, framework call-off, dynamic market, direct award or other compliant procurement routes. Publication requirements shall be managed by KFM in accordance with applicable legislation and Trust policy.

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2.1.3	**Goods and Services and Works Greater than the Relevant Statutory Procurement Threshold**	Procurement Service (KFM) to manage the procurement process and determine the appropriate route to market	Procurement activity shall be conducted in accordance with the Procurement Act 2023, the Provider Selection Regime (where applicable), the Procurement Policy and the Scheme of Delegation. Applicable notices and transparency requirements shall be managed by KFM through Find a Tender, Contracts Finder and other systems required by legislation
2.2	**Insufficient Market Response**		
2.2.1	For contracts up to Public Procurement Threshold Capital projects / Works	Head of Procurement (below FTS threshold); Director of Procurement KFM and Chief Financial Officer (above FTS threshold)	Where a procurement exercise results in an insufficient market response, KFM shall assess the outcome and document the rationale for any award recommendation. Approval of the award shall remain subject to the applicable financial approvals.
2.2.2	Goods and Services	Head of Procurement (below FTS threshold); Director of Procurement KFM and Chief Financial Officer (above FTS threshold)	

REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
2.3	**Procurement Procedures**		Procurement procedures delegated to KFM as the Trust Procurement Service.
2.3.1	Receipt of tenders	All quotations and tenders (with the exception of pharmacy goods and services) greater than £10,000 shall be administered through the Procurement Service (KFM).	Quotations and tenders shall be received electronically through the Trust's approved procurement systems. KFM shall maintain the procurement audit trail and ensure compliance with the Procurement Policy and applicable legislation.
2.3.2	Opening of tenders	All tenders, with the exception of pharmacy goods and services, shall be opened by the Procurement Service (KFM)	Tender opening shall be undertaken through the Trust's approved electronic procurement system, maintaining an appropriate audit trail.
2.3.4	Permission to consider late tenders	Head of Procurement (below statutory threshold); Director of Procurement (above statutory threshold)	Late tenders shall not normally be considered. Any decision to accept a late submission must be documented and justified.

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2.4	**Decision to award or terminate a contract, including authorisation of actions to conclude commercial terms or mitigate commercial risk:**	Executive Director / Chief Financial Officer / Investment Board / Board of Directors in accordance with the applicable financial approval limit, and on the recommendation of the Procurement Board	Contract award, extension, variation or termination shall be supported by a recommendation from the budget holder and procurement lead. Procurement assurance shall be provided by KFM. The total contract value shall include all extension options and potential contractual commitments. Relevant commercial, procurement and legal advice shall be obtained where appropriate. Authority to award a contract does not remove the requirement to comply with the Procurement Policy, Standing Financial Instructions or applicable procurement legislation. Director of Procurement
2.4.1	**For contracts up to the Public Procurement Threshold:** Capital projects / Works	Appropriate Trust Officer in accordance with Table 2 Authorisation Limits	Procurement assurance to be provided by the Head of Procurement (KFM) or delegated officer.
2.4.2	Goods and Services	Appropriate Trust Officer in accordance with Table 2 Authorisation Limits	Procurement assurance to be provided by the Head of Procurement (KFM) or delegated officer.
2.4.3	**For contracts over the Public Procurement Threshold**: Greater than £5,336,937 Capital projects / Works	Chief Financial Officer	Procurement assurance to be provided by the Director of Procurement (KFM) or delegated officer
2.4.4	Greater than £138,760 Goods and Services	Chief Financial Officer & Director of Procurement	
2.4.5	For contracts over £1,000,000:	Chief Executive	Subject to procurement assurance from KFM and any applicable Investment Board approvals

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
2.4.6	**Signing of contracts (including letters of intent)** For Clinical Services and Capital Works:	For Clinical Services and Capital Works: £25,000 and above, but less than £100,000, Directors of Operations, Directors/Medical Directors/Directors of Nursing/Deputy CFO/Directors of Finance; £100,000 and above, but less than £250,000 Executive Directors; £250,000 and above, but less than £1,000,000 Chief Financial Officer; £1,000,000 and above, but less than £5,000,000 Chief Executive; £5,000,000 and above Chief Executive on direction of the Board of Directors. For Goods and Services (provided via KFM): £10,000 - £50,000 Head of Procurement / Contracts (KFM); £50,000 – £100,000 Director of Procurement (KFM); £100,000-£500,000 Director of Procurement (KFM); £500,000 to £1,000,000 Managing Director KFM; £1,000,000+ Managing Director (KFM) & Chief Executive (KCH)	All Trust contracts of £5m and above must be sealed or executed as a deed, where, in the reasonable view of the Chief Financial Officer, there is a potential long-term liability to remain with the contractor. Subject to budget holder authorisation; subject to tender ratification and award being completed (see 2.4). Subject to budget holder authorisation, completion of the procurement process, and compliance with the IFSA, Procurement Policy, Standing Financial Instructions and Scheme of Delegation. KFM officers exercise these authorities on behalf of the Trust in accordance with the delegated responsibilities set out in the IFSA.
2.5	**Direct Awards and Other Non-Competitive Procurement Routes**	Director of Procurement (below statutory procurement threshold); Director of Finance KFM and Chief Financial Officer (above statutory procurement threshold).	All requests for goods, services and works shall be referred to KFM. KFM shall determine the appropriate procurement route and may authorise a direct award or other non-competitive procurement route where permitted by applicable legislation and supported by an objective and documented rationale.

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
2.5.1	Monitoring of Direct Awards, Non-Competitive Procurement Routes and Procurement Compliance	Audit Committee on behalf of the Board of Directors	Appropriate records shall be maintained by KFM. Summary reports covering direct awards, procurement activity, procurement compliance and other matters deemed significant shall be reported to the Audit Committee at least every six months.
2.7	**Supplier and Contract Management**		All contracts shall be subject to a proportionate contract management approach, taking account of value, risk, criticality and complexity. Contract and supplier performance shall be monitored to ensure delivery of contractual obligations, achievement of value for money and maintenance of appropriate service standards
2.7.1 2.7.2	Maintenance of Contract Register – Works Contracts	Chief Financial Officer	Maintained by the KFM Director of Finance and delegated to the Director of Procurement. The register shall record contract ownership, value, term, renewal arrangements and other information required by the Procurement Policy.
	Maintenance of Contract Register – Goods and Services Contracts	Chief Financial Officer	Maintained by the KFM Director of Finance and delegated to the Director of Procurement. The register shall record contract ownership, value, term, renewal arrangements and other information required by the Procurement Policy.
	Maintenance of Procurement Pipeline and Forward Work Plan	Chief Financial Officer	Maintained by KFM as the Trust Procurement Service. Directorates shall provide information on planned procurement activity to support procurement planning, governance and compliance.
2.8	**Approval of variations or extensions to contract:**		All proposed contract variations, modifications and extensions shall be referred to KFM for procurement assessment prior to approval. KFM shall
2.8.1 2.8.2	For contracts less than £10,000: Capital projects / Works	General Manager	
	Goods and Services	General Manager	
2.8.3	For contracts up to the Public Procurement Threshold: Capital projects / Works	Executive Director	
	Goods and Services	Executive Director	

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2.8.4 2.8.5 2.8.6 2.8.7	For contracts over the Public Procurement Threshold up to £1m: Capital projects / Works Goods and Services For contracts over £1,000,000:	 Director of Procurement (KFM) and Chief Financial Officer KFM Director of Procurement and Chief Financial Officer Chief Executive	determine whether the proposed modification is permissible under the contract and applicable procurement legislation, and advise on the appropriate procurement route where required
	For contracts over £5,000,000	Trust Board	This may be delegated to Finance and Commercial Committee.
2.8.8	Assessment of Contract Variations and Extensions	Director of Procurement (KFM)	KFM shall determine whether the proposed variation or extension is permissible under the contract, the Procurement Act 2023 (or other applicable legislation), and the Procurement Policy, and shall advise whether a new procurement exercise is required.

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2.8.8	Contract variations with KCH subsidiaries	Director of Financial Strategy, Planning and Investment	Where business cases are approved by in line with the SoD, authority is delegated to the Deputy CFO and the Chair of the Contract Management Committee for KFM to sign off the relevant contract changes with KCH subsidiaries
2.8.9	Sealing of documents	Chairman (or Deputy Chairman in the absence of the Chairman) and one Director	Subsidiary pages of Works contracts to be signed in accordance with Power of Appointment procedure

3	SERVICE AGREEMENTS FOR THE PROVISION OF HEALTHCARE		
3.1	Approval of award of healthcare contracts Less than £250,000 £250 to £1m £1m and above	 Chief Financial Officer Chief Executive Trust Board	
3.2	Approval of variations to healthcare contracts: Less than £250,000	Chief Financial Officer	Variations shall only be approved where they are permitted by the contract and applicable legislation.
	£250,000 to £1m	Chief Executive	
	£1m and above	Trust Board	
3.3	Authorisation of credit notes relating to healthcare contracts: Less than £250,000	Chief Financial Officer, delegated to the Deputy CFO	
	£250,000 and above	Chief Executive	
	£1m and above	Trust Board	

4	PURCHASING AND PAYMENTS (INCLUDING PAYROLL)		
4.1	Authorisation of internal requisitions: Less than £25,000	General Manager / Clinical Director / Head of Nursing / Deputy Director of Operations	Directorates will determine appropriate values for further delegation, which will be notified to and agreed by the Director of Financial

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
	£25,000 and above, but less than £100,000	/Medical Directors/Directors of Nursing/Deputy CFO/Directors of Finance	Operations (for the Chief Financial Officer) and recorded on the "Authorised Signatory List"
	£100,000 and above, but less than £250,000	Executive Directors	
	£250,000 and above, but less than £1,000,000	Chief Financial Officer	
	£1,000,000 and above, but less than £5,000,000	Chief Executive	
	£5,000,000 and above	Chief Executive on direction of the Board of Directors	
4.2	Authorisation of official orders	Authorised list maintained by the Director of Financial Operations (for the Chief Financial Officer)	Authorised list: "List of Trust officers permitted to authorise official orders"
4.3	Authorisation of **INVOICES** due for payment where it has not been possible to follow the normal requisitioning process: Less than £25,000	General Manager / Clinical Director / Head of Nursing / Deputy Director of Operations	See 4.1 above Authorised List: "Authorised Signatory List"
	£25,000 and above, but less than £100,000	Directors of Operations /Medical Directors/Directors of Nursing/Deputy CFO/Directors of Finance	
	£100,000 and above, but less than £250,000	Executive Directors	
	£250,000 and above, but less than £1,000,000	Chief Financial Officer	
	£1,000,000 and above, but less than £5,000,000	Chief Executive	
	£5,000,000 and above	Chief Executive on direction of the Board of Directors	
	Approval of invoices paid through national procurement process and underwritten by NHS England	Deputy CFO	Where NHS Supply Chain invoices include products ordered through the national procurement, these invoices can be paid without the formal checking process, on the basis that the risk of non-receipt will be underwritten by NHS England
4.4	Authorisation of petty cash payments	Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Management Information and Analysis (for the Chief Financial Officer).	The authorising officer must be the claimant's line manager or above Authorised List: "Authorised Signatory List"

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
4.5	Authorisation of employee expenses claims	Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Management Information and Analysis (for the Chief Financial Officer). Authorised List: "Integra Authorised Signatory List"	The authorising officer must be the claimant's line manager or above. Any expenses claimed by the Chairman shall be authorised by the Chief Executive, or by the Chief Financial Officer if payments relating to the Chief Executive are included within the claim.
4.6	Authorisation of manpower returns	Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Operations (for the Chief Financial Officer). Authorised List: "Payroll Authorised Signatory List"	The authorising officer must not be included on the return and must be senior to all staff listed on the return
4.7	Authorisation of timesheets	Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Operations (for the Chief Financial Officer). Authorised List: "Payroll Authorised Signatory List"	
4.8	Authorisation of agency timesheets and payments	Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Management Information and Analysis (for the Chief Financial Officer). Authorised List: "Integra Authorised Signatory List"	**The authorising officer must be an authorised signatory of the Trust and must have knowledge of the agreed rate and therefore the value of the timesheet being signed.**

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	PHARMACY ORDERS

REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
	Pharmacy Orders • Up to £20,000 • Up to £100,000 • Up to £500,000 • Over £500,000	 Pharmacy Stores Manager Deputy Chief Pharmacist Chief Pharmacist Chief Executive	**Pharmacy orders are processed within the EPIC system**

5	INCOME AND DEBT WRITE-OFF		
5.1	Authorisation of invoice requests	Executive Directors, Directors of Operations and Deputy Director of Operations, who will determine the extent of further delegation. These will be notified to and agreed by the Director of Financial Operations (for the Chief Financial Officer).	Authorised List: "Oracle Authorised Signatory List"
5.2	Authorisation of credit notes (non-healthcare income)	Authorised list maintained by the Director of Financial Operations	Authorised list: "List of Trust officers permitted to approve credit notes"
5.3	Authorisation of discounts	Authorised list maintained by the Director of Financial Operations	Authorised list: "List of Trust officers permitted to authorise discounts on invoices"
5.4	Authorisation to refer debts to debt collection agency	Chief Financial Officer	Process operated by Director of Financial Operations
5.5	Authorisation of debt write-off:		Threshold refers to debtor account balance proposed for write-off, not individual invoice value
	Less than £25,000	Deputy CFO or Director of Financial Operations	
	£25,000 and above but less than £50,000	Chief Financial Officer	
	£50,000 and above but less than £150,000	Chief Executive	
	£150,000 and above	Board of Directors	

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5.6	Monitoring of Debt Write-off	Audit Committee on behalf of the Board of Directors	A report must be submitted every 6 months to the Audit Committee by the Director of Financial Operations

6	LOSSES AND SPECIAL PAYMENTS		
6.1	Authorisation of losses and special payments, including ex-gratia payments:		
	Less than £5,000	Financial Controller	
	Above £5,000 but less than £25,000	Deputy CFO/Director of Financial Operations	
	Above £25,000 but less than £50,000	Chief Financial Officer	
	£50,000 and above	Board of Directors	
6.2	Authorisation of clinical negligence payments	Chief Financial Officer	
6.3	Monitoring of losses and special payments	Audit Committee	A report must be submitted annually to the Audit Committee by the Director of Financial Operations
6.4	Authorisation of early retirement, redundancy and other termination payments to staff:		All payments should be checked with HR with respect to regulations of these payments by HM Treasury and the NHS regulator. The Board must be notified of any payment requiring external approval.
	Less than £20,000	Directors of Operations	
	£20,000 and above, but less than £50,000	Chief Financial Officer	
	£50,000 and above,	Chief Executive	

7	BUDGETARY CONTROL		
7.1	Delegation of budgets	Chief Executive and Chief Financial Officer	
7.2	Approval of virements (budget transfers): - Within a budget and within a budget type (pay, non-pay or income) - Between pay and non-pay authorised control totals	Budget holder and Director of Financial Management Information and Analysis Chief Delivery Officer, Chief Financial Officer and Chief People Officer	

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7.3	Approval of transfers from reserves	Chief Financial Officer	Managed by Deputy CFO/Director of Financial Management Information and Analysis

8	**STORES**		
8.1	Management and control of stores: - Warehouse, Receipt & Distribution - Pharmacy - Other Stores	- Director of Supply Chain (KFM) - Chief Pharmacist - Director of Operations or Executive Director	

9	**BANK ACCOUNTS AND PAYMENT METHODS**		
9.1	Opening of bank accounts	Chief Financial Officer	Managed by Director of Financial Operations
9.2	Signing of cheques for cash, signing of other cheques, and authorisation of CHAPs payments & BACs payment schedules	Authorised signatory list: "Authorisation of Payments from Trust Bank Accounts"	Lists to be maintained by the Director of Financial Operations and approved by the Chief Financial Officer

10	**FEES AND CHARGES**		
10.1	Approval of fees and charges		

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	Setting Fees, Charges and agreeing patient service contracts Private Patient, Overseas Visitors, Income Generation, Trust sponsorship and other patient related services • Setting fees and charges for contracts up to £100,000 per annum • Setting fees and charges for contracts over £100,000 per annum	Deputy CFO Chief Financial Officer	
	Price of NHS Contracts • Setting fees and charges for contracts up to £100,000 per annum • Setting fees and charges for contracts over £100,000 per annum	Deputy CFO Chief Financial Officer	

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	Rental Agreements • Where annual charge does not exceed £10,000 and/or term does not exceed five years; • Where annual charge exceeds £10,000 and/or term exceeds 5 years • Where annual charge exceeds £100,000 and/or term exceeds 10 years • Where annual charge exceeds £250,000 and/or term exceeds 15 years •	Deputy CFO Chief Financial Officer Chief Executive Board of Directors	

11	STANDARDS OF BUSINESS CONDUCT		
11.1	Maintenance of the register of interests:		Maintained by the Foundation Trust Office
	Board of Directors and Trust Management	Chief Executive	
	Other Staff	Executive Directors / Divisional Directors of Operations	
11.2	Maintenance of gifts and hospitality registers:		Maintained by the Foundation Trust Office
	Executive Board of Directors and Trust Management	Chief Executive	
	Other Staff	Executive Directors / Divisional Directors of Operations	
11.3	Monitoring of gifts and hospitality registers	Audit Committee on behalf of the Board	To report annually to the Audit Committee

12	INSURANCE		
12.1	Insurance arrangements	Chief Financial Officer	Managed by Director of Financial Strategy, Planning and Investment

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13	FRAUD AND IRREGULARITY		
13.1	Counter fraud and corruption work in accordance with the NHS standard contract and NHS Counter Fraud Authority standards for providers.	Chief Financial Officer (Delegated to Director of Financial Operations)	In liaison with Local Counter Fraud Specialist and the NHS Counter Fraud Authority as appropriate
13.2	Investigation of suspected cases of irregularity not related to fraud or corruption	Chief Financial Officer	Process operated by Head of Security

14	INVESTMENTS		
14.1	Approval of Treasury Management Policy	Board of Directors	
14.2	Investment decisions	Board of Directors	Process operated by Director of Financial Operations (related to cash investments)

15	BORROWING		
15.1	Approval of loans:		
	Loans with repayment periods of over one year	Board of Directors	
	Loans with repayment periods of less than one year	Chief Executive	Managed by Director of Financial Operations

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Table 2: Oracle Authorisation Matrix – Delegation Limits

Level	Staff Group	Max Approval Level
Level 4	General Manager / Clinical Director / Head of Nursing / Deputy Director of Operations	£25,000
Level 3	Director of Operations / Medical Director / Director of Nursing / Deputy CFO / Director of Financial Operations / Director of Capital, Estates & Facilities / Hospital Director	£100,000
Level 2	Chief of Division / Deputy Chief Delivery Officer	£150,000
Level 1	Executive Directors	£250,000
Level 0	Chief Financial Officer	£1,000,000
Level 0	Chief Executive	Unlimited, subject to any approvals reserved to the Board of Directors*

* This relates to payment of invoices and raising POs, not the decision to spend.
** Any orders above £5m requires Board approval prior to sign-off.
*** Financial approval limits relate to the authority to approve expenditure within Oracle. They do not remove the requirement to comply with the Procurement Policy, Standing Financial Instructions, Scheme of Delegation, Investment Approval Process or any applicable procurement legislation.

Note that all new investment decisions need to be approved via the Investment process.

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Table 3: Required Number of Quotes and Tenders

The estimated contract value shall be calculated over the total anticipated term of the contract, including all extension options, and in accordance with the Procurement Act 2023 and the Trust Procurement Policy. Contract values shall not be artificially divided to avoid procurement thresholds or approval requirements.

Limits	Staff Group
Under £10,000	A proportionate assessment of value for money shall be undertaken. The procurement route shall be determined by KFM where procurement support is required.
£10,000 up to the relevant statutory procurement threshold	KFM shall determine the most appropriate procurement route, which may include quotations, framework call-off, dynamic market, competitive procedure or other compliant procurement route.
Above the relevant statutory procurement threshold	Procurement to be undertaken by KFM in accordance with the Procurement Act 2023, applicable procurement legislation and the Trust Procurement Policy. Required notices and transparency obligations shall be managed by KFM.

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APPENDIX B

Summary of Minimum retention periods for records

(For full details see Annex D2 of the NHS Records Management Code of Practice. The following table is subject to the provisions of the NHS Records Management Code of Practice, as may be amended from time to time.)

No.	Class of Document	Retention Period
	FINANCIAL	
1.	Salaries and Wages Records	10 Years after the end of the financial year to which they relate.
2.	Pay sheets and records of unpaid salaries and wages.	6 years after the end of the financial year to which they relate.
3.	Copies of forms SD55 (ADP) and SD55J	10 Years after the end of the financial year to which they relate.
4.	Principal ledger records including cashbook, ledgers and journals.	6 Years after the end of the financial year to which they relate.
5.	Bills, Receipts and Cleared Cheques.	6 Years after the end of the financial year to which they relate.
6.	Debtors Records.	2 years after the end of the financial year in which they are paid or are written off, but at least 6 years in respect of any unpaid account which has not yet been written off.
7.	Creditor Payments Records	3 Years after the end of the financial year to which they relate.
8.	Requisitions	1.5 years after the end of the financial year to which they relate.
9.	Minor accounting records; passbooks, bank statements, deposit slips, cheques; petty cash expenditure accounts, travel and subsistence records, minor vouchers, duplicate receipt books etc.	2 years after the end of the financial year to which they relate.
10.	Cost accounts prepared in accordance with the directions of the Secretary of State or at the request of the department.	3 years after the end of the financial year to which they relate.
11.	Tax Forms	6 years after the end of the financial year to which they relate.
12.	V.A.T Records	6 years after the end of the financial year to which they relate.
13.	Budgets	2 years from the completion of the audit.
14.	Major establishment records including personal files, letters or appointments, contract references and related correspondence and records of leave.	6 years after the officer leaves the services of the hospital or on the date on which the officer would reach the age of 70, whichever is the later. Provided that if an adequate summary of the personal and health record is kept for this period, the main records may be destroyed after the officer leaves the hospital's service.
15.	Minor establishment records e.g. leave records, timesheets	2 years from the completion of the audit.
16.	Stores Records - Major (Stores Ledger Etc.)	6 years after the end of the financial year to which they relate.

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17.	Stores Records – Minor (requisitions, issue notes, transfer vouchers, goods received books, delivery notes etc)	1.5 years after the end of the financial year to which they relate.
18.	Audit Reports.	2 years after the formal clearance by the appointed auditor.
19.	Accounts – Annual (Final - One set only)	Permanent
20.	Accounts – Working Papers	3 years after the end of the financial year to which they relate.
21.	Documents other than those of permanent relevance in relation to trust funds and the terms of any trusts administered by health authorities.	6 years after the financial year in which the trust monies are finally spent or the gift in kind was accepted.

	NON-FINANCIAL	
22.	Property Acquisitions / Disposal Records	Permanent
23.	Buildings and engineering works, inclusive of projects abandoned or deferred - key records (e.g. final accounts, surveys, site plans, bills of quantities)	Permanent
24.	Contracts – non sealed (other) on termination	6 years after the expiry date of the contract.
25.	Contracts – sealed and associated records	6 years after end of contract
26.	Tenders - Unsuccessful	6 years after award/decision or end of contract.
27.	Inventories (not in current use) of items having a life of less than 5 years	1.5 years after the end of the financial year to which they relate
28.	Records of custody and transfer of keys.	1.5 years after the end of the financial year to which they relate.
29.	Patient activity data	3 years after the end of the financial year to which they relate.
30.	Procurement documentation (business cases, evaluation reports, clarification questions, procurement file)	6 years after completion of the procurement or end of the financial year
31.	Contract register / approved supplier records	Retain while current, then retain the superseded version for an appropriate period

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AGENDA ITEM: 16.

BOARD/COMMITTEE REPORT COVER PAPER

Report to:	Board of Directors
Date of meeting:	16 September 2026
Subject:	**Maternity & Neonatal Quality & Safety Integrated Report (June-July 2026)**
Author(s):	Mitra Bakhtiari, Director of Midwifery/Gynaecology Nursing Dr Lisa Long, Clinical Director Women's Health
Sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery
History:	Divisional Quality and safety, Women's Care Group maternity governance
Status:	

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

Purpose

This report is submitted to provide oversight of maternity service across KCH and to escalate for review as required.

Recommendations:

The board is asked to discuss the report for evidence and assurance of the MATNEO service and the Maternity incentive Scheme MIS (year 8) for board recommendation.

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**	

Appendixes 1, 2, 3, 4, 6, 7, 8, 11, and 12 are in the reading room on diligent.

Key implications

Strategic risk - Link to Board Assurance Framework	*BAF 2 7 8*
King's Improvement Impact (KIM):	The report reflects KIM by demonstrating learning from data, feedback, measuring progress through KPIs, to enhance maternity and neonatal care quality and safety
Quality Impact	Board Safety Champions oversight
Health Equity Impact	Perinatal culture leadership, improving culture in maternity and neonatal services, supporting the equality assessment, and creating inclusive environment.
Workforce Impact	Triangulation of workforce metrics that supports high quality and safer maternity and neonatal care as well as consistent standards of care through learning from incidents, training and best practice, and ongoing monitoring of implementation and outcomes.
Research/Innovation Impact	Women's health research studies support service improvement and innovation within maternity services and learning from national education and shared learning across the multidisciplinary team and for further research, innovation and improvement.
Digital Impact	digital transformation using digital platforms for evidence submission, data collection and monitoring
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	Minimal AI tools have been used in line with trust policy
Committee that will provide relevant oversight KMC, Quality & Research Committee	

1. Executive Summary

- **Regional assurance:** The London Regional Enhanced Support and Oversight Group visited the Trust in July 2026 and recognised significant progress. Improvement activity is increasingly embedded within routine governance, quality and safety processes, providing assurance that the programme is being sustained.
- **CQC Maternity Improvement Action Plan:** Progress remains strong, with no overdue actions.
- **MNSI:** There were no new referrals during the reporting period. Two final reports were received (Appendices 1 and 2) that did not identify the outcomes as preventable.
- **MOSS/ATAIN:** No MOSS signal was received during the reporting period and a mock exercise is planned for September 2026 to test the Trust's preparedness. ATAIN performance remains below the national threshold of 6% and continues to be monitored through established governance arrangements.
- **Fetal growth surveillance:** An updated Fetal Growth Restriction (FGR) protocol has been implemented, including a 40-week growth scan for women identified as being at increased risk, aim to enhance ability to detect babies at risk of small growth and preterm.
- **Perinatal outcomes:** There were 11 perinatal deaths during the reporting period, of which **64% occurred before 37 weeks' gestation**. The overall pattern has been reviewed and is considered consistent with expected variation given the Trust's population and clinical complexity.
- **National maternity requirements:** Following the publication of the Amos and Ockenden reports in June 2026, a national review is underway, with a Maternity and Neonatal Plan expected later this year. In the interim, NHS England has issued a 10-Point Action Plan and supporting benchmarking tools, with the Trust submission due on 25 September 2026 and Board oversight scheduled for 16 September 2026. Work is progressing on the 10-Point Action Plan, Perinatal Equity and Anti-Discrimination Programme (PEADP) and Martha's Rule, with implementation planned by March 2027. Learning from the Southeast London MNVP inclusivity project (Appendix 3) is supporting delivery of the PEADP.
- **Perinatal culture and improvement:** In response to national learning and alongside the CQC action plan, the Trust has established a time-limited Improvement Management Group (IMG) to provide strengthened executive oversight. The programme brings together independent clinical and culture reviews across safety, leadership and workforce, with staff and family voice central to the approach. Progress, impact and emerging learning will be reported through Executive and Board governance.
- **Maternity Incentive Scheme (MIS) Year 8:** MIS Year 8 continues to progress positively and is monitored through the monthly MIS Panel. Areas of risk are identified, monitored and escalated through established governance arrangements, with overall delivery remaining on track.

Key risks and mitigations

- **Theatre capacity:** Rising caesarean activity continues to place pressure on theatre capacity and represents a potential risk to timely access to operative birth. A business case to address capacity requirements has been developed and is progressing through Trust governance.
- **BAPM compliance and neonatal workforce:** Compliance with BAPM standards remains an area of focus within MIS Year 8. A business case is being developed to consider workforce requirements and options to support sustainable compliance and maintain safe neonatal services.

- **Listening to women and families:** Patient feedback and complaints continue to identify opportunities to strengthen how women and families feel listened to, responded to, consistent with the learning from the Amos recommendations. Mitigations include ongoing Friends and Family Test (FFT) monitoring, partnership working with the Maternity and Neonatal Voice Partnership (MNVP), clinical debrief and listening clinics, and delivery of the CQC Maternity Survey action plan.

2. Perinatal Quality Oversight Model

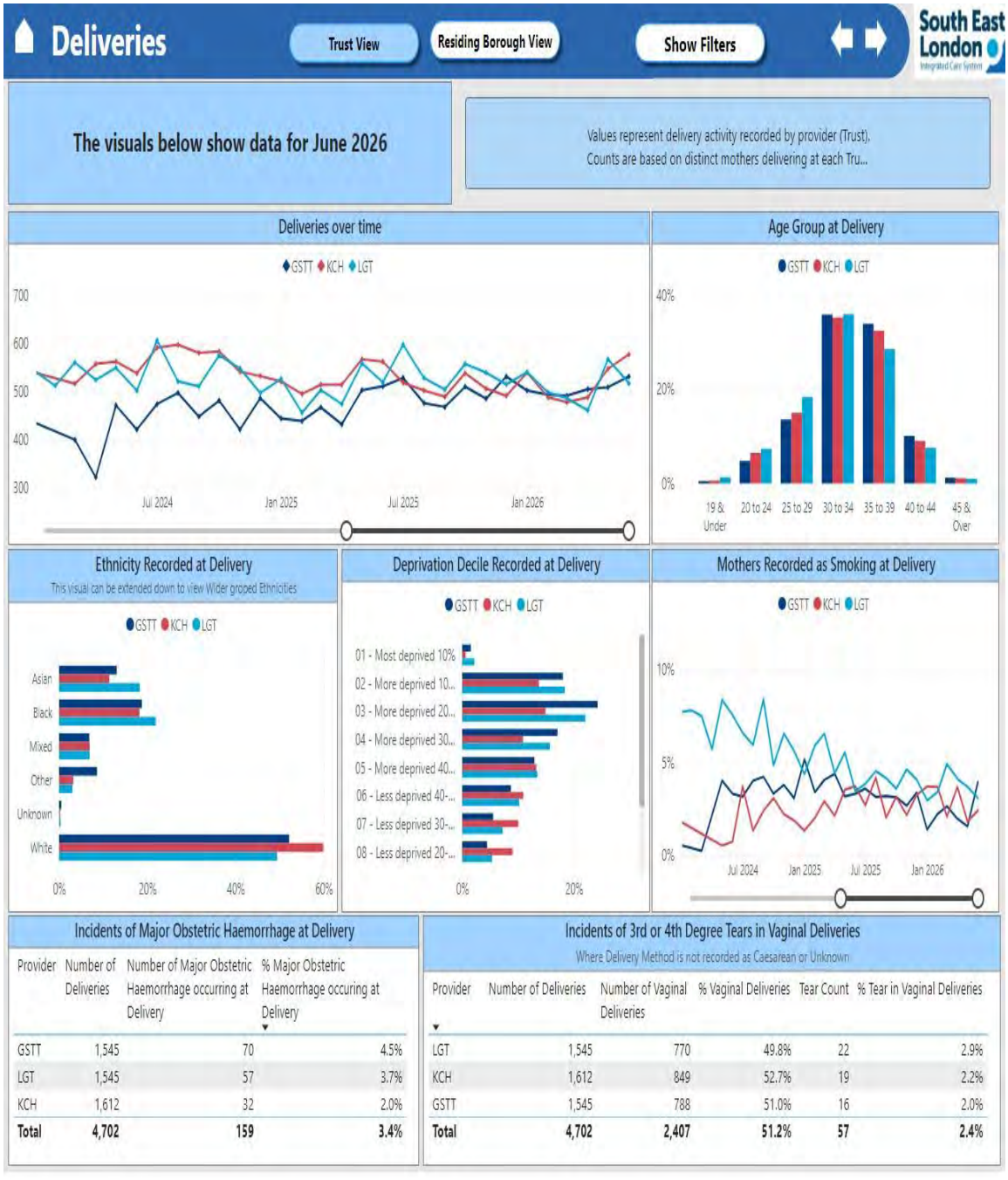
Since August 2025, the Trust has reported against the requirements of the Perinatal Quality Oversight Model (PQOM), previously known as the Perinatal Quality Surveillance Model. The model, originally implemented by NHS England in 2020, was revised and renamed in August 2025. Under the PQOM, local maternity units are required to report against an agreed set of quality and safety measures. The Trust provides information to the London Perinatal Quality Safety Improvement Group (LPQSG**)**, as part of regional oversight and assurance for maternity and neonatal services (Appendix 4). The LPQSG governance framework supports the structured collection, triangulation and review of intelligence relating to quality, safety, workforce, operational pressures and patient experience. Given the Trust's current maternity CQC rating, the service continues to receive regular insight visits from the London Regional Perinatal Team, undertaken on a six-monthly basis. The most recent visit, in July 2026, demonstrated sustained compliance with the exit criteria from the Maternity Support Programme, from which the Trust successfully exited in December 2024**.**

2.1 Maternity services dashboard: Appendix 5 provides an overview of Trust maternity performance. Overall, maternity activity remains broadly stable, with 612 registered births and 745 bookings, representing a booking attrition rate of 18%. Key areas of assurance:

- Extreme preterm births: Performance remains within the established control limits. This will continue to be monitored through the maternity quality and safety governance arrangements.
- Post-partum haemorrhage (PPH): There has been an increase in PPH ≥1.5 litres following vaginal births, with 17 cases compared with a mean of 11. Individual case reviews have not identified concerns regarding the quality of care or service delivery. However, the increase warrants continued monitoring and thematic review.
- Caesarean section rates: The overall increase is predominantly attributable to an increase in elective Caesarean births and Caesarean birth following maternal request.
- Assisted vaginal births: The rate remains below the expected level. The Trust is undertaking an audit of Caesarean births at full dilatation to understand the factors contributing to the observed pattern and identify any opportunities for improvement.
- Early access to maternity care: Access at 9+5 weeks remains a positive position and provides assurance regarding timely engagement with maternity services.
- Third- and fourth-degree perineal tears: Rates remain within the established control limits, with no indication of significant deterioration in performance.
- Stillbirth review: strong compliance with PMRT, with learning and actions identified, implemented and monitored through the appropriate governance structures. No MOSS alerts have been received.

2.2 LMNS dashboard: For the month of June 2026, table below suggest that overall KCH is performing strongly, with good outcomes. The highest births 1,612, best post-partum haemorrhage

rates of 2.0%, lowest of all providers. Vaginal delivery rate: Highest at 52.7% and Perineal Tear rates of 2.2%, broadly comparable with other providers.



King's College Hospital NHS Foundation Trust

3.0 Patient Safety incident Framework

	PMRT Compliance	MNSI Cases (new)	Still Births			HIE Cases	Neonatal Deaths	Maternal Mortality
			All	Term	Intrapartum			
Apr		0	9	0	0	0	1	0
May		2	1	0	0	0	2	0
June		0	5	0	0	0	3	0
July		0	1	0	0	0	2	0

Learning from Incidents

	InPhase				PSIIs	Never Events
	New Incidents	No. Closed	Remaining Open Month	Moderate Harm or Above		
Apr	184	168	16	1	0	0
May	168	117	51	3	2 MNSI	0
June	232	196	35	5	0	0
July	204	136	65	8	0	0

MNSI referrals:

- No new MNSI referrals in June or July 2026
- No PSII declared

Final MNSI reports received

MI-050533, InPhase 111117

- A mother in her 2nd pregnancy booked as low risk planned a homebirth.
- Spontaneous labour at term, complicated by a shoulder dystocia and subsequent transfer to Nightingale Birth Centre Obstetric Theatres by Ambulance. The birth was facilitated by 2 obstetric consultants. A baby boy was born in poor condition requiring extensive resuscitation and therapeutic cooling. A brain MRI showed severe HIE.
- MNSI acknowledged appropriate counselling with safety recommendations related to intrapartum intermittent auscultation. No indication that the outcome could have been prevented.

MI-050534, InPhase 111079

- An 18yr old mother in her 1st pregnancy with a history of learning disabilities booked with a specialist continuity of care midwifery team that offered enhanced care from midwives alongside disability nurses
- The mother went into spontaneous labour at term and contacted LAS that transferred the mother to labour ward at DH promptly.
- Sadly, bedside scan confirmed an intrauterine death. The mother subsequently gave birth to a stillborn baby; the birth was complicated by a postpartum haemorrhage (a known complication).
- MNSI safety recommendations include using learning disability passports within maternity for consistency of information sharing particularly with LAS.

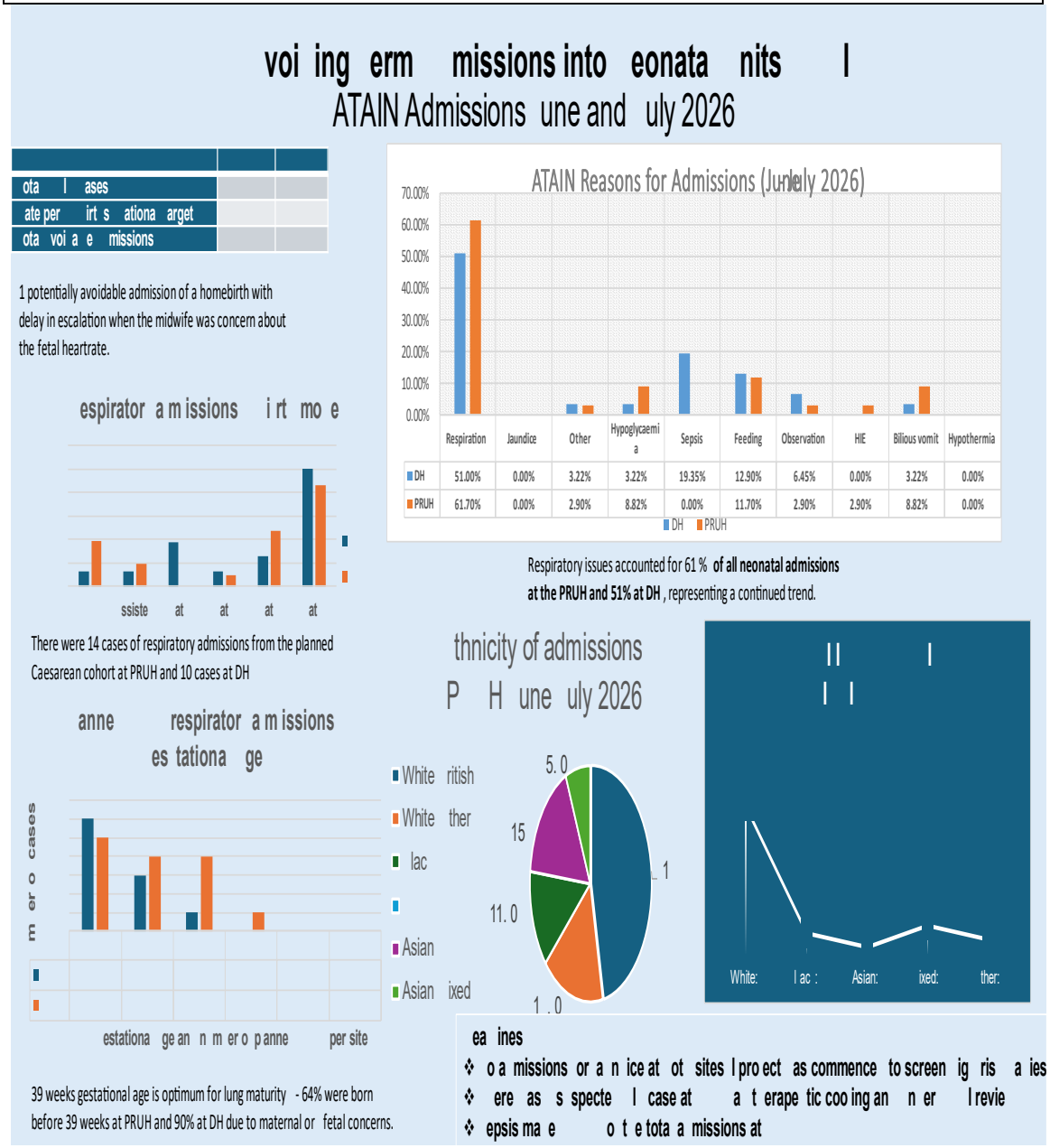
AARs completed

- 130902- MDT for shoulder dystocia during out of guidance homebirth
- 130819- MDT for baby born on Oasis Birth Centre with subsequent seizures (diagnosis of in utero stroke)
- 132355- AAR for missing postnatal care on PRUH Maternity Ward
- MDT for IUD and placental abruption at 29/40

- 136288- MDT, neonatal therapeutic cooling (rejected by MNSI)
- 134859/134555- MDT, neonatal death at 21/40
- 137418- MDT for safeguarding incident

Ongoing action plans:
6 ongoing MNSI action plans
Regulation 28 report: none issued
Coroner's' reports: none received

Avoidable Term Admission to the neonatal unit (ATAIN): Unexpected term admission to the neonatal unit remain the high reporting incidents and the trust remain on the 6% national target.



4.0 NHS resolution score card: Appendix 6 provides the most recent NHS Resolution maternity scorecard (2025), and key themes arising from claims. The next scorecard is expected towards the end of 2026. The table below summarises the key themes identified and supports ongoing learning and risk management.

e so tion corecar

A uarterly review of Trust s claims scorecard alongside incident and complaint data, and any learning from investigations sh ould be discussed by the maternity, neonatal and trust board level safety champions at a trust level (board or directorate) uality m eeting

emes i enti ie rom aims corecar ears	emes i enti ie rom omp aints c rrent
Top 5 in uries by volume for obstetrics rain damage, additional unnecessary operations, psychological damage, fatality, unnecessary pain. 5 of the volume and 5 of the total value. Top causes by volume for obstetrics 20 delay treatment, 16 delay diagnosis, 10 monitoring in second stage of labour, recognise complications and abnormal fetal heart	No claims were incident related. Themes from complaints include: Communication, listening and information, esponsiveness to pain relief re uest Clinical decision ma i ng, Postnatal care and discharge Continuity of information,
emes i enti ie rom aternit eonata atient a et Inci ents	**emes i enti ie rom ot er so rces e g sta ee ac ami ee ac etc**
stetric aemorr age eview of cases identified no specific management concerns. **o n in ection rea missions** strengthening PIC dressing practice, antibiotic prophylaxis, staff training and consideration of additional infection prevention measures. **ra g cose to erance testing** capillary sampling and accurate e uipment labelling. **a eg ar ing** history ta ing, referrals, documentation, **r egree tears** increased rates observed, all appropriately managed. Continue monitoring	anagement of waiting times Communication during scanning procedure clarity of information Staff attitudes Positive feedbac : overall star rating .6 . 5 for involvement in care, dignity across all care areas.
improvement actions rom i enti ie t emes	**tstan ing ris s mitigations**
pic documentation audit, staff training related to e uipment safety chec s , management of PIC dressing, safeguarding ris assessment at every antenatal contact	Theatre capacity in view of rising elective caesarean sections IS year successful submission relies on AP compliance, implementing maternity care bundle. usiness cases are progressing.
DT review of all rd and th degree tears	ngoing PSI review

5.0 Home birth services: The service has an established guideline for home birth including management of out of guidance birth options. Learning and actions taken from review of any related incidents are discussed at PSIRF. All planned births are discussed at home birth forums following a MDT approach and discussed at monthly governance meetings for oversight, and escalation for any additional guidance. Existing birth option models supports personalised care planning and individualised counselling. The Trust completed a full review of home birth services in line with the national recommendations in Dec 2025 and is fully aligned as per national expectations with:

- NICE guideline
- Home birth guideline
- Equipment availability
- Staff training and on call arrangements/inter discipline collaboration

King's College Hospital NHS Foundation Trust

6.0 CQC Maternity Improvement Action Plan

Good progress continues against the CQC Maternity Improvement Action Plan, with 37 of 45 actions (82%) completed, 8 actions (18%) in progress and no actions currently beyond their target date. Improvements have been sustained across safe care, governance and staffing, including risk assessment, Fetal monitoring, equipment checks, safeguarding and VTE. Remaining actions are focused on embedding and evidencing the sustainability of improvements, particularly documentation quality, fluid balance recording, Epic data completeness and implementation of national maternity triage standards. These are subject to ongoing audit, observation, safety huddles and established governance oversight. Overall, the programme remains on track, with residual risks actively monitored and mitigated through the Maternity Governance framework.

7.0 Perinatal Mortality Reviews using PMRT

The Perinatal Mortality Review Tool (PMRT) supports robust and standardised local reviews of care when babies die. These reviews aim to provide answers for bereaved parents and families about why their baby died. The reviews inform local and national learning to improve care, reduce safety-related adverse events, and prevent future baby deaths.

7.1 mma r o cases

From 1st June to 31st July 2026, 15 deaths have been notified to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), 11 of these meet the criteria for review using the PMRT.

Date	Outcome	Gestation	Ethnicity
22/7/2026	Neonatal death	24 weeks	Any other ethnic group
17/07/2026	Stillbirth	36 weeks	White and black African
15/07/2026	Neonatal death	37 weeks	White
29/06/2026	Stillbirth 25 weeks	25 weeks	Black African
27/06/2026	Neonatal death	35 weeks	Any other black background
26/06/2026	Stillbirth	24 weeks	White
18/06/2026	Stillbirth	22 weeks	White
14/06/2026	Neonatal death	36 weeks	White and black Caribbean
12/06/2026	Stillbirth	29 weeks	White
11/06/2026	Stillbirth	30 weeks	White
08/06/2026	Stillbirth	29 weeks	Black African

7.2 as es revie e Between 1st June and 31st July 2026, 7 cases were reviewed cross-site. The table below shows the themes and actions identified in the cases reviewed in this period. During this period, the reviews did not identify any new themes. However, important learnings were highlighted and acted upon, as shown in the table below.

Issue	Actions
Right place of birth	Existing systemwide collaboration to direct care to an appropriate tertiary unit
Accurate documentation of due data	Epic has been updated to ensure EDD is corrected after the dating scan.

7.3 Saving babies' lives: This section highlights which elements have been identified during the reviews covered by the Saving abies' Lives Care undle, version , a framework used as part of national ambition to reduce neonatal deaths and stillbirths.

- Element 1 – Smoking: none
- Element 2 – Diabetes: 2 mothers had well managed gestational diabetes.
- Element 3 – Small for gestational age: none
- Element 4 – Reduced fetal movements (RFM): one case which was well managed.
- Element 5 – Preterm: except for one, all babies were born prematurely.
- Element 6 – Fetal heart monitoring: none

7.4 Grading of Care (see appendix 7): Most reviews graded care as A or B, with no cases graded D. One case was graded C, relating to the neonatal death of a baby born at 23 weeks. Learning identified the need for earlier consideration of in-utero transfer and clearer communication with the family regarding the risk of preterm birth. The C grading reflected the potential impact of an earlier in-utero transfer.

Outcome	Gestation	Date of birth/death	Grading	Cause of death	Learnings
Stillbirth	34	25/04/26	A, A	Undetermined	None
Late misc.	22	15/04/26	A, A	Undetermined	None
NND	23	18/04/26	C, B, A	Pulmonary Haemorrhage	Limited consideration of preterm labour during admission, missed opportunities to assess cervical length, missed opportunity for antenatal transfer to a Level 3 maternity unit, and to discuss optimisation of extremely preterm birth.
Late misc.	22	18/04/26	Not yet graded		
NND	25	07/03/26	A, B, A	Pulmonary haemorrhage and Pseudomonas sepsis	Review not complete
NND	40	09/03/26	A, B, A	Severe refractory pulmonary hypertension and acute renal failure with multiorgan failure, With Hypoxic ischaemic encephalopathy and Trisomy 21	Review not complete
NND	23	16/02/26	B, B, A	Extreme prematurity, with severe respiratory distress syndrome and GBS	Suboptimal thermal management and documentation during resuscitation

7.5 o mp iance it e q ire ments an l ear

PMRT timescales are monitored in line with MIS Year 8 requirements. (Appendix 8). The Trust remains compliant, with all required standards met:

- Qualifying events notified via SPEN: **100%**
- Parents' views sought: **100%**
- External multidisciplinary reviewers: **100%**
- Parents offered a meeting with relevant specialists: **100%**
- Thematic learning and action reports produced regularly.

King's College Hospital NHS Foundation Trust

8.0 Biannual midwifery Workforce

Recruitment, retention and workforce planning remain key priorities to reduce reliance on temporary staffing and strengthen maternity workforce resilience. Current Band 5 and 6 midwifery vacancies total 13.67 WTE (4.3%), in line with the Trust target, and the Trust remains compliant with Birthrate Plus (March 2025). As of July 2026, 12.39 WTE midwives. Sickness absence has improved, reducing from 8% to 6%. The table below outlines current vacancies and recruitment pipeline.

Staff Group	July 2026 WTE Vacancy	Vacancy %	Current Recruitment / Mitigation	Expected Timescale
Midwives (Band 5 & 6)	**13.67**	**4.3%**	Host student recruitment completed, with successful candidates offered posts. A further opportunity is planned to interview previously unsuccessful candidates. Preceptees will be interviewed individually three months before completion of their fixed-term contracts for substantive posts.	**November 2026**
Maternity Support Workers	**27.05**	**30.25%**	Vacancies are being reviewed following the Band 2 uplift. Recruitment team is preparing for the advertisement to go live. Internal development pathways are also being supported for substantive support workers qualifying as midwives.	**Autumn 2026**
Obstetricians & Gynaecologists	**0**	**0%**	Recruitment has been completed.	**Low vacancy recruitment completed**
Bank Workforce – Bands 3 & 6	N/A	N/A	Ongoing quarterly recruitment to the Bank, with potential conversion to substantive posts where vacancies allow.	**Ongoing**

i rates

The service continues to maintain close oversight of staffing levels through twice-daily safety huddles, daily review of red flag events, and established escalation processes. Staffing levels are monitored in real time to ensure safe deployment of staff and to identify and mitigate any emerging risks to patient safety. During June and July 2026, temporary staffing fill rate is 78.7%. There have been no related incidents due to staffing.

Category	Jun 2026	Jul 2026	Total
Registered (band 5,6)	555 / 708 = **78.4%**	624 / 876 = **71.2%**	1179 / 1584 = **74.4%**
Unregistered	483 / 563 = **85.8%**	542 / 653 = **83.0%**	1025 / 1216 = **84.3%**
Overall	1038 / 1271 = **81.7%**	1166 / 1529 = **76.2%**	2204 / 2800 = **78.7%**

8.2 Sickness

The July 2026 workforce position is mixed compared with July 2025, against Trust targets of 10% vacancy, 3.5% sickness absence and 13% voluntary turnover. While progress has been made in some areas, increased absence is evident across several services, particularly the Maternal Assessment n it, P H aternity Assessment nit and P H Women's Administration. The

average position across the reported areas increased from 6.2% in June to 9.0% in July. Targeted actions and continued oversight are in place to address areas of deterioration, support staff wellbeing and facilitate a safe return to work. Key areas requiring focus are detailed in the table below. Support provided include:

- onthly sic n ess review meetings
- Ad hoc meetings to review advise on sic n ess mployee elation ( ) cases with Specialist, Associate P P, and P P as and when re uired
- a nd sic n ess case support available as and when re uired
- Sic ne ss management training available and promoted
- Investigation training available and promoted
- Despite this increase overall there has been a decline in sic e ns rates as seen in table below.

Department	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Birthing Centre PRU	8.04%	10.08%	16.16%	16.17%	15.72%	13.00%	17.14%	6.12%	0.93%	0.38%	0.00%	0.52%	2.87%
Colposcopy Admin	29.70%	29.70%	0.00%	0.00%	0.00%	0.00%	3.41%	3.37%	0.00%	0.00%	0.00%	0.00%	0.00%
Colposcopy SLHT (PRUH)	2.33%	0.79%	0.00%	8.66%	0.00%	9.28%	5.57%	1.64%	4.91%	0.00%	4.87%	4.74%	2.61%
Community & Practice Midwives	5.05%	7.98%	6.98%	11.11%	6.35%	9.57%	12.65%	13.04%	10.70%	5.39%	4.39%	7.27%	10.20%
E.P.D.U. PRUH	4.29%	0.00%	1.33%	0.00%	0.00%	3.87%	2.67%	0.00%	0.00%	0.00%	0.00%	2.08%	5.08%
Gynae Admin	0.55%	0.00%	0.26%	2.63%	2.77%	9.71%	12.87%	15.35%	11.20%	8.78%	8.68%	19.26%	23.79%
Gynaecology Outpatients	8.06%	6.82%	1.76%	1.32%	1.37%	2.69%	3.93%	6.63%	8.07%	0.87%	1.53%	0.36%	1.77%
Harris Birthright Unit	0.54%	1.11%	5.44%	0.00%	10.60%	17.16%	2.78%	3.26%	2.40%	2.40%	2.70%	5.55%	6.84%
Inpatient MSW's PRUH	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.16%	0.00%	0.00%	0.00%	5.42%	0.00%	11.56%
Labour Ward	8.25%	6.89%	4.88%	6.01%	6.76%	6.89%	8.41%	7.43%	7.25%	4.51%	6.81%	9.12%	9.26%
Maternal Assessment Unit	7.50%	18.17%	29.79%	39.97%	5.09%	3.28%	0.00%	0.65%	0.00%	14.29%	6.10%	2.38%	33.65%
Maternity Admin	4.62%	14.00%	15.24%	12.20%	8.41%	9.97%	8.45%	14.00%	16.59%	11.75%	16.24%	15.66%	3.13%
Med Staff-Obstet+Gynae	2.78%	2.80%	2.48%	3.00%	2.53%	0.08%	0.76%	0.69%	0.09%	0.75%	0.52%	0.26%	0.43%
Nursing & Midwifery Senior Management	15.33%	13.65%	12.98%	0.00%	0.00%	0.00%	0.00%	0.94%	0.00%	1.73%	0.84%	0.43%	0.42%
PRUH Community Midwives	8.14%	7.28%	9.77%	8.64%	10.84%	8.88%	7.42%	6.39%	4.58%	3.62%	6.14%	8.44%	8.17%
PRUH Labour Ward	6.04%	5.91%	5.03%	3.63%	4.82%	3.06%	8.74%	6.29%	6.11%	5.13%	4.05%	2.80%	5.71%
PRUH Maternal Assessment Unit	8.81%	1.01%	0.99%	14.16%	7.74%	6.00%	9.91%	8.70%	1.25%	2.64%	0.33%	12.27%	18.41%
PRUH Postnatal Ward	7.54%	8.39%	9.48%	13.17%	11.80%	12.14%	11.24%	14.96%	13.14%	6.51%	6.13%	8.64%	6.45%
PRUH Womens Admin	5.56%	7.77%	8.68%	7.84%	8.79%	8.17%	8.74%	11.11%	8.71%	13.07%	15.40%	10.96%	14.45%
Senior Gynaecology Nursing	24.55%	23.73%	18.92%	18.92%	18.38%	14.86%	1.61%	0.00%	3.88%	0.00%	0.00%	3.24%	0.65%
Specialist Midwifery	8.60%	8.95%	15.14%	13.30%	13.22%	11.06%	7.79%	7.28%	9.79%	8.89%	3.95%	2.87%	11.06%
Specialist Midwives (PRUH)	0.92%	0.37%	0.00%	1.59%	6.53%	9.07%	8.38%	8.56%	15.44%	9.21%	0.00%	0.60%	1.42%
TOPS	2.19%	0.00%	0.00%	0.00%	0.00%	1.31%	6.57%	10.91%	0.88%	1.81%	0.00%	0.60%	0.00%
Urogynaecology	1.61%	0.00%	23.33%	3.23%	0.83%	1.61%	2.42%	0.89%	24.19%	25.00%	25.00%	6.67%	0.00%
WH DH FLOW	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.67%	0.00%	0.00%	19.28%	33.93%	18.06%	20.52%
WH PRUH FLOW	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.77%
William Gilliatt	10.06%	11.56%	16.39%	13.12%	9.45%	10.46%	12.26%	13.73%	11.62%	10.26%	10.29%	10.80%	10.88%

Department	Jul-25	Jul-26	Change	Trend
Birthing Centre PRUH	8.04%	2.87%	**-5.17pp**	Improved
Community & Practice Midwives	5.05%	10.20%	**+5.15pp**	Deteriorated
Harris Birth Unit	0.54%	6.84%	**+6.30pp**	Significant deterioration
Labour Ward	8.25%	9.26%	**+1.01pp**	Deteriorated
Maternal Assessment Unit	7.50%	33.65%	**+26.15pp**	Significant deterioration
Maternity Admin	4.62%	3.13%	**-1.49pp**	Improved
Med Staff – Obs & Gynae	2.78%	0.43%	**-2.35pp**	Improved
Nursing & Midwifery Senior Management	15.33%	0.42%	**-14.91pp**	Significant improvement
PRUH Community Midwives	8.14%	8.17%	**+0.03pp**	Stable
PRUH Labour Ward	6.04%	5.71%	**-0.33pp**	Slight improvement
PRUH Maternity Assessment Unit	7.81%	18.41%	**+10.60pp**	Significant deterioration
PRUH Postnatal Ward	7.54%	6.45%	**-1.09pp**	Improved
PRUH Women's Admin	5.56%	14.45%	**+8.89pp**	Significant deterioration
Specialist Midwifery	8.60%	11.06%	**+2.46pp**	Deteriorated
Specialist Midwives (PRUH)	0.92%	1.42%	**+0.50pp**	Slight deterioration
William Gilliatt	10.06%	10.88%	**+0.82pp**	Deteriorated

8.3 Sickness Absence Analysis – July 2026

The July 2026 short term sickness dashboard shows 141 staff recorded as sick across 150 episodes, resulting in 683 days lost during the month and 825 days lost in total across the episodes. Overall sickness absence is reported at 2.59%, which provides a relatively low overall position. The main causes of absence were gastrointestinal illness, cold/cough/flu and anxiety/stress-related conditions

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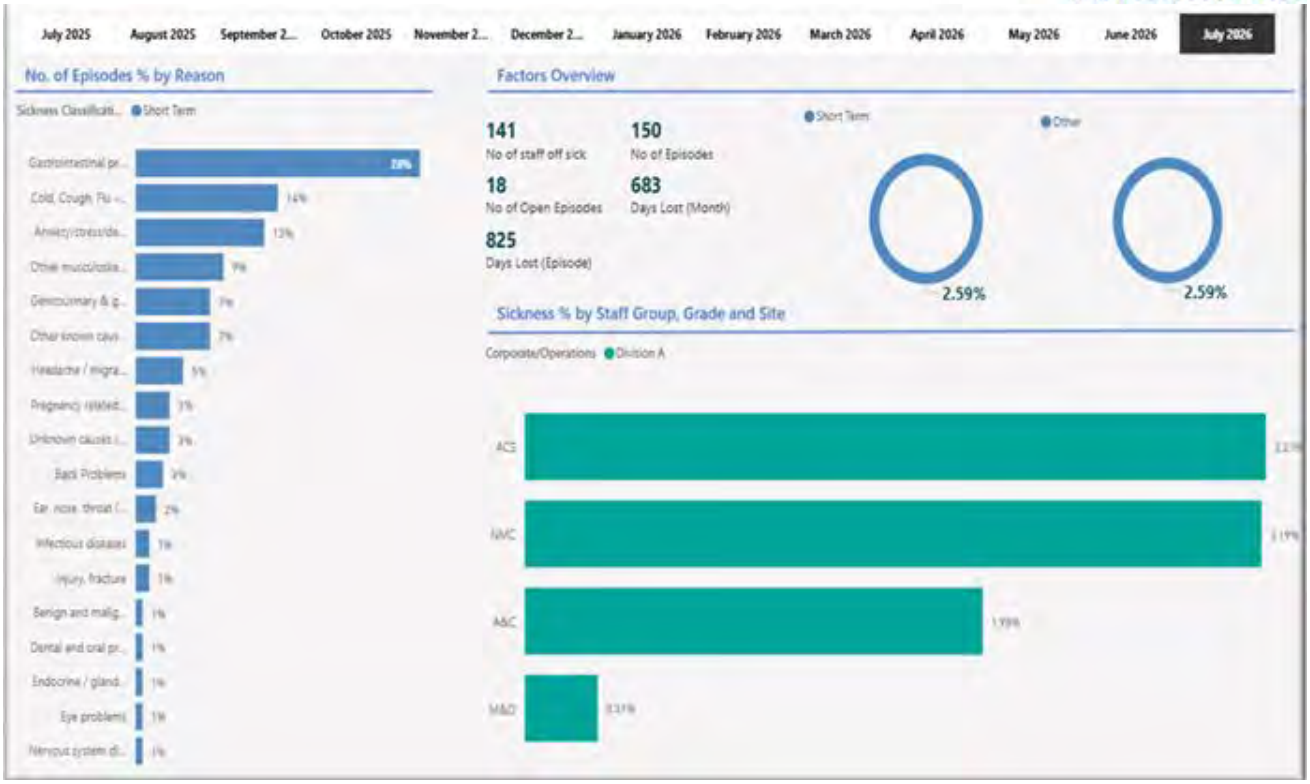
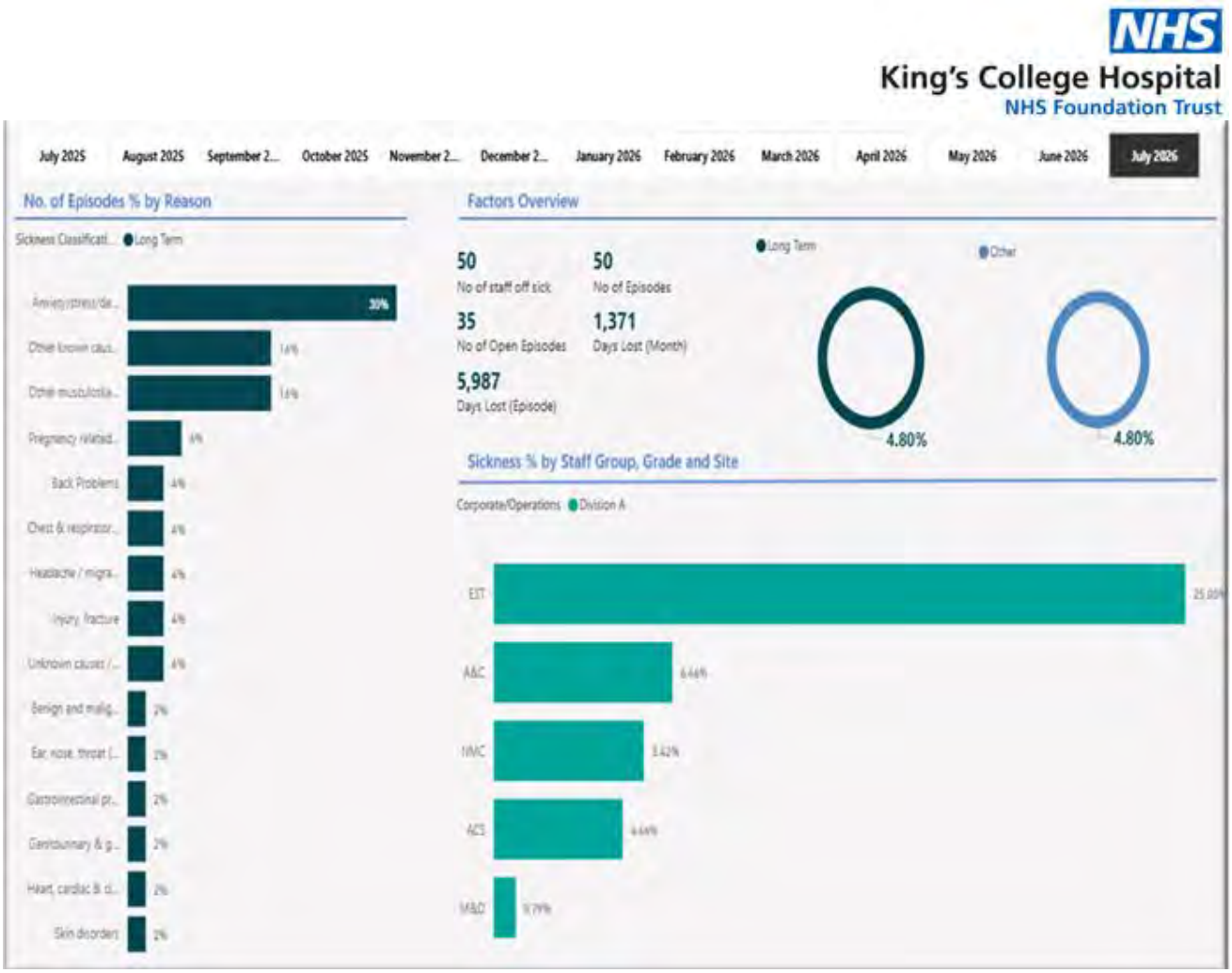


8.4 Long-Term Sickness Absence Analysis – July 2026

The July 2026 position shows 50 staff on long-term sickness, accounting for 50 episodes, with 1,371 days lost during the month and 5,987 days lost across the duration of these episodes. The overall long-term sickness rate is 4.80%. The main causes were anxiety/stress-related conditions and musculoskeletal illness. Long-term sickness will continue to be monitored through workforce governance, with targeted support and case management in areas with elevated absence.



8.5 Voluntary Turnover Rate: The voluntary turnover rate shows a positive year-on-year improvement, reducing from 9.31% in July 2025 to 7.08% in July 2026. Although there has been a modest increase from 6.52% in June 2026, the current rate remains **2**.23 percentage points lower than the previous year, providing positive assurance that workforce retention continues to strengthen.

VOL. TURNOVER RATE

Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
9.31%	8.86%	8.20%	7.88%	8.42%	7.78%	7.45%	6.68%	6.80%	7.80%	7.16%	6.52%	7.08%

8.6 The following section provides an overview of red flag events across DH and PRUH for June–July 2026, highlighting key themes, trends and actions taken to mitigate risk. Further detail on the individual red flag events and service-specific learning can be found in the (Appendix 9 &10).

8.6.1 Red Flag Events – DH and PRUH, June–July 2026: Both DH and PRUH recorded a reduction in maternity red flag events during June–July 2026, with four events at each site, two fewer than the previous reporting period. Events were primarily associated with delays in admission/commencement of induction of labour (IOL) and coordinators being unable to maintain supernumerary/supervisory status. Coordinator events occurred overnight, with acuity returning to a stable level within four hours on Birthrate Plus. Twice-daily maternity huddles, MDT risk assessment, consultant review and real-time acuity monitoring provide robust oversight, enabling emerging capacity and clinical risks to be identified, escalated and mitigated promptly. IOL delays

are actively monitored with consultant review and ongoing assessment of maternal and fetal wellbeing, with clear communication to affected families. Overall, the reduction in red flag events and strengthened escalation processes provide positive assurance regarding the management of maternity capacity and safety risks.

8.7 Training: remains compliant in line with core competency framework v2 and MIS year 8 safety action B.

a et ction raining

Reporting Period: July 2026	Can you demonstrate 90% attendance for the following staff groups?								
Fetal Monitoring									
Target 90%	DH			PRUH			Cross-site		
	No. Eligible	No. Compliant	%	No. Eligible	No. Compliant	%	No. Eligible	No. Compliant	%
Obstetric Consultants	17	16	94.1%	12	12	100%	29	29	96.6%
Obstetric Doctors	41	41	100%	21	21	100%	62	62	100%
Midwives	272	267	98.1%	217	211	97.2%	489	478	97.8%
Maternity Emergencies/ MDT (PROMPT)									
Target 90%	DH			PRUH			Cross-site		
	No. Eligible	No. Compliant	%	No. Eligible	No. Compliant	%	No. Eligible	No. Compliant	%
Obstetric Consultants	20	19	95%	12	12	100%	32	31	96.9%
Obstetric Doctors	38	37	97.4%	19	18	94.7%	57	55	96.5%
Midwives	265	255	96.2%	212	198	93.4%	477	453	95%
Maternity support workers& health care assistants	48	42	87.5%	41	39	95.1%	89	81	91%
Obstetric Anaesthetic Consultants	12	11	91.7%	18	17	94.4%	30	28	93.3%
Obstetric Anaesthetic Doctors	28	26	92.9%	21	21	100%	49	47	95.9%
Can you demonstrate that **at least one** MDT emergency scenario is conducted in a clinical area or at point of care during the MIS reporting period?								Yes	
Neonatal Basic Life Support									
Target 90%	DH			PRUH			Cross-site		
	No. Eligible	No. Compliant	%	No. Eligible	No. Compliant	%	No. Eligible	No. Compliant	%
Neonatal Consultants or Paediatric Consultants covering neonatal units			100%			100%			100%
Neonatal Junior Doctors			100%			100%			100%
Neonatal Nurses			98%			90.5%			96%
Advanced Neonatal Nurse Practitioner (ANNP)			100%			n/a			100%
Midwives			96.2%			93.4%			90.9%
Is a formal plan in place demonstrating how you will ensure a minimum of 90% **neonatal and paediatric medical staff** who attend neonatal resuscitations have a **valid resuscitation council NLS certification** by year 7 of MIS and ongoing?								Yes	

9.0 erinata exec t ive an ro nt ine ea ers' safety Champion Walkabouts

Two Maternity Safety Champion walkabouts were undertaken, one at Orpington and one at the DH Community Midwifery Centre, providing an opportunity to hear directly from community midwives about access, personalised care and safety in out-of-hospital maternity services. The visits provided assurance that community teams remain focused on delivering safe, personalised care closer to home, supporting the national ambition for neighbourhood-based care. Staff feedback highlighted the importance of continuity, appropriate staffing and capacity, effective escalation and strong communication between community and hospital services. A key theme was ensuring that women receiving care outside the hospital environment have equitable access to specialist advice, clinical support and digital systems, including EPIC, to enable timely access to information and support safe clinical decision-making. The walkabouts also provided a valuable safe space for staff to speak openly about pressures, risks and opportunities for improvement, reinforcing the role of Maternity Safety Champions in listening to staff, identifying concerns and supporting a positive safety culture. Points of escalation was related to temperature control and hydration facilities for staff and families. The actions are agreed and in progress.

10.0 Maternity Incentive Scheme (MIS) Year 8

The Trust is progressing all elements of the requirements of the Maternity Incentive Scheme (MIS) Year 8, with the end-of-scheme assessment point in November 2026. This is overseen through the

monthly MIS Oversight Panel chaired by Chief Nurse & Executive Director of Midwifery, which provides ongoing scrutiny of progress, risks, and actions required to achieve compliance in Appendix 11. Key areas requiring continued monitoring and escalation include compliance with British Association of Perinatal Medicine (BAPM) standards, and the development of a sustainable plan for theatre and elective capacity in response to rising caesarean section rates, business case planning and options are progressing through governance. Implementation plans are also progressing across the Maternity Care Bundle, with several actions dependent on system-wide delivery. This includes specific actions for the ICB, where progress and evidence of delivery will be required to enable the Trust to fully meet the MIS Year 8 requirements by the end-of-scheme assessment.

10.1 Saving Babies lives care bundle v3: the Trust is on track and that the standard expected at this stage of MIS year8 as shown in table below**.**

Saving Babies Lives Care Bundle

Element	Description	% Interventions Fully Implemented
Element 1	Reducing Smoking in Pregnancy	80%
Element 2	Fetal Growth Restriction	95%
Element 3	Reduced Fetal Movements	50%
Element 4	Fetal Monitoring in Labour	100%
Element 5	Preterm Birth	88%
Element 6	Diabetes in Pregnancy	100%

Overall compliance 90% across all elements

Interventions Implemented	Interventions with Action Plans
Element 1 – 8 out of 10 Element 2 – 19 out of 20 Element 3 – 1 out of 2 Element 4 – 5 out of 5 Element 5 – 23 out of 26 Element 6 – 6 out of 6	**Element 1:** CO monitoring at 36/40 improved from 69% to 77.6% (target 80%), Quit rates at 4 weeksalso improved and business case for tobacco dependency support workers approved. **Element 2:** 40-week scan for at risk women being introduced in next few weeks. **Element 3:** Next day USS for RFM rates improving on audit, work ongoing on Epic to improve referrals. **Element 4:** Fully Compliant **Element 5:** Preterm Birth leaflet in final stages of production. **Element 6:** Fully Compliant

10.2 Safety Action E Care Bundles: Implementation plan is progressing well, with 14 of 17 actions completed or partially completed (82%)**.** Three actions have not yet commenced, pending EPIC/digital development. There are currently no associated risks identified, supported by initial pregnancy risk assessment and self-referral processes. Progress is evident across key areas including VTE, escalation of care for deteriorating pregnant and maternal patients, epilepsy in pregnancy and maternal mental health. The Trust is across the regional Maternal Medicine Network to review actions, share learning and to ensure all pathways are aligned systemwide. table below outlines Year 8 progress.

Element	Process Indicator	Description	Compliance Status	Notes
1 - VTE	1.1a	Incorporate early pregnancy VTE risk assessment into antenatal self-referral form	Completed	Launch date 10.08.26
	1.1b	Embed or have an agreed plan to embed early pregnancy VTE risk assessment into secondary care EPRs	Not Started	Need EPIC input
	1.2a	Pathways for prescribing LMWH have been agreed by primary care, emergency departments and EPUs.	Not Started	ICB Meeting 26.08.26
	1.3	Agreed protocol in place for timely responses to VTE questionnaires and referral of high risk women for standardised dosage LMWH	Partial	Meeting with gynae HON 18.08.26
2 - Escalation of unwell pregnant women and maternal deteriorating patient	2.2a	Pre-alert system and SOP in place for each labour ward (ambulance service)	Partial	SOP to be reviewed
	2.2b	Review of signage to labour ward and action plan to rectify any issues	Partial	To liaise with LAS and confirm plans
	2.3a	Local protocols in place from acute settings to MMC for red flag symptoms	Partial	Awaiting confirmation from MMN
	2.3b	Pathways as per 2.3a agreed by MMN	Partial	Covered by 2.3a in 1st 12 months
3 - Epilepsy in pregnancy	3.1a	Local guideline in place outlining local epilepsy team staffing, clinic schedule and referral pathway	Partial	Minor amendments to existing guideline and MMN agreement required
	3.2a	Local guideline in place with criteria and referral to MMC in line with regional guidelines, co-created with MMN	Partial	Awaiting confirmation from MMN
	3.2b	Members of the epilepsy in pregnancy team have attended MDT teaching sessions facilitated by the MMN	Completed	
4 - Maternal Mental Health	4.1a	Local guideline in place for self-administration of Whooley questions at appts for booking, 25-28/40, 31-34/40 and 10-14 days PN	Partial	Needs EPIC input
	4.1f	Whooley questions are embedded into patient facing digital systems	Completed	
	4.2b	Local guideline in place on self-administration of EPDS where appropriate	Not Started	Whooley pathway needs finalised before commencing
	4.2c	EPDS embedded in patient facing digital systems	Partial	To be added to flowsheets
	4.3a	Local guideline in place setting out local perinatal mental health provision and how to refer	Completed	
5 - Management of haemorrhage	5.1a	Clinical guideline for cumulative quantitative measurement of blood loss and escalation in line with MCB	Partial	Minor amendments to existing guideline required

11.0 Perinatal Equity and Anti-Racism Programme: The Perinatal Equity and Anti-Racism Programme commenced in June 2025 in response to the findings and recommendations of the Amos report on racism in maternity services. The programme runs alongside the Trust's Improvement Management Group (IMG) and brings together clinical safety, culture, leadership, workforce, governance, CQC actions, and staff and family voice. The programme is supported by an external clinical review and an independent review of culture, leadership and staff experience

by Kaleidoscope Health and Care. Evidence from incidents, complaints, CQC findings, staff feedback and Freedom to Speak Up is being used to identify both areas for improvement and good practice. Staff and family voices remain central, with confidential opportunities to contribute. Progress is monitored through Executive and Board governance, with a focus on demonstrable and sustained improvement rather than completion of actions alone. (Appendix 12)

12.0 KCH Maternity Patient Experience

12.1 Star rating: for the period: 1 January–31 July 2026 overall patient feedback across antenatal, labour and postnatal maternity services was very positive, with 412 responses in total. Labour care received the highest overall rating, with strong scores also seen across antenatal and postnatal care.

Care area	Responses	Overall score	Positive experience	5-star score
Antenatal	199	**4.52/5**	87.94%	4.49/5
Labour	202	**4.82/5**	98.51%	4.80/5
Postnatal	11	**4.68/5**	90.91%	4.45/5

Overall star rating: 4.67/5 across the three care areas, based on the reported overall experience scores. Patient experience across KCH Maternity was strongly positive during January–July 2026, with an overall rating of approximately 4.67/5 from 412 responses. Labour care was the strongest performing area at 4.82/5, with 98.5% reporting a positive experience. Postnatal care also performed strongly at 4.68/5, although response numbers were low (n=11). Antenatal care scored 4.52/5, with 87.9% positive feedback. Across all care areas, dignity and involvement were consistent strengths. The key opportunities are to continue working closely with safety champions and leadership teams and MNVP user groups to increase rates.

12.2 Patient experience: Overall sentiment is strongly positive: 66.32% positive, 30.56% negative, and only 3.12% neutral. Patient Care (116) and Staff Behaviour (115) are the biggest themes, indicating these areas generate the most feedback. Within sub-themes, Caring Staff (83) and Approachable Staff (79) stand out as major positive drivers. Main improvement opportunities are around communication, waiting time, facilities, and appointment availability. Overall summary: Strong patient satisfaction, with staff behaviour and quality of care as key strengths and operational/service delays as the main areas to improve.

13.0 National Reports: Following publication of the AMOS and Ockenden reports, a national review of maternity recommendations is underway, with a new Maternity Plan expected later in 2026. In the interim, the national 10-point plan is being implemented, including completion of the national triage benchmarking exercise by 25 September 2026. Much of the plan is already embedded within MIS Year 8 and established quality and safety processes. The benchmarking exercise provides an opportunity to assess alignment with emerging national expectations and identify further improvements. The Trust is also on trac to implement artha's ule across maternity and neonatal services by March 2027.

14.0 Research and Quality Improvement: The Women's Health ese arch Team is leading 21 maternal and fetal medicine studies, involving more than 15,000 women, with KCH currently ranked second in the UK for recruitment. Research includes evaluation of AI-enabled ultrasound technology to support assessment of gestational age, fetal weight and other maternal-fetal parameters. Collaboration with the MNVP is being strengthened to improve participation from Black, Asian and minority ethnic groups, currently representing approximately 15% of recruitment, with a focus on addressing disparities identified through the EDI dashboard (an increase from 10%). The PRUH Induction of Labour QI project has also been accepted onto the NHS England Maternity and Neonatal Futures Hub, alongside eight other trusts, supporting sustained improvement in IOL pathways and outcomes. The project has demonstrated significant improvement in timeliness, including a reduction in delays transferring women to the Labour Ward from 52% to 28%.

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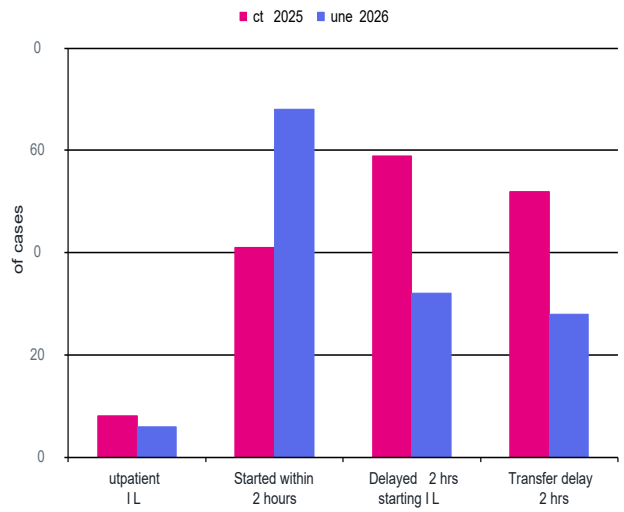
une shows improved timeliness: more inductions started within 2 hours and fewer treatment transfer delays.



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Note: percentages compare ctober 2025 audit cases with une 2026 audit cases .

15.0 Conclusion

The Trust continues to make good progress in strengthening maternity quality, safety and governance. External regional oversight in July 2026 recognised significant improvement, with improvement work increasingly embedded within routine governance arrangements. The CQC action plan is progressing well, with no overdue actions, and there are established interventions to support culture improvements with key metrics planned to measure improvements. National requirements from the Amos and Ockenden reports are being incorporated into the Trust's improvement programme, alongside continued delivery of MIS Year 8, PEADP and Martha's Rule. Key residual risks relate to theatre capacity, neonatal workforce and BAPM compliance, and patient and family experience; actions are in place to address these through established governance and improvement programmes. NHS England's national 10-Point Plan requires Board-approved baseline assurance submissions by 25 September 2026, reinforcing the importance of continued oversight and demonstrable progress. Whilst the trusts are waiting national response to Amos listening to family's plan, the trust continues to build of established processes to listen to families, working closely with MNVP and other user groups.

16.0 Appendices

Appendix No.	Title
Appendix 1	MNSI report 050533
Appendix 2	MNSI report 050534
Appendix 3	Inclusive project
Appendix 4	LPQSIG KCH slides
Appendix 5	KCH clinical outcomes
Appendix 6	Obstetric claims update
Appendix 7	PMRT grading
Appendix 8	PMRT MIS year 8 compliance
Appendix 9	DH red flags
Appendix 10	PRUH red flags
Appendix 11	MIS panel slides
Appendix 12	Perinatal Equity and Anti-Discrimination Programme

King's College Hospital NHS
NHS Foundation Trust

Hermione Jackson
and Kate Greenlees
DH & PRUH Digital Midwives

Digital Update:
Governance August2026
BIU Data: June 2026

BIU Dashboard Data

King's College Hospital NHS Foundation Trust

Domain / Metric	2025-06	2025-07	2025-08	2025-09	2025-10	2025-11	2025-12	2026-01	2026-02	2026-03	2026-04	2026-05	2026-06
Performance													
Activity													
Registerable Births	618	624	604	611	656	608	579	627	599	586	592	633	612
C-Section Births	310	309	296	307	333	277	297	307	296	279	285	310	301
C-Section Births - Total Rate %	50.2%	49.5%	49.0%	50.3%	50.8%	45.6%	51.3%	49.0%	49.4%	47.6%	48.1%	49.0%	49.2%
C-Section Births - Elective Rate %	24.8%	23.7%	21.2%	26.5%	25.6%	20.7%	24.2%	23.4%	24.9%	24.7%	23.3%	22.3%	26.3%
C-Section Births - Emergency Rate %	25.4%	25.8%	27.8%	23.7%	25.2%	24.8%	27.1%	25.5%	24.5%	22.9%	24.8%	26.7%	22.9%
Spontaneous Vaginal Births	238	250	231	237	259	250	228	247	238	247	242	270	244
Spontaneous Vaginal Births %	38.5%	40.1%	38.3%	38.8%	39.5%	41.1%	39.4%	39.4%	39.7%	42.2%	40.9%	42.7%	39.9%
Assisted Vaginal Births	69	65	77	67	64	81	54	73	65	61	66	54	67
Assisted Vaginal Births %	11.2%	10.4%	12.8%	11.0%	9.8%	13.3%	9.3%	11.6%	10.9%	10.4%	11.2%	8.5%	11.0%
Preterm Births	44	43	66	51	56	50	62	52	42	41	63	69	58
Extreme Preterm Births	2	1	0	4	2	6	4	3	2	4	4	6	6
Home Births %	1.6%	1.1%	1.3%	1.8%	1.4%	2.0%	1.2%	1.4%	1.8%	1.7%	1.9%	1.7%	1.5%
Births in water %	5.3%	4.2%	2.5%	5.9%	4.3%	6.1%	3.3%	3.8%	6.2%	5.1%	3.2%	4.4%	4.9%
Number of Bookings	698	818	673	760	765	690	706	761	692	836	721	650	745
Bookings By 9+6 Weeks	68.3%	63.6%	68.7%	66.1%	68.1%	67.8%	71.4%	61.5%	64.6%	68.8%	64.8%	68.5%	68.5%
Birth Outcomes													
Total Stillbirths >=24 weeks	4	1	0	4	4	4	5	3	1	0	4	0	6
% Stillbirths >=24 weeks	0.7%	0.2%	0.0%	0.7%	0.6%	0.7%	0.9%	0.5%	0.2%	0.0%	0.7%	0.0%	1.0%
3rd & 4th Degree Tears %	2.9%	2.2%	2.0%	2.6%	0.9%	1.5%	1.1%	1.6%	2.3%	2.3%	2.3%	1.5%	2.9%
3rd & 4th Degree Tears of Assisted Vaginal Births %	4.4%	4.6%	3.9%	0.0%	3.1%	2.5%	3.7%	2.7%	4.6%	4.9%	4.6%	3.7%	6.0%
3rd & 4th Degree Tears of Spontaneous Vaginal Births %	3.8%	2.8%	2.6%	3.4%	1.2%	2.0%	1.3%	2.0%	2.9%	2.9%	2.9%	1.9%	3.7%
PPH >=1.5L Caesarean Births	13	5	12	8	8	10	11	7	12	12	6	5	9
PPH >=1.5L - Vaginal Births	11	5	10	20	9	7	10	8	10	10	14	15	17
PPH >=1.5L - Caesarean Births %	4.3%	1.7%	4.3%	2.7%	2.5%	3.7%	3.9%	2.4%	4.2%	4.4%	2.2%	1.7%	3.1%
PPH >=1.5L - Vaginal Births %	3.6%	1.6%	3.3%	6.6%	2.8%	2.1%	3.6%	2.5%	3.3%	3.3%	4.6%	4.7%	5.5%
Neonatal Clinical Indicators													
Baby readmission w/in 28 days of birth %													
Postnatal Maternal Readmissions Within 42 Days													
Apgar Score <7 at 5 mins (Term)	13	4	8	13	7	13	8	11	10	4	12	8	10

DH Scorecard

King's College Hospital NHS Foundation Trust

Domain / Metric	2025-06	2025-07	2025-08	2025-09	2025-10	2025-11	2025-12	2026-01	2026-02	2026-03	2026-04	2026-05	2026-06
Performance													
Activity													
Registerable Births	323	334	326	344	358	327	330	343	328	319	333	353	346
C-Section Births	169	161	171	176	177	152	170	184	175	162	160	188	176
C-Section Births - Total Rate %	52.3%	48.2%	52.5%	51.2%	49.4%	46.5%	51.5%	53.6%	53.4%	50.8%	48.1%	53.3%	50.9%
C-Section Births - Elective Rate %	25.1%	24.3%	23.6%	24.4%	22.9%	22.3%	22.1%	27.1%	26.2%	25.7%	22.8%	23.0%	28.9%
C-Section Births - Emergency Rate %	27.2%	24.0%	28.8%	26.7%	26.5%	24.2%	29.4%	26.5%	27.1%	25.1%	25.2%	30.3%	22.0%
Spontaneous Vaginal Births	121	141	112	135	138	129	130	124	123	126	132	139	135
Spontaneous Vaginal Births %	37.5%	42.2%	34.4%	39.2%	38.6%	39.5%	39.4%	36.2%	37.5%	39.5%	39.6%	39.4%	39.0%
Assisted Vaginal Births	33	32	43	33	43	46	30	35	30	32	42	27	35
Assisted Vaginal Births %	10.2%	9.6%	13.2%	9.6%	12.0%	14.1%	9.1%	10.2%	9.2%	10.0%	12.6%	7.7%	10.1%
Preterm Births	23	23	37	36	37	28	36	37	29	26	46	43	38
Extreme Preterm Births	2	1	0	3	2	4	4	3	1	4	4	6	6
Home Births %	3.1%	1.8%	2.5%	2.3%	1.7%	2.1%	1.8%	1.5%	2.4%	2.8%	1.8%	2.3%	1.2%
Births in water %	3.4%	3.0%	2.2%	5.2%	3.4%	4.3%	2.1%	2.3%	5.8%	2.8%	2.1%	2.8%	3.8%
Number of Bookings	381	449	360	439	428	382	395	405	392	480	418	370	415
Bookings By 9+6 Weeks	68.5%	66.4%	67.2%	65.4%	68.7%	68.9%	71.7%	63.7%	64.5%	67.3%	62.9%	71.9%	68.4%
Birth Outcomes													
Total Stillbirths >=24 weeks	2	0	0	2	4	2	3	3	1	0	3	0	4
% Stillbirths >=24 weeks	0.6%	0.0%	0.0%	0.6%	1.1%	0.6%	0.9%	0.9%	0.3%	0.0%	0.9%	0.0%	1.2%
3rd & 4th Degree Tears %	3.3%	3.5%	2.6%	3.6%	0.6%	2.3%	1.9%	0.6%	4.6%	0.6%	2.9%	1.8%	2.4%
3rd & 4th Degree Tears of Assisted Vaginal Births %	6.1%	6.3%	4.7%	0.0%	2.3%	2.2%	6.7%	0.0%	10.0%	0.0%	2.4%	7.4%	5.7%
3rd & 4th Degree Tears of Spontaneous Vaginal Births %	4.1%	4.3%	3.6%	4.4%	0.7%	3.1%	2.3%	0.8%	5.7%	0.8%	3.8%	2.2%	3.0%
PPH >=1.5L Caesarean Births	12	2	7	5	3	5	9	6	9	3	2	3	7
PPH >=1.5L - Vaginal Births	6	2	6	12	6	3	7	4	5	2	10	9	9
PPH >=1.5L - Caesarean Births %	7.2%	1.3%	4.2%	3.0%	1.7%	3.3%	5.5%	3.4%	5.4%	1.9%	1.4%	1.6%	4.1%
PPH >=1.5L - Vaginal Births %	3.9%	1.2%	3.9%	7.1%	3.4%	1.7%	4.4%	2.5%	3.3%	1.3%	5.8%	5.5%	5.4%
Neonatal Clinical Indicators													
Baby readmission w/in 28 days of birth %													
Postnatal Maternal Readmissions Within 42 Days													
Apgar Score <7 at 5 mins (Term)	10	2	7	10	6	9	6	10	5	2	10	8	7

PRUH Scorecard

King's College Hospital NHS Foundation Trust

Domain / Metric	2025-06	2025-07	2025-08	2025-09	2025-10	2025-11	2025-12	2026-01	2026-02	2026-03	2026-04	2026-05	2026-06
Performance													
Activity													
Registerable Births	295	288	278	266	295	277	248	282	269	266	257	279	263
C-Section Births	141	148	125	131	156	125	127	123	121	117	125	122	125
C-Section Births - Total Rate %	47.8%	51.4%	45.0%	49.3%	52.9%	45.1%	51.2%	43.6%	45.0%	44.0%	48.6%	43.7%	47.5%
C-Section Births - Elective Rate %	24.4%	23.3%	18.4%	29.3%	29.2%	19.1%	27.0%	19.2%	23.4%	23.7%	24.1%	21.5%	23.2%
C-Section Births - Emergency Rate %	23.4%	28.1%	26.6%	19.9%	23.7%	26.0%	24.2%	24.5%	21.6%	20.3%	24.5%	22.2%	24.3%
Spontaneous Vaginal Births	117	107	119	101	118	117	97	121	113	120	108	130	106
Spontaneous Vaginal Births %	39.7%	37.2%	42.8%	38.0%	40.0%	42.2%	39.1%	42.9%	42.0%	45.1%	42.0%	46.6%	40.3%
Assisted Vaginal Births	36	33	34	34	21	35	24	38	35	29	24	27	32
Assisted Vaginal Births %	12.2%	11.5%	12.2%	12.8%	7.1%	12.6%	9.7%	13.5%	13.0%	10.9%	9.3%	9.7%	12.2%
Preterm Births	21	20	29	15	19	22	26	15	13	15	17	26	20
Extreme Preterm Births	0	0	0	1	0	2	0	0	1	0	0	0	0
Home Births %				0.8%	0.3%	0.4%		0.7%	0.4%		1.2%	0.7%	0.8%
Births in water %	7.5%	5.2%	2.9%	6.4%	4.8%	6.9%	4.4%	5.3%	6.3%	7.9%	4.7%	6.1%	5.3%
Number of Bookings	297	358	302	307	327	294	298	338	291	344	292	266	315
Bookings By 9+6 Weeks	71.0%	61.7%	72.2%	68.4%	69.4%	68.7%	72.2%	61.5%	66.3%	72.7%	69.2%	67.3%	71.1%
Birth Outcomes													
Total Stillbirths >=24 weeks	2	1	0	2	0	2	2	0	0	0	1	0	2
% Stillbirths >=24 weeks	0.7%	0.4%	0.0%	0.8%	0.0%	0.7%	0.8%	0.0%	0.0%	0.0%	0.4%	0.0%	0.8%
3rd & 4th Degree Tears %	2.6%	0.7%	1.3%	1.5%	1.4%	0.7%	0.0%	2.5%	0.0%	4.0%	1.5%	1.3%	3.6%
3rd & 4th Degree Tears of Assisted Vaginal Births %	2.8%	3.0%	2.9%	0.0%	4.8%	2.9%	0.0%	5.3%	0.0%	10.3%	8.3%	0.0%	6.3%
3rd & 4th Degree Tears of Spontaneous Vaginal Births %	3.4%	0.9%	1.7%	2.0%	1.7%	0.9%	0.0%	3.3%	0.0%	5.0%	1.9%	1.5%	4.7%
PPH >=1.5L Caesarean Births	1	3	5	3	5	5	2	1	3	9	4	2	2
PPH >=1.5L - Vaginal Births	5	3	4	8	3	4	3	4	5	8	4	6	8
PPH >=1.5L - Caesarean Births %	0.7%	2.1%	4.3%	2.3%	3.3%	4.1%	1.7%	0.8%	2.5%	7.8%	3.2%	1.7%	1.6%
PPH >=1.5L - Vaginal Births %	3.3%	2.1%	2.6%	6.0%	2.2%	2.6%	2.5%	2.5%	3.4%	5.4%	3.0%	3.8%	5.8%
Neonatal Clinical Indicators													
Baby readmission w/in 28 days of birth %													
Postnatal Maternal Readmissions Within 42 Days													
Apgar Score <7 at 5 mins (Term)	3	2	1	3	1	4	2	1	5	2	2	0	3

KCH Metric Assurance

King's College Hospital NHS Foundation Trust

	Latest Reporting Period	Metric Value	Target	Assurance	Mean	LCL	UCL
Activity							
Registerable Births	Jun 2026	612			606	532	680
C-Section Births	Jun 2026	301			282	223	342
C-Section Births - Total Rate %	Jun 2026	49.2%			46.6%	36.3%	56.9%
C-Section Births - Elective Rate %	Jun 2026	26.3%			21.3%	13.9%	28.7%
C-Section Births - Emergency Rate %	Jun 2026	22.9%			25.3%	20.3%	30.3%
Spontaneous Vaginal Births	Jun 2026	244			250	185	315
Spontaneous Vaginal Births %	Jun 2026	39.9%			41.3%	31.7%	51.0%
Assisted Vaginal Births	Jun 2026	67			73	55	91
Assisted Vaginal Births %	Jun 2026	11.0%			12.0%	10.1%	14.0%
Preterm Births	Jun 2026	58			49	17	80
Extreme Preterm Births	Jun 2026	6			2	-3	7
Home Births %	Jun 2026	1.5%			1.7%	0.0%	3.3%
Births in water %	Jun 2026	4.9%			4.8%	2.7%	6.9%
Number of Bookings	Jun 2026	745			729	590	868
Bookings By 9+6 Weeks	Jun 2026	68.5%			64.4%	52.1%	76.7%
Birth Outcomes							
Total Stillbirths >=24 weeks	Jun 2026	6			2	-2	6
% Stillbirths >=24 weeks	Jun 2026	1.0%			0.3%	-0.3%	0.9%
3rd & 4th Degree Tears %	Jun 2026	2.9%			2.0%	-0.3%	4.4%
3rd & 4th Degree Tears of Assisted Vaginal Births %	Jun 2026	6.0%			3.3%	-2.2%	8.7%
3rd & 4th Degree Tears of Spontaneous Vaginal Births %	Jun 2026	3.7%			2.6%	-0.5%	5.7%
PPH >=1.5L Caesarean Births	Jun 2026	9			9	-4	22
PPH >=1.5L - Vaginal Births	Jun 2026	17			11	2	20
PPH >=1.5L - Caesarean Births %	Jun 2026	3.1%			3.3%	-1.8%	8.4%
PPH >=1.5L - Vaginal Births %	Jun 2026	5.5%			3.3%	0.7%	5.9%
Neonatal Clinical Indicators							
Apgar Score <7 at 5 mins (Term)	Jun 2026	10			10	3	17

5

DH Metric Assurance

King's College Hospital NHS Foundation Trust

	Latest Reporting Period	Metric Value	Target	Assurance	Mean	LCL	UCL
Activity							
Registerable Births	Jun 2026	346			326	265	387
C-Section Births	Jun 2026	176			156	123	189
C-Section Births - Total Rate %	Jun 2026	50.9%			47.7%	38.8%	56.6%
C-Section Births - Elective Rate %	Jun 2026	28.9%			22.4%	12.4%	32.4%
C-Section Births - Emergency Rate %	Jun 2026	22.0%			25.3%	20.4%	30.3%
Spontaneous Vaginal Births	Jun 2026	135			132	88	175
Spontaneous Vaginal Births %	Jun 2026	39.0%			40.4%	29.2%	51.6%
Assisted Vaginal Births	Jun 2026	35			39	23	54
Assisted Vaginal Births %	Jun 2026	10.1%			11.8%	8.1%	15.5%
Preterm Births	Jun 2026	38			29	7	51
Extreme Preterm Births	Jun 2026	6			2	-3	7
Home Births %	Jun 2026	1.2%			2.6%	-0.2%	5.5%
Births in water %	Jun 2026	3.8%			3.5%	1.3%	5.6%
Number of Bookings	Jun 2026	415			388	308	467
Bookings By 9+6 Weeks	Jun 2026	68.4%			69.5%	56.5%	82.4%
Birth Outcomes							
Total Stillbirths >=24 weeks	Jun 2026	4			1	-3	5
% Stillbirths >=24 weeks	Jun 2026	1.2%			0.3%	-0.8%	1.4%
3rd & 4th Degree Tears %	Jun 2026	2.4%			2.2%	-1.3%	5.6%
3rd & 4th Degree Tears of Assisted Vaginal Births %	Jun 2026	5.7%			4.5%	-5.5%	14.5%
3rd & 4th Degree Tears of Spontaneous Vaginal Births %	Jun 2026	3.0%			2.8%	-1.7%	7.3%
PPH >=1.5L Caesarean Births	Jun 2026	7			5	-4	15
PPH >=1.5L - Vaginal Births	Jun 2026	9			6	-3	16
PPH >=1.5L - Caesarean Births %	Jun 2026	4.1%			3.6%	-3.0%	10.2%
PPH >=1.5L - Vaginal Births %	Jun 2026	5.4%			3.8%	-1.4%	9.0%
Neonatal Clinical Indicators							
Apgar Score <7 at 5 mins (Term)	Jun 2026	7			6	2	10

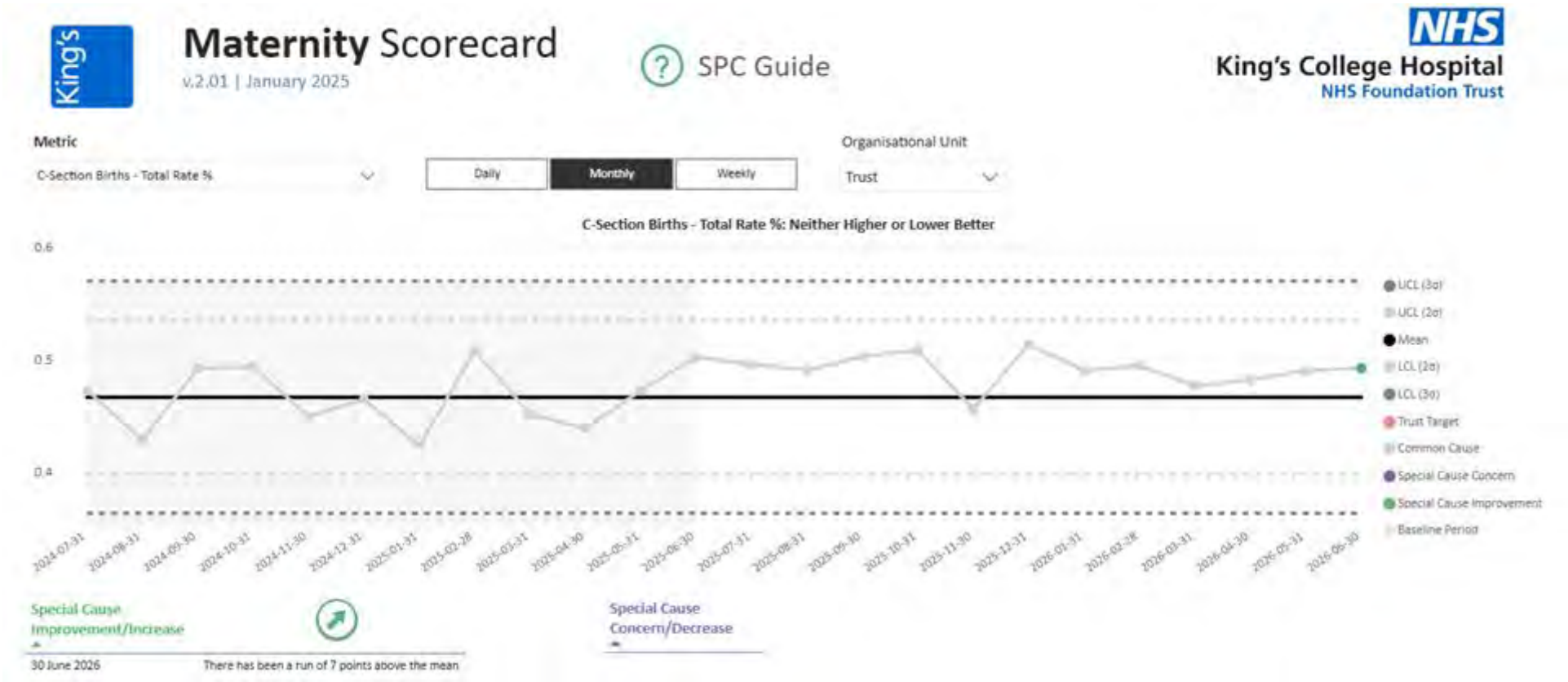
PRUH Metric Assurance

King's College Hospital NHS Foundation Trust

	Latest Reporting Period	Metric Value	Target	Assurance	Mean	LCL	UCL
Activity							
Registerable Births	Jun 2026	263			280	240	320
C-Section Births	Jun 2026	125			127	81	172
C-Section Births - Total Rate %	Jun 2026	47.5%			45.2%	33.2%	57.2%
C-Section Births - Elective Rate %	Jun 2026	23.2%			20.1%	14.0%	26.2%
C-Section Births - Emergency Rate %	Jun 2026	24.3%			25.1%	16.6%	33.6%
Spontaneous Vaginal Births	Jun 2026	106			118	94	143
Spontaneous Vaginal Births %	Jun 2026	40.3%			42.4%	33.8%	51.0%
Assisted Vaginal Births	Jun 2026	32			35	24	45
Assisted Vaginal Births %	Jun 2026	12.2%			12.4%	7.5%	17.2%
Preterm Births	Jun 2026	20			20	6	34
Extreme Preterm Births	Jun 2026	0			0	-1	2
Home Births %	Jun 2026	0.8%			0.7%	-0.4%	1.9%
Births in water %	Jun 2026	5.3%			6.3%	2.3%	10.3%
Number of Bookings	Jun 2026	315			324	247	402
Bookings By 9+6 Weeks	Jun 2026	71.1%			60.6%	42.9%	78.3%
Birth Outcomes							
Total Stillbirths >=24 weeks	Jun 2026	2			1	-3	4
% Stillbirths >=24 weeks	Jun 2026	0.8%			0.3%	-0.9%	1.5%
3rd & 4th Degree Tears %	Jun 2026	3.6%			1.8%	-0.1%	3.8%
3rd & 4th Degree Tears of Assisted Vaginal Births %	Jun 2026	6.3%			2.0%	-2.9%	6.9%
3rd & 4th Degree Tears of Spontaneous Vaginal Births %	Jun 2026	4.7%			2.4%	-0.1%	4.9%
PPH >=1.5L Caesarean Births	Jun 2026	2			4	-3	10
PPH >=1.5L - Vaginal Births	Jun 2026	8			4	0	9
PPH >=1.5L - Caesarean Births %	Jun 2026	1.6%			2.9%	-2.5%	8.3%
PPH >=1.5L - Vaginal Births %	Jun 2026	5.8%			2.8%	-0.1%	5.6%
Neonatal Clinical Indicators							
Apgar Score <7 at 5 mins (Term)	Jun 2026	3			4	-2	9

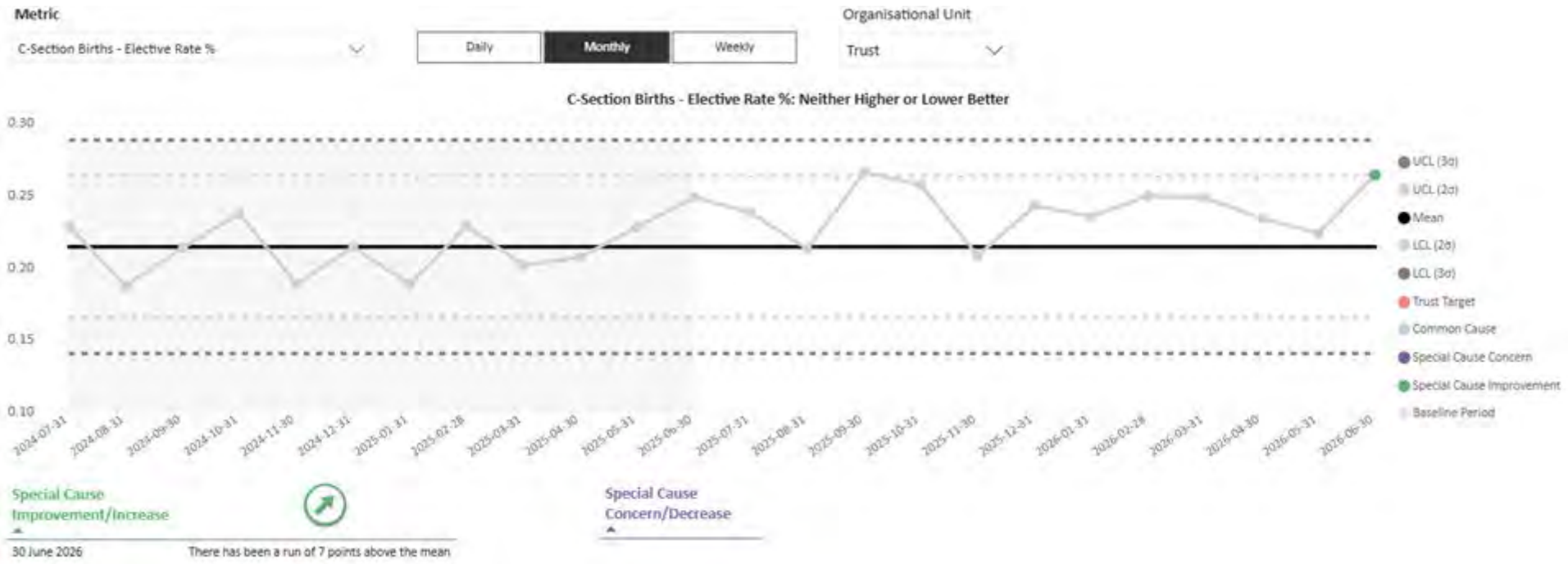
KCH - Total CS Rate

King's College Hospital NHS Foundation Trust



KCH Elective CS

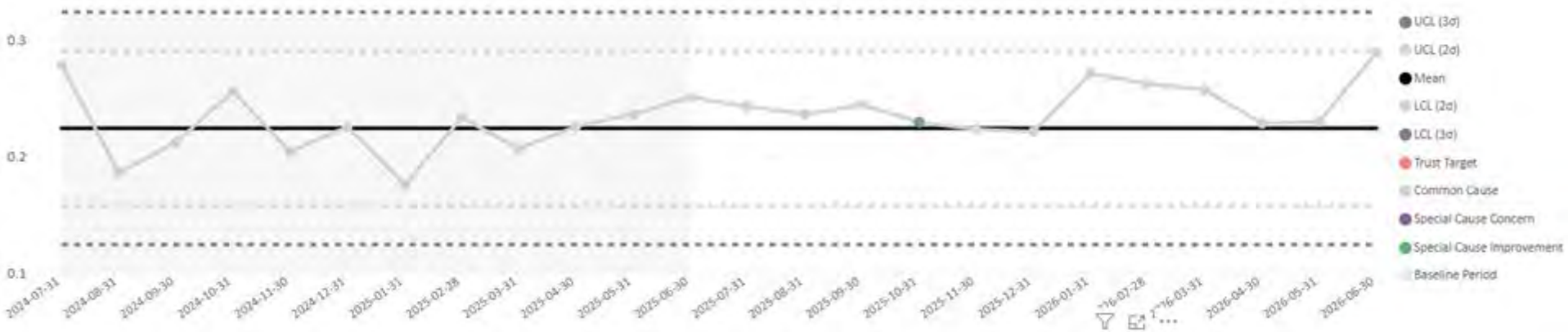
King's College Hospital NHS Foundation Trust



ELCS site focus

King's College Hospital NHS Foundation Trust

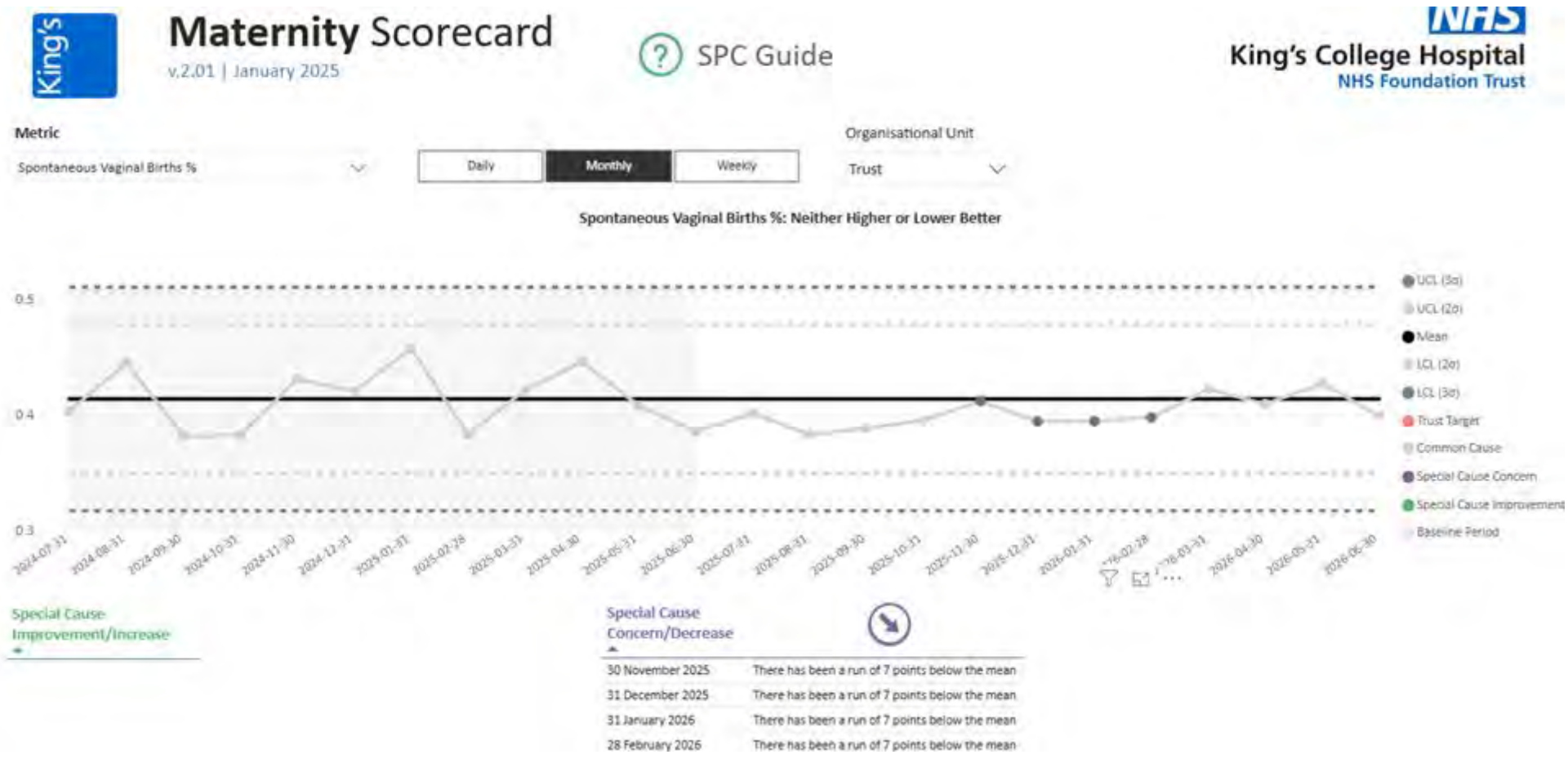
Denmark Hill



PRUH

Appendix 3
KCH Total Spontaneous Vaginal Births %

King's College Hospital NHS Foundation Trust



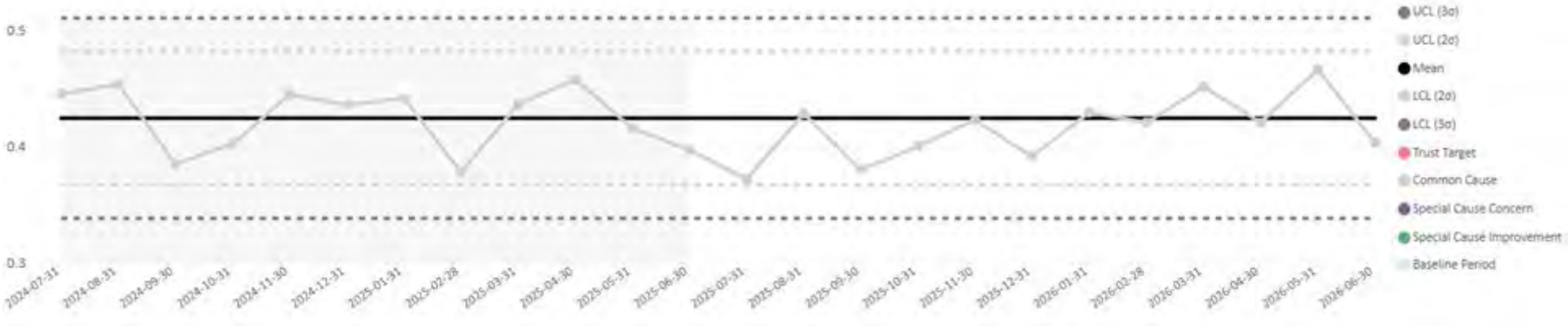
11

SVB site focus

King's College Hospital NHS Foundation Trust

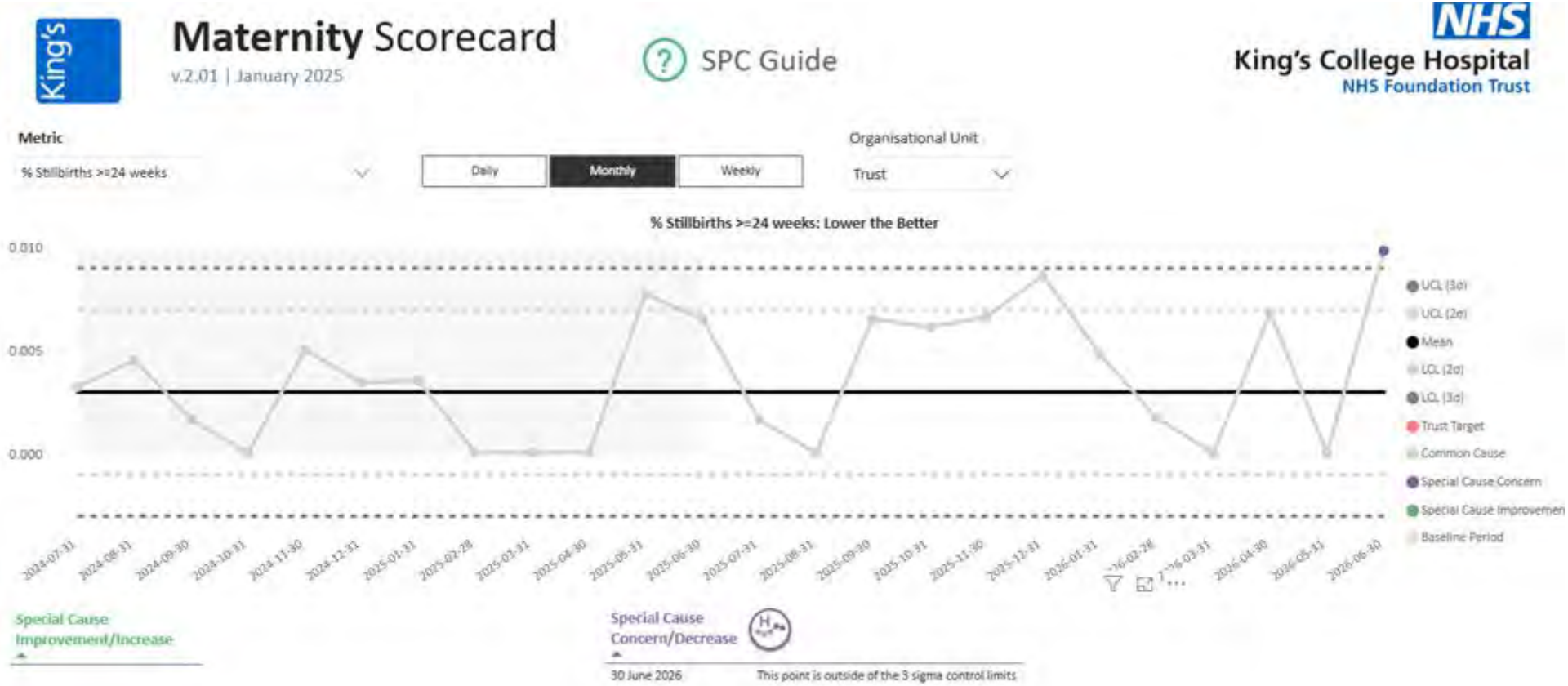
Denmark Hill

PRUH



KCH - Stillbirth Rate

King's College Hospital NHS Foundation Trust



Bookings by 9+6 - PRUH

King's College Hospital NHS Foundation Trust

Maternity Scorecard

v.2.01 | January 2025

SPC Guide

King's College Hospital NHS Foundation Trust

Metric: Bookings By 9+6 Weeks

Daily | Monthly | Weekly

Organisational Unit: PRUH

⚠ Please note that there has been recent consistency in special variation. You may need to consid...

Special Cause Improvement/Increase

31 December 2025	There has been a run of 7 points above the mean
31 January 2026	There has been a run of 7 points above the mean
28 February 2026	There has been a run of 7 points above the mean
31 March 2026	There has been a run of 7 points above the mean
30 April 2026	There has been a run of 7 points above the mean
31 May 2026	There has been a run of 7 points above the mean
30 June 2026	There has been a run of 7 points above the mean

Special Cause Concern/Decrease

30 September 2024	Two out of the last three points have been below the Lower 2 sigma limit
31 October 2024	Two out of the last three points have been below the Lower 2 sigma limit

Appendix 1: SPC Explanation

King's College Hospital NHS Foundation Trust

Maternity Scorecard

v.2.01 | January 2025

King's College Hospital NHS Foundation Trust

Statistical Process Control

An SPC chart is a plot of data over time. It allows you to distinguish between common and special cause variation.

Glossary of Terms

- Baseline Period - The first 12 periods of each metric/metric frequency
- Mean - The average metric value calculated in the baseline period
- UCL (3σ) - Three standard deviations above the mean
- UCL (2σ) - Two standard deviations above the mean
- LCL (3σ) - Three standard deviations below the mean
- LCL (2σ) - Two standard deviations below the mean
- Trust Target - The fixed target set either locally by the Trust or nationally
- Common Cause - Variation that is not seen as significant
- Special Cause Concern - Variation that is likely to indicate a significant decrease in performance
- Special Cause Improvement - Variation that is likely to indicate a significant increase in performance
- Special Cause Decrease - Variation that is likely to indicate a significant decrease (where neither high or low is considered good or bad)
- Special Cause Increase - Variation that is likely to indicate a significant increase (where neither high or low is considered good or bad)

SPC Rules

To help interpret the data for each metric, each data point is either highlighted as Special Cause Concern/Decrease, Special Cause Improvement/Increase or Common Cause as based on the following rules:

1. A run of 7 points or more that are consecutively ascending or descending
2. A run of 7 points or more that are above or below the mean
3. Two out of the last three data points are above or below the 2σ control limits (but not crossing the mean)
4. A single point falls outside of the process limits

Should a data point satisfy more than one of the above rules, each rule is applied in the above order

Icon Key

Variation

- Variation is calculated from the first 12 periods of each metric (highlighted in SPC chart as the baseline period)
- All these rules are aids to interpretation but still require further examination of the data
- This SPC tool highlights when a rule has been broken and highlights whether this is improvement or deterioration

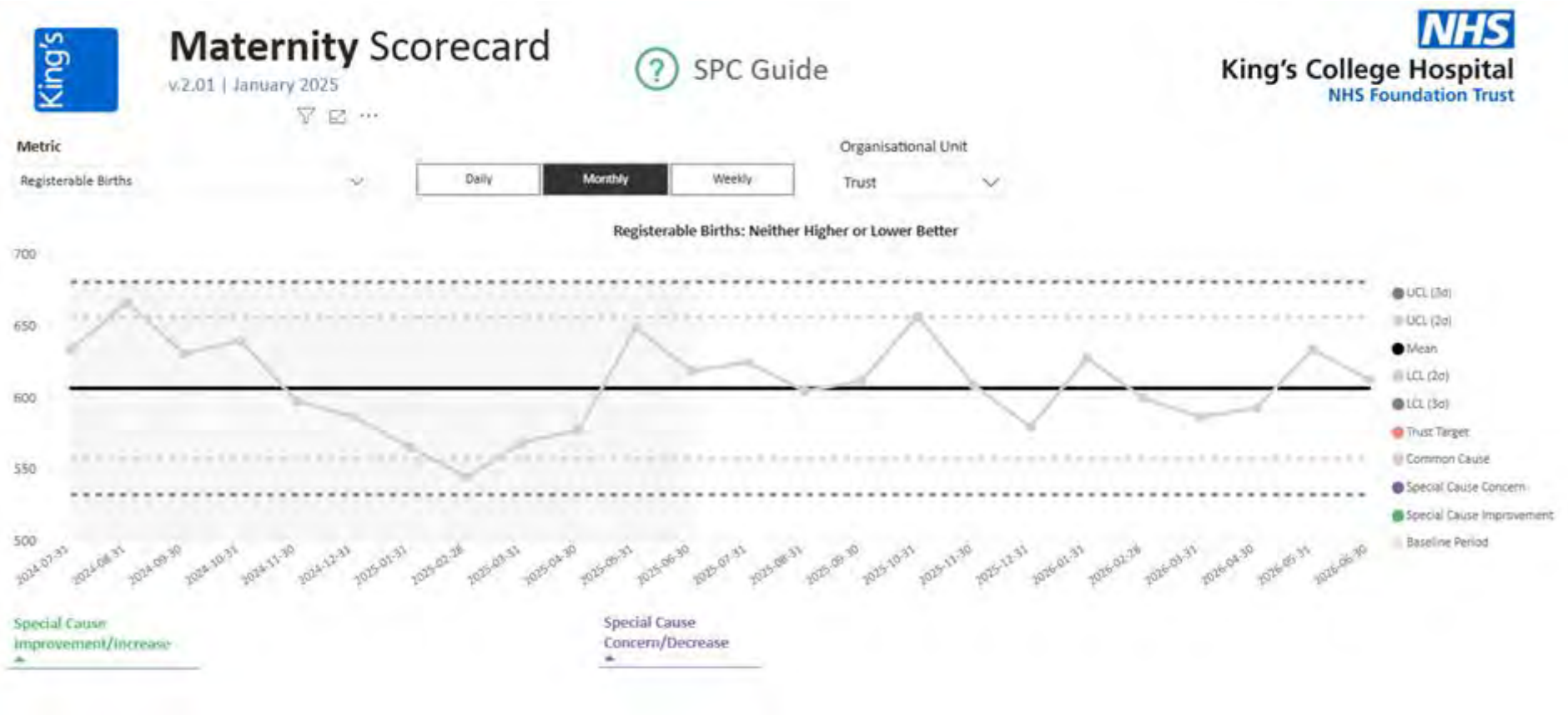
Assurance

- Assurance is comparing the variance to the fixed target for the Trust
- If the target is outside of the 3σ control limits of the whole range of data (ie. not restricted to the baseline cohort), it is deemed a pass or fail (depending on whether high or low is positive)
- If the target is between the 3σ control limits, it is deemed to be "Hit and miss"

Report by **Lisa Wood**, Senior Business Intelligence Analyst and **Tom Price**, Operational Reporting Manager | **Business Intelligence Unit** | kch-tr.performance-team@nhs.net

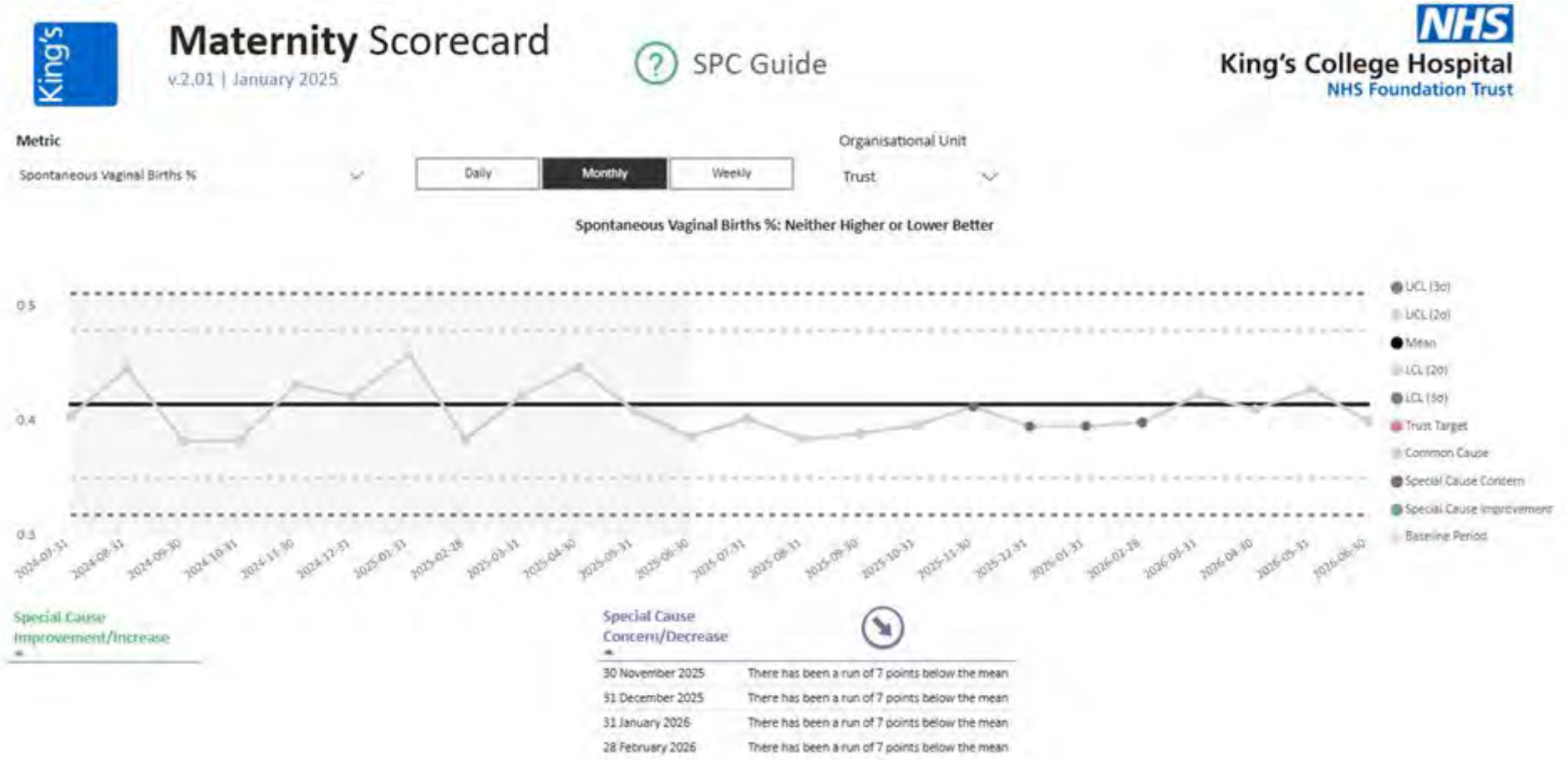
Appendix 2: KCH Total Registerable Births

King's College Hospital NHS Foundation Trust



Appendix 3
KCH Total Spontaneous Vaginal Births %

King's College Hospital NHS Foundation Trust



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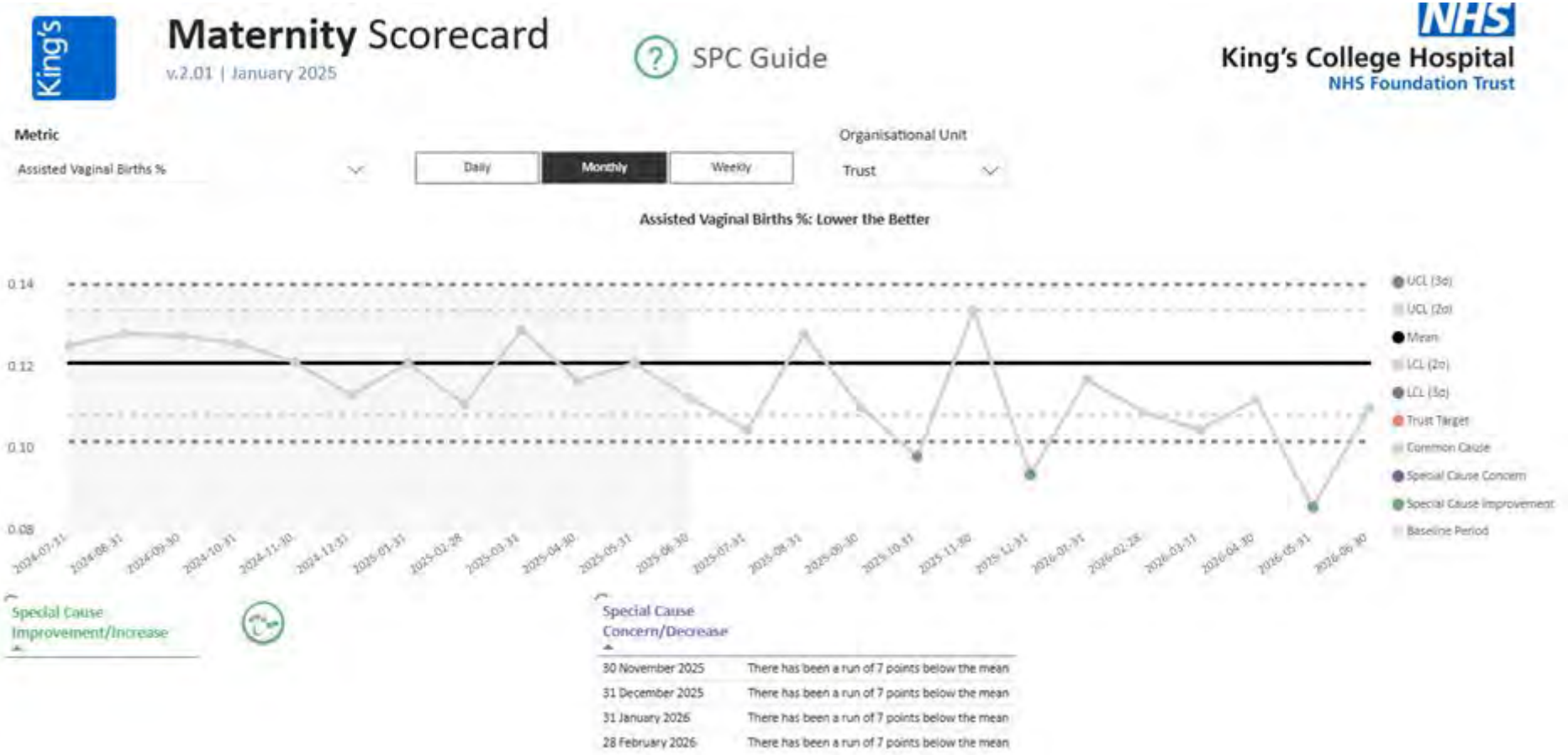
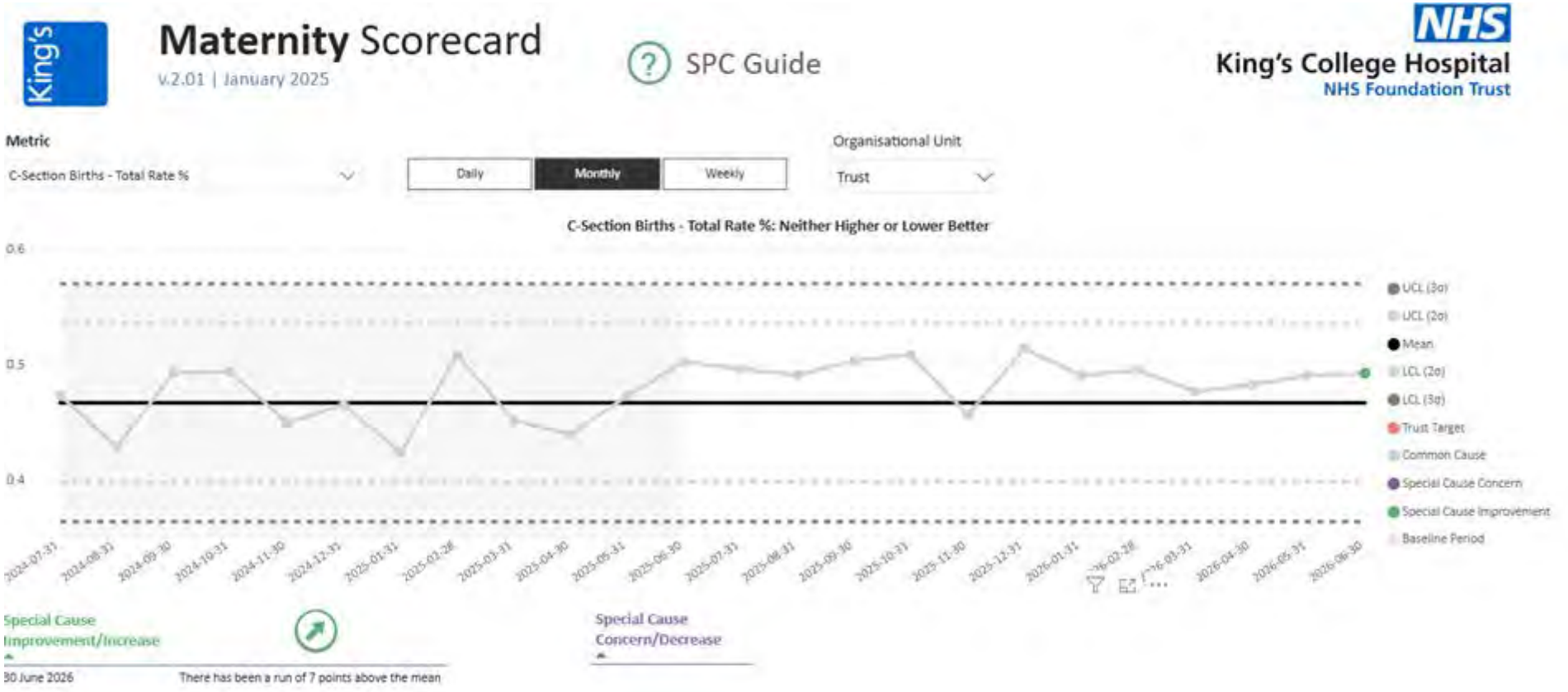
Appendix 4
KCH Assisted Vaginal Births %

King's College Hospital NHS Foundation Trust



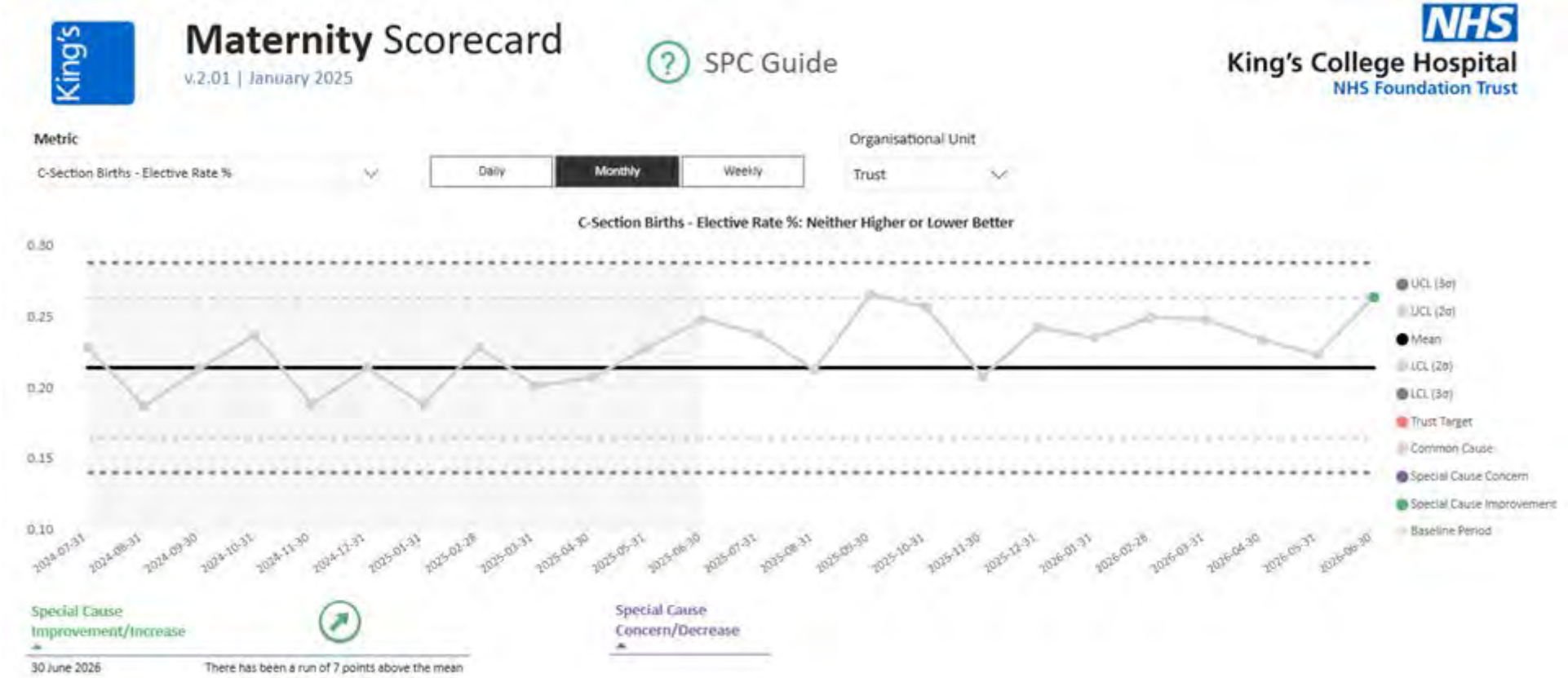
Appendix 5
KCH Caesarean Births %

King's College Hospital NHS Foundation Trust



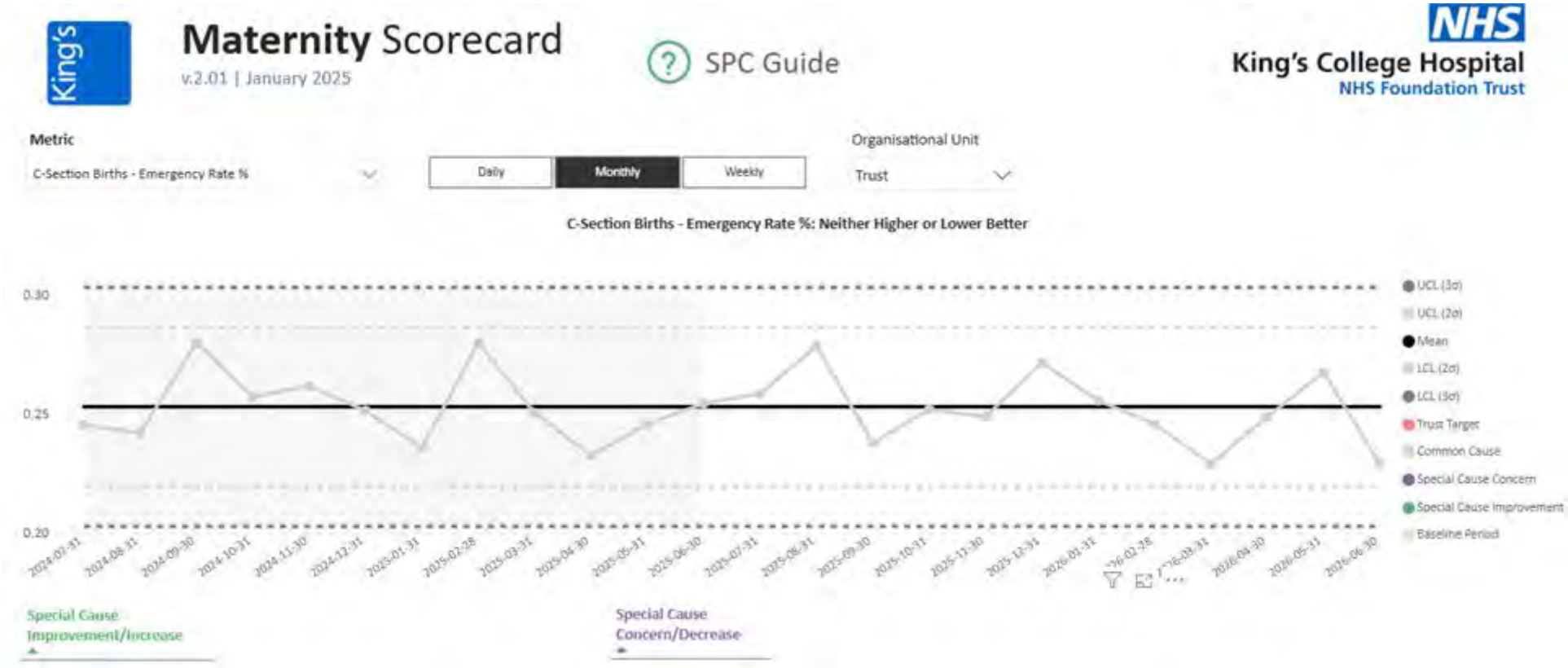
Appendix 6
KCH Elective CS

King's College Hospital NHS Foundation Trust



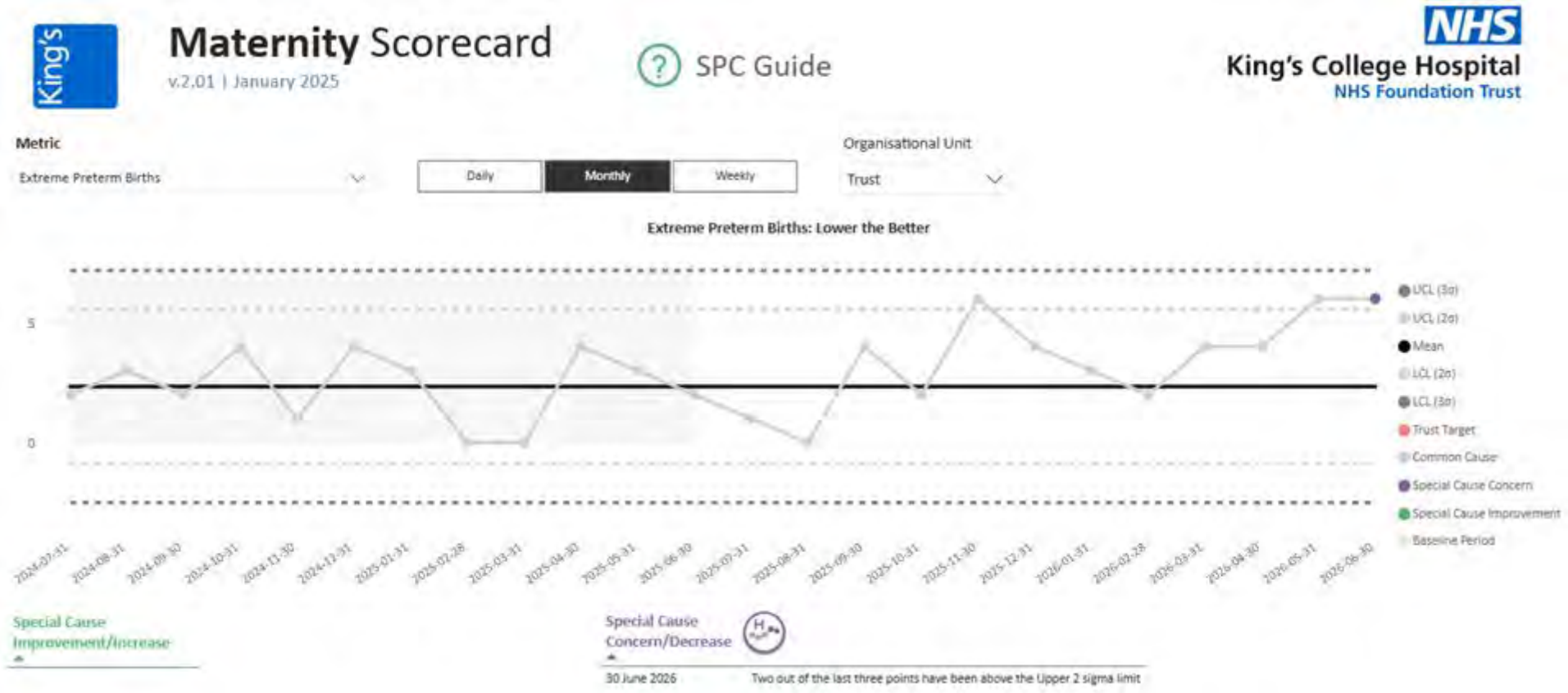
Appendix 7
KCH Emergency CS

King's College Hospital NHS Foundation Trust



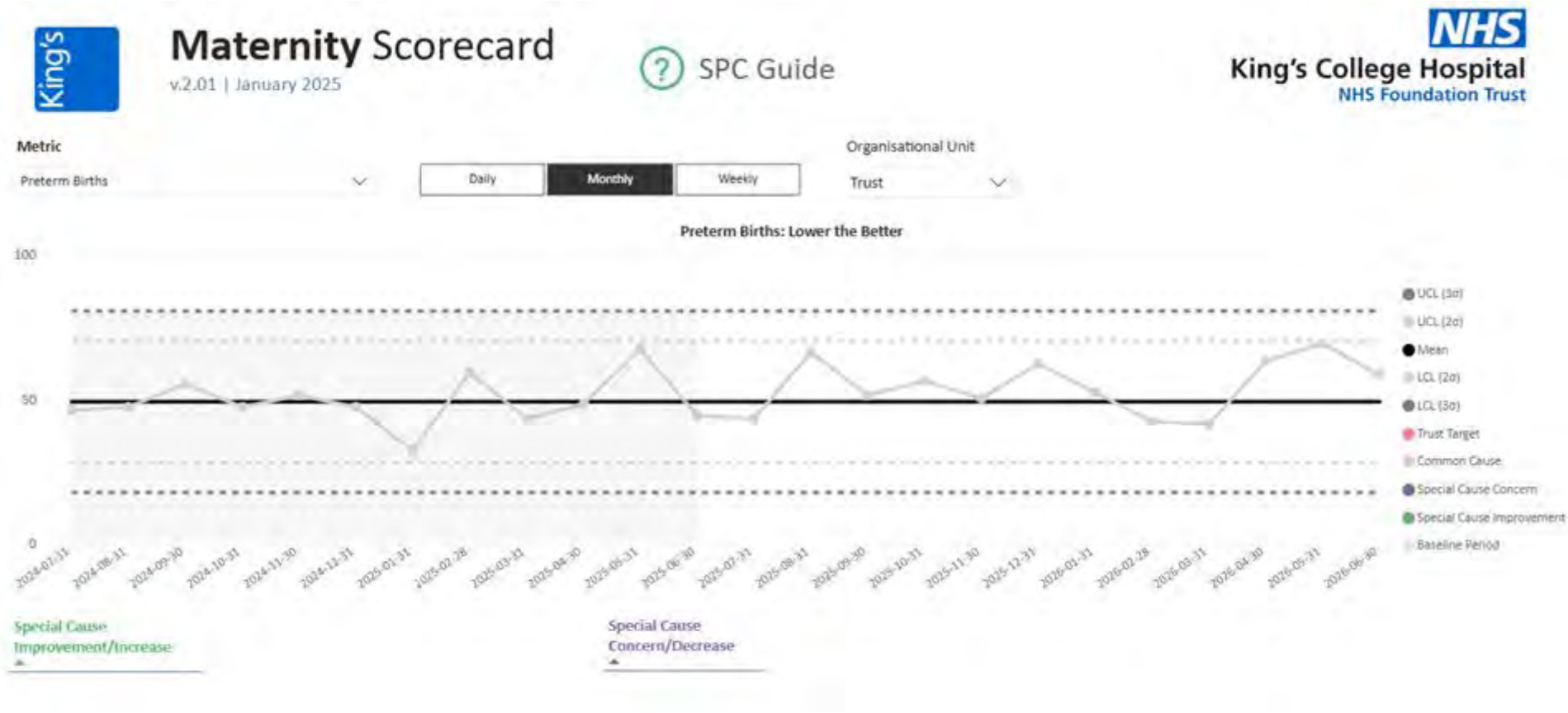
Appendix 8
KCH Extreme Preterm

King's College Hospital NHS Foundation Trust



Appendix 9
KCH Preterm Births

King's College Hospital NHS Foundation Trust



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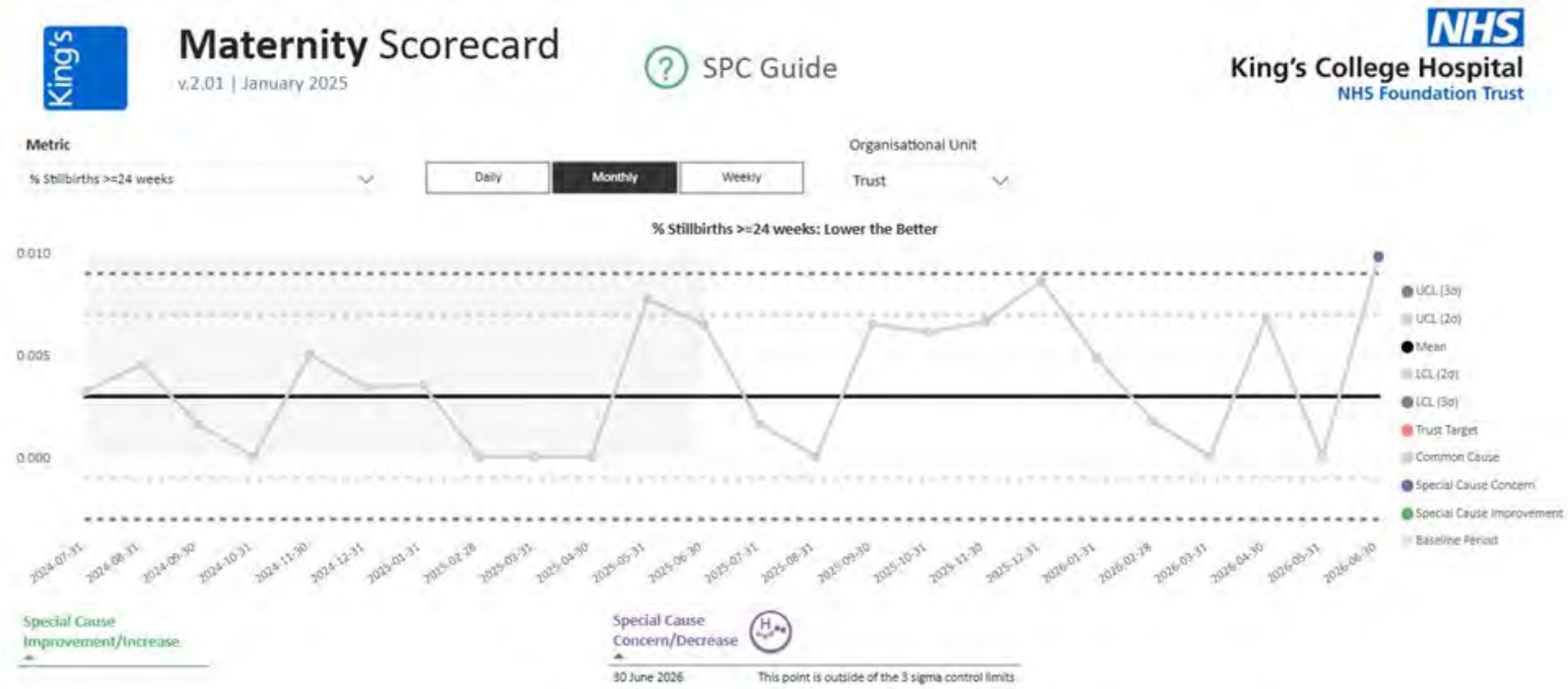
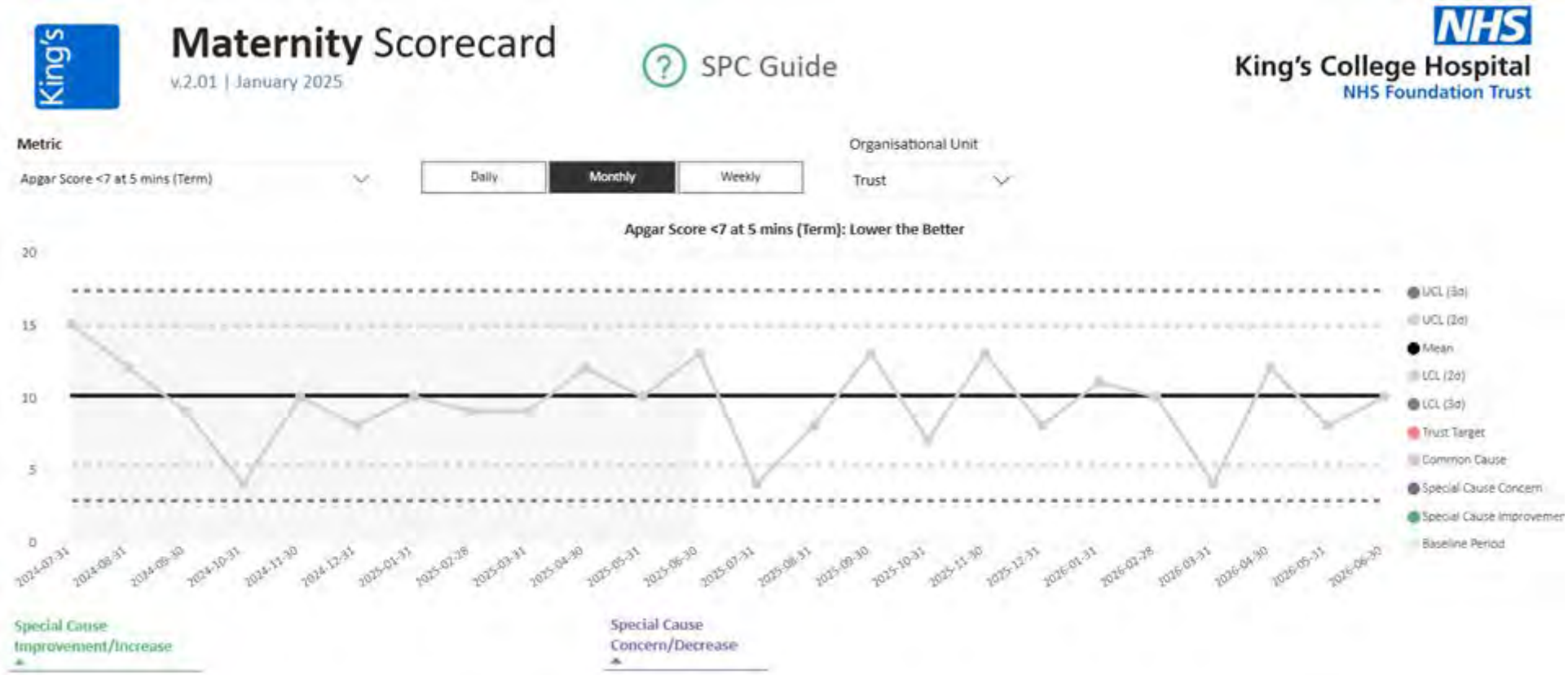
Appendix 10
KCH % Stillbirths >=24wks

King's College Hospital NHS Foundation Trust



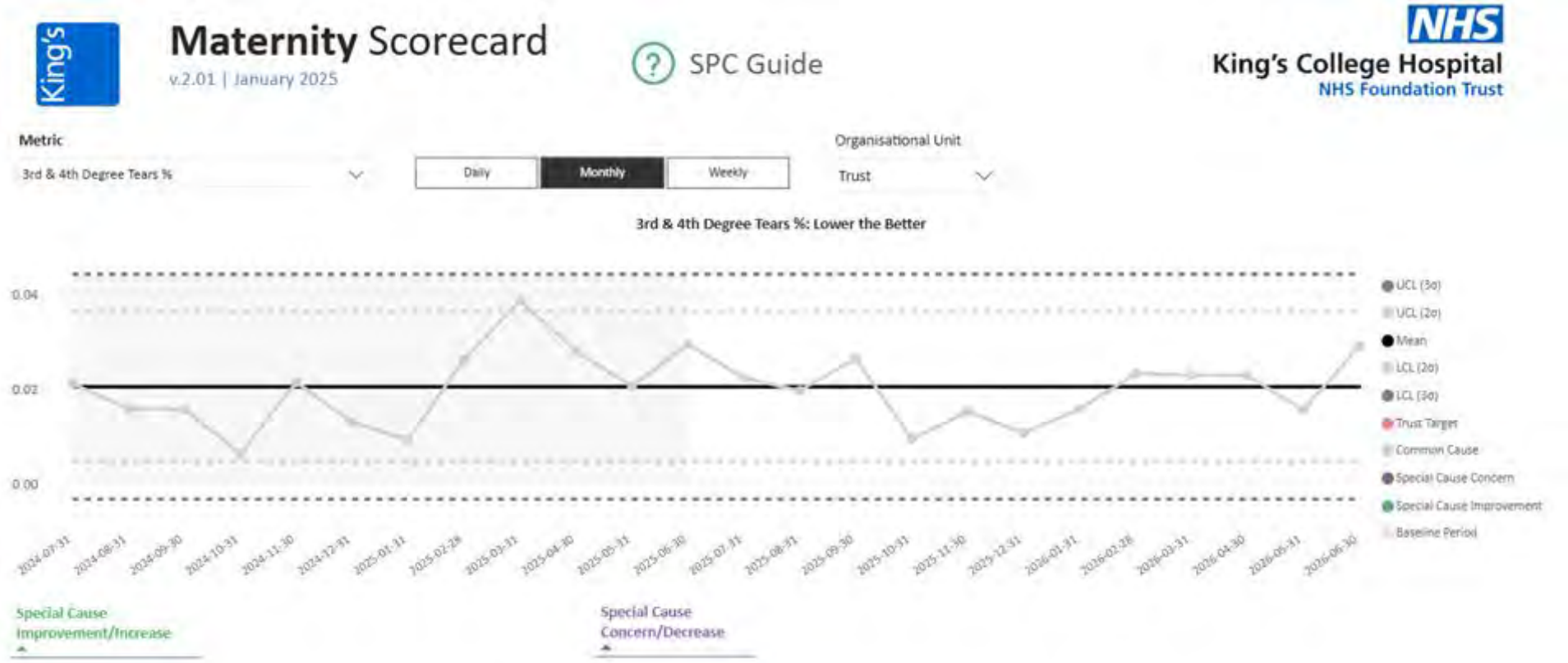
Appendix 11
KCH Apgar Score <7 at 5 mins

King's College Hospital NHS Foundation Trust



Appendix 12
KCH 3rd & 4th degree Tears

King's College Hospital NHS
NHS Foundation Trust

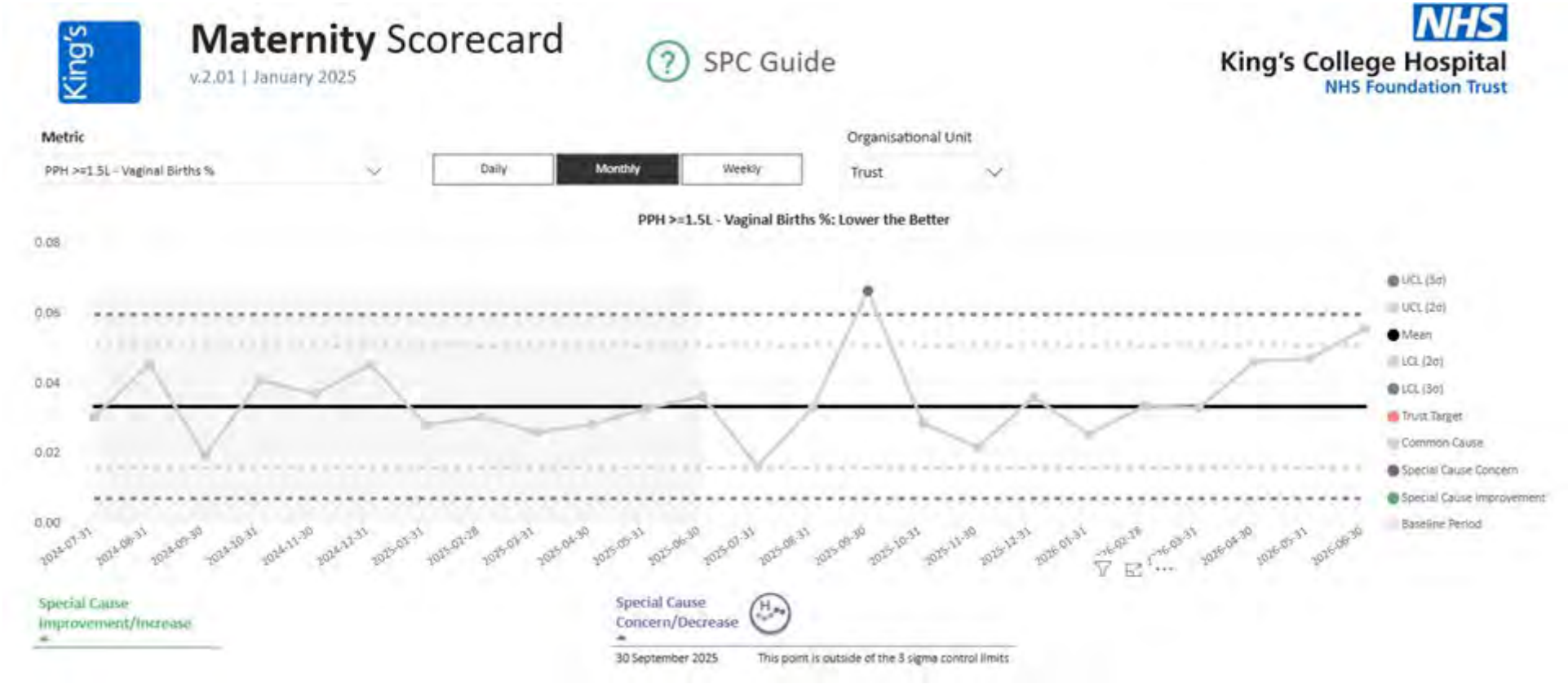


Appendix 13
MOH >1.5L CS Births

King's College Hospital NHS Foundation Trust

Appendix 14
MOH >1.5L Vaginal Births

King's College Hospital NHS Foundation Trust



Appendix 15
Births in Water %

King's College Hospital NHS Foundation Trust

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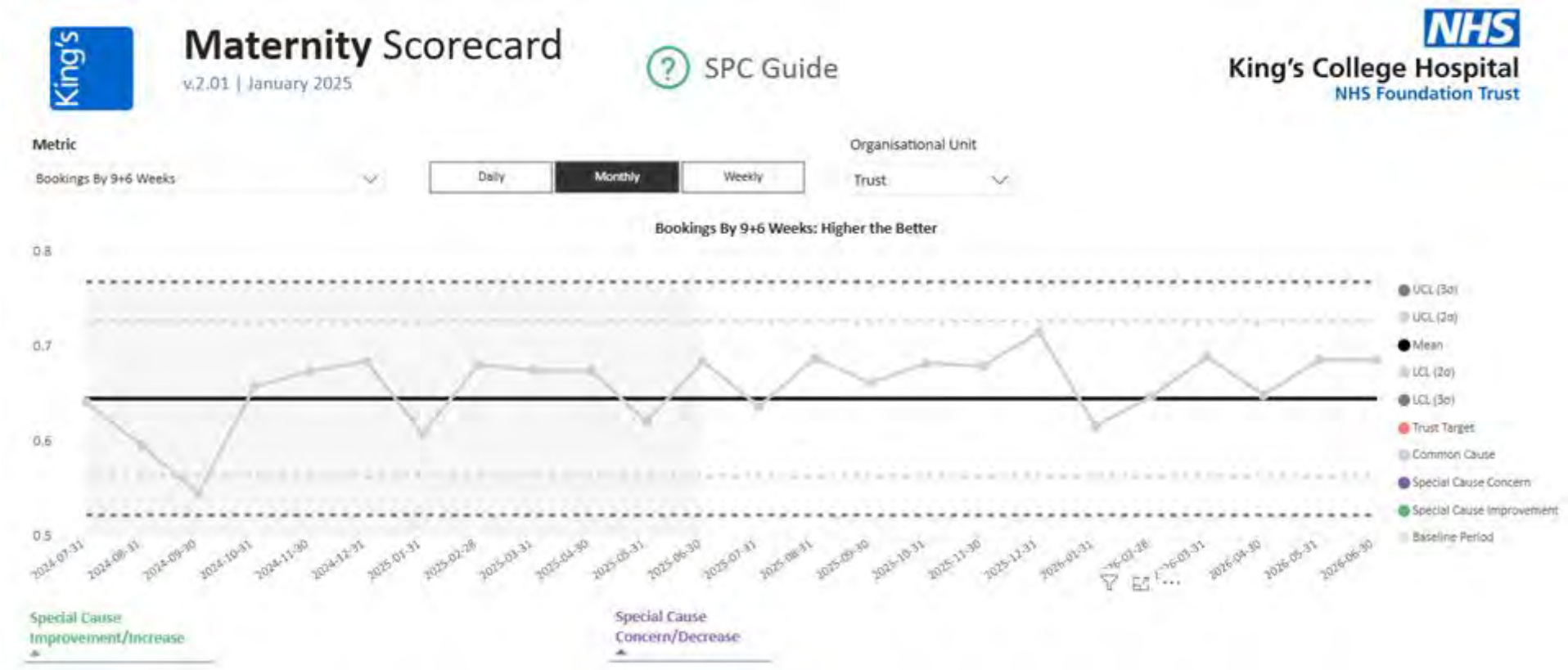
Appendix 16
Bookings by 9+6

King's College Hospital NHS Foundation Trust



Appendix 17
Total Bookings

King's College Hospital NHS Foundation Trust

King's

NHS
King's College Hospital
NHS Foundation Trust

Red Flags audit DH June-July 2026

King's

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An Academic Health Sciences Centre for London

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Data collection

- Data has been taken from the Birthrate Plus acuity tool red flags submission where red flags are documented by the coordinator or flow midwife when submitting acuity
- This aligns with NICE 2015: Safe midwifery staffing for maternity settings- Maternity Red Flags and is listed opposite
- Acuity including red flags is recorded 4 hourly in inpatient areas
- There are 2 daily maternity huddles where acuity and red flags are discussed and if a red flag has happened then plans made to mitigate
- If there is a red flag outside the timeframes of the huddles then the flow midwife or coordinator escalates to matron, or midwife manager on call out of hours to enact escalation and support
- Inphase incident forms are submitted alongside the red flag when they occur for MDT review at weekly PSIRF meetings

- **List of red flag triggers:**
- Delayed or cancelled time critical activity
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)
- Delay in providing pain relief
- Delay between presentation and triage
- Full clinical examination not carried out when presenting in labour
- Delay between admission for induction and beginning of process
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour
- Coordinator not able to maintain supernumerary/supervisory status - providing 1:1 care in Labour
- Coordinator unable to maintain supernumerary status- NOT providing 1:1 care

Overall

Number of Red Flags recorded

01/06/2026 to 31/07/2026

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	2	50%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Coordinator not able to maintain supernumerary/supervisory status - providing 1:1 care in Labour	0	0%
RF11	Coordinator unable to maintain supernumerary status- NOT providing 1:1 care	2	50%
TOTAL		4	

*The % is rounded to nearest whole number

- There were 4 red flag events June-July 2026
- This is 2 fewer than the previous audit
- The most common event was evenly split between delay in admission for induction and beginning of process and coordinator unable to maintain supernumerary/supervisory status however not providing 1:1 care).
- Both incidents of coordinator providing care were during the night and the acuity had returned to a stable level within 4 hours on BR+.
- Delays in IOL are highlighted through the twice daily maternity huddles, each service user has risk assessment through MDT.
- Maternal and fetal wellbeing are confirmed through monitoring and there is a consultant review for every service user who is delayed
- Communication with affected families is prioritised to minimise poor patient experience
- Red flags are identified during the twice daily huddles in conjunction with the overall acuity and real time activity.

June 2026

Number of Red Flags recorded

01/06/2026 to 30/06/2026

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	1	100%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Coordinator not able to maintain supernumerary/supervisory status - providing 1:1 care in Labour	0	0%
RF11	Coordinator unable to maintain supernumerary status- NOT providing 1:1 care	0	0%
TOTAL		1	

*The % is rounded to nearest whole number

- There was 1 red flag event in June 2026.
- This reflects improved vacancy rates and reduction in LTS absence which impacts on overall flow and ability to provide care in the unit

King's

July 2026

Number of Red Flags recorded

01/07/2026 to 31/07/2026

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	1	33%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Coordinator not able to maintain supernumerary/supervisory status - providing 1:1 care in Labour	0	0%
RF11	Coordinator unable to maintain supernumerary status- NOT providing 1:1 care	2	67%
TOTAL		3	

*The % is rounded to nearest whole number

- There were 3 red flag events in July 2026.

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Red Flags audit DH June-July 2026

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Data collection

- Data has been taken from the Birthrate Plus acuity tool red flags submission where red flags are documented by the coordinator or flow midwife when submitting acuity
- This aligns with NICE 2015: Safe midwifery staffing for maternity settings- Maternity Red Flags and is listed opposite
- Acuity including red flags is recorded 4 hourly in inpatient areas
- There are 2 daily maternity huddles where acuity and red flags are discussed and if a red flag has happened then plans made to mitigate
- If there is a red flag outside the timeframes of the huddles then the flow midwife or coordinator escalates to matron, or midwife manager on call out of hours to enact escalation and support
- Inphase incident forms are submitted alongside the red flag when they occur for MDT review at weekly PSIRF meetings

- **List of red flag triggers:**
- Delayed or cancelled time critical activity
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)
- Delay in providing pain relief
- Delay between presentation and triage
- Full clinical examination not carried out when presenting in labour
- Delay between admission for induction and beginning of process
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour
- Coordinator not able to maintain supernumerary/supervisory status - providing 1:1 care in Labour
- Coordinator unable to maintain supernumerary status- NOT providing 1:1 care

Overall

Number of Red Flags recorded

01/06/2026 to 31/07/2026

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	2	50%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Coordinator not able to maintain supernumerary/supervisory status - providing 1:1 care in Labour	0	0%
RF11	Coordinator unable to maintain supernumerary status- NOT providing 1:1 care	2	50%
TOTAL		4	

*The % is rounded to nearest whole number

- There were 4 red flag events June-July 2026
- This is 2 fewer than the previous audit
- The most common event was evenly split between delay in admission for induction and beginning of process and coordinator unable to maintain supernumerary/supervisory status however not providing 1:1 care).
- Both incidents of coordinator providing care were during the night and the acuity had returned to a stable level within 4 hours on BR+.
- Delays in IOL are highlighted through the twice daily maternity huddles, each service user has risk assessment through MDT.
- Maternal and fetal wellbeing are confirmed through monitoring and there is a consultant review for every service user who is delayed
- Communication with affected families is prioritised to minimise poor patient experience
- Red flags are identified during the twice daily huddles in conjunction with the overall acuity and real time activity.

June 2026

Number of Red Flags recorded

01/06/2026 to 30/06/2026

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	1	100%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Coordinator not able to maintain supernumerary/supervisory status - providing 1:1 care in Labour	0	0%
RF11	Coordinator unable to maintain supernumerary status- NOT providing 1:1 care	0	0%
TOTAL		1	

*The % is rounded to nearest whole number

- There was 1 red flag event in June 2026.
- This reflects improved vacancy rates and reduction in LTS absence which impacts on overall flow and ability to provide care in the unit

July 2026

Number of Red Flags recorded

01/07/2026 to 31/07/2026

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	1	33%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Coordinator not able to maintain supernumerary/supervisory status - providing 1:1 care in Labour	0	0%
RF11	Coordinator unable to maintain supernumerary status- NOT providing 1:1 care	2	67%
TOTAL		3	

*The % is rounded to nearest whole number

- There were 3 red flag events in July 2026.

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Red Flags audit PRUH June-July 2026

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Data collection – PRUH

- Data has been taken from the Birthrate Plus acuity tool red flags submission where red flags are documented by the coordinator or flow midwife when submitting acuity
- This aligns with NICE 2015: Safe midwifery staffing for maternity settings- Maternity Red Flags and is listed opposite
- Acuity including red flags is recorded 4 hourly in intrapartum inpatient areas
- There are 2 daily maternity huddles where acuity and red flags are discussed and if a red flag has happened then plans made to mitigate
- If there is a red flag outside the timeframes of the huddles then the flow midwife or in her absence MIC escalates to matron, or midwife manager on call out of hours to enact escalation and support
- Inphase incident forms are submitted alongside the red flag when they occur for MDT review at weekly PSIRF meetings

- **To note** – the definition of a delay in care/ activity and treatment differs on BR+ acuity tool to the National Maternity SitRep submission - Delays are reported when they have occurred for more than 24 hours between the planned and actual start of the procedure. A delay is considered to occur if the woman is not admitted or treatment does not commence for their procedure on the day and time it was originally scheduled.

Breakdown of Red Flags
Delayed or cancelled time critical activity
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)
Delay in providing pain relief
Delay between presentation and triage
Full clinical examination not carried out when presenting in labour
Delay between admission for induction and beginning of process
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour
Coordinator not able to maintain supernumerary/supervisory status - providing 1:1 care in Labour
Coordinator unable to maintain supernumerary status- NOT providing 1:1 care

Overall Labour Ward

Number of Red Flags recorded

01/06/2026 to 31/07/2026

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	2	33%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	1	17%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	3	50%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Coordinator not able to maintain supernumerary/supervisory status - providing 1:1 care in Labour	0	0%
RF11	Coordinator unable to maintain supernumerary status- NOT providing 1:1 care	0	0%
TOTAL		6	

*The % is rounded to nearest whole number

- There were **6 red flag events** June-July 2026

- The most common event was **Delay between admission for induction and beginning of process –** 3 occurrences in 2 month period:

1. 11/7 12:00 sickness 2 RMs redeployed to LW to support activity
2. 17/7 11:30 2 RMs redeployed from LW to MAU
3. 17/7 13:00 As above

- Delays in IOL are highlighted through the twice daily maternity huddles and Birthrate Plus tool, each service user has risk assessment through MDT review.
- Maternal and fetal wellbeing are confirmed through monitoring and there is a consultant review for every service user who is delayed
- Second most prevalent event was **Delayed or cancelled time critical activity -** 2 occurrences in 2 month period:

1. 20/6 08:00hrs 2 Inductions waiting for ARM , due to staff shortages (sickness & bank not filled)
2. 26/6 activity delayed as LW RM redeployed to Mat ward.

- The remaining event was **Delay between presentation and triage –** 1 occurrence in time frame:

1. 3/7 Unexpected sickness, RM redeployed from Oasis to LW to support activity.

Summary

- There were more red flags events in July than June.
- The events were varied in nature and all occurred during daytime hours when senior clinical and operational staff were available to implement timely mitigations and maintain safe care.
- Red flag events are reviewed alongside incidents and clinical outcomes using a PSIRF-informed approach to determine whether they have contributed to any patient safety concerns or adverse outcomes. This ensures that learning focuses on both system factors and the effectiveness of mitigations in place.
- A range of daily mitigations are consistently implemented across the service. Where red flag events occur, additional actions are taken to maintain safety during periods of increased acuity, demand, or staffing pressures. This includes consideration of cross-site working arrangements to reduce delays in responding to acuity concerns and to ensure individual risk factors for women and babies are appropriately managed.
- Where induction of labour (IOL) is delayed, maternal and fetal monitoring is undertaken as part of an ongoing risk assessment process. Multidisciplinary team (MDT) discussions take place to review clinical priorities, agree an individualised care plan, and determine the most appropriate timing for induction.
- MDT ward rounds and safety huddles are undertaken each shift to support situational awareness, review capacity and acuity, and coordinate safe care delivery. Elective activity is reviewed regularly, and proactive arrangements are made where delays are anticipated.

Red flag data is reported to the Trust Board through the Perinatal Quality Surveillance Model, providing assurance regarding maternity staffing, highlighting emerging risks, and ensuring appropriate escalation of any challenges affecting service delivery and patient safety.

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 17.

Report to:	Board of Directors
Date of meeting:	16 September 2026
Subject:	Risk Register Report
Author(s):	Samantha Machen, Assistant Director of Quality Governance
Sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery
History:	Regular monthly report
Status:	Risk and Governance Committee, 27/08

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 being undertaken
- Detailed overview of the corporate risks and current risk exposure profile

Recommendations:

The Board of Directors is asked to receive the report for discussion and 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**	✓

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Key implications

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

Main Report

Between June and August 2026, three risks were reduced in score, two risks increased in score, three new risks were escalated and no risks were closed. Work to enhance the risk maturity of the organisation has continued, including reporting on metrics relating to actions against risks and target completion dates, and further risk management training sessions

Two new risks were approved at August's Risk and Governance Committee – more information about these two risks are on slide 6 and 7. Risk 3963 relates to Radiology capacity and performance.

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Risk Management

Report to Trust Board – 16 September 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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Risk Refresh | Risk Assurance | Next Steps

Section 1
Risk Refresh -

- Summary overview of progress
- Risk management refresh Gantt chart

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

Risk Refresh | Risk Assurance | Next Steps

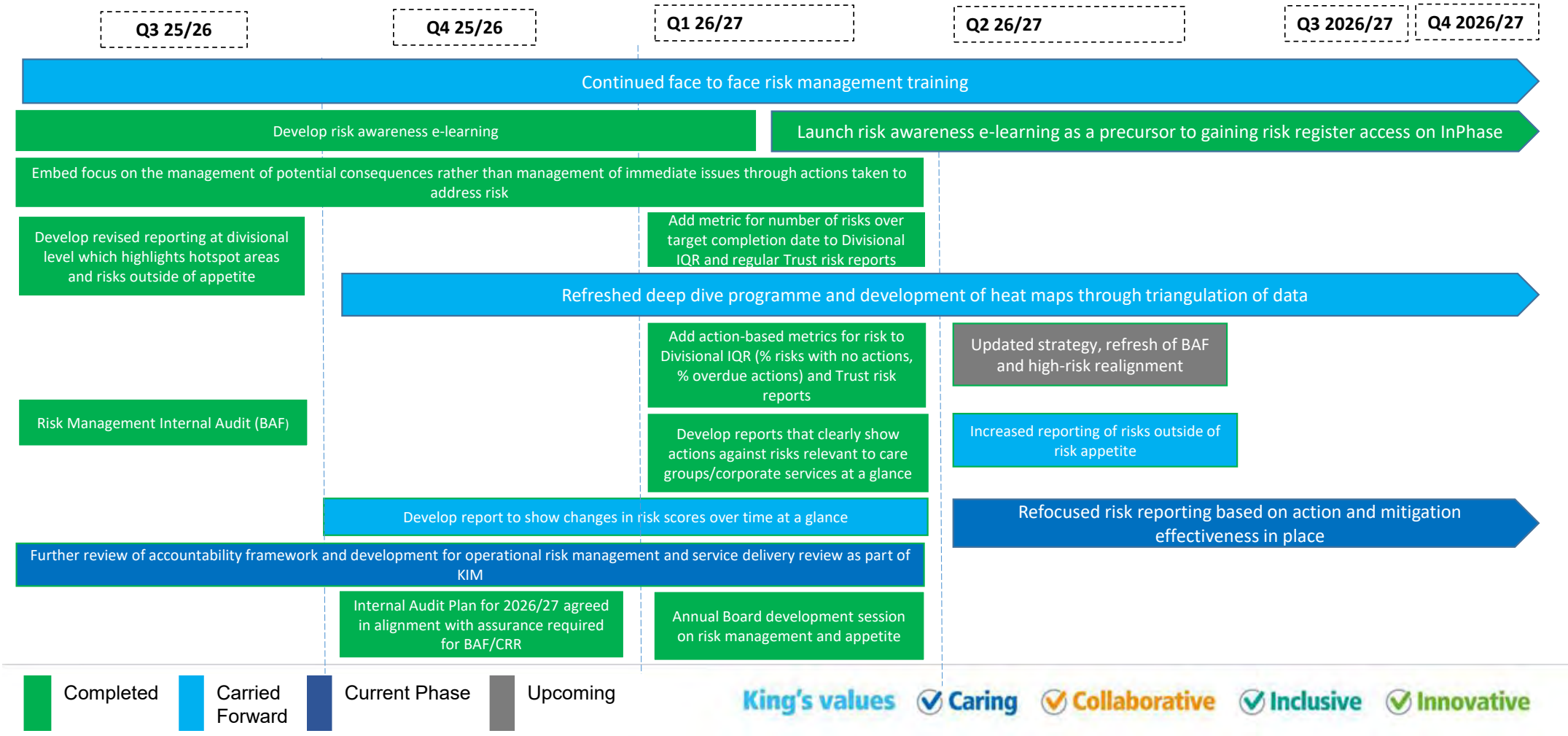
Risk Refresh

- Since the last report:
- Two further Level 2 training sessions have been held and the e-learning format for Level 1 training has been revised following initial feedback and is now held and undertaken via an InPhase form. This allows for greater tracking of attendance and streamlines the process for system access once the user has passed. We have now trained over 70 staff in Level 2 Risk Management.
- The new metrics for risk (risks with actions underway, high-risk actions overdue, risks past their target date for closure) are embedding and included in divisional IQRs and the report to the Risk and Governance Committee
- These changes will drive a re-focus of discussions towards actions to effectively reduce risk to a level the organisation will tolerate within or outside risk appetite, monitoring these, and where not possible to reduce risk to be clear about the reasons why and mitigation. The next stage is to embed the actions focus and drive improvement. This feeds into the overall improvement in organisational risk maturity

4

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

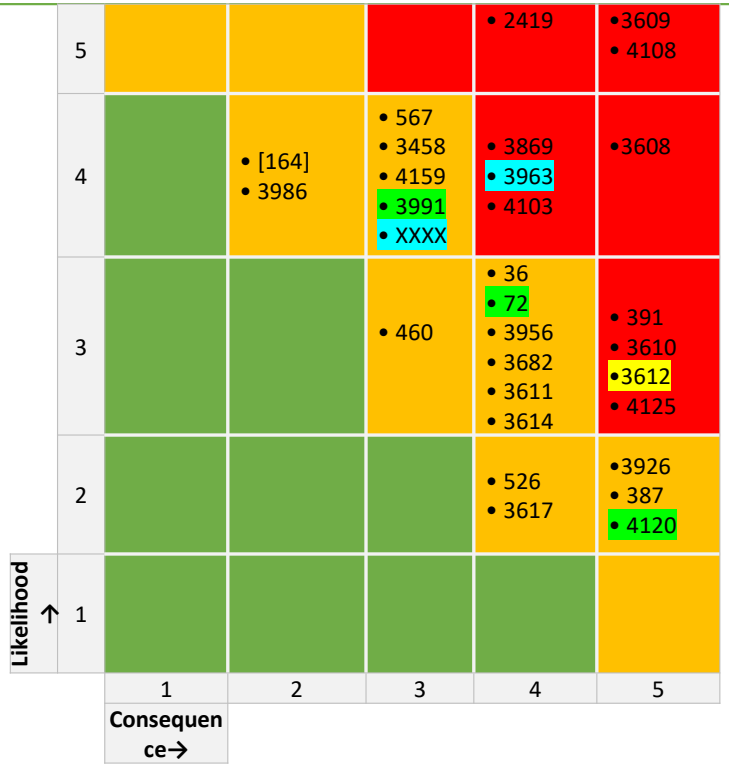
Corporate risk register

Current Risk exposure profile

Risk Register Movement (July-August 2026)

ID	Risk title	Risk Scores Initial	Current	Target	Change	Risk Type
36	Bullying and harassment	*16*	**12**	*6*	=	Workforce
72	Data and Cyber security of third party organisations accessing our network	*20*	**12**	*4*	↓	IT
164	Fraud Bribery and Corruption [tolerated risk]	*8*	**8**	*8*	=	Finance
387	Water Contamination	*12*	**10**	*6*	=	Quality
391	R03 Malware such as Ransomware Compromising Unpatched Servers	*15*	**15**	*5*	=	IT
460	Large Scale Staff Shortage	*16*	**9**	*3*	=	Workforce
526	Sustainability and Net Zero	*12*	**12**	*6*	=	Sustainability
567	Harm from Violence, abuse and challenging behaviour	*12*	**12**	*12*	=	Workforce
3458	Delayed Diagnosis	*8*	**12**	*4*	=	Quality
3419	Corridor Care	*25*	**20**	*4*	=	Quality
3608	Identification & delivery of efficiency requirements	*25*	**20**	*12*	=	Finance
3609	Expenditure Control	*20*	**25**	*8*	=	Finance
3610	Investment decisions	*20*	**15**	*8*	=	Finance
3611	Validity of activity assumptions	*20*	**12**	*3*	=	Finance
3612	Delivery of elective activity in line with financial plan	*15*	**15**	*4*	↑	Finance
3614	Capital programme	*16*	**12**	*5*	=	Finance
3617	Cost Inflation	*16*	**8**	*4*	=	Finance
3682	PRUH (PFI) building - Estate issues	*20*	**12**	*8*	=	Estates
3869	Elective Performance 2025/26	*16*	**16**	*12*	=	Performance
3926	Withholding of Deficit Support Funding	*8*	**10**	*4*	=	Finance
3963	Radiology Capacity and Performance	*20*	**16**	*4*	New	Performance
3956	Monitoring to Prevent Patient Deterioration	*12*	**12**	*4*	=	Quality
3991	Delayed pathology tests/results	*15*	**12**	*6*	↓	Quality
4103	Backlog Maintenance Projects 2026/27	*16*	**16**	*8*	=	Estates
4159	Care of Patients requiring therapeutic mental health intervention	*12*	**12**	*6*	=	Quality
4108	Financial impact of industrial action	*20*	**20**	*10*	↑	Finance
4120	Strategic investments	*16*	**10**	*6*	↓	Finance
4125	National Review of Band 5 Nurses	*15*	**15**	*12*	New	Finance
XXX	Workforce Morale and Culture During Change	*12*	**12**	*6*	New	Workforce

September 2026 (following changes agreed at RGC in August 2026)



Risk score increased

Risk score decreased

Risk score stable – no shading

New/newly escalated risk

Risk Refresh | Risk Assurance | Next Steps

Corporate Risk Register Management July-August 2026

In July and August, the following changes were made to the Corporate Risk Register:

Risk	Current Score (LxC)	New Score (LxC)	Change
4120 Strategic Investments	4x5=20	2x5=10	Reduced likelihood score based on M3 position
3963 Radiology Capacity and Performance	New (Escalated)	4x4 =16	Escalation of to the corporate risk register as recommended by the Outstanding Care Board August meeting. This is a consolidated overarching risk encompassing a number of previous service-specific risks relating to the impact of radiology service provision on other care groups and their patients. This outlines the underlying causes, controls and organisational impacts. Based on the latter it is felt this meets the criteria for escalation to the corporate risk register.
3612 Delivery of elective activity in line with financial plan	2x5 =10	3x5 =15	In month 4 we saw lower in month activity performance and the alignment of previously unassigned commissioner activity to fixed payment contracts, so the likelihood score is increased to reflect this.
3991 Delayed pathology test results	5x3 =15	4x3 =12	Reduction in likelihood score due to reduction in the frequency of clinical incidents reported and improved turnaround times.
72 Data and Cyber security of third party organisations accessing our network	4x4 =16	3x4 =12	Reduction in likelihood score, as no incidents identified and increased assurance from Synnovis.

Next steps

- Review of strategy to make sure changes made in Q1-Q2 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.

King's College Hospital NHS Foundation Trust

AGENDA ITEM:

BOARD/COMMITTEE REPORT COVER PAPER

Report to:	Public Board meeting
Date of meeting:	16 September 2026
Subject:	Report from Governors
Author(s):	Jane Lyons MBE, Lead Governor
Sponsor:	Chair of the Board of Directors
History:	Not previously considered by Board/Committee/KE
Status:	

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

Purpose

To brief on current situation regarding status of Council of Governors.

Recommendations:

The Board is asked to support any efforts to ensure that patient and community voice is resourced such that it is heard, acted upon and supported at the highest level within the Trust.

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**	

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Key implications

Strategic risk - Link to Board Assurance Framework	This paper aims to describe how any potential risk of loss of patient and community representation through the removal of Councils of Governors might be mitigated.
King's Improvement Impact (KIM):	KIM has not been applied.
Quality Impact	Removal of Councils of Governors reduces the routes for patients to raise concerns or suggestions.
Health Equity Impact	No EqIA has been undertaken on the potential impact of removal of Councils of Governors.
Workforce Impact	Engagement levels would drop.
Research/Innovation Impact	It does not support any of above.
Digital Impact	These have not been considered.
Financial Impact	It is understood that there will be a cost saving from within the Foundation Trust Office because of the removal of the need to support Governors administratively through elections, meeting attendance and dealing with any queries raised by Governors.
Legal/ regulatory compliance	If current proposals go through, there will be a shift in statutory responsibilities as those currently with Governors will need to be allocated elsewhere.
Communications and Engagement	There is a need to further communicate and engage on any plans emerging to succeed the current Council of Governors model.
Use of Artificial Intelligence Tools	No AI used is preparing this paper.
Committee that will provide relevant oversight Board of Directors	

Main Report

Governors are pleased to submit a written report to the Public Board.

The majority of Governors are elected by their local communities, patients and staff working at King's College Hospital NHS Foundation Trust and currently have statutory and public accountability and patient engagement roles within the Trust. All are volunteers and therefore give of their time freely.

In summary, Governors contribute to the work of the Trust currently through holding Non-Executive Directors to account and participation in committees, the raising of concerns or suggestions and visiting wards and other functions within the Trust.

It is believed that within the Trust there is recognition of the skills and experience from within the Governor body.

The role of Governors is currently under question with a proposal within the NHS Bill that Councils of Governors are removed from NHS Trusts from the end of March 2027. The Bill is going to Report Stage on Monday 7 and Tuesday 8 of September so some aspects may have changed before the Trust's Board meeting is held on Wednesday 16 September but at the time of writing this report events so far are described here https://commonslibrary.parliament.uk/research-briefings/cbp-11078/

There is a clear concern amongst Governors at the Trust of what may be lost in the removal of the Council of Governors, and a belief that we need to retain and indeed build the patient and community voice at a meaningful level within the Trust. Plans are underway to hold workshops and planning sessions between Governors and other relevant parties, and we look forward to reporting back on progress on this in due course.

Finally, Governors look forward to meeting members of King's at the upcoming Annual Members' Meeting | King's College Hospital NHS Foundation Trust which is being held on Tuesday 29 September 2026, further details through this link on website.

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 19

BOARD/COMMITTEE REPORT COVER PAPER

Report to:	Public Board Meeting
Date of meeting:	16 September 2026
Subject:	NHS Staff Standards – Briefing and Implementation Approach
Author(s):	Damian McGuinness, Chief People Officer
Sponsor:	Damian McGuinness, Chief People Officer
History:	
Status:	

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

Purpose

The purpose of this report is to brief the board the introduction of the mandatory NHS Staff Standards and to seek discussion, assurance and endorsement of King's proposed implementation approach.

In practical terms, it is asking KE to:

- **Note** the six NHS Staff Standards and their mandatory status for NHS secondary care providers.
- **Understand** the implications of the new NHS Oversight Framework Staff Standards score from 2026/27.
- **Review and discuss** King's proposed approach to implementation, governance and assurance.
- **Endorse** the development of a Trust-wide implementation plan and baseline assessment against the six standards.
- **Receive future updates** through the People Committee and Trust Board

Executive Summary

The NHS Staff Standards introduce, for the first time, a nationally mandated minimum standard for staff experience across NHS providers, reflecting commitments in the NHS 10-Year Health Plan and forming part of the NHS Oversight Framework. The standards are

intended to ensure that staff experience is given the same strategic priority as quality, finance and operational performance. They apply to NHS-employed staff across acute, ambulance, mental health and community providers and are expected to be delivered within existing resources.

The Six NHS Staff Standards
The standards focus on six priority areas:

1. Line Management
2. Health & Wellbeing
3. Violence Prevention & Reduction
4. Championing Sexual Safety
5. Tackling Racism
6. Promoting Flexible Working

Each standard sets minimum expectations for employers, requiring board oversight, partnership with staff and trade unions, and measurable improvement actions.

Key Implications for Boards
Boards are expected to:

- Treat staff experience as a core strategic priority.
- Review existing policies and programmes against the new standards.
- Establish board-level ownership and accountability for delivery.
- Engage staff, staff networks and trade unions in implementation.
- Develop a clear baseline, identify gaps and create a prioritised action plan.
- Monitor progress through workforce data and NHS Staff Survey metrics.

Accountability and Oversight
A new NHS Staff Standards score will be introduced within the NHS Oversight Framework (NOF) from 2026/27. This score will:

- Measure organisational performance against the six standards.
- Contribute to NHS England segmentation and oversight assessments.
- Be derived largely from NHS Staff Survey measures.
- Influence external assurance discussions, including workforce and cultural assessments.

NHSE does not expect full compliance immediately. Instead, successful organisations will demonstrate:

- Board discussion and visible leadership.
- Clear baselines and gap analysis across all six standards.
- A credible, prioritised improvement plan aligned to workforce strategies.
- Strong staff and trade union engagement.
- Clear understanding of how performance will be assessed and reported

King's proposed implementation approach

King's will use the NHS Employers implementation planning tool to support a consistent, evidence-based assessment of its current position against each of the six NHS Staff Standards. The tool will be used as a practical framework for identifying existing strengths, relevant evidence, gaps and areas requiring improvement. Although use of the tool is voluntary, it provides a structured basis for local implementation and assurance.

1. Complete a baseline self-assessment against each standard through the People Committee, drawing on workforce data, NHS Staff Survey results, policies, existing programmes and staff experience evidence.
2. Record current evidence, identify gaps and assess the maturity of existing arrangements for each requirement.
3. Engage staff, trade unions, staff networks, line managers and relevant subject-matter leads to validate the assessment and co-produce priorities.
4. Develop a consolidated implementation plan setting out the required actions, named owners, milestones, delivery timescales, intended outcomes and measures of success.
5. Prioritise actions according to staff impact, organisational risk, statutory or regulatory requirements and deliverability within existing resources.
6. Create a Staff Standards dashboard combining quantitative measures with qualitative evidence, including staff voice, to demonstrate improvement and support assurance.
7. Embed the implementation plan within the new People Strategy, aligning each standard to the relevant strategic priority, delivery programme, outcome measure and governance route.
8. Establish clear executive and Board-level ownership, with regular reporting through the People Committee and Trust Board.
9. Review and refresh the assessment and implementation plan periodically as evidence, workforce experience and national expectations evolve.

This work will therefore not operate as a standalone programme. The completed assessment, improvement actions and measures will become part of the new People Strategy delivery framework. This will integrate the Staff Standards with the Trust's wider priorities for staff experience, culture, leadership, wellbeing, inclusion and workforce sustainability, while avoiding duplication with existing improvement programmes.

The approach reflects the national expectation that employers should assess progress locally, work in partnership with staff and trade unions, and use existing workforce policies and initiatives to deliver measurable improvement. The standards are mandatory and will be

reflected in the NHS Oversight Framework, although the NHS Employers planning tool itself is voluntary and intended to support locally determined implementation.

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 standards directly support mitigation of the Trust's People-related strategic risks relating to staff engagement, culture, wellbeing, workforce capability, leadership and retention. Failure to implement the standards effectively may adversely affect staff experience, organisational performance, workforce sustainability and NHS Oversight Framework performance.*
King's Improvement Impact (KIM):	*Supports continuous improvement in workforce experience, leadership effectiveness and organisational culture.*
Quality Impact	*Evidence indicates that staff engagement, wellbeing and supportive leadership are associated with improved patient outcomes, safety and service delivery*
Health Equity Impact	*The standards include specific requirements relating to tackling racism, inclusion, equality and equitable access to flexible working and wellbeing support.*
Workforce Impact	*Significant positive workforce impact through improved staff experience, wellbeing, retention, leadership capability and employee engagement. The standards create new expectations regarding oversight, monitoring and accountability.*
Research/Innovation Impact	*No direct research implications identified.*
Digital Impact	*Potential development of workforce dashboards and reporting arrangements to monitor implementation and performance against the standards.*
Financial Impact	*No additional national funding has been identified. NHS England expects implementation to be delivered within existing resources and budgets.*
Legal/ regulatory compliance	*Supports compliance with NHS England expectations and contributes to oversight, assurance and provider capability assessments. Failure to deliver may adversely affect NHS Oversight Framework ratings*
Communications and Engagement	*A comprehensive programme of staff, trade union, staff network and leadership engagement will be required to support implementation and ensure staff voice informs local delivery.*
Use of Artificial Intelligence Tools	
Committee that will provide relevant oversight PIEC	

NHS
King's College Hospital
NHS Foundation Trust

NHS Staff Standards

Damian McGuinness, CPO

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NHS Staff Standards: Key Messages

A summary of the key information for the new NHS Staff Standards

Why?	There has been considerable focus on **improving staff experience** via the NHS People Promise with many organisations working hard to drive improvements, which is reflected in some of the 2025 NHS Staff Survey results. But this has been inconsistent across the NHS and more needs to be done to bring all organisations up to the required level and ensure staff experience is treated as a priority. In line with the 10 Year Health Plan's commitments, the NHS Staff Standards will, for the first time, set a national required standard which employers must meet.
What?	The new standards focus on six key areas for organisations to improve staff experience: **1) promoting flexible working; 2) line management; 3) health and wellbeing; 4) violence reduction and prevention; 5) tackling racism; and 6) championing sexual safety in the workplace.**
Who?	**Acute trusts, ambulance trusts, and mental health and community trusts are in scope** of the new standards. However, all organisations delivering NHS services should reflect on the new standards and seek to improve their staff experience in these key areas. The standards apply to NHS employed staff; this includes appropriate and proportionate application for bank staff and students. There is encouraged alignment for agency staff via contractual and commissioning mechanisms.
How?	**Regions and organisation boards** should begin reviewing their existing staff experience provision and monitoring to ensure their policies, procedures and operational initiatives reflect the requirements of the new standards. Delivery against the standards will be measured with a new score that will be part of the NHS Oversight Framework.
The Bottom Line?	Employers are expected to implement the NHS Staff Standards from **within existing budgets**. The standards reflect minimum actions for employers which they should reasonably be expected to have in place, or be working towards already, to bring all organisations to the same national minimum expectation. This is about building on existing work rather than introducing new funded programmes.

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NHS Staff Standards: What do they mean for senior leaders?

Prioritising staff experience	The standards are about making staff experience a core priority for your organisation – building on your existing initiatives to support continuous improvement. Boards and executive teams are accountable for making sure the standards are understood, implemented and monitored. A key aim is to see staff experience given the same level of focus and grip given to other organisational priorities such as finance, operational performance and quality of care.
Partnership with your workforce	Implementation should be done in partnership with staff, staff networks, trade unions and local partnership arrangements. This partnership approach will be important for identifying what matters most locally, shaping practical actions, and providing assurance that the standards are being embedded in a way that reflects the needs of different staff groups and services.
Boards and leaders to drive	It is ultimately up to senior leaders to have a visible role in setting expectations for respectful, inclusive and supportive workplaces. Leaders should ensure managers are equipped to lead well and facilitate them to help drive staff experience – as well as improving the experience of managers themselves. Leaders should also make sure staff can raise concerns, share feedback and see that action is being taken in response.

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Background: Transformation context for NHS Staff Standards

The 10 Year Health Plan committed to developing the NHS Staff Standards to ensure that staff experience is given increased priority in the NHS.

NHS Staff Standards in the 10 Year Health Plan:

"A positive experience of work and the workplace should not be a 'nice to have'. We will work with the Social Partnership Forum to develop a new set of staff standards, which will for the first time outline minimum standards for modern employment. They will underpin the NHS Oversight Framework, and poor performance on staff-related outcomes will act as an early warning signal for CQC."

Fit for the Future: The 10 Year Health Plan for England, Pg 105, July 2025

The 10 Year Workforce Plan will set out action to deliver a new workforce model, to support delivery of the 10 Year Health Plan. We will deliver that change by making sure that staff are better treated, have better training, more fulfilling roles, and hope for the future.

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Case for Change

Why are the NHS Staff Standards needed?

Case for Change

Improvements to support staff experience have been inconsistently applied by organisations across the NHS.

- Lack of mandation for existing frameworks means workforce benefits have been patchy and inconsistent across the NHS.
- Better staff engagement is associated with improved experience and job satisfaction.
- Staff burnout, stress and fatigue are consistently linked to patient safety incidents and adverse events.
- Higher staff turnover is associated with higher patient mortality.
- The productivity loss from absenteeism, presenteeism, lost capacity, and harm to staff is a serious issue across the NHS.

Scope

Staff in Scope

The standards apply to NHS employed staff in secondary care; this includes appropriate and proportionate application for bank staff and students. There is encouraged alignment for agency staff via contractual and commissioning mechanisms

Organisations in Scope

- Secondary Care providers, including acute trusts, ambulance trusts, and mental health and community trusts
- All organisations delivering NHS services should consider the new standards
- Options for expanding the scope of mandating the standards across Primary Care and other NHS services will be considered

Objectives

It is intended that the NHS Staff Standards will achieve…

1. Improvements in staff experience
2. Reductions in turnover and increased retention
3. Positive impact on service delivery
4. Increase the priority level organisations give to staff experience

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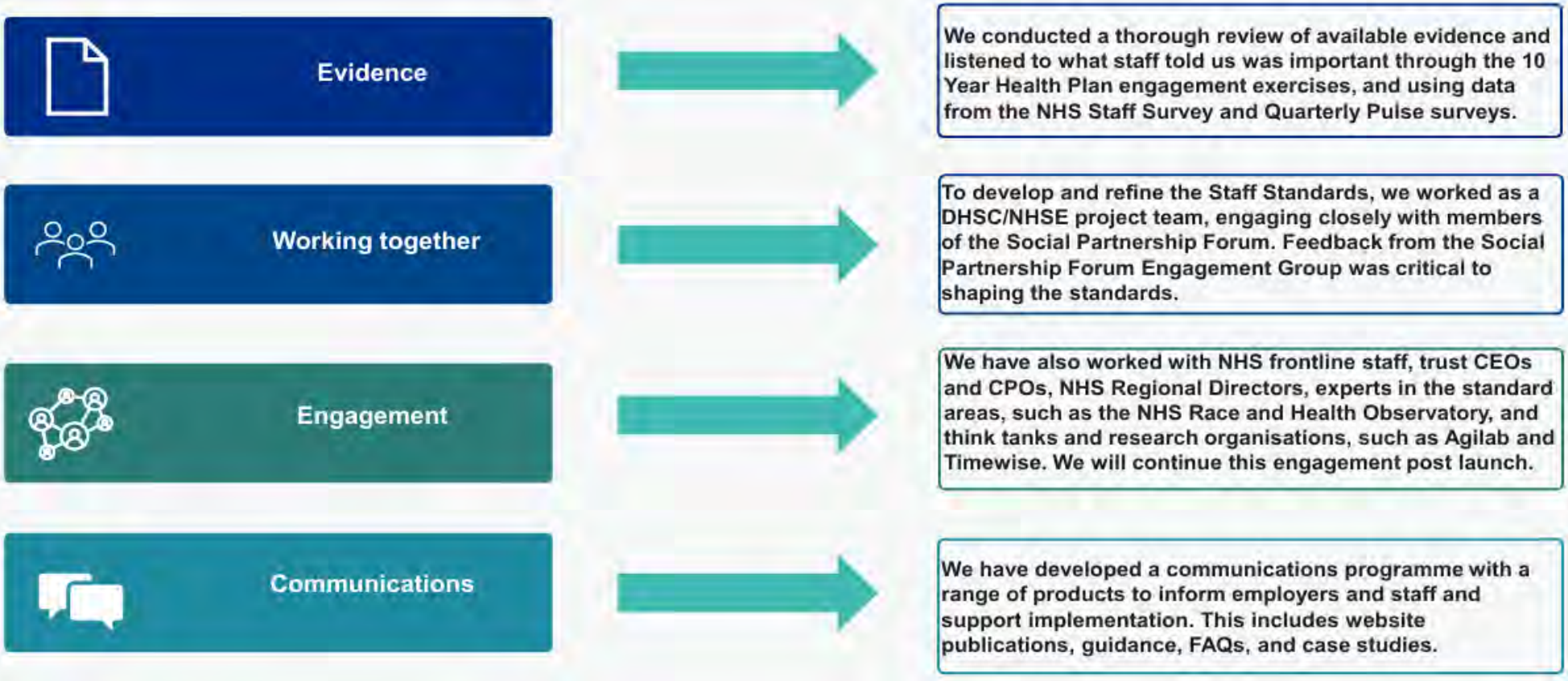
NHS Staff Standards – How we did it

Deliverables produced in this phase and how they will support regional provider preparedness.



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Data, evidence and consultation

More detail on sources

Evidence

- NHS Staff Survey results
- NHS Pulse Survey results
- 10 Year Health Plan People Group engagement exercises
- Industrial Relations engagement
- Research from experts including the Race and Health Observatory and think tanks and research organisations such as Agilab and Timewise

Engagement

Close engagement with:

- Social Partnership Forum Engagement Group
- NHS England and DHSC policy and analyst leads
- CQC

Consultation with:

- NHS frontline staff
- NHSE Regional Directors and regional design leads
- Social Partnership Forum groups – wider group, Violence Reduction Oversight Group, regional co-chairs.
- Chief People Officers
- NHS CEOs
- Experts in standard areas

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NHS Staff Standards – alignment to existing frameworks

The NHS Staff Standards do not replace existing guidance, policies or improvement programmes – rather they are complementary. They are also not intended to replace or cut across action already underway locally to drive improvements that are working well. Instead, they bring together and strengthen what is already in place, setting a clear national baseline for what all NHS employers are expected to deliver for staff and a clear framework to help Boards prioritise their efforts.

The NHS People Promise - as an example - can provide guidance and resources to support implementation of the standards and ensure continuous improvements in staff experience.

Unlike many previous initiatives, delivery of the standards is mandatory, and performance will be measured through national oversight and assurance processes, including the NHS Oversight Framework.

The NHS Staff Standards should complement and work alongside local programmes of change and improvement that organisations already have in place and that are working well.

The NHS Staff Standards

Line Management

Health & Wellbeing

Violence Reduction & Prevention

Championing Sexual Safety

Tackling Racism

Promoting Flexible Working

The following slides give an overview of the actions for employers for each of these standards. Full detail of all the requirements is available in the supporting materials for the NHS Staff Standards online.

NHS Staff Standards – overview of the standards

LINE MANAGEMENT

Staff can expect supportive, fair, developmental and compassionate line management, enabled by employer support for line managers, to help staff to perform well, feel valued and fulfil their potential.

Actions for employers

Employers must:

- Embed the NHS Leadership and Management Framework across strategies, policies, training, appraisal and recruitment, and require all managers to complete the self-assessment tool
- Ensure line managers have access to comprehensive line management training through the NHS Leadership and Management Framework (with a focus on first-time managers) and monitor and address line management quality
- Ensure job plans accurately allocate sufficient time for line management responsibilities
- Ensure all role descriptions have clear, accurate and up-to-date job descriptions and review role changes promptly through agreed processes when requested, in accordance with the NHS Job Evaluation Scheme
- Ensure all line managers have appropriate supervision and mentoring for their own line managers and ensure that line management policies are accessible to enable timely and effective people management
- Ensure board-level oversight on how line managers are enabled by collecting and acting on feedback from line managers
- Work in partnership with trade unions through local arrangements to review workforce data, culture, health and safety risks and equality impacts

So that line managers are enabled to:

- Deliver high-quality appraisals, regular feedback and meaningful development and career support to their line reports
- Model inclusive, respectful behaviours, provide compassionate support, and foster psychologically safe teams that are well-led, connected and feel able to raise concerns or problems

NHS Staff Standards – overview of the standards

HEALTH & WELLBEING

Staff can expect their organisation to protect their health, safety and wellbeing at work. Employers are responsible for supporting staff wellbeing, preventing ill-health associated with work and helping staff to feel safe, cared for, and able to perform well.

Actions for employers:

- Appoint a Health and Wellbeing Guardian at board level
- Use the NHS Health & Wellbeing Framework to produce a localised Health & Wellbeing Strategy that is built on workforce data and provides needs-driven health and wellbeing support
- Take steps to ensure that, where practicable, staff have access to safe, non-clinical environments to take their rest periods
- Ensure that all staff, regardless of work location or shift pattern, have reliable access to nutritious food and drink. Alternatively, employers should ensure that there are safe options available for staff to store and prepare their own food
- Ensure all managers are supported to complete mandated competencies on safety, health and wellbeing so that all staff can expect health & wellbeing conversations to be embedded into 1-1s and appraisals
- Ensure managers are trained on how to discuss reasonable adjustments with disabled staff and staff with alternative needs
- Ensure protection and provision for pregnant and breastfeeding staff and for those experiencing perimenopause and menopause
- Ensure all staff have access to Occupational Health and Wellbeing support and local services
- Work in partnership with trade unions through local arrangements to review data and monitor progress

NHS Staff Standards – overview of the standards

VIOLENCE PREVENTION & REDUCTION

Staff have a right to feel safe and supported at work, in an environment that takes meaningful action to prevent violence, aggression, intimidation or abuse in any form. Staff should have access to simple, safe and supportive channels for reporting violence in the workplace; timely, compassionate support after any violent or harmful incident; and the right training to equip them with the confidence and knowledge to keep themselves and others safe.

Actions for Employers:

- Implement and embed the Violence Prevention Reduction (VPR) standard, as well as having a named Senior Responsible Officer for VPR with an annual VPR improvement plan
- Ensure that reporting systems are in place and actively promoted, so that all staff feel supported to report any incident of violence or abuse, irrespective of a patient's circumstances or condition
- Accurate and timely data should be recorded to inform strategies on tackling and preventing violence and feed into national VPR data collections
- Staff who are subject to violence or abuse should have access to high quality post incident psychological and welfare support. Managers as well as HR policies and procedures should provide the right support following incidents and during investigations
- Ensure that all staff receive training appropriate to their role
- Ensure the appropriate Health and Safety Committee/Forum is engaged in VPR planning and monitoring
- Work in partnership with trade unions through local arrangements, staff networks and local VPR groups to provide assurance on support for staff and to encourage staff to call out where organisations are failing. This should ensure that staff voice shapes local improvements

NHS Staff Standards – overview of the standards

CHAMPIONING SEXUAL SAFETY

Staff have a right to feel safe and supported at work, in an environment that is free from sexual harassment, abuse and unwanted or inappropriate sexual behaviours. Staff can expect: their organisation to take clear, consistent action to prevent sexual misconduct and harassment; promote a culture of transparency and openness that ensures incidents are reported and acted upon promptly and appropriately; training to be provided on how to recognise and report inappropriate behaviours; and a victim centred approach, with support provided to those affected and lessons learned to reduce the risk of future incidents.

Actions for employers:

- Fully implement the actions set out in the sexual safety in healthcare organisational charter, assessing progress using the sexual safety charter assurance framework, ensuring board level ownership and accountability
- Ensure all staff to complete Understanding sexual misconduct in the workplace e-learning
- Ensure that investigators of sexual misconduct allegations receive specialist training
- Ensure they have robust staff policies and processes for dealing with sexual misconduct and that staff do not suffer detriment as a consequence of reporting, in line with victimisation legislation
- Share concerns about employees with future employers and host organisations
- Ensure all staff are familiar with the sexual misconduct people policy framework so that they understand how to recognise and report sexual misconduct, and what actions should be taken when sexual misconduct is reported and where staff are the perpetrators, including the other policies that might be used
- Work in partnership with trade unions and staff networks through local arrangements to provide assurance on support for staff, to shape local plans and to encourage staff to call out where organisations are failing

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NHS Staff Standards – overview of the standards

TACKLING RACISM

Staff should feel safe and supported at work, in an environment where their organisation takes sustained and meaningful action to prevent all instances of racism and discrimination in the workplace.

Actions for employers:

- Set consequential outcomes for misconduct at the individual level, from penalties for certain behaviours and/or repeated incidents to potential refusal of care for patients in non-emergency situations, and consequences for organisational performance and professional non-compliance
- Work with Trade Unions to ensure representation of the staff voice; ensuring policies are fair/proportionate; support staff to speak up; and support during formal procedures to ensure racism is taken seriously
- Ensure implementation and monitoring of the six High Level Impact Actions as part of the NHS EDI Improvement Plan
- Ensure every board member has a published Specific Measurable Achievable Relevant Time-bound objective on tackling racism
- Implement inclusive recruitment and talent management practices including recruitment and career progression plans for equity of opportunity
- Work to create inclusive cultures that encourage staff at all levels to report, and for employers to consistently work to root out racist behaviour
- Where appropriate, evaluate and implement the recommendations of key leading bodies on good practice
- Update emergency protocols and responses to include adequate and appropriate responses that help to maintain safe working environments
- Update grievance, disciplinary and investigative processes so they are responsive to the experiences of racism and discrimination and are void of biased applications in their process. Ensure they encourage thorough and unbiased investigation, with careful examination of evidence
- Where appropriate, evaluate and implement the recommendations of key leading bodies on good practice

NHS Staff Standards – overview of the standards

PROMOTING FLEXIBLE WORKING

NHS staff can expect flexible working (flexibility in how, where and when they work) to be openly encouraged and supported, fairly and equitably considered, and embedded into everyday practice, creating a "flexible first" culture, rather than treated as an exception. Requests must be considered objectively and not unreasonably refused, and where they cannot be agreed, alternatives will be explored.

Actions for employers:

- Appoint a board level flexible working champion who is responsible for promoting and leading improvements in flexible working
- Implement a Flexible Working Action Plan using organisational workforce data which is owned by the Board
- Implement preference-based team e-rostering for all frontline workers (where operationally appropriate)
- Collect data on the number of flexible working requests which are approved or rejected, the types of flexible working requests, and broken down by protected characteristic, staff groups / professions, bands and at department level
- Publish this data for staff and linked to the Flexible Working Action Plan set out what actions will be taken to improve areas of concern
- Work in partnership with Trade Unions through local partnership arrangements to assess progress
- Ensure that managers, leaders and staff members have training in line with their roles to ensure they are confident to lead flexible teams
- Include flexible working as an option in all job adverts, job interviews, pre-retirement conversations, and line manager conversations such as appraisals or regular one to one discussion
- Ensure your organisation is following the guidance set out in The National Flexible Working People Policy Framework and reference this within the local flexible working policy

NHS Staff Standards – Accountability & Assurance

In the first year (2026-27), the following accountability tools will be used to ensure organisations are embedding the NHS Staff Standards as a core element of their efforts to improve staff experience

NHS Oversight Framework (NOF)

NHS Staff Standards score	• New score based on delivery across the standards Sub-scores for each of the standards will also be made available to organisations to view • Will inform segmentation for the People & Workforce domain and overall
Engagement Score	• Existing score – will be used in conjunction with the new NHS Staff Standards score for increased understanding of staff experience. • Also informs segmentation for the People & Workforce domain and overall

Provider Capability Assessment

When the existing framework is updated in 2026, it will include updates to look at how organisations are working to improve staff engagement

Organisation self assessment	• Updated guidance in the People & Culture section to request evidence of organisations' use of staff experience information • NHS Staff Standards will be referenced in the indicative lines of inquiry
NHSE assessment	• Triangulate staff experience assurance received from the trust with any other information – e.g. what is its score, are there material staff concerns, do CQC well-led reviews highlight cultural issues? Concerns reflected in organisation's RAG rating

The new NHS Staff Standards NOF score

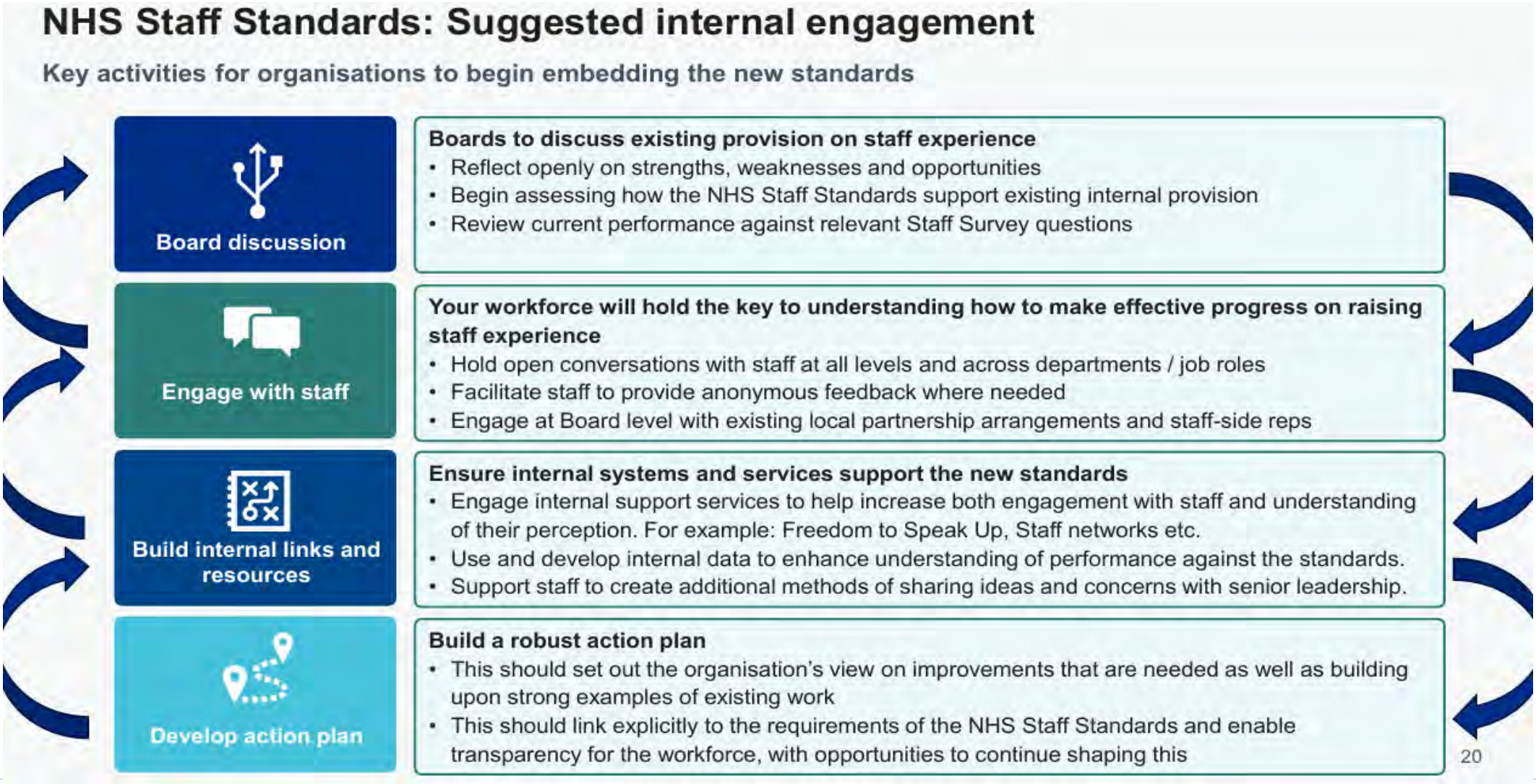
- ***The NOF is a key part of ensuring organisations are accountable for delivery of the NHS Staff Standards.***
- ***The new score contributes to an organisation's segmentation in both the People & Workforce domain and for the overall segmentation.***
- Introduced from Q1 2026/27 - initially based upon the 2025 NHS Staff Survey (NSS) data (Q1-3)
- Q4 will introduce the data from the upcoming 2026 NSS – ensuring opportunity for each organisation's score to be impacted in the first year of the new standards
- Detailed methodology will be available in the NOF Technical Guidance

NHS Staff Standards – accountability & assurance

The standards will be assessed using the following NHS Staff Survey questions:

	NHS Staff Survey Questions
Line Management	*Q7a,h Q9d,f,i; Q23a,c,d; Q24d,e*
Health & Wellbeing	*Q11a,c Q12b*
Violence Prevention & Reduction	*Q13a,b,c; Q13d*
Championing Sexual Safety	*Q17b*
Tackling Racism	*Q14a,b,c; Q15; Q16a,b*
Promoting Flexible Working	*Q4d, Q6b,d*

Question list: Survey documents related to conducting the survey | NHS Staff Survey



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NHS Staff Standards: Suggested internal engagement

Key activities for organisations to begin embedding the new standards

While the standards set clear expectations for employers, staff also have an important role to play in creating a positive culture and workplace. Organisations should ensure their staff voice shapes local improvements.

Organisations should ensure that their plans to embed the standards facilitate working with trade union representatives through their local partnership arrangements and provide ways for staff to engage with the Board to support application of the standards.

NHS Staff Standards – What 'good' looks like in year one

In year one, good delivery means organisations have focus, grip and a clear direction of travel. Not everything will be fully embedded.

Board leadership and accountability

- The Board has discussed the NHS Staff Standards and agreed how they align with existing staff experience priorities.
- Required Board-level roles and ownership are in place, with regular visibility and assurance on progress.

Understanding current position

- Organisations have established a clear baseline across the six standards, drawing on existing data, staff feedback and NHS Staff Survey results and understand where minimum expectations are already being met and where gaps remain

Credible, prioritised action

- A proportionate year-one action plan is in place, focused on meeting minimum expectation[No Title] reducing the most significant risks to staff experience.
- Actions are clearly owned, time-bound and integrated with existing workforce and people plans.

Listening to staff and working in partnership

- Staff and trade union representatives have been engaged through local partnership arrangements.
- Staff voice is shaping priorities and there is transparency about what will change.

Fit for purpose assurance

- The organisation understands how delivery will be assessed through the NHS Oversight Framework.
- Leaders can explain their Staff Standards position, what is driving it, and how they are responding.

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