King's College Hospital NHS Foundation Trust

# AGENDA

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| **Meeting** | **Council of Governors** |
| **Date** | **Thursday 26 November 2026** |
| **Time** | **16:30 – 18:30** |
| **Location** | **The Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill** |

| No. | Item | Purpose | Format | Lead & Presenter | Time |
|---|---|---|---|---|---|
| **1.** | **STANDING ITEMS** | | | | |
| | 1.1. Welcome and Apologies | FI | Verbal | Chairman | **16:30** |
| | 1.2. Chair's introduction - CEO | | | | |
| | 1.3. Declarations of Interest | | | | |
| | 1.4. Minutes of Previous Meeting – 30 July 2026 | FA | Enc. | | |
| | 1.5. Chair's Action | FI | Verbal | | |
| | 1.6. Action Tracker | FD | Enc. | | |
| | 1.7. Matters Arising<br>▪ Governor Protocol<br>▪ Patient Leaflets & Wheelshare Update | FI<br>Verbal<br>Enc. | Enc. | Director of Corporate Affairs<br>Chief Nurse & Executive Director of Midwifery | |
| | **QUALITY, PERFORMANCE, FINANCE AND PEOPLE** | | | | |
| **2.** | Report from the Chair of the Audit and Risk Committee | FD/A | Verbal. | Chair of Audit and Risk Committee | **16:40** |
| **3.** | Report from the Chair of the Finance and Commercial Committee<br><br>Incl. Trust Financial Position | FD | Enc. | Chair of the Finance and Commercial Committee | **16:50** |
| **4.** | Report from the Chair of the Performance, Transformation and Improvement Committee<br><br>The Integrated Performance report is in the information section of the agenda | FD | Enc. | Chair of Performance Tranformation and Improvement committee | **17:00** |
| **5.** | Report from the Chair of the People, Education and Inclusion Committee | FD | Enc. | Chair of the People, Education and Inclusion Committee | **17:10** |
| **6.** | Report from the Chair of the Quality and Performance Committee | FI | Enc. | Chair of the Quality and Research Committee | **17:20** |
| **7.** | Apprenticeships | FD | Enc. | Chief Nurse & Executive Director | **17:30** |

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

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| | | | | of Midwifery/Chief People Officer | |
| **8.** | Winter Preparations | FD | Enc. | Chief Operating Officer<br><br>Site Direcctors for PRUH and DH | **17:40** |
| | **GOVERNANCE** | | | | |
| **9.** | **Governor Involvement and Engagement** | | | | |
| | 9.1. Future of Governors Meeting Update | FI | Enc. | Director of Corporate Affairs | **17:50** |
| | 9.2. Governor Engagement and Involvement Activities | FI | Enc. | Governors | **18:00** |
| | 9.3. Observation of Board & Board Committees | FI | Enc. | Governors | **18:10** |
| | 9.4. Nominations Committee Update | FI | Verbal. | Chair | **18:20** |
| **10.** | **Other Governance Matters** | | | | |
| | 10.1. Draft Agenda 26 January 2027 Meeting | FD | Enc. | Chair | **18:25** |
| **11.** | **FOR INFORMATION** | | | | |
| | 11.1 Integrated Performance Report | FA | Enc. | Chief Operating Officer<br>Director of Performance & Planning/Assistant Director of Performance & Contracts | * |
| **12.** | **Any Other Business** | | | | |
| | Any Other Business | FI | Verbal. | Chair | **18:30** |
| **13.** | **Date of the next meeting:**<br>Thursday 26 January 2027, 16:30 – 18:30 The Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill | | | | |

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| **Members:** | | |
| | Sir David Behan | Chair |
| **Elected:** | | |
| | Prof. Koku Adomdza | Patient Governor |
| | Rashmi Agrawal | Lambeth Public Governor |
| | Christopher Akwagba | Staff Governor |
| | Lindsay Batty-Smith | Southwark Public Governor |
| | Angela Buckingham | Southwark Public Governor |
| | Bernie Butler | Lambeth Public Governor |
| | Fr Grant Ciccone | Patient Governor |
| | Dr Melanie Dalby | Staff Governor |

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| | Anthony Darroch | Bromley Public Governor |
| | Hilary Entwistle | Southwark Public Governor |
| | Emily George | Lambeth Public Governor |
| | Deborah Johnston | Patient Governor |
| | Tunde Jokosenumi | Staff Governor |
| | Prof Daniel Kelly OBE | Lambeth Public Governor |
| | Jane Lyons MBE | Lead Governor Southwark Public Governor |
| | Pauline Manning | Patient Governor |
| | Devon Masarati | Patient Governor |
| | Billie McPartlan | Bromley Public Governor |
| | Katie Smith | Bromley Public Governor |
| | Temitayo Taiwo | Lambeth Public Governor |
| **Nominated Governors** | | |
| **Appointed local authority governors:** | | |
| | Cllr Colin Bately | Southwark Council |
| | Cllr Jeremy Issacs | Lambeth Council |
| **Partnership Organisations:** | | |
| | Dr Yogesh Tanna | Trust's Joint Staff Committee |
| **University Governors:** | | |
| | | |
| **In Attendance:** | | |
| | Sir David Behan | Chairman |
| | Dame Christine Beasley | Non-Executive Director |
| | Nicholas Campbell-Watts | Non-Executive Director |
| | Prof. Tracey Carter MBE | Chief Nurse & Executive Director of Midwifery |
| | Roy Clarke | Chief Financial Officer |
| | Siobhan Coldwell | Director of Corporate Affairs |
| | Dr Jane Fryer | Non-Executive Director |
| | Zowie Loizou | Corporarte Governance Officer |
| | Prof Graham Lord | Non-Executive Director |
| | Dena Marshall | Chief Operating Officer |
| | Sheena Mackay | Non-Executive Director |
| | Gerry Murphy | Non-Executive Director |
| | Prof. Anthony Schapira | Non-Executive Director |
| | Angela Spatharou | Non-Executive Director |
| | Matthew Trainer | Chief Executive Officer |

King's College Hospital NHS Foundation Trust

# Council of Governors Meeting – Public Session

**Draft** Minutes of the Council of Governors (Public Session) meeting held on
Thursday 30 July 2026 at 16:30 – 18:30
Dulwich room, Hambleden Wing, King's College Hospital, DH & MS Teams

**Present:**

**Chair**

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| Nicholas Campbell-Watts | Acting Chair |
| Sir David Behan | Trust Chair (MS Teams) |

**Elected Governors**

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|---|---|
| Prof. Koku Adomdza | Patient Governor |
| Christopher Akwagbe | Staff Governor |
| Lindsay Batty-Smith | Southwark Public Governor |
| Cllr Colin Boyle | Southwark - Local Authority |
| Angela Buckingham | Southwark Public Governor |
| Bernie Butler | Lambeth Public Governor |
| Fr Grant Ciccone | Patient Governor |
| Melanie Dalby | Staff Governor |
| Tony Darroch | Bromley Public Governor |
| Hilary Entwhistle | Southwark Public Governor |
| Emily George | Lambeth Public Governor |
| Jeremy Issacs | Lambeth - Local Authority |
| Gnananandan Janakan | Staff Governor |
| Deborah Johnston | Patient Governor |
| Tunde Jokosenumi | Staff Governor |
| Jane Lyons | Southwark Public Governor/Lead Governor |
| Pauline Manning | Patient Governor |
| Billie McPartlan | Bromley Public Governor |
| Devon Masarati | Patient Governor |
| Katie Smith | Bromley Public Governor |
| Yogesh Tanna | Trust's Joint Staff Committee |

**In Attendance:**

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|---|---|
| Roy Clarke | Chief Financial Officer |
| Siobhan Coldwell | Director of Corporate Affairs |
| Paul Dossett | External Auditor |
| Angela Helleur | Chief Delivery Officer |
| Zowie Loizou | Corporate Governance Officer (minutes) |
| Julie Lowe | Deputy Chief Executive Officer |
| Sheena Mackay | Non-Executive Director |
| Akhter Mateen | Non-Executive Director |
| Damian McGuinness | Chief People Officer |
| Gerry Murphy | Non-Executive Director |
| Mamta Shetty Vaidya | Chief Medical Officer |
| Elizabeth Shutler | Director of Strategy |
| Matthew Trainer | Chief Executive Officer |
| Members of the Public | |

**Apologies:**

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| Christine Beasley | Non-Executive Director |
| Dr Jane Fryer | Non-Executive Director |
| Prof. Daniel Kelly | Lambeth Public Governor |
| Angela Spatharou | Non-Executive Director |
| David Tyler | Patient Governor |

| Item | Subject |
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King's College Hospital NHS Foundation Trust

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| | **Standing Items** |
| **26/28** | **Welcome and Apologies** |
| | The Chair welcomed governors, colleagues attending in person and online, and members attending for the first time. The above apologies were noted. |
| | **Chair's introduction including introducing the new CEO Matthew Trainer** |
| **26/29** | The Chair welcomed Matthew Trainer to his first Council of Governors meeting as Chief Executive Officer. |
| | Matthew Trainer introduced himself, noting his previous roles at the Trust, including Site Managing Director at Princess Royal University Hospital (PRUH), and more recent positions as Chief Executive of neighbouring NHS Trusts. He expressed his enthusiasm for returning to King's and working with governors, staff and partners to provide the best possible care for patients and communities. |
| | The Chair also outlined the focus for the meeting, highlighting the External Auditor's Report, King's Strategy, Governor Engagement and Any Other Business as key discussion areas. |
| **26/30** | **Declarations of Interest** |
| | There were no declarations of interest |
| **26/31** | **Chair's Action** |
| | There had been no Chair's actions. |
| **26/32** | **Minutes of the Previous Meeting** |
| | The minutes of the meeting held on 30 April 2026 were reviewed. It was confirmed that the minutes were an accurate record and were approved. |
| **26/33** | **Matters Arising/Action Tracker** |
| | **Governor Protocol** |
| | The quarterly Governor Protocol report was received. The Director of Corporate Affairs noted that the report provided governors with visibility of issues raised during the quarter and the Trust's responses. |
| | Governors welcomed the introduction of the report as a useful mechanism for sharing concerns and outcomes more transparently. A governor raised a query regarding a previously submitted concern about facilities, and a response was provided regarding the rationale for current arrangements. The Council agreed that the report continued to provide a valuable record of matters raised and that the quarterly updates should continue. |
| | **Action Tracker** |
| | The Council reviewed the action tracker and received the following updates: |
| | The Council noted that both outstanding actions had been completed and updated accordingly within the action tracker. |
| | **26/10:** Governor Questions – Open session: |
| | Update governors on progress regarding the search for a new location for the chemo day unit at Denmark Hill as part of the estates strategy, including expected timelines. Update: The development of the new estates strategy commenced in June 2026 following the new Director of Estates joining the Trust in April 2026. The strategy work will assess the proposed options for the Chemo day unit and assess funding requirements and programme. The strategy is expected to be completed with Board approval in November 2026. Action closed. |
| | **26/21:** Operational Plan 2026/27 Executive follow-up with the Head of Radiology to review workforce capacity and any mitigations required to support delivery of diagnostic targets. |

Update: Performance workforce escalations and challenges continue to be managed through the relevant performance meetings and committees. A follow-up meeting between the Chief People Officer and the outgoing Clinical Director is scheduled to ensure no concerns are being missed. Action closed.

**The Council noted the matters arising and action updates.**

**QUALITY, PERFORMANCE, FINANCE AND PEOPLE**

**26/34 Report from the Chair of the Audit and Risk Committee**

The Chair of the Audit and Risk Committee presented the Committee report update and advised that the Committee's most recent meeting had focused primarily on the review of the Trust's Annual Report and Accounts. The Committee was pleased to note that the accounts had been submitted ahead of the national deadline and that the year-end reporting process had been completed successfully. The Chair highlighted this as a significant achievement reflecting continued improvement in the Trust's financial governance and reporting arrangements.

In addition to the annual accounts, the Committee had reviewed the Board Assurance Framework (BAF), the work of the Risk & Governance Committee and the Trust's insurance arrangements as part of its regular programme of assurance. The Committee had noted that lessons learned from the current year's reporting process would be incorporated into future planning to support further improvements and efficiencies.

Governors received assurance that the positive outcomes reflected sustained improvements in the Trust's financial governance, control environment and oversight arrangements over recent years. The Chair emphasised that this progress had been achieved through a collective effort across the organisation and provided a strong foundation from which to address the Trust's ongoing financial challenges and long-term sustainability objectives.

**The Council noted the report and welcomed the continued improvement trajectory demonstrated in the Trust's governance and assurance processes.**

**26/35 Report from the External Auditor**

The Council received the annual report from the Trust's External Auditor, Grant Thornton. The Auditor reported that the Trust had achieved a clean, unmodified audit opinion on its financial statements and had successfully completed the audit process ahead of the national deadline. The audit had identified only a small number of minor adjustments, none of which were material to the accounts. The Auditor noted that, when benchmarked against other NHS organisations, the Trust's audit process had been exceptionally well managed and was the first within Grant Thornton's NHS client portfolio to be signed off this year.

The Auditor also presented the annual Value for Money assessment, which considers the Trust's arrangements for financial sustainability, governance and the economical, efficient and effective use of resources. It was noted that, whilst the Trust continued to operate within a challenging financial environment, significant improvements had been demonstrated over recent years in the robustness of financial governance and oversight arrangements. As a result, issues previously reported as significant weaknesses had been removed and replaced with lower-level improvement recommendations.

Governors sought assurance regarding the delivery of recurrent savings, the management of temporary staffing costs and the Trust's long-term financial sustainability. The Executive team acknowledged the financial challenges that remained and advised that the Trust's financial strategy was centred on operational and clinical improvements, including reducing reliance on temporary staffing, improving patient flow and redesigning services to improve productivity. It was emphasised that maintaining strong financial governance arrangements would be essential in supporting the Trust's longer-term sustainability objectives.

The Council welcomed the positive external audit findings and formally recorded its appreciation to all staff involved in the preparation of the accounts and supporting

documentation. Members noted that the report provided strong assurance regarding the Trust's financial governance, accountability and control environment.

**The Council noted the report.**

**26/36 Report from the Chair of the Finance and Commercial Committee Incl. Trust Financial Position**

The Council received the report from the Chair of the Finance and Commercial Committee, covering the Committee meetings held since the previous Council meeting. Members had noted that the Trust's financial position remained slightly ahead of plan on a net basis for the first two reporting periods and reflected effective financial control across the organisation. However, the Committee had acknowledged continued challenges in delivering the Cost Improvement Programme (CIP), with savings delivery behind the planned trajectory. As a result, the associated financial risk rating had been increased to reflect the ongoing challenge of achieving the required level of recurrent savings.

The Committee had been advised that significant work was underway to improve operational efficiency and support delivery of the Trust's financial strategy. Discussions had focused on reducing reliance on temporary staffing, improving patient flow, and delivering service improvements that would enable sustainable cost reductions while maintaining patient safety and quality of care. Governors raised questions regarding staffing levels, bank and agency expenditure, and the impact of workforce changes on services. The Executive team confirmed that workforce establishment reviews continued to be undertaken to ensure staffing levels remained appropriate and that patient safety remained the overriding priority.

Governor Christopher Akwagbe (CA) raised concerns regarding ward staffing levels and reliance on temporary staff. Assurance was given that nursing establishment reviews were undertaken to ensure staffing reflects patient acuity and reduces reliance on temporary staffing. The Governor also requested that the matter be discussed, noting that he had submitted it for consideration; the Chair advised that, as it was not a substantive agenda item, it could not be considered in detail at this meeting and could be considered for a future agenda through the agreed process.

The Committee had also reviewed the Trust's capital programme and estate developments. Members noted that lessons had been learned from the previous year's capital expenditure programme and that approvals for major schemes were being brought forward earlier in the year to support more effective delivery. The Committee had recently approved the procurement process for the Soft Facilities Management contract at the Denmark Hill site.

Governors sought assurance regarding procurement value, use of non-pay expenditure and the potential for services to be brought back in-house. The Executive team advised that procurement savings remained a key component of the Trust's financial plans and confirmed that options raised through staff-side engagement would be considered as part of the contract evaluation process.

Regarding Estates, the Southwark Public Governor raised concerns about the maintenance and operation of hearing loop equipment across the Trust. She advised that volunteers undertake regular checks and had identified instances where hearing loops were either not working or had not been switched on. The concern was acknowledged and it was agreed that the issue would be investigated further.

**Action:** To review the maintenance, monitoring and operational status of hearing loop equipment across the Trust and provide an update on arrangements in place to ensure hearing loops are functioning correctly. **Julie Lowe.**

**The Council noted the report and the ongoing focus on delivering financial sustainability while maintaining high-quality patient care.**

**26/37 Report from the Chair of the Performance, Transformation and Improvement Committee**

The Council received the Performance, Transformation and Improvement Committee Chair's report, presented on behalf of the Committee Chair. Members were advised that the Committee continued to provide detailed oversight of operational performance, transformation programmes and improvement activity across the Trust. Particular focus had been given to performance against key access standards, including referral-to-treatment waiting times, long waits and cancer performance, with Committee members providing constructive challenge where improvement trajectories remained below target. Follow-up reports had been requested in a number of areas to monitor progress and ensure delivery of agreed improvement actions.

The Committee had reviewed diagnostic performance, including pathology turnaround times following the transition to the Synnovis pathology hub. Members had noted that turnaround times had improved, although performance continued to be closely monitored to ensure further recovery and minimise operational impact on clinical services.

The Committee had also considered workforce pressures and the impact of reliance on bank staffing. It had been noted that the Trust continued to operate with a higher proportion of temporary staffing than planned, partly due to unplanned demand and workforce availability. Members had received assurance that patient safety remained the overriding priority and that work was ongoing to align staffing establishments with patient acuity and service demands, reducing reliance on temporary staffing where appropriate.

During the meeting, governors had sought assurance regarding cleaning, portering and support services provided through outsourced contracts and highlighted concerns raised by staff regarding service delivery standards. Assurance was provided that robust service specifications, contractual performance measures and safeguards would be incorporated into future procurement arrangements, and that requests to consider alternative delivery models would form part of the evaluation process.

The Committee had also noted progress in the Trust's digital programme. Responsibility for oversight of the Trust's Digital Strategy had transferred to the Committee, while digital operational performance and expenditure remained within the remit of the Finance & Commercial Committee. Members were advised that the Trust's Digital Strategy had been reviewed and was nearing finalisation as a supporting component of the wider five-year organisational strategy.

**The Council noted the report and the Committee's continued oversight of performance improvement, transformation activity and operational delivery across the Trust.**

**26/38 Report from the Chair of the People, Education and Inclusion Committee**

The Council received the report from the Chair of the People, Education and Inclusion Committee. Members had noted continued positive progress across a range of workforce indicators and welcomed the improvements achieved through sustained organisational focus on recruitment, retention and staff experience. The Committee had received assurance that delivery of the Workforce Plan remained on track, although it was recognised that continued management oversight and control measures would be required to achieve longer-term workforce reduction ambitions and organisational objectives.

The Committee had also reviewed the outcomes of the Trust's most recent flu vaccination campaign and had noted a significant improvement in staff uptake compared with previous years. Members were advised that the Trust had achieved the highest vaccination uptake rate in London and that lessons learned from the campaign would be incorporated into planning for future vaccination programmes.

A deep dive had been undertaken into violence and aggression incidents affecting staff. Whilst recognising the extensive work already underway, the Committee had expressed

concern that both the number and severity of incidents continued to increase. Assurance had been provided regarding ongoing initiatives to improve the safety and wellbeing of staff and patients, and the Committee agreed to continue close oversight of this area.

The Committee had also received an update from the Interfaith and Belief Network as part of its programme of engagement with staff networks. Members welcomed the work being undertaken by the network but noted concerns regarding capacity and the challenges associated with engaging a wider range of staff.

In relation to education, the Committee had received assurance on medical appraisal, revalidation, training quality and safe working arrangements. Members had also reviewed the draft Workforce Strategy and Culture and Organisational Development Strategy, which set out a five-year framework to support workforce sustainability, leadership development, staff wellbeing and organisational culture.

Governors discussed staff engagement, wellbeing and organisational culture, including concerns raised about staff experiencing significant workplace pressures. The Executive team advised that a comprehensive wellbeing strategy was in place and welcomed further Governor involvement in discussions related to workforce culture and staff experience.

The Council also noted improvements in national trainee survey outcomes and received assurance that educational quality indicators continued to improve across the Trust, including within areas that had previously required targeted support.

**The Council noted the report and welcomed the positive progress made in workforce, education and inclusion, whilst acknowledging the continued focus required on staff wellbeing, violence and aggression, and organisational culture.**

**26/39 Report from the Chair of the Quality and Research Committee Incl. Quality Account Priorities**

In the absence of the Chair of the Quality Committee, the Council Chair presented the Committee update. Members were advised that maternity and neonatal services continued to receive regular oversight through the Committee, with ongoing assurance sought regarding quality improvement activity. The Committee had noted the publication of the Nottingham Maternity Review and recognised that the findings may have implications for maternity services across the NHS, including further considerations for improvement at King's.

The Committee had also considered the continued challenge of corridor care across the Trust. Members had been advised that the Trust's ambition remained the elimination of corridor care wherever possible and that performance was being monitored against the updated national definitions issued by NHS England. Assurance was provided that a comprehensive flow improvement programme was in place, focused on reducing unnecessary attendances, expanding same-day emergency care pathways, reducing avoidable admissions and improving discharge processes to support patient flow and reduce overcrowding. Governors discussed the impact of corridor care on patient safety, reflecting concerns raised during the meeting.

Members had also received an update on the refreshed Quality Assurance Framework (QAF), which had been redesigned to provide improved triangulation of quality, safety, leadership and governance information across care groups. The Committee welcomed the development of the framework and agreed that future iterations should place greater emphasis on measuring outcomes and demonstrating the impact of improvement initiatives.

Discussion also took place regarding quality indicators and staff and patient experience measures. Governors received assurance regarding improving clinical education outcomes, performance in national trainee surveys and learning from recent quality reviews. Positive progress was noted in areas that had previously been subject to enhanced monitoring.

In relation to the Trust's Quality Account priorities, members noted that the Committee remained focused on improving patient safety, reducing corridor care, strengthening quality governance arrangements and supporting sustained improvements in maternity and neonatal services. These priorities would continue to be monitored through the Committee's assurance processes.

**The Council noted the report and welcomed the continued focus on patient safety, quality improvement and delivery of the Trust's Quality Account priorities.**

**26/40 King's Strategy – 2026 to 2031**

The Director of Strategy presented the Trust's new five-year strategy for 2026–2031. Members heard that the strategy had been developed over the previous year through extensive engagement with staff, patients, local communities, voluntary sector organisations and partners across the Trust's boroughs. Feedback highlighted the high regard in which King's was held by local communities, whilst also identifying opportunities to strengthen partnership working, improve patient pathways, enhance staff wellbeing and promote greater inclusion and culturally competent care.

The Council noted that the strategy was built around six strategic ambitions: delivering high-quality care, becoming a great place to work, advancing research, innovation and education, developing strong partnerships, improving timely and efficient patient care, and achieving financial sustainability. Members were advised that a series of supporting strategies, including workforce, digital and sustainability strategies, were being developed to underpin delivery of the overall strategic objectives.

It was further noted that each strategic ambition had been linked to measurable five-year outcomes and annual performance metrics to enable progress to be tracked and reported regularly to the Board. The strategy would be delivered through the King's Improvement approach.

Governors welcomed the strategy and discussed a range of issues including community engagement, staff wellbeing, organisational culture, sustainability and social value. Members emphasised the importance of maintaining strong links with local communities and ensuring senior leaders remained visible and engaged with frontline services. Questions were raised regarding environmental sustainability and the Trust's wider role as an anchor institution within the communities it serves. In response, assurance was provided that environmental sustainability commitments and social value objectives were embedded within supporting strategies and would continue to be developed alongside wider partnership and community engagement work.

Governors also discussed the importance of maintaining focus on areas requiring improvement as well as celebrating successes, with members noting the need for clear organisational priorities and transparent reporting on progress against strategic objectives. The Executive Team confirmed that annual metrics would be reviewed regularly to ensure focus remained on the areas requiring the greatest improvement and impact.

The Council thanked the Director of Strategy for her leadership in developing the strategy, and members acknowledged the team's contribution to the development of the strategy and wider organisational improvement work.

**The Council noted the report and endorsed the strategic direction outlined for the Trust over the period 2026–2031.**

**GOVERNANCE**

**26/41 The Future of the Council of Governors and public and patient engagement**

The Director of Corporate Affairs presented a report on the future of the Council of Governors in light of proposals contained within the NHS Health Modernisation Bill, which, if enacted in its current form, would abolish Councils of Governors, Trust memberships and certain associated engagement functions. Members noted that the legislation was still

progressing through Parliament and that no final decision had yet been taken. It was recognised, however, that the Trust should begin considering how public, patient and community engagement could be maintained should the legislative changes proceed.

Members were advised that many of the current statutory responsibilities of Governors, including the appointment of the Chair, Non-Executive Directors and External Auditors, together with oversight responsibilities related to significant transactions and accountability arrangements, would transfer to the Secretary of State under the proposed legislation. The Trust's focus was therefore on identifying how the valuable contribution made by Governors and members could continue through alternative engagement arrangements.

The discussion highlighted the significant value Governors bring through representing the views of patients, members and local communities, as well as contributing to strategic development and service improvement. Particular emphasis was placed on ensuring that the Trust continued to receive meaningful feedback from local communities regardless of the future legislative position.

The Trust Chair emphasised the importance of maintaining strong connections with patients, service users and the diverse communities served by the Trust, noting that there remained considerable scope to strengthen engagement arrangements. He reiterated the Board's commitment to improving both public engagement and organisational culture and welcomed the contribution Governors could make in designing future engagement models.

Governors expressed their support for the continued involvement of patients and communities in shaping Trust services, and several members indicated their interest in participating in future work on engagement arrangements. Members also noted that the legislation, as currently drafted, would permit Foundation Trusts to retain a Council of Governors should this be considered appropriate, and agreed that all options should remain under consideration until further national guidance and legislative clarity were available.

The Council agreed that a proactive approach should be taken and supported the proposal to establish a working group involving Governors and Trust representatives to consider future arrangements for public, patient and community engagement and to make recommendations for consideration by the Trust.

**Action:** Establish a joint working group of Governors and Trust representatives to review future options for public, patient and community engagement and develop proposals to ensure meaningful involvement of local communities should the proposed legislative changes proceed. **Siobhan Coldwell.**

**The Council noted the report and reaffirmed its commitment to maintaining effective public, patient and community engagement irrespective of the outcome of the proposed legislative changes.**

**26/42 Governor Engagement and Involvement Activities**

The Council received an update on Governor engagement and involvement activities undertaken since the previous meeting. Members noted the written reports submitted by Governors and recognised the continued contribution made through attendance at meetings, engagement events and discussions with patients, staff and local communities.

During the discussion, Governors highlighted a concern regarding patient information materials, specifically related to previous discussions around radiographer's patient information leaflets. Members advised that concerns had been raised over a prolonged period regarding the accuracy and development of patient-facing information and felt that the matter warranted further consideration. It was noted that responses had been received from the Trust and that Governors wished to continue discussions with the relevant

Executive leads to better understand the lessons learned and future arrangements for involving patients and Governors in the development of information materials.

The Council also received an update on issues previously raised by governors through various means. Members noted that work related to end-of-life care governance had recommenced and that responses had been provided to questions raised regarding nurse apprenticeships. It was reiterated that any issues Governors wished to bring forward for future Council meetings should continue to follow the agreed agenda-setting process.

The Chair reminded Governors that the draft agenda for future meetings would continue to be developed through the established arrangements with the Lead Governor and Foundation Trust Office, ensuring that emerging issues could be considered appropriately and prioritised within the available meeting time.

**Action:** Foundation Trust Office to facilitate a follow-up discussion between Governors and The Chief Nurse & Executive Director of Midwifery (CNO) regarding concerns raised about patient experience and end of life and involvement of governors. **Tracey Carter.**

**The Council noted the update and thanked Governors for their continued engagement and contribution to the work of the Trust.**

**OTHER GOVERNOR MATTERS**

**26/43** **Draft Agenda 26 November 2026 Meeting**

The draft agenda was noted, subject to any further amendments arising through the agreed process.

**FOR INFORMATION**

**26/44** **Annual Report and Accounts**

The Council noted the Annual Report and Accounts.

**Integrated Performance Report**

The Council noted the Integrated Performance Report.

**ANY OTHER BUSINESS**

**26/45** **Any Other Business**

- Wheelshare Contract Update

The Chair advised that a meeting was scheduled to take place involving Council of Governors representatives and relevant Trust colleagues to discuss the Wheelshare contract. Members agreed that the outcome of this meeting should be awaited before any further consideration by the Council.

**Action:** Meeting to be set up with CNO to discuss questions raised about procurement and the contract. **Tracey Carter.**

- End of Life Care Governance Committee – Restart and Leadership

Members were advised that the End of Life Care Governance Committee had recommenced activity, with arrangements and leadership now being re-established. It was agreed that no further discussion was required at this stage and that the matter could be closed pending future updates.

- Nurse Apprenticeships

The Council noted that The Chief Nurse & Executive Director of Midwifery had provided a written response to questions previously raised regarding nurse apprenticeships. Members

acknowledged that further questions may arise and agreed that the issue remained important and should be considered through a talent management agenda item.

**Action:** Meeting on nurse apprenticeships has been arranged as part of ongoing work to consider inclusion of a talent management and apprenticeships item at a future Council of Governors meeting. Further update to follow once discussions have taken place. **Tracey Carter.**

- FDA Platform – do not have plans to use Palantir.

The Council noted a question regarding the NHS Federated Data Platform and the use of Palantir technology. The Chair reaffirmed that the Trust does not currently use the Federated Data Platform and had no plans to do so. It was further noted that, should the Trust's position change in future, Governors would be informed accordingly.

Governors recorded their thanks to Angela Helleur (AH), Chief Delivery Officer, for her commitment, support and contribution to the Trust, and wished her well for the future as she leaves the organisation.

**The Council noted the updates.**

There being no other business, the Chair formally ended the meeting.

**26/46** **Date of the next meeting:**
Thursday 26 November 2026, 16:30 - 18:30 The Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill

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| CoG ACTION TRACKER - Updated 26 November 2026 | | | | | |
|---|---|---|---|---|---|
| **Date / Item Ref** | **Action** | **Lead** | **Due Date** | **Status** | **Update** |
| **ACTIONS - DUE** | | | | | |
| **30/07/2026 26/34** | **Report from the Chair of the Finance and Commercial Committee Incl. Trust Financial Position**<br>To review the maintenance, monitoring and operational status of hearing loop equipment across the Trust and provide an update on arrangements in place to ensure hearing loops are functioning correctly. | **CF** | **Nov-26** | **COMPLETE** | **update: Director of Capital, Estates and Facilities to write a summary paragraph on the current position and send: Maintenance of hearing loop equipment is managed by site. Contacta maintains the equipment at Denmark Hill and Orpington under an annual Trust contract, while Vinci is responsible for maintenance at the PRUH. Under the Contacta contract, faults are reported through the Trust Helpdesk, with Contacta providing a reactive response and undertaking planned preventative maintenance (PPM) every 12 months.<br>All hearing loop assets are recorded on the Trust's Concept Computer-Aided Facilities Management (CAFM) system, supporting asset management and maintenance tracking.<br>These arrangements provide a combination of scheduled maintenance and reactive fault response to support the ongoing operation of hearing loop equipment across the Trust.** |
| **30/07/2026 26/39** | **The Future of the Council of Governors and public and patient engagement**<br>Establish a joint working group of Governors and Trust representatives to review future options for public, patient and community engagement and develop proposals to ensure meaningful involvement of local communities should the proposed legislative changes proceed. | **SC** | **Nov-26** | **COMPLETE** | **update: Meeting held on 22 October 2026** |
| **30/07/2026 26/40** | **Governor Engagement and Involvement Activities**<br>Foundation Trust Office to facilitate a follow-up discussion between Governors and CNO regarding concerns raised about patient experience and end of life and involvement of governors. | **TC** | **Nov-26** | **COMPLETE** | **update: Meeting has taken place.** |
| **30/07/2026 26/43** | **Any Other Business - Wheelshare Contract Update**<br>Meeting to be set up with CNO to discuss questions raised about procurement and the contract. | **TC** | **Nov-26** | **COMPLETE** | **update: Meeting has taken place.** |
| **30/07/2026 26/43** | **Any Other Business - Nurse Apprenticeships**<br>Meeting on nurse apprenticeships has been arranged as part of ongoing work to consider inclusion of a talent management and apprenticeships item at a future Council of Governors meeting. Further update to follow once discussions have taken place. | **TC/DM** | **Nov-26** | **COMPLETE** | **update: A meeting took place & to consider a wider agenda item on apprenticehsips & career development.** |
| **PENDING** | | | | | |
| **Date / Item Ref** | **Action** | **Lead** | **Due Date** | **Status** | **Update** |
| | | | | | |

King's College Hospital NHS Foundation Trust

**Patient Booklets**

The Chief Nurse & Executive Director of Midwifery and Director of Communications met with governors Hilary Entwistle and Lindsay Batty-Smith. An apology was provided as the mistake in the booklet should not have happened and was missed as part of proof reading even though the process was followed. It was agreed moving forward that where people with expert knowledge, which could be in many different settings, they will be approached, listened to and respected. There are processes in place that will be used to prevent something like this happening again and that we can use the patient experience committee, the governor patient experience & safety committee to report and discuss these matters and board committee mechanisms to this effect.

It was agreed to close the matter based on these assurances.

**Wheelshare governor meeting**

Some meetings took place in the summer with Lindsay Batty-Smith and Hilary Entwistle of the points outlined.

**1. Procurement and value for money**

The procurement was undertaken through a mini competition under the NHS Supply Chain framework. Bids were assessed against published quality and cost criteria. The successful provider offered additional savings compared with the current arrangement and delivered the best overall value for money. The contract value is approximately £61,000 over three years (circa £20,000 per annum), representing a relatively low-value contract for this service.

**2. NHS framework and alternative providers**

The NHS Supply Chain framework was used for this procurement and includes a number of approved suppliers capable of delivering this service. Suppliers were assessed against the published evaluation criteria.

Public procurement regulations require suppliers to be treated equally, and therefore a company's country of ownership or origin cannot be used as an award criterion. While there was some supplier interest, market appetite to deliver this service at King's was limited.

**3. Ethical and sustainable procurement**

Due diligence and evaluation requirements were undertaken through the NHS Supply Chain framework and the Trust's procurement processes. Social value, sustainability and governance considerations formed part of the procurement assessment, and no issues were identified that prevented contract award.

**4. Patients, accessibility and Board assurance**

Equality, accessibility and patient needs were reflected within the service specification and evaluation criteria. The evaluation panel included two patient representatives and the Head of Patient Experience, ensuring patient perspectives informed the assessment process.

The Trust is satisfied that the procurement process identified the provider offering the best overall balance of quality, accessibility, service delivery and value for money.

King's College Hospital NHS Foundation Trust

**AGENDA ITEM: 2**

# BOARD/COMMITTEE REPORT COVER PAPER

| | |
|---|---|
| **Report to:** | Council of Governors |
| **Date of meeting:** | 26 November 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**

The purpose of this report is to provide the Council of Governors with the highlight reports presented to the Public Board meeting held on 17 November 2026, for noting and assurance. The following reports are included:

1. Finance and Commercial Committee (1 October and 5 November 2026 meetings),
2. Performance, Transformation and Improvement Committee (PTIC) (8 October and 5 November 2026 meetings),
3. People, Inclusion and Education Committee (24 September and 22 October 2026 meetings).
4. Quality and Research Committee (30 September and 20 October 2026 meetings),

**Recommendations:**

The Council of Governors is asked to note the summary of discussions at the Board subcommittee meetings and take assurance from the oversight provided by the respective committees.

**Strategy alignment**

| | | | |
|---|---|---|---|
| **High Quality Patient Care** | ✓ | **Strong Successful Partnerships** | ✓ |
| **A Great Place to Work** | ✓ | **Timely and Efficient Care** | |

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

| | | | |
|---|---|---|---|
| Pioneering Research, Innovation and Education | ✓ | Financial Sustainability | ✓ |

**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**<br>Board of Directors | |

King's College Hospital NHS Foundation Trust

# AGENDA

| | |
|---|---|
| **Committee** | **Finance and Commercial Committee – Chair's Report to the Board** |
| **Date** | **Thursday 1 October, 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<br>Apologies were received from Non-Executive Director Angela Spatharou. | FI | Verbal | Chair | |
| | 1.2. Declarations of Interest<br>No new declarations were made. | FI | Verbal | | |
| | 1.3. Chair's Actions<br>The Chair noted that since the last meeting on 3 September 2026, there had been a detailed discussion about the financial recovery plan at the Board meeting held on 16 September 2026. | FI | Verbal | | |
| | 1.4. Minutes of Previous Meeting<br>The minutes were approved. | FA | Enc. | | |
| | 1.5. Action Tracker<br>The Committee noted the action tracker updates. | FA | Enc. | | |
| | 1.6. Matters Arising<br>There were no matters arising. | FD | Verbal | | |
| **2.** | **FINANCIAL REPORTING 2026 / 27** | | | | |
| | 2.1. Finance Performance Report – Month 5<br>The Committee noted the Trust's £16.2m year-to-date deficit, £0.2m adverse to plan, and the significant risk to achieving year-end breakeven due to the £63.1m CIP gap and potential loss of deficit support funding. The Committee emphasised the need for stronger | FD/A | Enc. | Chief Financial Officer | |

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

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| | financial recovery plans, additional expenditure controls, measurable savings and improved delivery of the capital programme, where underspending and slippage remain key concerns. | | | | |
| | 2.2. 2027/28 Operational Planning launch<br><br>The Committee reviewed the 2027/28 Operational Planning Framework, noting the significant efficiency requirement of £143.3m and a £10.4m capital funding gap. It emphasised reducing the current recurrent deficit, strengthening divisional and clinical accountability for savings, and prioritising sustainable improvements in patient pathways, operational performance and quality, while continuing to pursue national capital funding opportunities. | FD/A | Enc. | Chief Financial Officer | |
| | 2.3. Investment Board update<br>The Committee reviewed and approved two business cases exceeding £5m for Trust Board Approval. The committee noted the discussions and approvals from the September Investment Board. | FD/A | Enc. | Chief Financial Officer | |
| | 2.4. Capital Variation<br>The Committee approved several budget adjustments and funding allocations, including VAT recovery credits, energy and capital project adjustments, the KFM laptop replacement programme and use of Medtronic loyalty points, with relevant allocations subject to Investment Board business case approval. | FD | Enc. | Chief Financial Officer | |
| | 2.5. WTE Reduction Trajectory Plans<br>The Committee noted that the Trust remains approximately 53 WTE above target, with a requirement for further WTE reductions, and emphasised stronger management oversight and reductions in bank and agency reliance. It stressed that workforce decisions must be evidence-based, balancing financial savings with patient safety, through improved demand and capacity planning, service redesign and better deployment of existing staff. | FD | Enc. | Chief People Officer | |
| **3.** | **GOVERNANCE** | | | | |
| | 3.1. There were no items | | | | |
| **4.** | **CAPITAL AND ESTATES** | | | | |
| | 4.1. There were no items | | | | |
| **5.** | **COMMERCIAL** | | | | |

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

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|---|---|---|---|---|---|
| | 5.1. Subsidiary Update<br>The Committee noted that the Group's subsidiaries face no immediate material risks, with KFM progressing its CIP and pursuing commercial diversification, while international hospital platforms continue to develop. It emphasised the importance of robust quality assurance and protecting the King's brand, noted plans to reduce King's Academy losses, and acknowledged potential further funding for relevant overseas platforms, subject to future Board consideration. | FI | Enc. | Chief Financial Officer | |
| | 5.2. International Platforms Expansion - Contract Approval<br>The Committee received an update on International Platform expansion and made approvals as relevant. | | | | |
| **1.** | **DIGITAL** | | | | |
| | 1.1. There were no items. | | | | |
| **2.** | **ANY OTHER BUSINESS** | | | | |
| | 2.1. Draft agenda FCC meeting – 5 November 2026<br>The Committee agreed to refine the draft agenda to reflect Month 6 financial reporting, include progress against the £20m CIP target and key variances, and allow sufficient time for the Estates Strategy discussions. | FD/A | Enc. | Chair | |
| | 2.2. Issues to be escalated to the Board (Board Highlight report)<br>There were no matters raised. | FD | Verbal | Chair | |
| **9.** | **Date of the next meeting: 5 November 2026** at 13:00 – 15:00 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** |
| **Date** | **Thursday 5 November, 2026** |
| **Time** | **13:00 – 15:00** |
| **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<br>Apologies were received from Akhter Mateen, Richard Taunt (Improvement Director) and Michael Duff (Deputy Director of Finance, NHSE London Region). Simon Foster and Malcolm London were in attendance from NHSE London and deputising for Michael Duff. | FI | Verbal | Chair | |
| | 1.2. Declarations of Interest<br>There were no new declarations of interests. | FI | Verbal | | |
| | 1.3. Chair's Actions<br>There were no Chair's actions. | FI | Verbal | | |
| | 1.4. Minutes of Previous Meeting<br>The minutes from the 1 October 2026 meeting were approved. | FA | Enc. | | |
| | 1.5. Action Tracker<br>The Committee noted updates to the action tracker. | FA | Enc. | | |
| | 1.6. Matters Arising<br>There were no matters arising. | FD | Enc. | | |
| **2.** | **FINANCIAL REPORTING 2026 / 27** | | | | |
| | 2.1. September 2026 Financial Position<br>The Month 6 financial position was presented, reporting an £18.3m year-to-date deficit, £2.1m favourable to plan, although the underlying position year to date is a £67.3m deficit after removal of non-recurrent items, £8.7m adverse to plan. The Committee noted progress against the CIP and the three interventions supporting the year end | FD/A | Enc. | Chief Financial Officer | |

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

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| | breakeven forecast, but recognised the significant risks associated with non-recurrent savings, bank and agency reductions and the potential £48m CIP shortfall carrying forward into the next financial year. Members emphasised the need to strengthen recurrent savings, divisional ownership and accountability for delivery. The Committee also noted the capital programme's continued breakeven forecast, while recognising the risk associated with 46% of expenditure being scheduled for Quarter 4. The Executive was asked to provide further assurance on delivery plans and progress against the financial recovery interventions. | | | | |
| | 2.2. Outcome of the October Investment Board<br>It was confirmed that KMC had reviewed all proposals and recommended them for FCC approval. The business cases primarily related to capital variations supporting the Trust's capital programme, including redevelopment works, mortuary refrigeration and other investments within the approved funding envelope. | FD/A | Enc. | Chief Financial Officer | |
| | 2.3. M6 September Workforce Plan vs Actual<br>This report highlighted modest improvements in substantive staffing, including a 58 WTE reduction compared with the previous year, but noted that workforce reductions and temporary staffing controls remained below plan. The Committee discussed bank expenditure, sickness absence, recruitment controls and the impact of winter pressures, noting the significant challenge of reducing bank usage while maintaining patient safety. The Committee also noted the introduction of tighter controls on bank and overtime expenditure and the need for further assurance on workforce reductions and the associated financial impact. | FD/A | Enc. | Chief People Officer | |
| **3.** | **GOVERNANCE** | | | | |
| | 3.1. Board Assurance Framework<br>The Director of Corporate Affairs presented the BAF updates for Financial Sustainability and Critical Infrastructure. The financial sustainability risk score remained at 25, with a target of 15 by March 2027, subject to delivery of the existing financial strategy. The critical infrastructure update highlighted progress on the PAM assessment and Estates | FA | Enc. | Director of Corporate Affairs | |

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

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|---|---|---|---|---|---|
| | Strategy, alongside ongoing risks to capital programme delivery. The Committee welcomed the improved visibility of mitigations and agreed that both risk scores should remain unchanged. | | | | |
| **4.** | **CAPITAL AND ESTATES** | | | | |
| | 4.1. Estates Strategy Report<br>The draft Estates Strategy was presented, outlining the proposed five-year programme, longer-term site masterplans and priorities for clinical developments, backlog maintenance and Net Zero commitments. The Committee welcomed the progress made but emphasised the need for stronger clinical involvement, appropriate governance, estate rationalisation and alignment with future service strategies. Members also discussed the affordability and prioritisation of capital investment, PRUH fire safety requirements and the potential increase in backlog maintenance. The Committee supported further development of the strategy, with an outline to be presented to the Private Board and a refined version completed by year end. | FD | Enc. | Deputy Chief Executive Officer | |
| | 4.2. Estates and facilities update including PAM update<br>The Estates and Facilities update was presented, including the PAM assessment and the £43.2m capital programme. The update highlighted strengthened programme oversight, progress across key projects and ongoing delivery risks, particularly the significant concentration of expenditure in Quarter 4. The Committee also noted the potential £1m risk related to delays in the Willowfield pharmacy project. The Director confirmed that the 2026 PAM assessment had been submitted and outlined improvement actions relating to policies, procedures and safety reporting. The Committee noted the update and the proposed oversight of the PAM action plan by the Trust Health and Safety Committee. | FD/A | Enc. | Deputy Chief Executive Officer | |
| | 4.3. ISS settlement proposal<br>The Director of Capital, Estates and Facilities presented the ISS settlement proposal, confirming that it represented a financially neutral reconciliation of historic outstanding matters and was supported by external legal advice. The Committee emphasised the need for full and final | FD/A | Enc. | Deputy Chief Executive Officer | |

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

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|---|---|---|---|---|---|
| | settlement, with no future liabilities or counterclaims, and approved the proposal. | | | | |
| **5.** | **COMMERCIAL** | | | | |
| | 5.1. Trust-wide commercial activity<br>The Trust-wide Commercial Activity Report was presented, providing greater visibility of the Trust's commercial activities and opportunities. The Committee sought assurance on the governance of intellectual property, ownership and royalty arrangements. It was confirmed that established policies and oversight arrangements were in place, including Board scrutiny of commercial investments with external non-executive representation. The Committee noted the report and was assured that appropriate governance arrangements were in place. | FI | Enc. | Chief Financial Officer | |
| **6.** | **DIGITAL** | | | | |
| | 6.1. No Items | | | | |
| **7.** | **ANY OTHER BUSINESS** | | | | |
| | 7.1. Draft agenda FCC meeting – 3 December 2026<br>The Committee reviewed and agreed the draft agenda for the next meeting, noting that agenda planning was undertaken within the monthly meeting cycle to avoid additional meetings. Executive members were invited to raise any significant concerns or proposed additions, and a Digital Update was added to the draft agenda. | FD/A | Enc. | Chair | |
| | 7.2. Issues to be escalated to the Board (Board Highlight report)<br>The Committee identified the Estates Strategy as a key item for discussion at private board in November 2026. | FD | Verbal | Chair | |
| **8.** | **Date of the next meeting: 3 December 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 ITEM: 3.**

# BOARD/COMMITTEE REPORT COVER PAPER

| | |
|---|---|
| **Report to:** | Council of Governors |
| **Date of meeting:** | 26th November 2026 |
| **Subject:** | September 2026 Financial Position |
| **Author(s):** | Alex Bartholomew, Deputy Chief Finance Officer |
| **Sponsor:** | Roy Clarke, Chief Finance Officer |
| **History:** | King's Management Committee |
| **Status:** | |

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

**Purpose**

To update the Council on the Trust's September 2026 financial position.

As of September, the KCH Group (KCH, KFM and KCS) has reported a £18.3m deficit year to date. This represents a £2.1m favourable variance to the March 2026 NHSE accepted plan.

The underlying position year to date is a £67.3m deficit after removal of non-recurrent items, £8.7m adverse to plan.

**Income**

£3.0m adverse variance:

- The Trust is reporting a £1.6m adverse variance against NHS patient care income driven by a £3.2m data quality adjustment and £0.8m activity over performance recognised in September.
- Private Patient income is £1.0m adverse to plan, primarily reflecting the timing of CAR-T cell activity. Given the low-volume, high-value and inherently variable nature of this service, the associated CIP remains forecast to be fully delivered by year-end.
- The adverse position is partially offset by £2.5m favourable variance of Overseas Visitors income reflecting increased activity.
- The £1.6m adverse Other Operating Income variance is primarily driven by £1.2m underperformance in Research & Development income, together with a £0.3m shortfall in Total Pancreatectomy with Islet Auto Transplantation (TPIAT) income within Liver, Gastro, Upper GI and Endoscopy services.

**Pay**

£13.4m adverse variance:

- The adverse variance is driven by £15.8m undelivered CIP against plan, with pay expenditure remaining higher than planned.
- Nursing pay is a £5.0m adverse variance mainly due to Bank spend driven by sickness cover, escalation and enhancement.
- Medical pay is £4.4m adverse, primarily driven by bank expenditure. £0.8m relates to vacancy cover, with 35 WTE more booked under this category than the substantive vacancy level. A further £2.5m adverse bank variance is mainly driven by sickness and other cover, Waiting List Initiatives, escalation and elective recovery. The net impact of the Resident Doctors' strike is £0.6m adverse, after a £0.3m pay clawback recognised in August.
- The adverse position was partially offset by £11.8m Administrative & Clerical and Other Staff vacancies.
- The Trust's WTE has decreased by 84 since August, primarily driven by a decrease in Nursing Bank utilisation.

**Non-pay**

£15.6m favourable variance:

- The favourable variance is mainly due to budgeted inflation expected to crystallise in future months.
- Private Patient expenditure is £1.0m favourable, consistent with the under delivery of Private Patient income due to lower activity, with a further £0.3m favourable variance reflecting lower business rates charges following a successful challenge with the Council.
- The favourable position partially offset pressures of £1.6m overspend in Patient Transport Services and £5.4m under delivery of CIP.

**CIP**

The Trust has confirmed plans to deliver £23.3m of Cost Improvement Programme (CIP), a planning gap of £61.6m against the £84.9m target. The Trust has delivered year-to-date recurrent savings of £10.6m (£2.8m pay and £7.8m non-pay), resulting in a £21.2m adverse variance. It must rapidly progress the financial improvement actions approved at September 2026 Trust Board, with failure to do so risking delivery of the 2026/27 financial plan, loss of £44.0m deficit support funding (DSF) in 2026/27, eligibility for DSF in 2027/28 and delivery of the Trust's financial strategy, including return to breakeven by 2029/30.

**Cash**

- Month end cash balances continue to show special cause improvement between August and September and remain within expected levels.

**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 September 2026, Trust confirmed capital sources for 2026/27 core projects stands at £70.4m, a movement of £1.2m as a result of £1.0m provisional Return to Constitutional Standards (RtCS) funding now confirmed by NHS England and £0.2m of charity and national funding, including £0.06m of Frontline Productivity Programme (FPP) funding.
- September 2026 year-to-date expenditure is £12.9m, against a year-to-date planned spend of £19.3m, giving a year-to-date variance of £6.4m. All project variances are currently expected to resolve in 2026/27, though concerns remain around the pace of delivery of key programmes including the Sexual Assault Referral Centre (SARC) and Willowfield. Following last month's Board report Finance, Estates and KFM agreed an action plan to tackle risks to capital spend. The year-to-date variance on Estates Safety Funding (ESF) and Backlog Maintenance (BLM) has reduced by £1.2m to £1.6m.
- The capital programme is significantly backloaded with 46% of spend (£33.7m) forecast in Q4, with Willowfield, SARC and Denmark Hill NICU particularly backloaded. This increases the risk of unfunded slippage late in the year, resulting in the Trust not getting full value from its capital budget. The action plan developed by Finance, Estates and KFM is making progress, with in-month spend of £3.9m across the identified projects compared with £4.5m year-to-date spend at August 2026. Continued close monitoring of capital programmes is required due to the level of spend required in Q4 to deliver to budget.

**Recommendations:**

The Council is asked to note the September 2026 financial position.

**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** | BAF 3 - Financial Sustainability |
| **King's Improvement Impact (KIM):** | Not applicable. |
| **Quality Impact** | The financial position has an impact on the resources the Trust has to delivery patient care. |
| **Health Equity Impact** | Not applicable. |
| **Workforce Impact** | Workforce is a key driver of the financial position. |
| **Research/Innovation Impact** | Research and development generate income for the Trust. |
| **Digital Impact** | Not applicable. |
| **Financial Impact** | The Trust has submitted a Board approved revenue and capital plan as part of the planning submissions. |
| **Legal/ regulatory compliance** | The financial position affects the metrics used to determine the Trust's regulatory risk assessment in the National Oversight Framework. |
| **Communications and Engagement** | The financial position is communicated to Trust staff through Core Brief and Finance Focus. |
| **Use of Artificial Intelligence Tools** | No AI tools have been used in the preparation of this paper. |
| **Committee that will provide relevant oversight**<br>Finance and Commercial Committee | |

NHS
King's College Hospital
NHS Foundation Trust

# Finance Report

September 2026

## Council of Governors

King's values Caring Collaborative Inclusive Innovative

# Contents

**This report sets out the Trust's financial performance and forms part of the Trust's performance reporting suite.**

**The report has been structured to provide the reader with an overview of the Trust's financial performance using the following framework.**

**It should be noted that Kings Facilities Management and Kings Commercial Services have been consolidated on a subjective basis in line with the Trust's planning submission.**


| | | |
|---|---|---|
| **1.0** | **Executive Dashboard** | **Page 3-6** |
| 1.1 | Executive Summary (Overview) | Page 3-5 |
| 1.2 | Executive Summary (Risk) | Page 6 |


**High level summary**

# 1.1 Executive Summary



**As of September, the KCH Group (KCH, KFM and KCS) has reported a £18.3m deficit year to date. This represents a £2.1m 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 £67.3m deficit after removal of non-recurrent items, £8.7m adverse to plan.**

**Income £3.0m adverse variance:**
- The Trust is reporting a £1.6m adverse variance against NHS patient care income driven by a £3.2m data quality adjustment and £0.8m activity over performance recognised in September.
- Private Patient income is £1.0m adverse to plan, primarily reflecting the timing of CAR-T cell activity. Given the low-volume, high-value and inherently variable nature of this service, the associated CIP remains forecast to be fully delivered by year-end.
- The adverse position is partially offset by £2.5m favourable variance of Overseas Visitors income reflecting increased activity.
- The £1.6m adverse Other Operating Income variance is primarily driven by £1.2m underperformance in Research & Development income, together with a £0.3m shortfall in Total Pancreatectomy with Islet Auto Transplantation (TPIAT) income within Liver, Gastro, Upper GI and Endoscopy services.

**Pay £13.4m adverse variance:**
- The adverse variance is driven by £15.8m undelivered CIP against plan, with pay expenditure remaining higher than planned.
- Nursing pay is a £5.0m adverse variance mainly due to Bank spend driven by sickness cover, escalation and enhancement.
- Medical pay is £4.4m adverse, primarily driven by bank expenditure. £0.8m relates to vacancy cover, with 35 WTE more booked under this category than the substantive vacancy level. A further £2.5m adverse bank variance is mainly driven by sickness and other cover, Waiting List Initiatives, escalation and elective recovery. The net impact of the Resident Doctors' strike is £0.6m adverse, after a £0.3m pay clawback recognised in August.
- The adverse position was partially offset by £11.8m Administrative & Clerical and Other Staff vacancies.
- The Trust's WTE has decreased by 84 since August, primarily driven by a decrease in Nursing Bank utilisation.

**Non-pay £15.6m favourable variance:**
- The favourable variance is mainly due to budgeted inflation expected to crystallise in future months.
- Private Patient expenditure is £1.0m favourable, consistent with the under delivery of Private Patient income due to lower activity, with a further £0.3m favourable variance reflecting lower business rates charges following a successful challenge with the Council.
- The favourable position partially offset pressures of £1.6m overspend in Patient Transport Services and £5.4m under delivery of CIP.

**CIP**
- The Trust has confirmed plans to deliver £23.3m of Cost Improvement Programme (CIP), a planning gap of £61.6m against the £84.9m target. The Trust has delivered year-to-date recurrent savings of £10.6m (£2.8m pay and £7.8m non-pay), resulting in a £21.2m adverse variance. It must rapidly progress the financial improvement actions approved at September 2026 Trust Board,, with failure to do so risking delivery of the 2026/27 financial plan, loss of £44.0m deficit support funding (DSF) in 2026/27, eligibility for DSF in 2027/28 and delivery of the Trust's financial strategy, including return to breakeven by 2029/30.

| | Current Month | | | Year to Date | | |
|---|---|---|---|---|---|---|
| NHSI Category | Budget £ M | Actual £ M | Variance £ M | Budget £ M | Actual £ M | Variance £ M |
| Operating Income From Patient Care Activities | 156.6 | 159.6 | 2.9 | 935.0 | 933.3 | (1.6) |
| Other Operating Income | (1.3) | 11.6 | 12.9 | 58.6 | 57.2 | (1.4) |
| **Operating Income** | **155.3** | **171.2** | **15.9** | **993.6** | **990.5** | **(3.0)** |
| Employee Operating Expenses | (92.8) | (96.0) | (3.2) | (558.3) | (571.8) | (13.4) |
| Operating Expenses Excluding Employee Expenses | (63.1) | (74.7) | (11.6) | (435.6) | (420.0) | 15.6 |
| Non Operating Expenses | (3.1) | (2.4) | 0.7 | (26.0) | (23.4) | 2.6 |
| **Trust Surplus / (Deficit)** | **(3.7)** | **(1.9)** | **1.8** | **(26.3)** | **(24.6)** | **1.7** |
| **Less Control Total Adjustments** | **(0.3)** | **(0.2)** | **0.0** | **5.9** | **6.3** | **0.4** |
| **Adjusted Financial Performance (NHSEI Reporting)** | **(4.0)** | **(2.1)** | **1.9** | **(20.4)** | **(18.3)** | **2.1** |
| Less: Non-recurrent Deficit Support Income (National) | (3.7) | (3.7) | 0.0 | (22.2) | (22.2) | 0.0 |
| Less: Non-recurrent Deficit support income (Local) | (2.7) | (2.7) | 0.0 | (16.0) | (16.0) | 0.0 |
| Less: Non-recurrent benefits and industrial action | 0.0 | 1.2 | 1.2 | 0.0 | (10.8) | (10.8) |
| **Adjusted Financial Performance excluding NR Items** | **(10.4)** | **(7.3)** | **3.1** | **(58.6)** | **(67.3)** | **(8.7)** |
| Cash and Cash Equivalent | 62.0 | 100.9 | 38.9 | 62.0 | 100.9 | 38.9 |
| Capital | 3.7 | 6.2 | 2.5 | 19.3 | 12.9 | (6.4) |
| CIP | 7.1 | 2.1 | (5.0) | 31.8 | 10.6 | (21.2) |

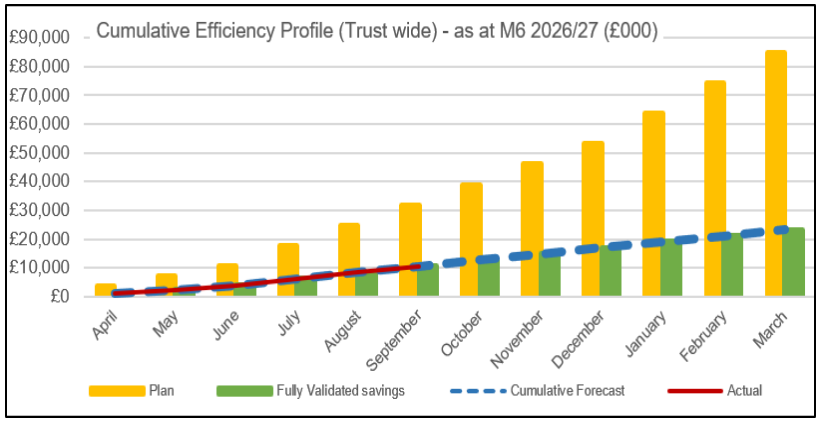


**Figure 1:** Cumulative Efficiency Profile (Trust-wide) as at September 2026

# 1.1 Executive Summary (Continued)

**As of September, the KCH Group (KCH, KFM and KCS) has reported an £18.3m deficit year to date. This represents a £2.1m favourable variance to the March 2026 NHSE accepted plan. Excluding non-recurrent support, this results in an underlying deficit of £67.3m, £8.7m adverse to plan.**

Employee Operating Expense shows expected variation, driven by temporary staffing costs associated with 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 September WTE position has decreased by 84 WTE, from 14,401 WTE to 14,317 WTE

Temporary staffing utilisation continued to improve during September, with Agency WTE reducing by 3 and Bank WTE by 46 compared to August, primarily driven by reduced enhanced care activity and lower sickness-related cover requirements.

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 £5.3m year to date; largely within Nursing bank staffing (£3.4m). This was exacerbated in April by additional backfill requirements during industrial action. April to September usage was to cover escalation, enhancement and sickness. Agency spend is however £0.3m below the target year to date, the improvement driven by Division A. Both bank and agency spend reduced in September, providing an early but not yet sustained indication of improved divisional grip and control to meet 2026/27 targets (see appendices 3 & 4).

Other Operating Income has returned to expected variation in September following the reset of subsidiary external income budgets.

Operating Expenses Excluding Employee Expenses (non-pay) is within expected variation since September 2024.

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.




**Figure 2:** Key metrics SPC charts April 2024 – September 2026

**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 14 for SPC chart interpretation and key.

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# 1.1 Executive Summary (Continued)



**As of September, the KCH Group (KCH, KFM and KCS) has reported a £18.3m deficit year to date. This represents a £2.1m favourable variance to the March 2026 NHSE accepted plan.**

**Cash:** Month end cash balances continue to show special cause improvement between August and September and remain within expected levels.

**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 September 2026, Trust confirmed capital sources for 2026/27 core projects stands at £70.4m, a movement of £1.2m as a result of £1.0m provisional Return to Constitutional Standards (RtCS) funding now confirmed by NHS England and £0.2m of charity and national funding, including £0.06m of Frontline Productivity Programme (FPP) funding.

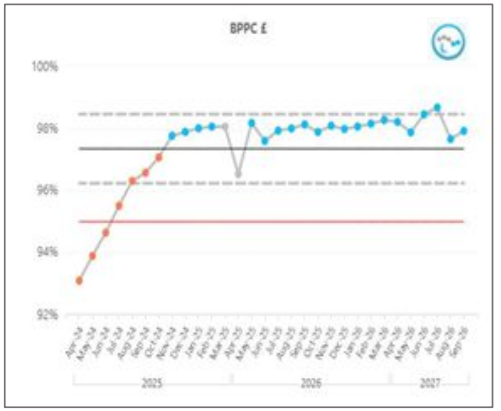
September 2026 year-to-date expenditure is £12.9m, against a year-to-date planned spend of £19.3m, giving a year-to-date variance of £6.4m. All project variances are currently expected to resolve in 2026/27, though concerns remain around the pace of delivery of key programmes including the Sexual Assault Referral Centre (SARC) and Willowfield. Following last month's Board report Finance, Estates and KFM agreed an action plan to tackle risks to capital spend. The year-to-date variance on Estates Safety Funding (ESF) and Backlog Maintenance (BLM) has reduced by £1.2m to £1.6m.

The capital programme is significantly backloaded with 46% of spend (£33.7m) forecast in Q4, with Willowfield, SARC and Denmark Hill NICU particularly backloaded. This increases the risk of unfunded slippage late in the year, resulting in the Trust not getting full value from its capital budget. The action plan developed by Finance, Estates and KFM is making progress, with in-month spend of £3.9m across the identified projects compared with £4.5m year-to-date spend at August 2026. Continued close monitoring of capital programmes is required due to the level of spend required in Q4 to deliver to budget.

**Key Actions**

1. Deliver the interventions approved by the Trust Board on 16 September 2026, as defined in the Trust Board paper and summarised:
   - Progress existing CIP schemes in Gateway 0-2 through movement into Gateway 3 + to increase the approved CIP position. These schemes are expected to improve the position by £19.4m in-year.
   - Take the agreed actions to mitigate the gap through reduced run rate expenditure.
   - Implement additional run rate reduction measures through bank staff reduction.
   - Enable delivery through strengthened improvement leadership, programme delivery capability and organisational focus on delivery.
2. By November 2026, these temporary recovery plans and run rate recovery actions will need to be replaced with recurrent savings to release further recurrent CIP.
3. 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.



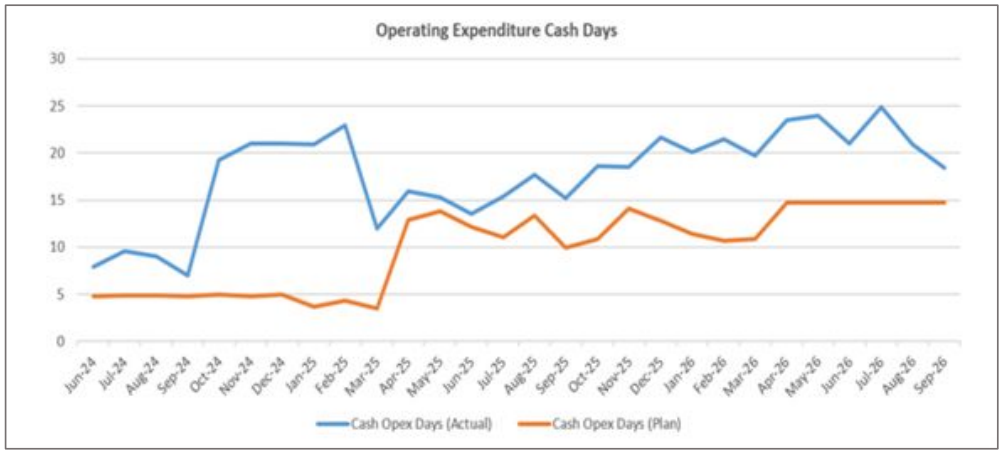




**Figure 3:** Cash and liquidity performance metrics trend to September 2026

# 1.2 Executive Summary - Risk

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

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

**Corporate Risk**
CIP Under Delivery (Risk A) is due to CIP under achievement against identified schemes. At September, CIP is £21.2m 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.

Risk H relates to the risk of strategic investments subject to central funding bids not receiving full revenue and capital support.

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. The risk has increased due to the impact of CIP under achievement on the Trust's overall financial performance.

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 £0.6m 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 latest published data (Q1 2026/27). Finance has a combined metric score of 2, which reflects a planned deficit greater than 2% of expenditure, mitigated by a positive variance against plan at Q1. The productivity metric used by NHSE has changed from Implied Productivity in 2025/26 to Relative difference in costs (reference costs) in 2026/27. KCH's performance of 100.7% against the national average of 100% gives a ranking of 72 out of 134 providers.

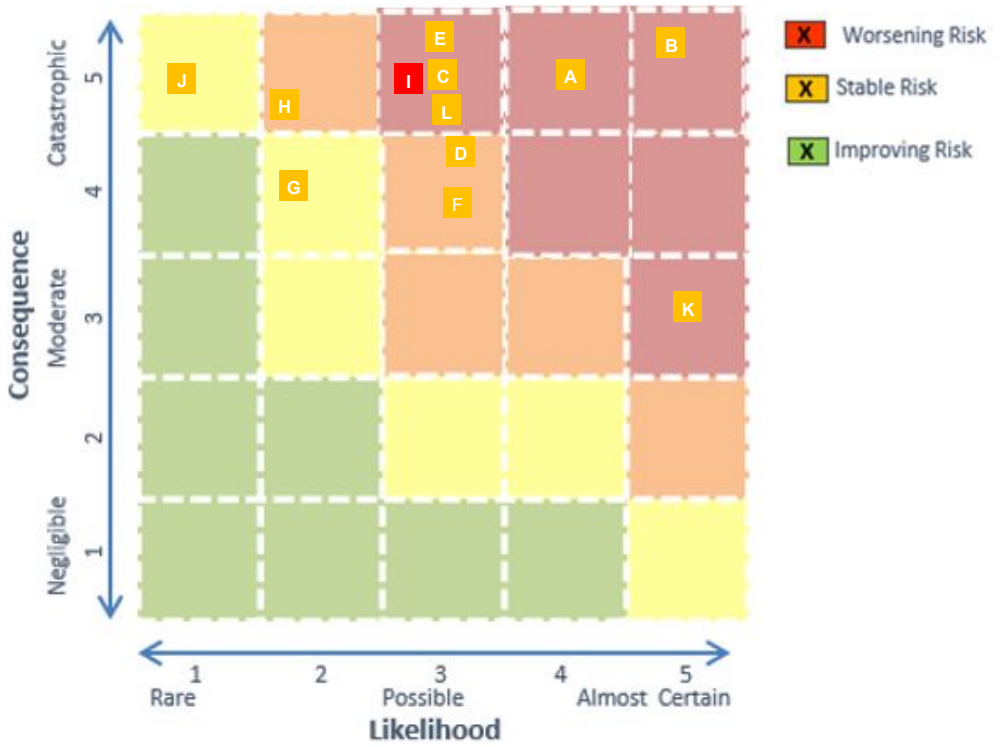



**Figure 4:** Strategic and Operational financial risk assessment September 2026

| Metric Sub-Domain | Description | Reporting date | Metric value | Units | Metric score | Rank |
|---|---|---|---|---|---|---|
| Finance | Planned surplus/deficit | Q1 2026/27 | -2.29 | % | 4.00 | 93 out of 134 |
| Finance | Variance year-to-date to financial plan | Q1 2026/27 | 1.48% | % | 1.00 | 1 out of 134 |
| Finance | Combined finance | Q1 2026/27 | | | 2.00 | |
| Productivity | Relative difference in costs | 2024/25 | 100.7 | % | 2.15 | 72 out of 134 |

**Figure 5:** NOF metric scoring at Q1 2026/27

King's College Hospital NHS Foundation Trust

# AGENDA

| | |
|---|---|
| **Committee** | **Performance, Transformation and Improvement Committee** |
| **Date** | **Thursday 8 October 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<br>The Committee noted the apologies received from:<br>Sir David Behan, Chair<br>Dr Mamta Shetty-Vaidya, Chief Medical Officer | FI | Verbal | Chair | |
| | 1.2. Declarations of Interest<br>There were no declarations of interest over and above those on record. | | | | |
| | 1.3. Minutes of the previous meeting and action tracker<br>The minutes of the meeting held on 15 September 2026 were approved as an accurate record. | FA | Enc. | Chair | |
| **OPERATIONAL PERFORMANCE** | | | | | |
| **2.** | Integrated Performance Report<br>The Committee discussed the Integrated Performance Report and noted a mixed position, with improvement in cancer Faster Diagnosis Standard performance alongside continuing challenges in urgent and emergency care, RTT and diagnostics. Four-hour performance was 71.8% and RTT performance was 66.2% against a plan of 67.9%; the year-end RTT position remained challenging, with an indicative gap of approximately 3,000 pathways. The Committee welcomed sustained improvements in nasendoscopy and echocardiography but remained concerned about daily corridor care, long waits and winter resilience. Further specificity was requested on the timing and impact of UEC interventions, clarification of outpatient RTT and theatre measures, and the inclusion of activity levels on performance charts to distinguish demand growth from factors within the Trust's control. | | | | |
| **3.** | Theatre Productivity<br>The Committee discussed the theatre productivity update and noted a 1.2% year-on-year improvement in utilisation, although performance remained approximately 5% below the NHS England target. On-the-day cancellations had reduced from a previous level of approximately 11% to approximately 9% at the time of the October meeting, and day-case performance was 86.8%, around 3% above London and national comparators. Members welcomed progress in digital pre-assessment, standby patient arrangements and standardisation across sites, while noting that avoidable dropped lists remained above plan. The Committee requested reconciliation of the theatre data with the Integrated Performance Report, including consideration of the different reporting periods, to explain the apparent deterioration in cases per four-hour session and utilisation. | | | | |

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

| No | Item | Purpose | Format | Lead & Presenter | Time |
|---|---|---|---|---|---|
| **4.** | Cancer Deep Dive Report<br><br>The Committee discussed the cancer deep dive and noted the Trust's strongest 28-day Faster Diagnosis Standard performance for two years, together with sustained 31-day performance in line with plan. The principal challenge remained 62-day performance, with risks concentrated in radiology, endoscopy and pathology and vulnerability arising from small specialist workforce. Members noted improvement in pathology and the use of tumour-specific action plans, CT prioritisation and AI-enabled opportunities to release radiology capacity. The Committee emphasised that successful recovery depended on effective collaboration across South East London because cancer pathways frequently crossed organisational boundaries, and that increased diagnostic capacity must be matched by timely reporting capacity. | | | | |
| **5.** | Minimum Standards of Elective Care<br><br>The Committee discussed the Trust's self-assessment against the eight NHS England minimum standards for elective care and noted assurance of compliance with three standards, partial assurance for three and limited assurance for two. An action plan and delivery timelines were being developed ahead of the January 2027 stocktake, although some requirements depended on further Epic functionality. Members highlighted the importance of consistent service adoption of MyChart, improved two-way communication with patients and meaningful Waiting Well updates. The position and expected trajectory would first return through KMC, with existing transformation, operational and patient experience programmes brought together to provide overarching assurance. | | | | |
| **6.** | National Oversight Framework and Regional Performance Management Update<br><br>The Committee discussed the recently published National Oversight Framework rankings and noted that the Trust remained in segment 3, including because of deficit support funding, with its overall ranking unchanged from the end of the previous year. Direct comparison was difficult because the revised framework included additional indicators and structural changes. Members noted that the framework shaped both regulatory assessment and wider NHS perceptions of the Trust, with potential implications for organisational standing and access to funding. The Committee agreed that the evolving framework and performance against its constituent indicators should continue to be monitored as further quarterly information became available. | | | | |
| **TRANSFORMATION AND IMPROVEMENT** | | | | | |
| **7.** | Transformation Programme Update<br><br>The Committee discussed the Transformation Programme and noted three connected priorities: maximising current-year delivery, developing robust plans for future years, and strengthening organisational capability and capacity to deliver change. Reviews had commenced with all 26 care groups to develop locally owned improvement plans and identify immediate opportunities. Members highlighted recurring issues concerning ownership of targets, budgets and workforce assumptions, and emphasised the need to balance accountability with sufficient autonomy and practical support. Examples from the initial reviews and the emerging cross-cutting themes were requested for the next report, following consideration through the Performance and Controls Leadership Group, to demonstrate how plans were developing and to identify recurring organisational barriers and opportunities. | | | | |
| **8.** | **ANY OTHER BUSINESS** | | | | |
| | 8.1 Issues for Escalation to the Board of Directors<br><br>No specific matters were identified for escalation from this meeting to the Board.<br><br>8.2 Any Other Business<br>No additional items of business were raised. | | | | |
| | **Date of the next meeting:** Thursday 5 November 2026at 10.00 – 12:00, Dulwich Room, Hambleden Wing, KCH, Denmark Hill. | | | | |

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

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King's College Hospital NHS Foundation Trust

# AGENDA

| | |
|---|---|
| **Committee** | **Performance, Transformation and Improvement Committee** |
| **Date** | **Thursday 5 November 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<br>Apologies received from:<br>Prof. Tracey Carter, Chief Nurse and Executive Director of Midwifery<br>Anna Clough, Deputy Chief Operating Officer, and<br>Dr Angela Sparharou, Non-Executive Director. | FI | Verbal | Chair | |
| | 1.2. Declarations of Interest<br>There were no declarations of interest over and above those on record. | | | | |
| | 1.3. Minutes of the previous meeting and action tracker<br>The minutes of the meeting held on 8 October 2026 were approved as an accurate record. | FA | Enc. | Chair | |
| **OPERATIONAL PERFORMANCE** | | | | | |
| **2.** | Integrated Performance Report<br>The Committee discussed the Integrated Performance Report and noted that regional oversight remained heightened. Four-hour performance was 69.16% against the 75% plan, and RTT incomplete performance was 67.65% against 68.7%. The 28-day Faster Diagnosis Standard had fallen from 78.6% in August to 73.2% in September, while 62-day cancer performance had fallen from 72.2% to 67.1% over the same period. Although reductions in the overall patient tracking list and long-wait cohorts were recognised, the Committee remained concerned that short-term recovery measures were not yet delivering sustained improvement. Further work was requested on vascular recovery, credible year-end forecasting and revised cancer trajectories, supported by clear actions and milestones. | | | | |
| **3.** | Operational Performance Deep Dive: Urgent and Emergency Care<br>The Committee discussed the Urgent and Emergency Care deep dive and noted that performance had remained significantly challenged since May 2026, with the increase in four-hour breaches concentrated within the non-admitted cohort. Progress in Same Day Emergency Care, frailty pathways, frontline engagement and strengthened winter site leadership was welcomed. However, the Committee sought stronger assurance that recovery modelling adequately reflected winter demand, flu and potential industrial action. Continued exploration of options to reduce the operational impact of mental health pressures within emergency departments was also requested. | | | | |
| **GOVERNANCE, RISK & REGULATORY ASSURANCE** | | | | | |

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

| No | Item | Purpose | Format | Lead & Presenter | Time |
|---|---|---|---|---|---|
| **4.** | 4.1. Board Assurance Framework Review<br><br>The Committee discussed the Board Assurance Framework and questioned whether the current risk score fully reflected the scale of the Trust's performance challenge and the history of recovery plans not consistently delivering the anticipated improvement. Members requested continued scrutiny of the effectiveness of the controls and remedial actions in place. Future reporting should provide clearer evidence that newer interventions are reducing the risk and delivering sustainable mitigation. | | | | |
| **TRANSFORMATION AND IMPROVEMENT** | | | | | |
| **5.** | Care Group Strategy Reviews: Early findings<br><br>The Committee discussed the early findings from the Care Group strategy reviews and noted that 19 of 20 reviews had been completed, involving approximately 300 colleagues. Recurring themes included unclear local ownership and accountability, barriers requiring practical organisational support, and the need for stronger collaboration across whole pathways. The Committee requested a consolidated assessment of findings and a proposed organisational response. Learning should inform the 2027/28 planning process and be reported to the Board because of its strategic relevance to culture, leadership and sustainable performance. | | | | |
| **6.** | AI-enabled Sustainable Coding and RTT Validation Update<br><br>The Committee discussed the update and noted that four pilots were being explored across long-stay and short-stay coding, RTT validation and waiting-list validation. Members supported continued exploration of the technology but sought assurance on accuracy, coding quality, information governance, workforce implications, recurrent funding and the sustainability of the future operating model. A further update will return as evidence from the pilots develops, including the benefits achieved and arrangements required for wider implementation. | | | | |
| **7.** | Elective Single Point of Access (SPOA) Update<br><br>The Committee discussed the Elective Single Point of Access update and noted that the Trust had met the October 2026 Wave 1 requirements across specialties covering approximately 41,000 referrals annually. Progress was welcomed, alongside recognition of risks relating to clinical triage capacity, administrative workload, application of RTT rules and outstanding Epic/e-RS integration. A further update will be provided after approximately six months to assess implementation, operational impact, technical progress and whether the anticipated transformation benefits are being realised. | | | | |
| **8.** | **ANY OTHER BUSINESS** | | | | |
| | 8.1 Issues for Escalation to the Board of Directors<br><br>The Committee discussed matters requiring escalation and agreed that the completed Care Group review findings should be reported to the Board. The findings were considered strategically significant because of their implications for organisational culture, ownership, accountability, leadership and sustainable performance improvement. The Board should receive the consolidated findings and proposed organisational response once the final review has been completed.<br><br>8.2 Any Other Business<br>No additional items of business were raised. | | | | |
| | **Date of the next meeting:** Tuesday 1 December 2026 at 10.00 – 12:00, 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

| | |
|---|---|
| **Committee** | **People, Inclusion & Education Committee** |
| **Date** | **Thursday 24 September 2026** |
| **Time** | **14:00 – 17:00** |
| **Location** | **Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill/ MS Teams** |

| No. | Item | Purpose | Format | Lead & Presenter | |
|---|---|---|---|---|---|
| **1.** | **STANDING ITEMS** | | | | |
| 1.1 | Welcome and Apologies<br>Apologies were received from Prof Tracey Carter (Helen Fletcher was deputising), Prof Anthony Schapira and Dr Anneliese Rigby. | FI | Verbal | Chair | |
| 1.2 | Declarations of Interest<br>There were no declarations of interest. | FI | Verbal | Chair | |
| 1.3 | Chair's Actions<br>There were no actions from the Chair. | FI | Verbal | Chair | |
| 1.4 | Minutes of the previous meeting<br>The minutes of the meeting on 1 July 2026 were approved. | FA | Enc. | Chair | |
| 1.5 | Action Tracker<br>The Committee reviewed and noted the updates to the action tracker. | FD | Enc. | Chair | |
| **2.** | **PART ONE – Highlight Report** | | | | |
| 2.1 | Workforce Performance Report<br>The Deputy CPO, highlighted progress on CIP workforce reductions, mandatory training compliance of 91.8%, sickness absence of 4.3%, and staff turnover remaining below the 10% target. The Committee emphasised the need for stronger staff absence management, improved control of temporary staffing costs, continued monitoring of attendance, and a review of workforce targets and reporting to ensure performance and workforce pressures are accurately reflected. | FA | Enc. | Chief People Officer | |
| 2.2 | Workforce Information Metrics | FA | Enc. | Chief People Officer | |

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

| No. | Item | Purpose | Format | Lead & Presenter | |
|---|---|---|---|---|---|
| | The Committee noted a reduction in WTE and that the CIP programme remained behind target. The Committee highlighted the need for a more transformational approach, including service redesign, productivity improvements, benchmarking and stronger temporary staffing controls, supported by quality and patient safety assessments. Work was also underway to establish a dedicated Transformation Team and embed continuous improvement across the Trust. . | | | | |
| 2.3 | People and Culture 5 Year Strategy<br>The committee received the five-year People and Culture Strategy, focusing on workforce planning, leadership, inclusion and staff experience. The Committee emphasised practical leadership development, safe and inclusive workplace culture, broader staff engagement, and greater clinical and operational ownership of transformation, supported by a clear delivery plan and a balance between short-term financial pressures and long-term workforce development. | FA | Enc. | Chief People Officer | |
| 2.4 | Quality Impact Assessment (EQIA)<br>An update on the QIA process was received, with 113 assessments progressed and 17 identifying impacts on patients or staff. The Committee was assured that appropriate processes were in place and supported improvements to QIA and EQIA reporting, clearer impact assessments, stronger mitigations and the development of a Culture Dashboard to monitor workforce and cultural risks. | FA | Enc. | Chief Nurse & Executive Director of Midwifery | |
| 2.5 | Resident doctor 10-point plan - Progress report<br>The Director of Medical Education presented an update on the Resident Doctor 10-Point Plan, confirming that eight of the ten requirements were being met, with further work needed on rotas and coordinated training. The Committee welcomed progress in resident doctor | FA | Enc. | Chief Medical Officer | |

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

| No. | Item | Purpose | Format | Lead & Presenter | |
|---|---|---|---|---|---|
| | engagement, leadership development and support, emphasising the need to sustain improvements and ensure safe working as doctors rotate through the organization. | | | | |
| **3.** | **DEEP DIVES – Discussion Papers** | | | | |
| 3.1 | EDI Update<br>An update was presented on a revised EDI reporting approach, highlighting persistent inequalities in recruitment, progression and staff experience. The Committee supported five priorities: safety, dignity and respect, progression, workload and burnout, and data confidence and trust with a focus on system wide change, leadership accountability, staff engagement and monitoring disparities in workforce and patient outcomes. | FD | Enc. | Chief People Officer | |
| 3.2 | Staff Network Presentation – REACH<br>The Committee received an update from the Race, Ethnicity and Cultural Heritage (REACH) Network, highlighting concerns around psychological safety, speaking up, confidentiality and the underrepresentation of Black and Asian colleagues in senior roles. The Committee emphasised stronger organisational accountability, improved career progression, early staff network involvement in organisational change and greater transparency in demonstrating how staff feedback is acted upon. | FD | Enc. | Chief People Officer | |
| **4.** | **EDUCATION** | | | | |
| 4.1 | Undergraduate and Postgraduate Training Updates<br>The Director of Medical Education reported strong performance in undergraduate and postgraduate education, with positive student feedback and trainee survey results consistently around 85% or above. The Committee highlighted the need to manage increasing placement demand, develop an Education Academy, | FI | Enc. | Chief Medical Officer | |

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

| No. | Item | Purpose | Format | Lead & Presenter | |
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| | promote equitable access to learning and development, and expand widening participation opportunities to support future workforce development. | | | | |
| 4.2 | Guardian of Safe Working<br>The Guardians of Safe Working reported increased exception reporting, highlighting the importance of psychological safety, confidentiality and protecting resident doctors from detriment. The Committee discussed removing the geolocation evidence requirement, subject to King's Management Committee review, and emphasised using reporting trends to address workload and rota concerns, alongside exploring a comprehensive electronic time and attendance system. | FI | Enc | Chief Medical Officer | |
| **5.** | **GOVERNANCE** | | | | |
| 5.1 | People Governance Framework<br>The Chief People Officer presented the revised People Governance Framework, strengthening accountability, organisational collaboration and Trust Board oversight of the People agenda through clearer governance structures and reporting arrangements. | FI | Enc | Chief People Officer | |
| 5.2 | Board Assurance Framework – Workforce Risk (Refreshed)<br>The Committee reviewed workforce-related BAF risks, increasing the workforce risk score to 20 and staff engagement and culture risk to 16, and agreed a new standalone leadership risk scored at 16. The revised scores and leadership risk were approved for escalation to the Trust Board, reflecting concerns around workforce savings, organisational culture, speaking up and leadership visibility. | FD | Enc | Director of Corporate Affairs | |
| 5.3 | Draft agenda for next meeting – 22 October 2026<br>The Committee discussed the draft agenda. It was agreed to invite the REACH and Women's Networks for | FD | Enc | Director of Corporate Affairs | |

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

| No. | Item | Purpose | Format | Lead & Presenter | |
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| | further discussion, using the existing staff network slot flexibly. | | | | |
| **6.** | **ANY OTHER BUSINESS** | | | | |
| 6.1 | Location of future People committee meetings<br>The Committee agreed that in-person meetings should be the preferred format to support engagement and discussion, while retaining flexibility for remote attendance when necessary. Meeting arrangements will be reviewed further, with a proposal brought back to the Committee. | FD | Verbal | Chair | |
| 6.2 | Issues for Escalation to the Board of Directors<br>There were no issues for escalation to the Board of Directors other than this report | FD | Verbal | Chair | |
| 6.3 | Any Other Business<br>The Committee clarified that Governors attending Board Committees primarily observe the effectiveness of discussions, challenge and scrutiny, and report relevant observations to the Council of Governors. It was agreed that the role and expectations of Governors would be clarified through future discussions with the Council of Governors. | FI | Verbal/ Enc. | Chair | |
| | **Date of the next meeting:** Thursday 22 October 2026 at 14:00 –17:00 in the 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

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|---|---|
| **Committee** | **People, Inclusion & Education Committee** |
| **Date** | **Thursday 22 October 2026** |
| **Time** | **14:00 – 17:00** |
| **Location** | **Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill/ MS Teams** |

| No. | Item | Purpose | Format | Lead & Presenter | |
|---|---|---|---|---|---|
| **1.** | **STANDING ITEMS** | | | | |
| 1.1 | Welcome and Apologies<br>The Chair welcomed all to the meeting. Apologies for absence were received from Professor Anthony Schapira, Matthew Trainer and Harprit Hockley. | FI | Verbal | Chair | |
| 1.2 | Declarations of Interest<br>There were no new declarations of interest. | FI | Verbal | Chair | |
| 1.3 | Chair's Actions<br>There were no actions from the Chair. | FI | Verbal | Chair | |
| 1.4 | Minutes of the previous meeting<br>The minutes of the meeting on 24 September 2026 were approved as a correct record. | FA | Enc. | Chair | |
| 1.5 | Action Tracker<br>The Committee noted the updates to the action tracker. | FD | Enc. | Chair | |
| **2.** | **PART ONE – Highlight Report** | | | | |
| 2.1 | Workforce Performance Report<br>The Committee noted limited month on month change in workforce performance indicators. Staff compliance such as Appraisal compliance remained in a good position. Following discussions with the regional team, potential stronger interventions for staff compliance had been proposed and were under consideration. The Committee acknowledged that this had been a longstanding issue and emphasised the need for a sustained approach to achieve improvement. | FA | Enc. | Deputy Chief People Officer | |

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

| No. | Item | Purpose | Format | Lead & Presenter | |
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| | The Committee requested further detail on bank and agency staffing expenditure and progress against the 6% target, with this addressed in the 2026/27 M6 September Workforce Plan vs Actual report. | | | | |
| 2.2 | 2026/27 M6 August Workforce Plan vs Actual<br>The Committee noted reductions in substantive staffing but highlighted ongoing challenges in achieving workforce savings, with further WTE reductions expected. Members emphasised the need to align workforce and financial plans with operational pressures and realistic transformation capacity, strengthen divisional accountability and develop a sustainable workforce trajectory for the next financial year. | FA | Enc. | Chief People Officer | |
| 2.3 | Improvement Management Group<br>The Committee noted that the Improvement Management Group review, covering organisational culture and clinical indicators, was at Stage 1, with regular updates to be provided. Members emphasised the need for transparency, accountability and decisive action on findings to deliver sustainable cultural change, alongside strengthening leadership, recruitment and workforce planning. | FA | Enc. | Chief People Officer | |
| 2.4 | Biannual Midwifery Workforce Review<br>The Committee noted that midwifery staffing remained compliant with Birthrate Plus requirements, with low vacancies and positive patient experience. Sickness absence, particularly stress and mental health-related, remained a key concern. Work is underway to develop workforce dashboards and targeted interventions to improve staff wellbeing, psychological safety and sustainable workforce planning. | FA | Enc. | Chief Nurse & Executive Director of Midwifery | |
| 2.5 | Seasonal Influenza 2026/2027<br>The Committee noted that flu vaccination | FA | Enc. | Chief Nurse & Executive Director of Midwifery | |

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

| No. | Item | Purpose | Format | Lead & Presenter | |
|---|---|---|---|---|---|
| | uptake stood at 26% overall and 27% among frontline staff, with further efforts needed to reach the 60% target. Initiatives include roving vaccinators, peer engagement and culturally informed communications through Staff Networks and faith groups, supported by visible leadership and improved understanding of barriers to vaccination. | | | | |
| 2.6 | Freedom to Speak Up Guardian Annual Report 2025-2026<br>The Committee noted that 262 concerns were raised through Freedom to Speak Up in 2025/26, an 18.4% decrease year-on-year, while staff confidence that concerns would be addressed rose to 43% but remained below the national average. Members emphasised the need to improve feedback, address underlying cultural issues and protect staff from actual or perceived detriment. The Freedom to Speak Up and HR teams will review relevant cases to provide assurance to the Committee. | FA | Enc. | Chief Nurse & Executive Director of Midwifery | |
| **3.** | **DEEP DIVES – Discussion Papers** | | | | |
| 3.1 | Staff Network Presentation – (REACH Network)<br>The Committee discussed how to strengthen support for Staff Networks and Race, Ethnicity and Cultural Heritage (REACH) through improved leadership engagement, early involvement in policy and change processes, and practical support for co-production. Concerns were raised about barriers to participation and perceived detriment when speaking up. Members supported exploring a collaborative working group with Staff Networks and management to identify causes and develop practical solutions aligned with the wider People Strategy. | FD | Enc. | Chief People Officer | |
| 3.2 | Staff Network Presentation – (Women's Network)<br>The Women's Network highlighted priorities around women's health, sexual | FD | Enc. | Chief People Officer | |

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| No. | Item | Purpose | Format | Lead & Presenter | |
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| | safety, workplace culture and career progression, sharing positive initiatives including the Baby Loss Policy and provision of sanitary products. The Committee acknowledged concerns around bullying, harassment, workplace violence and gender and intersectional pay gaps, supporting greater Network involvement in policy development and sexual safety training. | | | | |
| **4.** | **EDUCATION** | | | | |
| 4.1 | GMC Survey<br>The Committee noted further improvement in the 2026 GMC National Training Survey results and praised the Medical Education team's efforts to address concerns and enhance resident doctors' experiences. The Trust also received regional recognition for its work, with a commitment to sustaining progress and improving postgraduate medical education. | FD/A | Enc. | Chief Medical Officer | |
| 4.2 | Guardian of Safe Working<br>The Committee noted the report. | FD/A | Enc | Chief Medical Officer | |
| **5.** | **GOVERNANCE** | | | | |
| 5.1 | NHS Staff Standards Implementation<br>The Committee noted that further improvement was needed against the NHS People Standards, particularly in leadership and people practices. Members highlighted ongoing concerns around violence and aggression, staff safety and workplace culture, emphasising the need to support staff, challenge unacceptable behaviour and improve communication and feedback so concerns lead to meaningful, measurable improvements. | FD | Enc | Chief People Officer | |
| 5.2 | FQAI 2025-26 Designated Body Annual Board Report and Statement of Compliance<br>The Committee noted assurance that the Trust was meeting its statutory responsibilities for medical appraisal, revalidation and professional standards. Priorities include improving appraisal compliance and reducing delays in | FI | Enc | Chief Medical Officer | |

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| No. | Item | Purpose | Format | Lead & Presenter | |
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| | MHPS investigations, with an operational review underway to strengthen accountability, investigator capacity and staff feedback, alongside work with the GMC to reinforce professional behaviour and compassionate leadership. | | | | |
| 5.3 | Draft agenda for next meeting – 10 December 2026<br>The Committee reviewed the draft agenda for the next meeting. . It was noted that the agenda would need to be amended slightly. | FD | Enc | Director of Corporate Affairs | |
| **6.** | **ANY OTHER BUSINESS** | | | | |
| 6.1 | Issues for Escalation to the Board of Directors<br>There were no issues for escalation to the Board of Directors. | FD | Verbal | Chair | |
| 6.2 | Any Other Business<br>The Committee discussed Staff Network and FUTSU feedback on barriers to speaking up, including fear of retaliation and ostracism, emphasising the need to understand differing staff perspectives and identify opportunities to improve psychological safety. | FI | Verbal/ Enc. | Chair | |
| | **Date of the next meeting:** Thursday 10 December 2026 at 14:00 –17:00 in the 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**

| | |
|---|---|
| **Committee** | **Quality & Research Committee** |
| **Date** | **Wednesday 30 September 2026** |
| **Time** | **11:00 – 13:00** |
| **Location** | **Dulwich Meeting Room, Hambleden Wing, King's College Hospital, Denmark Hill** |

| No. | Item | Purpose | Format | Lead & Presenter |
|---|---|---|---|---|
| **1.** | **STANDING ITEMS (5 mins)** | | | |
| | 1.1. Welcome and Apologies<br>**Apologies were received from Matthew Trainer, CEO.** | FI | Verbal | Chair |
| | 1.2. Declarations of Interest<br>**No new declarations of interest were made in relation to the agenda items under consideration.** | FI | Verbal | |
| | 1.3. Chair's Actions<br>**There were no Chair's Actions.** | FI | Verbal | |
| | 1.4. Minutes of the previous meeting<br>**The minutes of the meeting held on 8 July 2026 were approved as an accurate record.** | FDA | Enc. | |
| | 1.5. Action Tracker<br>**The Committee reviewed the action tracker, closed the completed actions and noted that all other actions remained pending.** | FD | Enc. | |
| | 1.6. Matters Arising<br>**There were no additional matters arising.** | FI | Verbal | Chief Nurse & Executive Director of Midwifery/ Chief Medical Officer |
| | 1.7. Immediate Items for Information<br>**The Committee received an update on a patient safety incident at the PRUH relating to the use of cylinder oxygen during a period of capacity pressures. It was confirmed that appropriate engagement with those affected had taken place and that the matter was being addressed through established patient safety governance and investigation processes.** | FD | Verbal | Chair |
| **2.** | **COMMITTEE REFLECTIONS & EMERGING CONCERNS** | | | |
| | 2.1. Committee Reflections & Emerging Concerns | | | |

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| | **Members highlighted the importance of maintaining oversight of stroke outcomes while national Sentinel Stroke Audit data remained delayed. The Committee agreed that local outcome data should continue to be reviewed until national reporting resumed and reaffirmed its role in identifying and escalating emerging quality and safety concerns requiring further scrutiny.** |
| **3.** | **SAFETY & ASSURANCE** |
| | 3.1. Human Tissue Authority (HTA)<br>**The Committee discussed the findings of the unannounced HTA inspection of mortuary services undertaken in July 2026, which identified 38 shortfalls: three critical, 18 major and 17 minor. The findings included concerns relating to the dignity and care of deceased patients, mortuary capacity, retained tissue oversight, cleanliness and decontamination, security, environmental monitoring and governance. A comprehensive corrective and preventative action plan had been submitted to the Human Tissue Authority, and immediate controls had been strengthened. The Committee requested ongoing assurance and a review of HTA governance and the Committee Terms of Reference.** |
| | 3.2. Patient Experience & Outcomes<br>**The Committee noted that current patient experience and outcomes information was drawn from a range of sources, but was not yet consistently brought together to demonstrate the overall impact on quality. The Committee therefore supported the proposed move towards a patient-centred quality assurance model triangulating outcomes, experience and safety. Progress included the appointment of 48 Patient Expert Partners and the identification of ten outcome areas through patient engagement. Members emphasised that future reporting should demonstrate measurable impact and meaningful improvement, and include wider community engagement.** |
| | 3.3. Divisional Discussion - Division A<br>**The Committee received assurance on current priorities and risks. Radiology capacity, diagnostic reporting pressures and cancer pathway performance remained the most significant concerns. Faster Diagnosis Standard performance was the Trust's best in three years across South East London; however, 62-day cancer treatment performance remained below trajectory. Additional reporting and scanning capacity and pathway redesign were being progressed.** |
| **4.** | **RESEARCH & INNOVATION** |
| | 4.1. Research Strategy, MHRA Report and Research Delivery Update<br>**The Committee reviewed the Research Strategy and the response to the MHRA inspection, which identified four critical findings relating to documentation, data integrity, Principal Investigator oversight, research governance and patient safety. The MHRA had accepted the Trust response, with remaining corrective actions expected to be completed by year-end. Continued visibility of research governance, performance and strategic priorities was requested.** |
| **5.** | **GOVERNANCE, ASSURANCE & EXCEPTION ITEMS** |
| | 5.1. Board Assurance Framework<br>**The Committee reviewed the principal risks for Safer Care and Research & Innovation. Research & Innovation remained within risk appetite. Safer Care remained slightly above appetite, with a clear plan in place to reach the target level by year-end. The** |

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| | **Committee was satisfied that the proposed risk scores appropriately reflected the current position.** |
| | 5.2. CQC Inspections Update<br>**The Committee received assurance on strengthened oversight of CQC inspection action plans through divisional governance and the Group Outstanding Care Board. Progress was welcomed, but members emphasised that future reporting should identify overdue actions and focus on impact, implementation and sustainability rather than completion status alone.** |
| | 5.3. Annual Report<br>▪ Vulnerability Annual Report & IPC Annual Report<br>**The Committee received assurance on safeguarding and vulnerability arrangements, partnership working and pathways to identify and support vulnerable patients. The importance of maintaining staff training, timely escalation and appropriate intervention was recognised.** |
| **6.** | **FOR INFOMATION** |
| | 6.1. Integrated Quality Report - Concerning Trends and Quality Priorities<br>**The Committee welcomed the revised exception-based reporting approach. Members emphasised the need to move beyond monitoring performance to understanding which improvement actions were driving change, where unwarranted variation persisted and where additional intervention was required. The priorities would include improving patient outcomes and experience. Future discussions will focus on issues of greatest concern and strategic importance.** |
| | 6.2. Freedom to Speak Up Review – Terms of Reference (FTSU)<br>**The Committee noted the proposed revised Terms of Reference for the review, and requested that the review be considered within the Trust's wider ambition for an open and transparent speaking-up culture, staff engagement and psychological safety.** |
| | 6.3. Risk Register Report<br>**The Committee was satisfied that the risks, controls and mitigating actions were adequately reflected. The report was noted for assurance.** |
| **7.** | **ANY OTHER BUSINESS** |
| | 7.1. Issues to be escalated to the Board **The Committee agreed to escalate the following: HTA inspection findings and strengthened oversight of mortuary services; progress on the Patient Experience & Outcomes programme; radiology capacity, diagnostic reporting and cancer pathway pressures in Division A; and the MHRA inspection improvement programme and wider research governance arrangements.** |
| | 7.2. Any Other Business<br>**There was no further business.** |

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

King's College Hospital NHS Foundation Trust

# Q&RC Highlight Report

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| **Committee** | **Quality & Research Committee – Chair's Report to the Board** |
| **Date** | **Tuesday 20 October 2026** |
| **Time** | **11:00 – 13:00** |
| **Location** | **Dulwich Meeting Room, Hambleden Wing, King's College Hospital, Denmark Hill** |

| No. | Item | Purpose | Format | Lead & Presenter |
|---|---|---|---|---|
| **1.** | **STANDING ITEMS (5 mins)** | | | |
| | 1.1. Welcome and Apologies<br>**Apologies were received from non-executive directors, Dame Christine Beasley and Nicholas Campbell-Watts.** | FI | Verbal | Chair |
| | 1.2. Declarations of Interest<br>**No new declarations of interest were made in relation to the agenda items under consideration.** | FI | Verbal | |
| | 1.3. Chair's Actions<br>**No Chair actions were recorded in the meeting notes.** | FI | Verbal | |
| | 1.4. Minutes of the previous meeting<br>**The minutes of the meeting held on 30 September 2026 were approved as an accurate record.** | FDA | Enc. | |
| | 1.5. Action Tracker<br>**The Committee reviewed the action tracker, closed the completed actions and noted that all other actions remained pending.** | FD | Enc. | |
| | 1.6. Matters Arising<br>**There were no additional matters arising.** | FI | Verbal | Chief Nurse & Executive Director of Midwifery/ Chief Medical Officer |
| | 1.7. Immediate Items for Information<br>**No separate immediate item was recorded in the meeting notes.** | FD | Verbal | Chair |
| **2.** | **COMMITTEE REFLECTIONS & EMERGING CONCERNS** | | | |
| | 2.1. Committee Reflections & Concerns<br>**The Committee discussed a Never Event involving wrong-site incision and initial drilling in Neurosurgery. No patient harm was reported, and Duty of Candour had been completed. Members emphasised the importance of completing an appropriate safety huddle when responsibility for a surgical procedure transfers to another clinician. It was confirmed that an after-action review would be undertaken. The Committee also reviewed a maternity safety signal concerning three reported neonatal deaths at Denmark Hill. Two deaths had** | | | |

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| | **already been investigated; the third record was found to be incorrect and the source record was subsequently amended. The safety signal was used as a drill to test the response process, including completion of the required documentation, with the outcome shared with the region and Integrated Care Board. Follow-up was also being undertaken in relation to the underlying registration/data quality issue.** |
| **3.** | **SAFETY & ASSURANCE** |
| | 3.1. Divisional Discussion - Division B<br>**The Committee received an update on emergency care, medicine, liver services and cancer performance. Improvements had been achieved in the prostate cancer pathway following a six-month improvement programme, with 62-day performance reaching 77–78%, just below the 80% target; however, a subsequent deterioration in October 2026 was noted and would require continued focus. Enhanced-care reviews were identifying opportunities to adapt care levels, while progress continued in closing CQC actions. Corridor care remained a significant Trust-wide concern, with work focused on patient flow and discharge, patient experience and reducing reliance on corridor care. Mental health delays were also discussed, with continued challenges noted in securing timely onward care.** |
| | 3.2. Liver Report<br>**The Committee noted that approximately 500 liver transplants had been carried out at the Trust over the past two years – which is 27% of the total nationally during the same period - with excellent clinical outcomes for patients. This is positive, although work is underway to support wider multi-disciplinary improvements within the service, including in vital areas such as team culture, succession planning, staff training, and research. The CQC is being kept updated about how this work is progressing. The committee asked for an update on this work in six months' time, with any exception reports shared sooner if required.** |
| | 3.3. Freedom to Speak Up Guardian Annual Report<br>**The Committee considered persistent concerns about confidence in raising issues, bullying and whether staff believed speaking up would lead to change. A modest improvement in confidence that concerns would be addressed was noted, alongside targeted work in Ophthalmology at Orpington, Women's Health and other areas requiring support. Members emphasised the importance of triangulating Freedom to Speak Up data with staff survey findings, staff retention levels and other relevant intelligence to identify areas requiring further support, alongside clearer evidence of action and impact and safe routes for staff to speak up.** |
| | 3.4. Learning from Deaths and Patient Outcomes<br>**The Committee requested clearer presentation of national audit performance, including quartiles and direction of travel, and practical examples showing what had changed as a result of learning. Members discussed dissemination of mortality learning, the future use of Trust-level multidisciplinary learning, Summary Hospital-level Mortality Indicator (SHMI) interpretation, palliative care coding and patient outcome concerns relating to diabetes and stroke. Stroke operational performance will return in December 2026, and future SHMI reporting should separate PRUH and Denmark Hill.** |
| **4.** | **RESEARCH & INNOVATION** |
| | 4.1. Research - overview of the current programme and care group deep dive<br>**The Committee welcomed the research report and noted strengthened monthly and quarterly oversight of Research Delivery Units. Community-facing studies and work to reach underserved populations were highlighted. Concern was raised about recruitment delays** |

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

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| | **for externally funded posts and the effect of recruitment controls on delivery, morale and King's research reputation. The issue will return as a matter arising at the next meeting.** |
| **5.** | **GOVERNANCE, ASSURANCE & EXCEPTION ITEMS** |
| | 5.1. Risk Register Report<br>**The Committee reviewed pathology performance, including continuing issues affecting parts of the PRUH and concerns about specimen transport. Improvement activity and governance tracking were noted. Members also discussed patient monitoring, earlier recognition of deterioration, peri-arrest and cardiac arrest trends, acute kidney injury AKI work and differing mortality contexts between PRUH and Denmark Hill.** |
| **6.** | **FOR INFOMATION** |
| | 6.1. Integrated Quality Report - Concerning Trends and Quality Priorities<br>**The Committee queried a neonatal unit outlier, which was reported as temperature-related and linked to data quality, and requested further information on unexpected admissions to the perinatal unit. A further patient-level data query was being taken through the Outstanding Care Board.** |
| | 6.2. Inpatient Survey Results & Action Plans<br>**The report was received for information.** |
| **7.** | **ANY OTHER BUSINESS** |
| | 7.1. Issues to be escalated to the Board<br>**The Committee highlighted the Never Event learning on pre-procedure huddles; liver service development; persistent speaking-up concerns; corridor care and mental health delays; and recruitment barriers affecting externally funded research posts.** |
| | 7.2. Issues to be escalated to the Board<br>**Committee Effectiveness and Meeting Format**<br>**Members supported the discussion-led format and reduced use of presentations.**<br>**Members reflected positively on the revised meeting approach while requesting clearer reporting of impact, key data and governance follow-through.**<br>**There being no other business the Chair formally closed the meeting.** |

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

King's College Hospital NHS Foundation Trust

**AGENDA ITEM: 7.**

# BOARD/COMMITTEE REPORT COVER PAPER

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|---|---|---|---|---|---|---|---|
| **Report to:** | Council of Governors | | | | | | |
| **Date of meeting:** | 24 November 2026 | | | | | | |
| **Subject:** | Apprenticeships and Career Pathways | | | | | | |
| **Author(s):** | Lovenne Brown, Apprenticeship Lead and Elizabeth Leighton, Assistant Director of Nursing | | | | | | |
| **Sponsor:** | Tracey Carter, Chief Nurse | | | | | | |
| **History:** | N/A | | | | | | |
| **Status:** | N/A | | | | | | |
| **Decision/ Approval** | | **Discussion** | ✓ | **Assurance** | | **Information** | ✓ |

**Purpose**

This paper provides Governors with an overview of King's apprenticeship investment, participation and career pathways. It highlights current delivery, the operational and financial barriers that limit further expansion, and the actions needed to align future provision with workforce priorities.

**Recommendations:**

The Governors are asked to note the current apprenticeship position; discuss the barriers to equitable and scalable access; and support the proposed direction of aligning apprenticeship investment to evidenced workforce need, service capacity and measurable impact.

**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 paper supports assurance on workforce capacity, staff development, retention and leadership capability. Apprenticeships can mitigate workforce risks where they are linked to identified skills gaps, but unfunded release time and backfill may constrain delivery. |
| **King's Improvement Impact (KIM):** | N/A |
| **Quality Impact** | Potential benefits include improved workforce capability, patient flow and service continuity. Quality risks arise if protected learning, supervision or placements are delivered without safe staffing and appropriate backfill. |
| **Health Equity Impact** | N/A |
| **Workforce Impact** | There are 431 learners across more than 40 programmes and over 40 providers. Key implications include protected learning time, supervision, placement capacity, manager approval, backfill, career pathways. |
| **Research/Innovation Impact** | N/A |
| **Digital Impact** | N/A |
| **Financial Impact** | In 2025/26, £4.62m levy funding was received. Reported training-related payments were £1.71m, £2.29m expired and approximately £0.36m was transferred. The levy funds eligible training and assessment but not salaries or routine backfill. |
| **Legal/ regulatory compliance** | Apprenticeship delivery must comply with current funding rules, provider requirements and relevant professional standards. Nursing routes must meet NMC-approved theory, practice and placement requirements. AHP routes must meet profession-specific standards and approved provider requirements. |
| **Communications and Engagement** | Ongoing engagement is required with Governors, divisions, line managers, learners, Nursing, AHP leadership, Workforce, Finance, training providers, higher education institutions and South East London partners. Clear communication is needed about eligibility, protected learning time, approval and progression routes. |
| **Use of Artificial Intelligence Tools** | N/A |
| **Committee that will provide relevant oversight**<br>PIEC | |

# Governors Meeting 24.11.2026

NHS
King's College Hospital
NHS Foundation Trust

## Apprenticeships & Career pathways

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

## 1 | Apprenticeships: our investment and reach

2025/26 financial year | 431 learners • 40+ programmes • 40+ training providers

| £4.62m | £1.71m | £2.29m | £0.36m |
|---|---|---|---|
| Levy received | Training-related payments* | Levy expired | Levy transferred |

Why is funding not fully used? Protected learning time, service pressures, manager approval and unfunded staffing backfill.

**Reported levy payments: 37% | Expired: 50% | Transferred: 8% (percentages of £4.62m received)**

*£1.71m is the reported total of monthly, balance and completion payments; confirm finance reconciliation before calling it total spend.

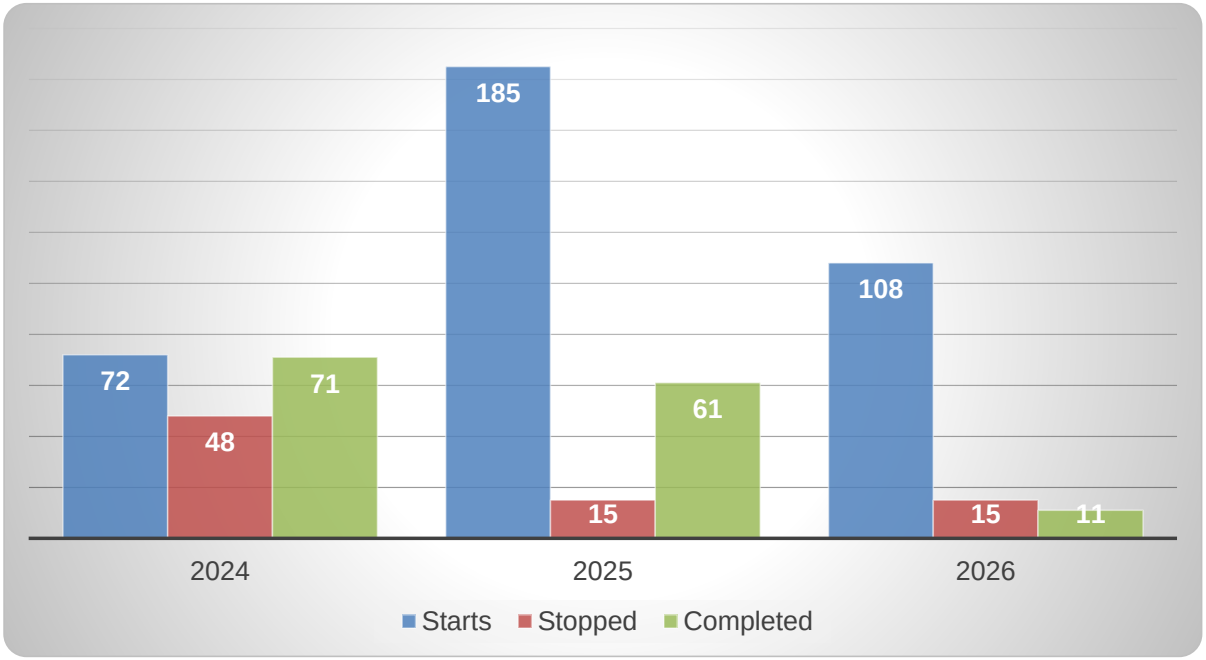
## 2 | Apprenticeships across King's: where learners are based

Recorded division totals and apprenticeship activity over time

### Learners by division (recorded extract)

| | |
|---|---|
| Division A | 134 |
| Division B | 88 |
| Division C | 93 |
| Corporate | 92 |
| Guthrie | 2 |
| R&D | 3 |
| SEL APC | 2 |
| Unknown | 16 |
| Total | 430 |

### Starts, stops and completions



## 3 | Three programmes that shaped our offer

Different programmes have grown for different workforce reasons | Overall starts fell 42% from 2025 to 2026

### Leadership & Management

Historically our most popular pathway.

Strong demand from existing staff for management development.

Recent government funding changes have restricted this offer.

### Business Analyst

Currently one of our largest programmes, developed with the Transformation Team.

96 learners reported, with another cohort pending.

Links staff development to measurable improvements in services.

### Senior HCSW (Level 3)

Over 100 HCAs enrolled following the 2024 drive to standardise the HCA pathway.

Changes to the approach have reduced new enrolments, but existing learners continue to complete.

## 4 | Nursing: why the apprenticeship route is not currently scalable

The central obstacle is the cost and clinical impact of releasing staff for NMC-regulated learning — not a lack of interest

### Current offer and unmet demand

King's offers Senior Healthcare Support Worker L3 as a foundation for career development.

The final 7 apprentices qualified as Band 4 Nursing Associates earlier this year after 2 years of study.

Nursing Associate L5 and Registered Nurse Degree L6 are no longer currently commissioned at the scale of staff interest.

Advice on alternative university routes is not the same as offering a funded nursing apprenticeship place.

### Clinical and financial constraints

NMC-approved programmes require substantial theory, supervised practice and placements away from substantive duties (4600 hours over 3 years).

Wards must still meet safe staffing and patient acuity requirements; release creates a real backfill need (approx. 127 hrs/month for a full time apprentice).

The levy pays eligible training costs — not salaries or routine backfill. Bank/agency cover can make delivery unaffordable as backfill creates a significant unfunded staffing cost for the Trust.

### Strategic route to expansion

Nursing, Finance and Workforce would need to consider a funded backfill model, safe placement capacity and supervision before committing to cohorts.

Target services where workforce gaps justify investment and release can be safely planned.

Evaluate recruitment, retention and long-term supply against full costs; explore regional partnerships.

Continue to support entry into registered nursing through traditional university routes and available national financial support schemes.

Governor decision: nursing expansion requires an agreed clinical workforce and funding model, not simply access to levy.

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

## 5 | AHP: why the apprenticeship route is not currently scalable

The main barriers are unfunded release time, limited establishment and placement capacity, and profession-specific workforce constraints.

### Current offer and unmet demand

Smaller professions struggle to achieve scale. London SLT work identifies release of existing staff and too few support-worker posts as barriers. The SEL AHP Faculty is therefore considering regional numbers and coordination rather than each organisation acting alone.

Dietetics currently has no apprenticeship provider in London.

KCH has no Band 5 podiatrists, so there is currently no career pathway for a podiatry apprentice.

Requirements differ between professional standards and local study-leave arrangements. SEL organisations seek a common position of 7.5 hours per week off-the-job learning and monitor learner experience and attrition.

### Clinical and financial constraints

Backfill and protected learning time are the most significant barriers. Undergraduate AHP apprentices require around 20% off-the-job learning, but services receive no backfill for this time.

Apprenticeships usually require conversion of an AHP assistant post or new funding, rather than being supported through routine establishment. This limits scale.

Apprentices add practice-placement demand alongside traditional students. Across SEL, capacity is constrained by workforce pressures, short-notice cancellations, educator requirements and physical space.

### Variation between AHP professions

Occupational Therapy: 4 apprentices; one recruited annually.

Physiotherapy: 1 apprentice in year 2. Oversupply from traditional HEI routes, including graduates unable to secure posts, has reduced the case for expansion.

SLT: KCH hopes to recruit 1 apprentice in the next cohort.

Radiography: 4 apprentices complete this year. Inability to undertake radiography-assistant activity has made the model difficult to support; no further apprentices are currently planned.

### Strategic route to expansion

Target expansion by individual AHP profession, not as a single Trust-wide programme. Proceed only where there is a demonstrable workforce shortage, a viable destination post and career pathway, a suitable support-worker pipeline, an available HEI/provider, sufficient placement and educator capacity, and funded 20% release time. Use SEL/London AHP collaboration for smaller professions; levy availability alone should not trigger recruitment.

Governor decision: AHP expansion requires profession-specific workforce need, funded release time, viable career pathways and SEL and wider coordinated placement capacity.

# 6 | Career pathways: developing our own workforce

## Examples of how apprenticeships can support progression at King's

### Nursing progression

Healthcare Assistant → Senior HCSW (L3) → Nursing Associate (L5) → Registered Nurse (L6).

### Health Play Specialist

Two Healthcare Assistants have recently joined the Health Play Specialist apprenticeship.

A real example of internal progression.

### Non-clinical pathways

Data Technician (L3) → Data Analyst (L4) → Data Scientist (Level 6) → Senior Data or Digital Leadership roles.

Business Admin (L3) → Learning & Skills Mentor (Level 4) → Learning & Development Consultant Business Partner (Level 5) → L&D Management opportunities

### AHP progression

OT: Support Worker → Assistant Practitioner (L5) → Occupational Therapist (L6)

Physiotherapy: Support Worker → Assistant Practitioner (L5) → Physiotherapist (L6)

SLT: Support Worker → Speech & Language Therapist (L6)

Radiography: Imaging Support Worker → Diagnostic/Therapeutic Radiographer (L6)

Podiatry: Support Worker → Podiatrist (L6)

Pathways illustrate opportunities, not guaranteed progression; availability depends on funding, eligibility and service approval.

## 6 | Why interest does not always lead to enrolment

The main barrier is releasing staff for protected learning time

### Protected learning time

Apprentices must learn during paid working hours.

Service pressure, rota cover and backfill make release difficult.

### Manager approval

Some requests are declined without clear reasons; others receive no response.

Approval is inconsistent across services.

### Support available

Direct advice and discussions with managers can resolve concerns.

Support is mainly reactive, with the function currently managed by one person.

**The challenge is not simply interest or levy availability — it is the capacity and commitment to support learning in practice.**

## 7 | Where the gaps remain

A funded training place does not automatically mean an affordable workforce pathway

### Nursing and clinical progression

Nursing Associate and Registered Nurse apprenticeship routes are not routinely commissioned to meet demand.

Clinical placements, supervision and protected time create substantial staffing and backfill pressures.

Levy funding covers eligible training and assessment — not salaries or routine backfill.

### AI, digital and future skills

Data and AI programmes are developing, but the offer needs to be aligned to identified skill shortages and service priorities.

Workforce planning should identify where training, new recruitment or redesigned roles will deliver the greatest benefit.

**Any nursing expansion needs a joint Nursing, Workforce and Finance plan for release, placements and backfill.**

## 8 | Next steps: build an offer around workforce need

Move from individual requests to targeted, measurable workforce investment

### 1 Plan against skills gaps

Work with divisions to identify vacancies, hard-to-fill roles, future skills and progression needs.

Refresh the apprenticeship offer around real demand, including nursing, AI and digital skills.

### 2 Demonstrate impact

Use the Business Analyst partnership as a model.

Reported outcomes: 25% fewer DNAs, approximately 3,000 more outpatient attendances per month and improved RTT performance.

### 3 Respond to policy change

Explore opportunities for younger recruits and early-career pathways.

Monitor proposed funding reforms and assess affordability, workforce capacity and equitable access before expansion.

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# King's strategy
## 2026 to 2031

**Our vision:**
## Transforming healthcare




**Our purpose:**

To provide outstanding patient care and experience to our communities and deliver world-leading research, education and training.

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

King's College Hospital NHS Foundation Trust

**AGENDA ITEM: 8.**

# BOARD/COMMITTEE REPORT COVER PAPER

| | |
|---|---|
| **Report to:** | Council of Governors Meeting |
| **Date of meeting:** | 26th of November 2026 |
| **Subject:** | Trust Winter Plan |
| **Author(s):** | Lesley Powls and Paul Larrisey- Hospital Directors |
| **Sponsor:** | Dena Marshall, Chief Operating Officer |
| **History:** | First Report to Meeting |
| **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 signed off at Trust Board in September. 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 has been shared widely across the organisation and uploaded onto the Resilience hub within the intranet.

**Recommendations:**

The Council of Governors are asked to note the Trust seasonal pressures plan and the operating arrangements for the winter period.

**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**<br>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.

**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 submitted the plan to board and completed a Board Assurance statement which was approved by NHSE.

**Recommendations**

The Council of Governors are asked to note the plan.




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# Kings Seasonal Pressures Plan

## Version 1.1

## November 2026

**Document Control**

| | |
|---|---|
| **Title:** | Kings Seasonal Pressures Plan |
| **Version:** | 1.1 |
| **Approved by:** | Kings Management Committee |
| **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 |
| 1.1 | September 2026 | Amends post KMC | DH Hospital Director |
| 1.2 | September 2026 | Amends post PTIC | DH Hospital Director |

| Target audience(s) | Method | Person responsible |
|---|---|---|
| Executive Directors | King's Management Committee | 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- including the aim to virtually eliminate corridor care.

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.

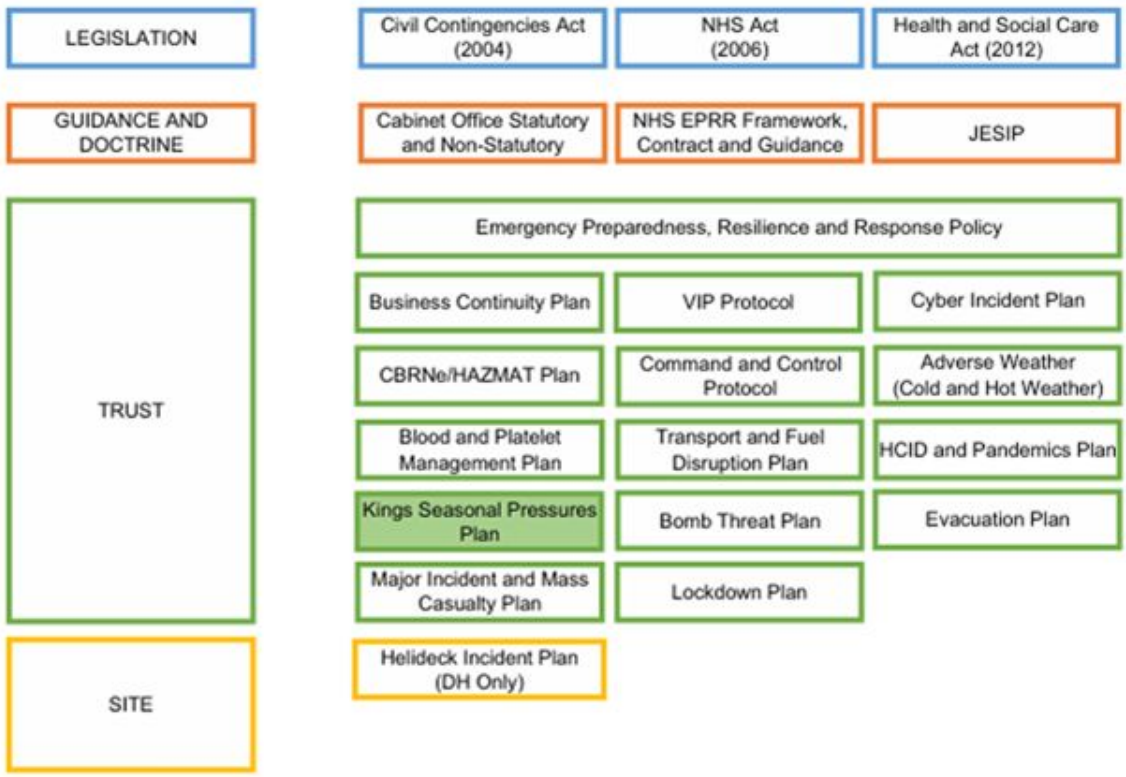



*Figure 1 - EPRR Legislation, Guidance and Trust and Site Level Incident Response Plans*

## 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 |

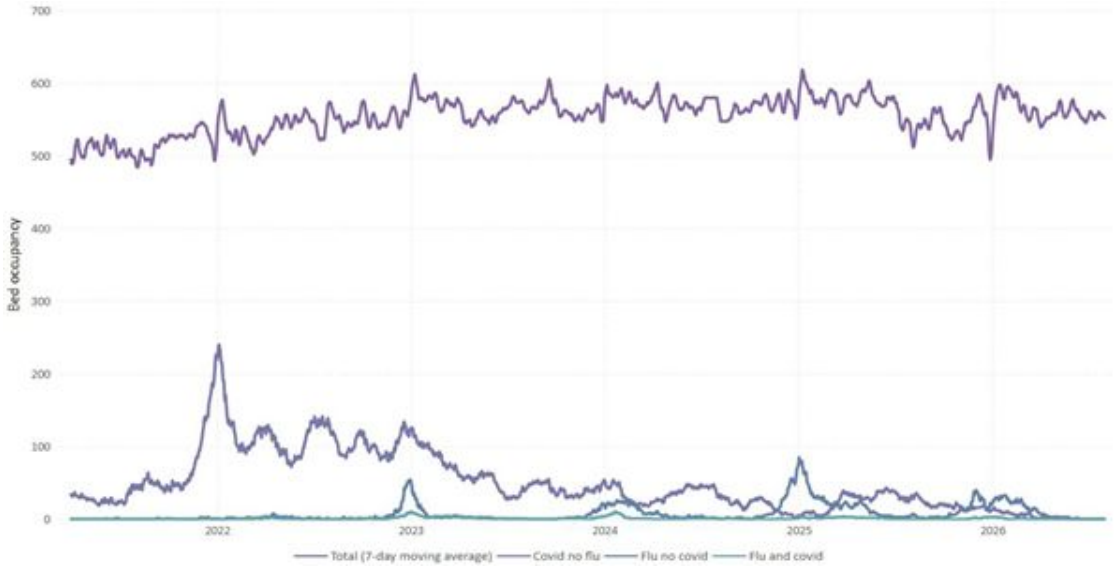
This represents core bed stock and does not consider any plans for closures

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*



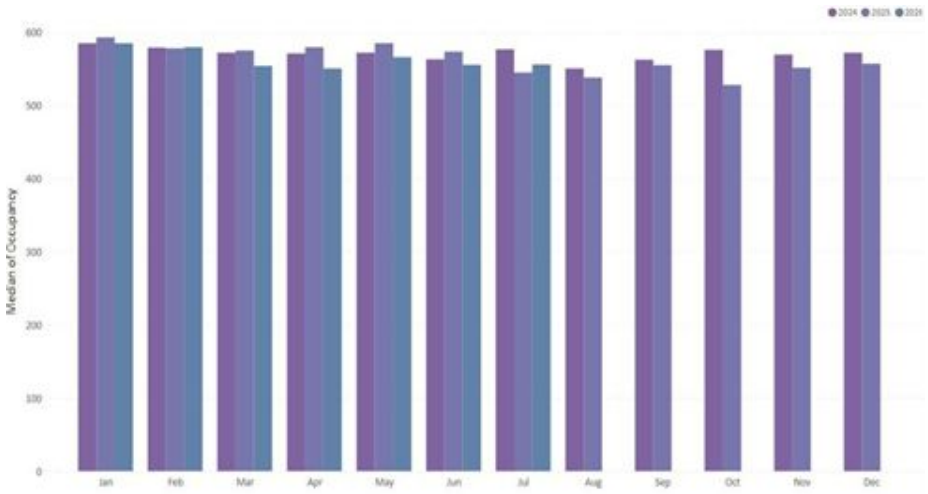

- The chart above shows non elective G&A bed use from April 2021 to July 2026
- Graph shows a gradual but consistent increase in use over time with clear changes that relate to covid spikes or winter with a sustained high period of occupancy in January 2026
- Non-elective bed use has stabilised around 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.



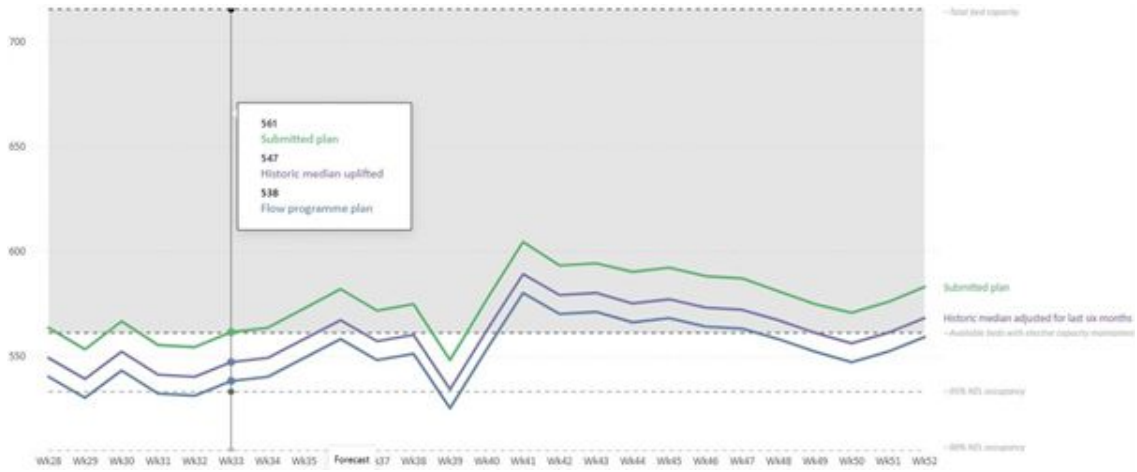

*Average Historic demand for non-elective G&A beds*

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.

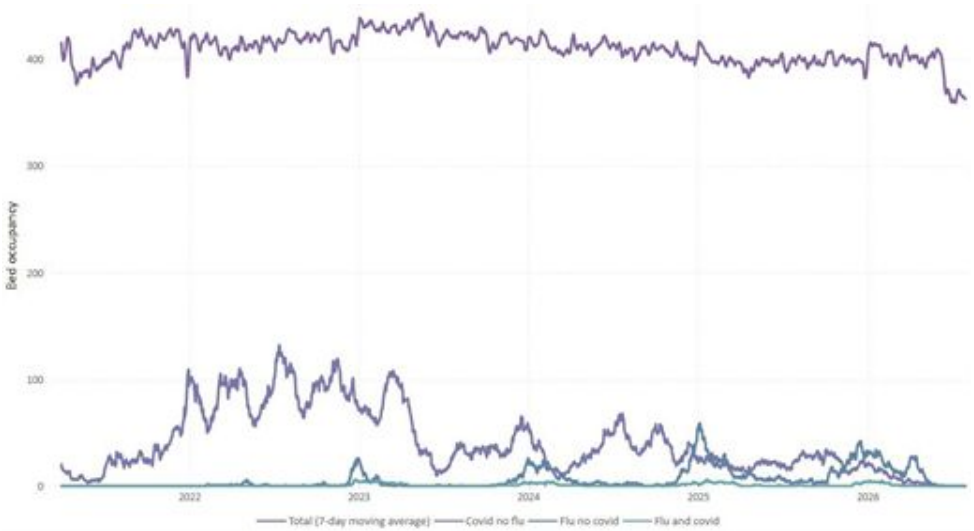
Unless reductions in length of stay are seen and sustained throughout winter the site will not be able to maintain elective performance and will not have available G&A beds for the January peak of winter pressures.

<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

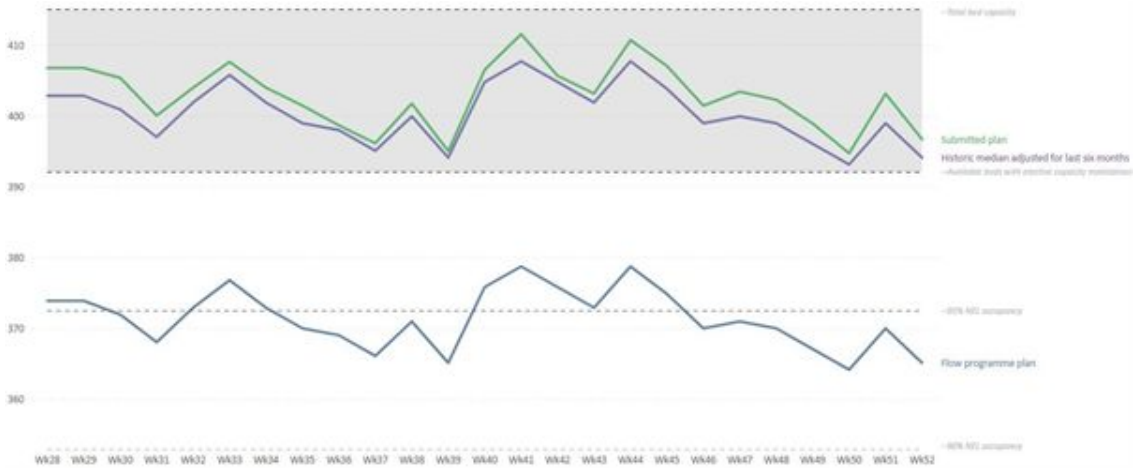
*Chart Forecasting PRUH*

*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.

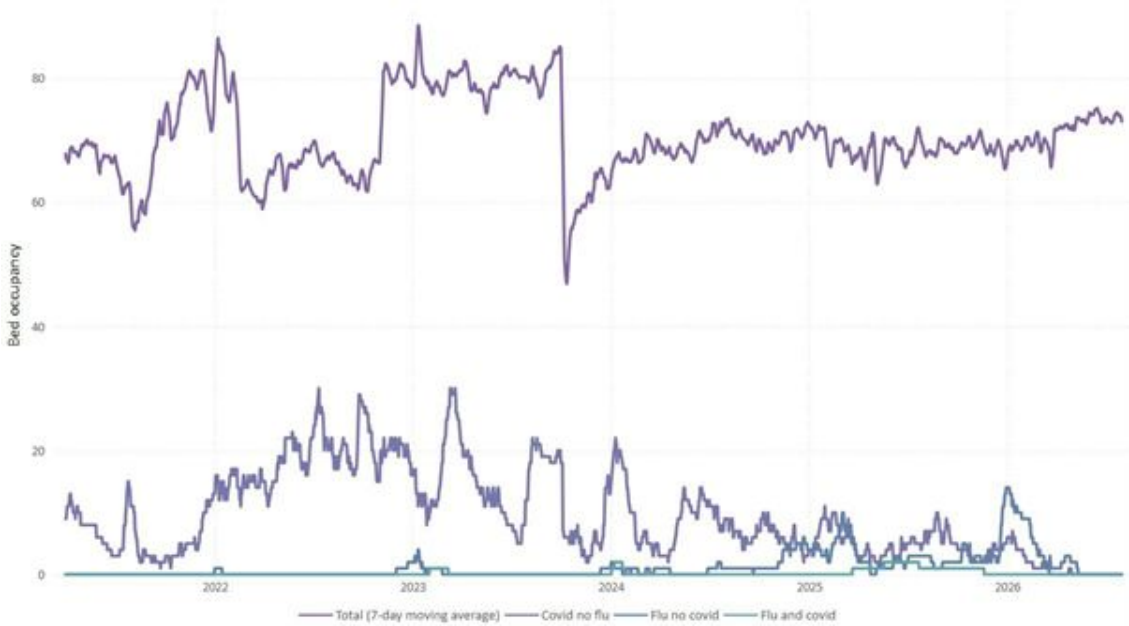
PRUH Scenario modelling winter 2026/27 non-elective G&A




- 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

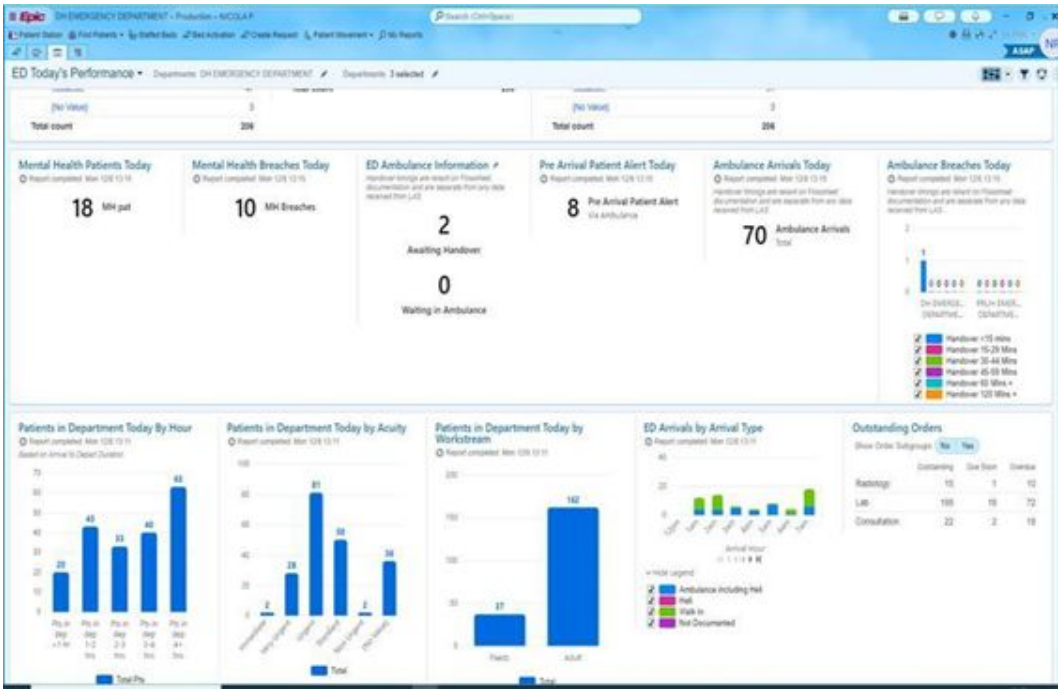
Winter de-briefs and a table top exercise to test the local business continuity were undertaken in May 2026.

Trust and site plans reflect learning from the previous winter.

### 1.6.4 OPEL Framework

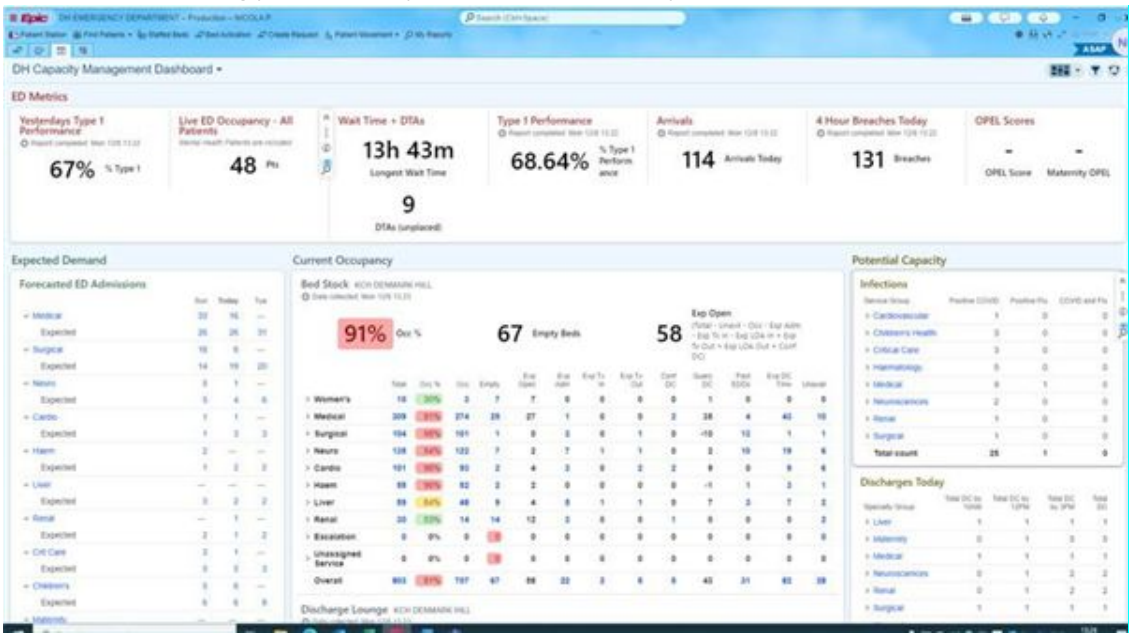
The available data for internal monitoring of the ED and the site in general is available in several live reports on Epic.

- 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 2026/27

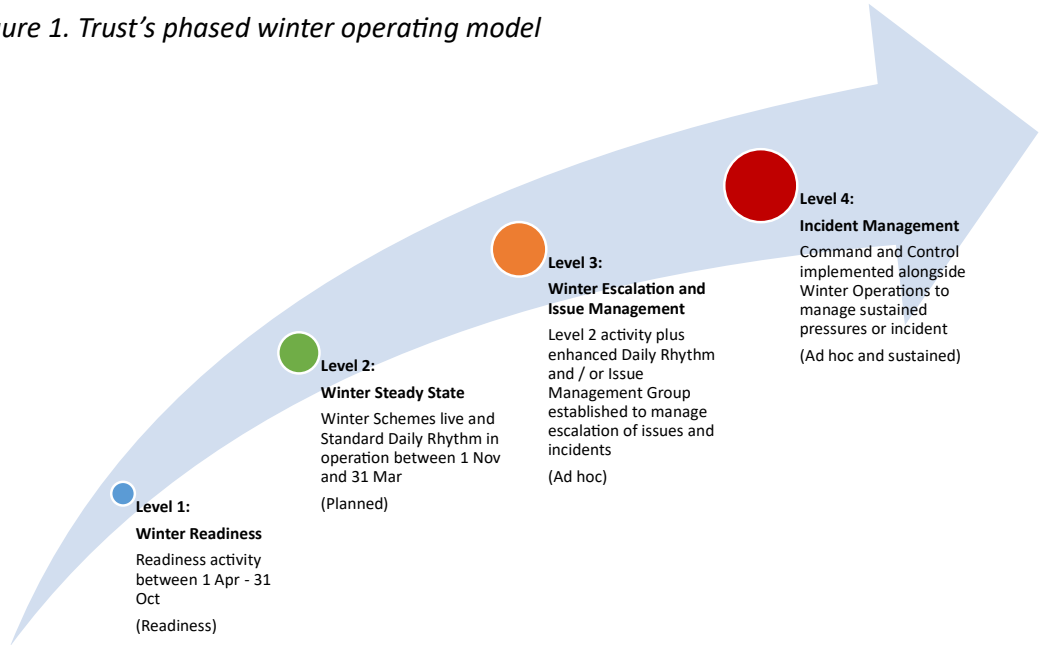
The following table defines the key terms used within this document:

*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 coordinate 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 the speciality 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. Due to sensitivity to the OPEL triggers local responses to pressures are tailored to a set of specific responses contained within the Internal flow and escalation policy.

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. However the Trust remain committed to the virtual elimination of corridor care.

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 care as 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

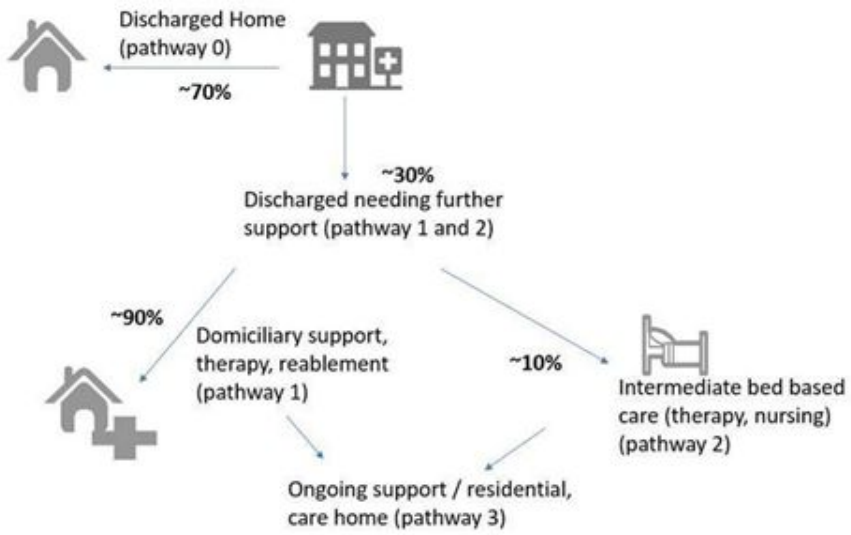
Discharge planning involves patients and carers early and meaningfully, in line with statutory duties (Health and Care Act 2022 s.91).

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, and the advice of the team would be used when considering cohort wards for management of infection (to include influenza)

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 have more capacity 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 nonfrontline 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 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 2026/27 is outlined in Section 1.7. The following table describes in more detail each of phase of the Trust's Winter 2026/27 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 – preplanned 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 |
| | Site Nursing Staff Call/ Meeting | 0845hrs and 1600hrs (Mon-Fri) | Site based Senior 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)**<br><br>*Based upon Internal Triggers* | Level 2: Winter Steady State continues | As soon as issue or escalation is identified | Hospital Directors |
| | Consider additional:<br>• Site Bed and Flow Meetings<br>• DH Site Operations Meetings<br>• Trust Executive Briefings<br>• Establishing an Issue Management Group<br>• External escalation where appropriate (i.e., Divert) | As required | Hospital Directors |
| **Level 4: Incident Management (Sustained pressures / incident declared)**<br><br>*Based upon Internal Triggers* | 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<br><br>Corridor Care Policy - Version 2_KE Paper | This policy sets out the daily operational management processes to effectively manage patient flow and bed capacity. It includes triggers for escalation and actions to be undertaken at times of increased operational pressure on bed capacity. |
| Site Escalation Policies<br>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)<br><br>Opening and Closure of Wards an | 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<br><br>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<br> <br>Safe Transfer of Care (Discharge) Poli Safe Transfer of Care (Discharge) Poli | 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:<br>Green - Normal circumstances where supply meets demand<br>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-Understanding-Grief-Leaflet.pdf |
| Community Support | Lambeth Larder Directory | Lambeth-Larder-Directory-Issue-10-202( |
| Community Support | Telephone & Neighbour Befriending Service Flyer | Befriending-CCL-Factsheet-Nov-25.docx |
| Cost of Living | Cost of Living - Guide to Support in Lewisham and Southwark | Financial-Hardship-CCL-Factsheet-Decem |
| Mental Health | Information Service Lambeth and Southwark | Mental-Health-Support-CCL-Factsheet-D |
| Transport | Community Connections Lewisham Factsheets - Community Transport | Transport-CCL-Factsheet-January-2026-u |

King's College Hospital NHS Foundation Trust

**AGENDA ITEM: 9.1.**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Report to:** | Council of Governors | | | | | | |
| **Date of meeting:** | November 2026 | | | | | | |
| **Subject:** | Responding to changes proposed by the NHS Modernisation Bill | | | | | | |
| **Author(s):** | Siobhan Coldwell, Director of Corporate Affairs<br>Experience | | | | | | |
| **Sponsor:** | Sir David Behan, Chair of the Council of Governors | | | | | | |
| **History:** | Updates on progress since the last report to the Council in July 2026 | | | | | | |
| **Status:** | | | | | | | |
| **Decision/Approval** | | **Discussion** | ✓ | **Assurance** | | **Information** | ✓ |

**Purpose**

This report provides the Council with an update on the Trust's options in response to the proposed NHS Modernisation Bill 2026. The Bill proposes significant changes to the external engagement landscape by removing NHS England, abolishing Healthwatch, changing data-sharing arrangements, and in Foundation Trusts, removes the membership and the Council of Governors.

Alongside this, there is a clear expectation that Trusts improve public and patient engagement. The Trust already has several routes for patient and public engagement, including complaints, compliments, surveys, Healthwatch feedback, voluntary and community sector links, governors, the King's Collaborators Hub, legal duty-to-involve processes, patient partner roles, audits, listening events, and committee structures.

However, if governors and Healthwatch are removed, the Trust needs to assess whether these existing mechanisms are sufficient to ensure patient voices remain represented at all levels.

At it's July meeting, the Council agreed to establish a working group to consider options.

**Recommendations:**

The Council is asked to note progress.

**Strategy alignment**

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

**Key implications**

| | |
|---|---|
| **Strategic risk - Link to Board Assurance Framework** | High quality care |
| **King's Improvement Impact (KIM):** | Not applicable |
| **Quality Impact** | Active engagement of patients and communities in service design, delivery and change will enable the Trust to improve patients' experiences |
| **Health Equity Impact** | Active engagement of patients and communities in service design, delivery and change can help the Trust to bridge the health inequality gap by listening to and shaping the service around those who are seldom heard or more likely to not engage |
| **Workforce Impact** | The proposal to remove the council of governors, removes one route for staff to raise issues with the Board of Directors, as the Trust's Council of Governors has representation from all staff groups and Staffside. . |
| **Research/Innovation Impact** | Not applicable |
| **Digital Impact** | Not applicable |
| **Financial Impact** | Not applicable as far as this report is concerned, but there may be implications over time. |
| **Legal/ regulatory compliance** | National Health Services Act 2006, as amended by the Health and Care Act 2022<br>'Working in partnership with people and communities: statutory guidelines'<br>NICE's 'Shared decision making' guideline. |
| **Communications and Engagement** | Engagement with governors and members |
| **Use of Artificial Intelligence Tools** | No AI tools have been used in the work reported in this paper |
| **Committee that will provide relevant oversight**<br>Council of Governors and Board of Directors | |

**Progress of the Bill**

The NHS Modernisation Bill 2026 was introduced to Parliament on 14th May 2026. The bill proposes to:

(1) disestablish NHS England with its operational responsibilities and commissioning functions transferred directly to the Department of Health and Social Care and local Integrated Care Boards

(2) enforce data sharing across all NHS providers (including GPs) to pool patient health information into one central, digital record accessible via the NHS App

(3) abolish Healthwatch England and local Healthwatch organisations with their responsibilities transitioning to local authorities and the Department of Health and Social Care. The Health Services Safety Investigations Body (HSSIB) will also be moved into the Care Quality Commission

(4) remove the requirement for NHS Foundation Trusts to have a membership and a council of governors

The bill is currently in committee stage in the House of Lords. At the time of writing, there has been limited discussion of the proposal to remove council of governors, and no amendments have been moved in relation to the proposal. There is still no indication of implementation timetables

**Working Group**

The first meeting of the working group took place on 22 October 2026 and was attended by Governors, Board members and relevant Trust officers. It was an exploratory meeting to look at the consequences, if the bill completes its passage through parliament unamended, of the abolition of the requirement for NHS Foundation Trusts to have a membership and a Councils of Governor.

There was recognition that individuals may oppose the proposal, the purpose of the group should be to ensure the Trust is prepared and has a clear plan to preserve the value currently provided by governors, members and community engagement structures. There was recognition of the significant commitment, sense of belonging and contribution that governors and members have made over many years, alongside concerns about fairness and the potential loss of local democratic accountability.

Strong views were expressed by many governors opposing the proposed abolition of Councils of Governors. There is real concern that the NHS could become less accountable to local communities. There is recognition that governors provide valuable challenge, scrutiny and local insight and it is important that patient voices continue to be heard, including those from specialist service users who may live outside the immediate local area. There is an acceptance

that the current governor model has limitations and inconsistencies, but broad agreement that valuable functions should be retained.

A number of key questions were posed on the agenda, in order to frame the approach. There was broad agreement that these were appropriate. These included clarity on what we are trying to achieve, “must-haves”, agreeing core deliverables and timelines and responsibilities. It was suggested that opportunities for collaboration are explored, and that the local statutory responsibilities/accountabilities are drawn out – e.g. health overview and scrutiny by local authorities. It was agreed there should be stakeholder engagement, to ensure that the Board’s proposal is well accepted and is representative of a broad range of views.

It was agreed the working group would aim to deliver a proposal to the Board for discussion in mid-March. The group would meet three times prior to that. The next meeting, in early December, will consider purpose.

**Update on national developments**

In early November NHS Alliance published a document called “What Follows Councils of Governors. It reflects on a number of engagement sessions they held over the summer with governors, NEDs/Chairs and governance leads about what qualities should be reflected in future arrangements. It also provides some case studies of local insight and or accountability arrangements, that could be developed moving forward. The working group will inevitably reflect on these in due course.

NHSE have a framework for public engagement which will be updated. NSHE are also likely to make changes to the Provider Capability Assessment Framework as well as the provider licence.

King's College Hospital NHS Foundation Trust

# Council of Governors Report Template

## Council of Governors – Activity Report

Please complete the following sections to report on governor activities. This information supports discussion and shared learning at the Council of Governors (COG) meeting.

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### 1. Governor Details

- **Name**: Fr Grant Ciccone
- **Designation/Role:** Patient Governor

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### 2. Activity Information

- **Date of Activity**: 10 September 2026
- **Summary of Activity / Commentary**:
  Attending a meeting convened by the Council of Governors at Guy's and St Thomas' NHS Foundation Trust gave me a valuable opportunity to reflect, not only on the increasingly uncertain future of NHS Foundation Trust Councils of Governors, but also on something I believe passionately: the NHS belongs to the people it serves, and those people must never lose their right to be heard, represented and respected.

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### 3. Reflections and Recommendations

As a Trust Governor at King's College Hospital NHS Foundation Trust, I take my responsibilities for public accountability, transparency and effective scrutiny extremely seriously. I did not become a Governor simply to attend meetings, receive reports or endorse decisions already made. I accepted this responsibility because I believe that patients, staff and local communities deserve a genuine voice in how their hospitals are governed. They deserve representatives prepared to ask difficult questions, challenge decisions when necessary, and hold Non-Executive Directors accountable.

King's College Hospital
NHS Foundation Trust

The legislative proposals currently before Parliament represent, in my view, a deeply troubling and potentially damaging change to NHS governance. The proposed removal of the statutory requirement for Councils of Governors threatens to dismantle an important mechanism of public accountability that has existed for many years. I find it particularly concerning that such a fundamental change is being contemplated without sufficient clarity about what will replace it or how the independence and effectiveness of public scrutiny will be protected.

I have repeatedly argued that abolishing Councils of Governors is not good for patients, accountability, or transparency. I remain firmly convinced of that position.

What troubles me most is the possibility that decisions affecting patients and local communities will become increasingly distant from the very people whose lives depend upon them. The NHS must never become an institution in which accountability flows exclusively upwards towards government, regulators and central authorities, while the voices of patients, staff and local communities are reduced to little more than consultation exercises.

For me, this is not simply an argument about legislation, organisational structures or governance arrangements. It is a matter of principle. It concerns the dignity of patients, the experience of frontline staff, the confidence of local communities and the fundamental responsibility of public institutions to remain answerable to the people they serve.

I am also deeply concerned that removing statutory Councils of Governors could leave future arrangements for public engagement and scrutiny largely dependent on the discretion of individual Trust Boards. Public accountability should never depend upon the goodwill of those who are themselves responsible for being held accountable. It requires independence, clearly defined responsibilities and meaningful powers of scrutiny.

Although the proposed legislation provides insufficient clarity about how existing Councils of Governors would be dissolved, I believe we must resist any suggestion that their disappearance is simply an administrative adjustment. It is not. It represents the potential loss of an important democratic safeguard within our National Health Service.

I remain committed to defending the role of Councils of Governors and, should Parliament ultimately decide otherwise, to ensuring that any replacement arrangements preserve meaningful public representation, independent scrutiny and genuine accountability of Non-Executive Directors.

I have no desire to defend a governance structure merely because it is familiar or longstanding. Structures can and should evolve. However, reform must strengthen accountability, not weaken it. It must bring patients and communities closer to decision-making, not push them further away.

My experience as a Governor has reinforced my conviction that the NHS is strongest when it listens, welcomes constructive challenge, and when those entrusted with leadership understand that accountability is not an inconvenience but a fundamental obligation.

I will continue to speak out because I believe that the patient and public voice is worth defending. I do not want future generations to look back and ask why we remained silent while an important mechanism of public accountability was dismantled.

The NHS is one of our nation's greatest public institutions. Its future must never be determined solely behind closed boardroom doors or by decisions taken in Whitehall. The people who depend upon it, work within it and sustain it through their trust and commitment must continue to have a meaningful voice in its governance.

For me, this is not about protecting the position of Governors. It is about protecting patients' rights, staff voices, and the accountability of those entrusted with leading our hospitals.

And that is a principle I am not prepared to surrender.

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**4. Additional Notes (Optional)**

- **Other Relevant Information**:
  *(Include anything else you'd like to highlight or record.)*

None

King's College Hospital NHS Foundation Trust

# Council of Governors Report CoG November '26

**Council of Governors – Activity Report**

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**1. Governor Details**

- **Name**: Lindsay Batty-Smith
- **Designation/Role** Southwark Public Governor

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**2. Activity Information**

**Date of Activity**: 9.9.26 Kings Able network meeting

- **Summary of Activity / Commentary**: Engaging discussion around the challenges that staff encounter with disabilities, neurodiversity and reasonable adjustments. We meet to learn, share and support each other as disabled peers and supportive allies

**Date of Activity**: 15.9.26 Schwartz round presenter Theme: Inclusion Week

- **Summary of Activity / Commentary**: I presented a case of a trans patients' experience in a breast clinic at another hospital and what KCH learnt from hearing this story. This was very well received

**Date of Activity**: 16.9.26 Boardwalk with CMO, NED Jane Fryer: DH Mortuary

- **Summary of Activity / Commentary** following the recent HTA inspection this was a very important Boardwalk. I was very impressed with the significant improvements in our DH mortuary, and importantly to maintain the moral of the staff after this inspection. My many years of experience working in mortuary's was very useful in this task.

**Date of Activity**: 23.9.26  21.10.26 Southwark Community Ambassadors meetings.

- **Summary of Activity / Commentary**: Topics: 23.9 Healthwatch legacy,  21.10.YoungMinds, The UK's leading charity fighting for a world where no young person feels alone with their mental health

**Date of Activity** 24.9.26 Breast screening promo planning meeting 13.10.26 Participated in the GJW promo

- **Summary of Activity / Commentary**: helped with the planning and delivery of a months breast screening promotion across the Trust

**Date of Activity** 21.10.26, 18.11.26, LDA oVRcome VR project meeting

- **Summary of Activity / Commentary**: part of the development and delivery of this innovative VR project and Imaging, sharing my community and radiology contacts with the LDA VR project team

**Date of Activity** 21.10.26 EoLC steering committee

- **Summary of Activity / Commentary**: Happy to have a new lead appointed. We discussed Grief week activities, community involvement, annual report and Chaplaincy

**Date of Activity 22.10.26** LDA QAP

- **Summary of Activity / Commentary:** Care navigation service, champions, digital flag launch, UCP's, lived experiences are and to be collected

**Date of Activity 19.11.26 PESC**

- **Summary of Activity / Commentary:** Progress continues on the Learning Disability and Autism Quality Priority, including the Epic Reasonable Adjustment Flag, Care Navigator program accessible information and improvements to paediatric and adult pathways. The patient experience survey highlighted ongoing concerns around sensory overload, waiting times and communication, reinforcing the need for consistent reasonable adjustments, accessible information and staff awareness. The key

governance priority is to ensure initiatives translate into measurable improvements in patient experience, with clear accountability for delivery and monitoring.

On going regular advocacy and support with Southwark residents with hospital appointments.

King's College Hospital NHS Foundation Trust

# Council of Governors Report November 2026

**Council of Governors – Activity Report**

**26th November 2026**

Please complete the following sections to report on governor activities. This information supports discussion and shared learning at the Council of Governors (COG) meeting.

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**1. Governor Details**

- **Name**: Jane Lyons MBE
- **Designation/Role** Public Governor (Southwark) and Lead Governor

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King's College Hospital NHS Foundation Trust

**2. Activity Information**

- **Date of Activity**: September - November 2026
- **Summary of Activity / Commentary**:
  *(Brief description of the engagement, meeting, or event. Include purpose, outcomes, and any notable points.)*
  - Ongoing meetings with senior team
  - One on one meetings with Sir David Behan, Chair of Trust
  - Separate one on one monthly meetings with Director of Corporate Affairs Siobhan Coldwell

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**3. Reflections and Recommendations**

- **Suggestions, Comments, or Learning for COG Consideration**:
  *(Share any insights, feedback, or ideas that may benefit the wider Council.)*

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**4. Additional Notes (Optional)**

- **Other Relevant Information**:
  *(Include anything else you'd like to highlight or record.)*

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**2. Activity Information**

- **Date of Activity**: September and November 2026
- **Summary of Activity / Commentary**:
  *(Brief description of the engagement, meeting, or event. Include purpose, outcomes, and any notable points.)*
    - Writing board paper and presenting at September and November public board meetings

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**3. Reflections and Recommendations**

- **Suggestions, Comments, or Learning for COG Consideration**:
  *(Share any insights, feedback, or ideas that may benefit the wider Council.)*
- Asked for advice on remote technical access to board meetings via teams requested and delivered as governors had been struggling to access

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**4. Additional Notes (Optional)**

- **Other Relevant Information**:
  *(Include anything else you'd like to highlight or record.)*

  Advice supplied but remote access to boards still an issue

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**2. Activity Information**

- **Date of Activity** April 2026 onwards
- **Summary of Activity / Commentary**:
  *(Brief description of the engagement, meeting, or event. Include purpose, outcomes, and any notable points.)*
  - Working to get the best outcome for the King's community from any change in Governor status (current Health Bill looks to remove Governors and Members from Foundation Trusts)
  - Development of and engagement with Working Group on the Future of Governors with aim to supply proposal to March 2027 board

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**3. Reflections and Recommendations**

- **Suggestions, Comments, or Learning for COG Consideration**:
  *(Share any insights, feedback, or ideas that may benefit the wider Council.)*

  Need to engage both Governors and wider King's community in developing any plan for the future

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**4. Additional Notes (Optional)**

- **Other Relevant Information**:
  *(Include anything else you'd like to highlight or record.)*

**2. Activity Information**

- **Date of Activity**: ongoing
- **Summary of Activity / Commentary**:
  *(Brief description of the engagement, meeting, or event. Include purpose, outcomes, and any notable points.)*
    - Continuing engagement with external parties to build understanding of potential cessation of Councils of Governors and how to manage that at King's
    - Including fellow Lead Governors at other Foundation Trusts, NHS Alliance

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**3. Reflections and Recommendations**

- **Suggestions, Comments, or Learning for COG Consideration**:
  *(Share any insights, feedback, or ideas that may benefit the wider Council.)*
    - Ongoing work needed to understand implications of current uncertainties for King's and its governors
    - Parties to be involved in future planning to be identified and gathered to discuss

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**4. Additional Notes (Optional)**

- **Other Relevant Information**:
  *(Include anything else you'd like to highlight or record.)*

**2. Activity Information**

**2. Activity Information**

- **Date of Activity**: ongoing September – November

- **Summary of Activity / Commentary**:
  *(Brief description of the engagement, meeting, or event. Include purpose, outcomes, and any notable points.)*
- Championing patient experience through
  - Attendance at Patient Experience committee meetings
  - Attendance at Governor Patient Experience and Safety Committee meetings (and chairing)
  - Attendance at Deteriorating Patient Improvement Group meetings
  - Ongoing involvement with the King's patient experience team

**3. Reflections and Recommendations**

- **Suggestions, Comments, or Learning for COG Consideration**:
  *(Share any insights, feedback, or ideas that may benefit the wider Council.)*
  - Continue to engage in building the patient voice at King's

**4. Additional Notes (Optional)**

- **Other Relevant Information**:
  *(Include anything else you'd like to highlight or record.)*

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**2. Activity Information**

- **Date of Activity**: ongoing
- **Summary of Activity / Commentary**:
  *(Brief description of the engagement, meeting, or event. Include purpose, outcomes, and any notable points.)*
- Meeting attendance
  - In addition to patient experience meetings ongoing attendance at
  - Audit and Risk Committee
  - Strategy Governance committee

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**3. Reflections and Recommendations**

- **Suggestions, Comments, or Learning for COG Consideration**:
  *(Share any insights, feedback, or ideas that may benefit the wider Council.)*

**4. Additional Notes (Optional)**

- **Other Relevant Information**:
  *(Include anything else you'd like to highlight or record.)*

**2. Activity Information**

- **Date of Activity**: September 2026
- **Summary of Activity / Commentary**:
  *(Brief description of the engagement, meeting, or event. Include purpose, outcomes, and any notable points.)*
- Attended and spoke at Member at annual meeting

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**3. Reflections and Recommendations**

- **Suggestions, Comments, or Learning for COG Consideration**:
  *(Share any insights, feedback, or ideas that may benefit the wider Council.)*
- Identify role of members for the future (if abolished)
- And understand how to capture the expertise and knowledge that lies within this group for the future benefit of King’s

**4. Additional Notes (Optional)**

- **Other Relevant Information**:
  *(Include anything else you'd like to highlight or record.)*

Report from Angela Buckingham as governor on the People Committee.

During the period there were two People committee meetings (24th September and 22th October).

Key points arising:

- There was a discussion about the need to reduce the use bank and agency, but with an understanding that gaps in rotas that happen at the last minute are unavoidable.
- Each year there is a spike of bank and agency use in March, cause by a backlog of annual leave, which needs to be addressed.
- There needs to be a realistic view of how maternity should be covered, particularly in wards where several people are off on mat leave at the same time.
- There was an update on the flu vaccination programme, including the use of mobile flu clinics and peer vaccinators. Vaccination rates need to improve, particularly amongst non-medical staff group. The committee and discussed work underway to improve vaccination rates amongst African-Caribbean staff.
- Any financial savings need to consider workforce and quality and there needs to be transparency at ward level about why decisions are being made.
- The importance of clinical leadership needs to be understood by the Board. The new strategy is seen as real opportunity to reset culture across teams.
- The Freedom to Speak Up guardian provided their annual report. Levels are low and support needs to be given to pockets of concern, including at ward level. People need to be held to account and learning needs to be shared. The committee suggested there was a 'you said, we did' summary of learning.
- There was a presentation from the Reach Network who talked about the importance of speaking up, particularly by global majority staff.
- The Women' Network did a presentation. They are concerned about the gender pay gap, because nearly 75% of staff are female. Career progression is a priority for the network. They are concerned that more training is needed, particularly for male staff, to ensure sexual safety at work.
- The committee discussed the implementation of the NHS Staff Standards. Violence and aggression was discussed. It should not be tolerated, but it is recognised that prevention can be awkward. The committee discussed the impact of corridor care as a cause of violence and aggression, noting there is a very good security, particularly at Denmark Hill. There was also a discussion about work place culture and the need to share staff stories so that learning can be shared.
- There was an update from the Guardian of Safe Working, and the discussion including how assurance is gained, when doctors work across multiple sites. Geo-location is being tested.
- The Chief Medical brought a report providing assurance that the Trust is complying with statutory responsibility for medical appraisals, revalidation and profession

standards. The committee discussed the need to be transparent about disciplinary outcomes, and the need for confidentiality.

King's College Hospital NHS Foundation Trust

# AGENDA

| | |
|---|---|
| **Meeting** | **Council of Governors** |
| **Date** | **Tuesday 26 January 2027** |
| **Time** | **16:30 – 18:30** |
| **Location** | **The Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill** |

| No. | Item | Purpose | Format | Lead & Presenter | Time |
|---|---|---|---|---|---|
| **1.** | **STANDING ITEMS** | | | | |
| | 1.1. Welcome and Apologies | FI | Verbal | Chairman | **16:30** |
| | 1.2. Chair's introduction | | | | |
| | 1.3. Declarations of Interest | | | | |
| | 1.4. Minutes of Previous Meeting – 26 November 2026 | FA | Enc. | | |
| | 1.5. Action Tracker | FD | Enc. | | |
| | 1.6. Matters Arising<br>▪ Governor Protocol | FI | Enc. | | |
| | **QUALITY, PERFORMANCE, FINANCE AND PEOPLE** | | | | |
| **2.** | Report from the Chair of the Audit and Risk Committee | FD/A | Enc. | Chair of Audit and Risk Committee | **16:40** |
| **3.** | Report from the Chair of the Finance and Commercial Committee<br><br>Incl. Trust Financial Position | FD | Enc. | Chair of the Finance and Commercial Committee | **16:50** |
| **4.** | Report from the Chair of the Performance, Transformation and Improvement Committee<br><br>The Integrated Performance report is in the information section of the agenda | FD | Enc. | Chair of Performance Tranformation and Improvement committee | **17:00** |
| **5.** | Report from the Chair of the People, Education and Inclusion Committee | FD | Enc. | Chair of the People, Education and Inclusion Committee | **17:10** |
| **6.** | Report from the Chair of the Quality and Performance Committee | FI | Enc. | Chair of the Quality and Research Committee | **17:20** |
| | **GOVERNANCE** | | | | |
| **7.** | **Governor Involvement and Engagement** | | | | |
| | 7.1. Governor Engagement and Involvement Activities [forward plan] | FI | Enc. | Governors | **17:30** |
| **8.** | **Other Governance Matters** | | | | |
| | 10.1. Draft Agenda 30 March 2027 Meeting [forward plan] | FD | Enc. | Chair | **17:50** |

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

King's College Hospital NHS Foundation Trust

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|---|---|---|---|---|---|
| **9.** | **FOR INFORMATION** | | | | |
| | 11.1 Integrated Performance Report [forward plan] | FI | Enc. | Chief Delivery Officer | * |
| **10.** | **Any Other Business** | | | | |
| | Any Other Business | FI | Verbal. | Chair | **18:00** |
| **11.** | **Date of the next meeting:** Tuesday 30 March 2027, 16:30 – 18:30 The Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill | | | | |

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|---|---|---|
| **Members:** | | |
| | Sir David Behan | Chair |
| **Elected:** | | |
| | Prof. Koku Adomdza | Patient Governor |
| | Rashmi Agrawal | Lambeth Public Governor |
| | Christopher Akwagba | Staff Governor |
| | Lindsay Batty-Smith | Southwark Public Governor |
| | Angela Buckingham | Southwark Public Governor |
| | Bernie Butler | Lambeth Public Governor |
| | Fr Grant Ciccone | Patient Governor |
| | Dr Melanie Dalby | Staff Governor |
| | Anthony Darroch | Bromley Public Governor |
| | Hilary Entwistle | Southwark Public Governor |
| | Emily George | Lambeth Public Governor |
| | Deborah Johnston | Patient Governor |
| | Tunde Jokosenumi | Staff Governor |
| | Prof Daniel Kelly OBE | Lambeth Public Governor |
| | Jane Lyons MBE | Lead Governor Southwark Public Governor |
| | Pauline Manning | Patient Governor |
| | Devon Masarati | Patient Governor |
| | Billie McPartlan | Bromley Public Governor |
| | Katie Smith | Bromley Public Governor |
| | Temitayo Taiwo | Lambeth Public Governor |
| **Nominated Governors** | | |
| **Appointed local authority governors:** | | |
| | Cllr Colin Bately | Southwark Council |
| | Cllr Jeremy Issacs | Lambeth Council |
| **Partnership Organisations:** | | |
| | Dr Yogesh Tanna | Trust's Joint Staff Committee |
| **University Governors:** | | |
| | | |
| **In Attendance:** | | |
| | Sir David Behan | Chairman |
| | Dame Christine Beasley | Non-Executive Director |
| | Nicholas Campbell-Watts | Non-Executive Director |
| | Prof. Tracey Carter MBE | Chief Nurse & Executive Director of Midwifery |
| | Roy Clarke | Chief Financial Officer |

King's College Hospital NHS Foundation Trust

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|---|---|---|
| | Siobhan Coldwell | Director of Corporate Affairs |
| | Dr Jane Fryer | Non-Executive Director |
| | Zowie Loizou | Corporarte Governance Officer |
| | Prof Graham Lord | Non-Executive Director |
| | Dena Marshall | Chief Operating Officer |
| | Sheena Mackay | Non-Executive Director |
| | Gerry Murphy | Non-Executive Director |
| | Prof. Anthony Schapira | Non-Executive Director |
| | Angela Spatharou | Non-Executive Director |
| | Matthew Trainer | Chief Executive Officer |

King's College Hospital NHS Foundation Trust

**AGENDA ITEM: 11.1**

# COMMITTEE REPORT COVER PAPER

| | |
|---|---|
| **Report to:** | Council of Governors |
| **Date of meeting:** | 26th November 2026 |
| **Subject:** | Integrated Performance Report Month 6 (September) 2026/27 |
| **Author(s):** | Steve Coakley, Director of Performance & Planning;<br>Simon Lee, Assistant Director of Performance & Planning |
| **Sponsor:** | Dena Marshall – Chief Operating Officer |
| **History:** | KMC – 2nd November 2026<br>PTIC – 5th November 2026 |
| **Status:** | |

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

**Purpose**

The performance report to the Kings Board Committee outlines published monthly performance data for September 2026 achieved against key national operational performance targets (noting that latest submitted cancer performance and quality data is August 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**

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

| | |
|---|---|
| **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**<br>Performance, Transformation and Improvement Committee | |

King's College Hospital NHS Foundation Trust

**Performance Summary:**

**Elective Activity at M6:**
At a Trust level, 108% of planned activity was delivered to the end of August. However, the activity level in each week of the month were below the operating plan.

**Emergency care:**

- 4 hour All Types performance deteriorated to 69.16% for September, below the operating plan trajectory of 75.0%.

Actions Underway:

- Development of care group plans for the 2026-27 flow programme.
- Working with DH and PRUH Urgent Treatment Centre (UTC) providers to optimise pathways.
- Re-focusing on ED assessment unit and SDEC pathway opportunities.
- Realisation of SDEC pathway opportunities, with expansion of medical SDEC and frailty ambulatory capacity.
- Implementation of POCT and AVT

**RTT:**

- There has been a run of 10 months RTT Incomplete performance above the mean to September 2026, with an increase to 67.65% in September, but remained below operating plan target.
- The total RTT PTL decreased by 2532 patients to 88,570 for September, however it remains above the Operating Plan target.

Actions Underway:

- 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.
- Additional internal activity and outsourcing taking place.

**Cancer performance:**

- **Cancer performance 62-day:** Submitted 62-day performance for August 2026 was 72.16%, below the 76.9% Operating Plan target.
- **28-day FDS:** Submitted June 2026 28-day FDS performance is 78.55%, above the 80% standard.
- **Cancer performance 31-day:** Submitted 31-day performance was 96.7% in June 2026 meeting the NHS Operating Plan target of 96%.

Actions underway:

- Radiology reporting backlog reducing through non-recurrent fund, service to bid for further SELCA funding.
- Pathology medical recruitment and cross site reporting integration.
- New post to be advertised for urology ANP to perform prostate biopsy.
- New Lung consultant starting November.
- Dh site review required for specific allocation of breast and colorectal theatre list
- Liver interventional radiology scheduling process being streamlined.

**Diagnostics**:

- There has been a run of over 11 months DM01 performance below mean to September 2026.
- Performance improved to 16.57% in September but remained above the Operating Plan target of 14.6%.

Actions underway:

- Neurophysiology – administrative recruitment and training will improve timely booking.
- 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, Safety and Patient Experience Summary:**

**Safe**

- 2 new PSIIs commissioned in August
- 1 new Never Event reported – retained guidewire with AAR completed September 2026
- Incidents awaiting review have remained below the mean for 9 consecutive months & learning responses taking more than five months has improved for 6 consecutive months
- 16 ongoing PSIIs (6 MNSI) – none overdue
- Audit compliance (slide 13) remains strong at 94.9%
- Duty of Candour remains an area requiring focus – current metrics show our performance below the Trust set target

**Caring**

- Inpatient and day-case FFT received 1,363 responses in August. Overall performance shows common-cause variation. Waiting, communication, overcrowding and ward temperature continue to feature in negative feedback
- Emergency Department FFT continues to show special-cause variation of concern, with 751 responses. Waiting times remain the principal concern, alongside communication, overcrowding and delays in receiving updates

- Maternity FFT remained high at 93.8%, with birthing services improving to 96.2% from 52 responses, the highest response volume recorded for the service in 2026
- Outpatient FFT remains below the benchmark and national average, continuing the position seen since February 2026. Ophthalmology remains a particular area of focus, with waiting and communication also reflected in PALS feedback

**Responsive**

- 147 complaints were received in August, 51% fewer than the record July position and broadly in line with the recent six-month monthly average. 140 complaints were closed during August
- Quality Alert volumes remain below the historical average and demonstrate special-cause improving variation. However, overdue alerts remain the principal concern, with performance continuing above the 20% target, requiring sustained focus on timely review and closure (Slide 36)
- 107 complaints were overdue by at least one day, representing 26% of open complaints, while 30 were four or more weeks overdue, up from nine in April. Eight complaints were 12 or more weeks overdue

**Well-Led**

- Safer staffing shows positive assurance and special-cause improvement in daytime and nighttime RN/RM and HCSW fill rates

## Workforce

- The Trust's sickness absence rate is 4.85%, placing it within the middle quartile when benchmarked against other large London Trusts. This provides a positive foundation from which to build, with the Trust maintaining a stable position against a backdrop of ongoing NHS workforce pressures. The focus remains on sustaining this position while pursuing opportunities to further improve attendance, support staff wellbeing and strengthen workforce productivity.

- A dedicated Sickness Absence Improvement Project Group was established in early September 2026 to lead the development and delivery of a Trust-wide improvement programme. The group has commenced work to identify the key drivers of sickness absence and develop targeted interventions to strengthen management capability, support staff wellbeing and improve attendance outcomes. This provides an important opportunity to embed a more proactive, consistent and supportive approach to attendance management, aligned with the Trust's People and Culture Strategy, workforce productivity and financial recovery objectives.

- Core Skills Training compliance improved from 88.57% in August to 89.03% in September 2026, although performance remains below the Trust's 90% target. This represents a modest improvement following recent fluctuations, but sustained progress is needed to achieve and maintain compliance.

- Medical and Dental staff compliance remains a priority area for improvement, alongside variation across divisions, care groups and individual training requirements. Targeted recovery activity is being progressed with divisional and clinical leaders, supported by strengthened reporting, clearer management

accountability and action to address barriers to training completion. Particular focus remains on essential training linked to patient safety, including resuscitation

- The Trust vacancy rate increased slightly to 6.64% but continues to significantly outperform the 10% Trust target. This reflects continued good progress in workforce stabilisation and vacancy management in line with Trust priorities. Additional controls have now been implemented for the remainder of the financial year in Corporate areas.
- AfC time-to-hire remains within KPI for bands 4-9 and was 0.1 days outside of target for bands 1-3.

- Consultant time-to-hire has increased to 143.9 days against the 100 days KPI. However, It should also be noted that volumes in this group are currently very low (4) with individual cases skewing the metric.

- Voluntary turnover has slightly decreased to 7.43% and remains well below the 13% target. Notably, turnover has consistently remained under target since October 2023, reflecting sustained retention performance.

**Finance**

- As of September, the KCH Group (KCH, KFM and KCS) has reported a £18.3m deficit year to date. This represents a £2.1m 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 £67.3m deficit after removal of non-recurrent items, £8.7m adverse to plan.
  The Trust has confirmed plans to deliver £23.3m of Cost Improvement Programme (CIP), a planning gap of £61.6m against the £84.9m target. The Trust has delivered year-to-date recurrent savings of £10.6m (£2.8m pay and £7.8m non-pay), resulting in a £21.2m adverse variance
  The September WTE position has decreased by 84 WTE, from 14,401 WTE to 14,317 WTE

Key Actions:

- Deliver the interventions approved by the Trust Board on 16 September 2026, as defined in the Trust Board paper and summarised:
  - Progress existing CIP schemes in Gateway 0-2 through movement into Gateway 3 + to increase the approved CIP position. These schemes are expected to improve the position by £19.4m in-year.
  - Take the agreed actions to mitigate the gap through reduced run rate expenditure.
  - Implement additional run rate reduction measures through bank staff reduction.
  - Enable delivery through strengthened improvement leadership, programme delivery capability and organisational focus on delivery.

- By November 2026, these temporary recovery plans and run rate recovery actions will need to be replaced with recurrent savings to release further recurrent CIP.

- 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.

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# Integrated Performance Report

## Month 6 (September) 2026/27

**Council of Governors**

**26th November 2026**

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

| | |
|---|---|
| Report to: | *Council of Governors* |
| Date of meeting: | *26th November 2026* |
| Subject: | *Integrated Performance Report 2026/27 Month 6 (September 2026)* |
| Author(s): | *Steve Coakley, Director of Performance & Planning;*<br>*Simon Lee, Assistant Director of Performance and Planning* |
| Presented by: | *Dena Marshall, Chief Operating Officer* |
| Sponsor: | *Dena Marshall, Chief Operating Officer* |
| History: | *KMC – 2nd November 2026; PTIC – 5th November 2026* |
| 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 September 2026 returns. Cancer performance and quality metrics are reported a month in arrears and therefore relate to August 2026.*

**Action required**

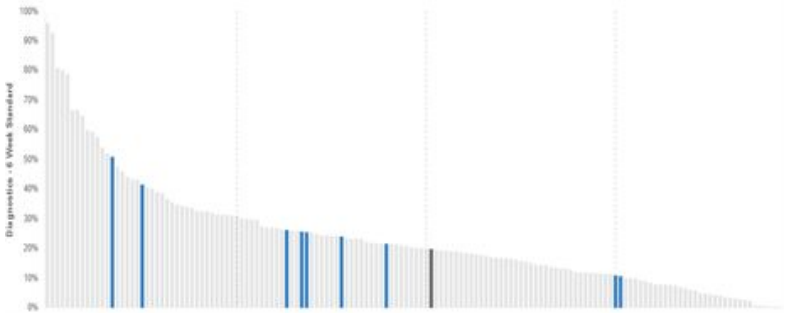
- *The Committee is asked to note the latest available 2026/27 M6 performance reported against key deliverables as set out in the national FY2026/27 Operating Plan guidance.*

## 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

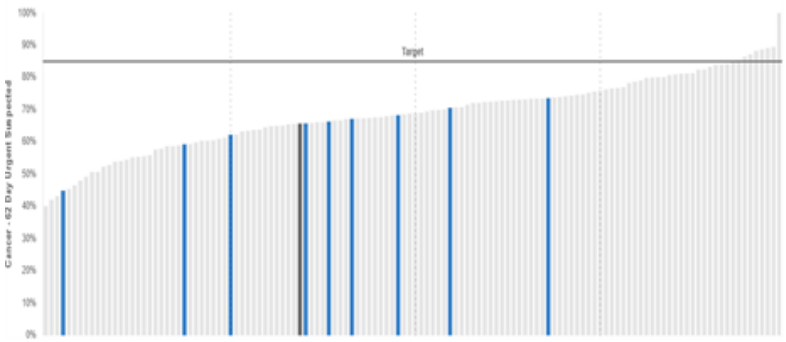
# Benchmarked Trust performance
## Based on latest national comparative data published



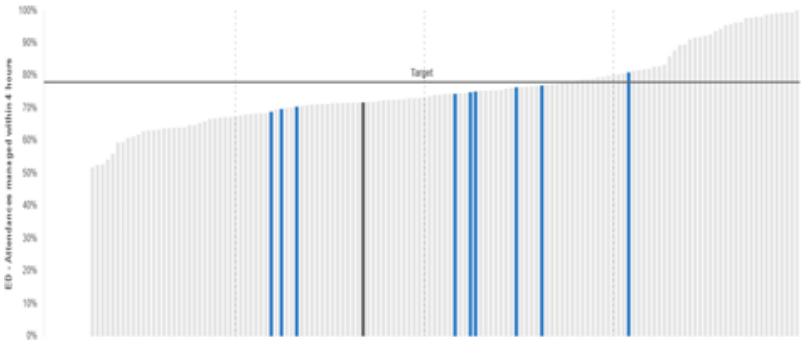
The chart above shows the national ranking against the DM01 diagnostic 6-week standard. **Kings is ranked 75 out of 153 selected Trusts based on August 2026 data published.**



The chart above shows the national ranking against the RTT 65-week waits. **Kings is ranked 143 out of 147 selected Trusts based on latest August 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 84 out of 128 selected Trusts based on latest August 2026 data published.**




The chart above shows the national ranking against the 4-hour Emergency Care Standard. **Kings is ranked 86 out of 148 selected Trusts based on latest August 2026 data published.**

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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 | 2026-08 | 78.55% | 80.68% | Fail |
| Cancer 31 day Performance - Submitted | 2026-08 | 95.77% | 96.68% | Pass |
| Cancer 62 Day Performance - Submitted | 2026-08 | 72.16% | 70.15% | Fail |
| Number of Urgent Suspected Cancer pathways waiting over 62 days | 2026-09 | 161 | 135 | Fail |
| **Diagnostics** | | | | |
| DM01 >6 week performance | 2026-09 | 16.57% | 19.86% | Fail |
| **Emergency Care** | | | | |
| A&E 4-hour performance (UEC Sitrep) | 2026-09 | 69.16% | 71.81% | Fail |
| Attendances in A&E over 12 hours % | 2026-09 | 13.16% | 11.39% | Fail |
| **Inpatients** | | | | |
| Average Discharge Delay - SUS | 2026-09 | 2.08 | 4.54 | Pass |
| Average Length of Stay (Elective) - Model Hospital Definition | 2026-09 | 10.1 | 8.2 | No Target |
| Average Length of Stay (Non-Elective) | 2026-09 | 8.1 | 8.8 | Pass |
| Elective Inpatient Spells - SUS | 2026-09 | 12477 | 11646 | No Target |
| Elective Inpatient Spells (Operational Planning) - SUS | 2026-09 | 12134 | 11340 | Pass |
| G&A bed occupancy (UEC Sitrep) | 2026-09 | 98.52% | 97.60% | Fail |
| Non-elective patients discharged by day 7 % - SUS | 2026-09 | 69.55% | 70.03% | Pass |
| Patients Discharged by Discharge Ready Date % - SUS | 2026-09 | 87.88% | 87.72% | Pass |
| Stranded Patients (LoS 7+ days) - Sitrep | 2026-09 | 612 | 606 | No Target |
| **Operational Planning** | | | | |
| First Outpatient Attendances - SUS | 2026-09 | 31574 | 26884 | Pass |
| First Outpatient Attendances - SUS (+Operational Planning inc. logic) | 2026-09 | 28806 | 24344 | Fail |
| Follow Up Outpatient Attendances - SUS | 2026-09 | 102253 | 87063 | Pass |
| Follow Up Outpatient Attendances - SUS (+Operational | 2026-09 | 77115 | 64459 | Fail |
| **Outpatients** | | | | |
| First appointment <18weeks | 2026-09 | 81.1% | 81.8% | Pass |
| First attendance or procedure % | 2026-09 | 40.2% | 40.1% | Fail |
| Outpatient DNA rate | 2026-09 | 8.6% | 8.4% | Fail |
| Outpatient PIFU Outcomes % | 2026-09 | 4.5% | 4.3% | Fail |
| **RTT** | | | | |
| % 52-week Waiters | 2026-09 | 2.36% | 2.20% | Fail |
| RTT 52 week waits | 2026-09 | 2091 | 2004 | Fail |
| RTT 65 week waits | 2026-09 | 364 | 340 | Fail |
| RTT Incomplete Performance | 2026-09 | 67.56% | 66.23% | Fail |

## Executive Summary

- **Diagnostics**: There has been a run of over 11 months DM01 performance below mean to September 2026.
- Performance improved to 16.57% in September but remained above the Operating Plan target of 14.6%.

- **RTT incomplete performance:** There has been a run of 10 months RTT Incomplete performance above the mean to September 2026, with an increase to 67.65% in September, but remained below operating plan target.

- The total RTT PTL decreased by 2532 patients to 88,570 for September, however it remains above the Operating Plan target.

- **Cancer performance 62-day:** Submitted 62-day performance for August 2026 was 72.16%, below the 76.9% Operating Plan target.

- **28-day FDS:** Submitted June 2026 28-day FDS performance is 78.55%, above the 80% standard.

- **Cancer performance 31-day:** Submitted 31-day performance was 96.7% in June 2026 meeting the NHS Operating Plan target of 96%.

- **Emergency care**: 4 hour All Types performance deteriorated to 69.16% for September, below the operating plan trajectory of 75.0%.

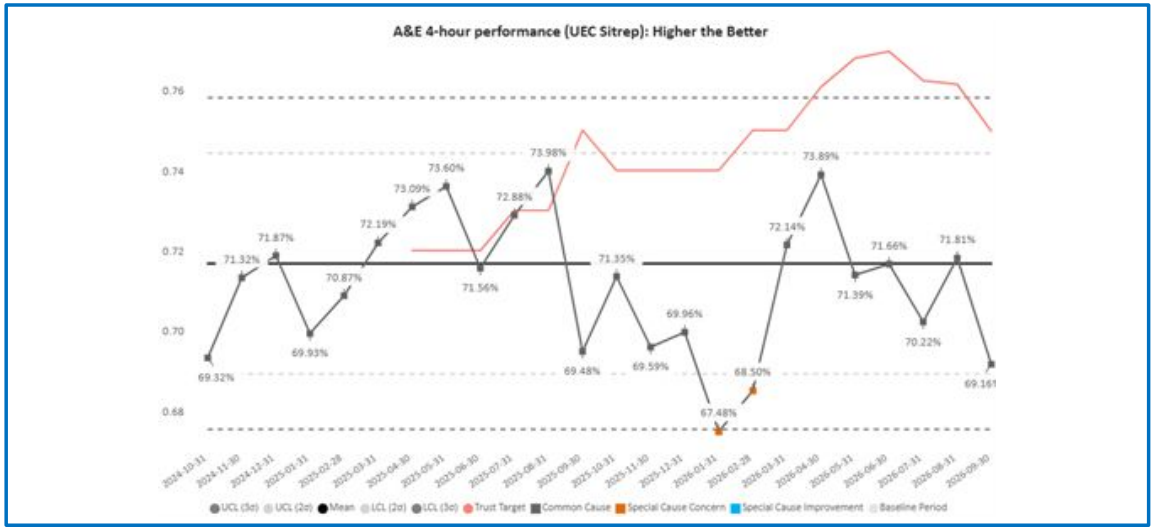
Performance

# 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. |

| September 2026 | Operating Plan September 2026 |
|---|---|
| 69.16% | 75.0% |

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




| Update since previous month | Current Issues | Key Dependencies | Future Actions |
|---|---|---|---|
| • 4 hour All Types performance deteriorated to 69.16% for September, below the operating plan trajectory of 75.0%. | • Despite variation and an increase from August, Type 1 attendances remained within expected levels at 16,246.<br>• High Mental Health demand on both sites resulting in reduced physical and requiring significant staffing resource to maintain safety.<br>• Slow flow to G&A inpatient wards leading to congestion and extended waiting times. | • Utilisation of conveyance and admission avoidance pathways in the community.<br>• Optimisation of referral pathways to SDECs to take lower risk presentations.<br>• Flow into G&A inpatient wards. | • Development of care group plans for the 2026-27 flow programme.<br>• Working with DH and PRUH UTC providers to optimise pathways.<br>• Re-focusing on front door pathway and streaming into ED assessment unit<br>• Realisation of SDEC pathway opportunities, with expansion of medical SDEC and frailty ambulatory capacity.<br>• Implementation of POCT and AVT . |

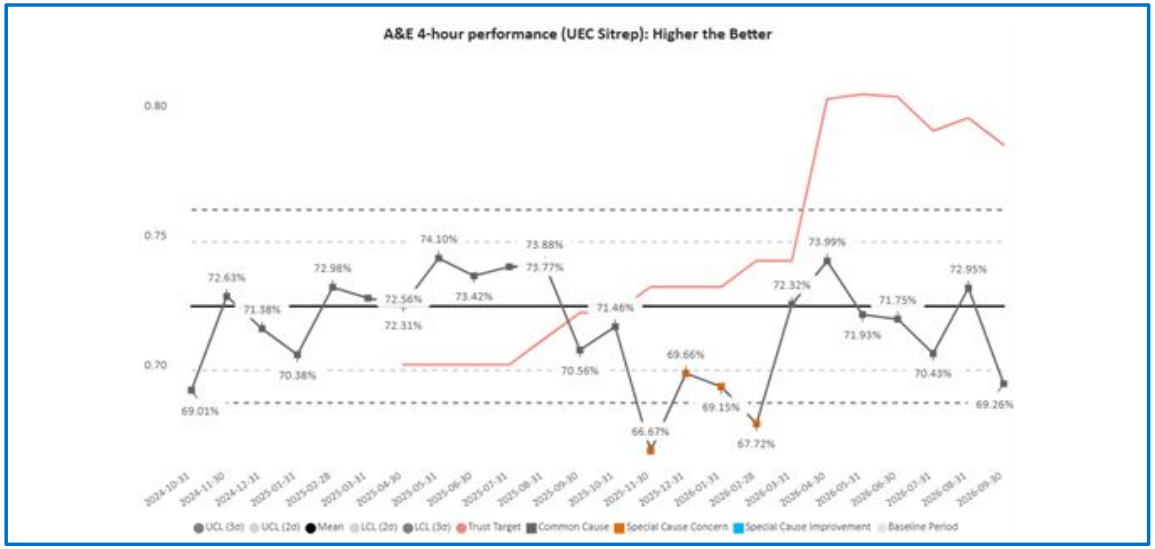
Performance

# 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. |

| September 2026 | Operating Plan September 2026 |
|---|---|
| 69.26% | 78.5% |

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




| Update since previous month | Current Issues | Key Dependencies | Future Actions |
|---|---|---|---|
| • 4 hour All Types performance remained below the operating plan of 78.5% at 69.26% in September. | • Type 1 attendances were in line with the mean of the last 24 months, with ambulance conveyances marginally below.<br>• DH Type 3 performance remains static at 92.45%<br>• Significant challenges with long Mental Health patient stays in ED, leading to cubicles being blocked for assessment. | • Utilisation of conveyance and admission avoidance pathways in the community.<br>• Optimisation of referral pathways to SDECs to take lower risk presentations.<br>• Flow into General & Acute (G&A) inpatient wards.<br>• Flow into MH inpatient wards. | • Working with UTC provider to optimise pathways and improve performance.<br>• Re-focusing on ED triage process and wait for 1st clinician through AMA.<br>• Expansion of ambulatory frailty capacity and medical SDEC throughput.<br>• Implementation of POCT and AVT. |

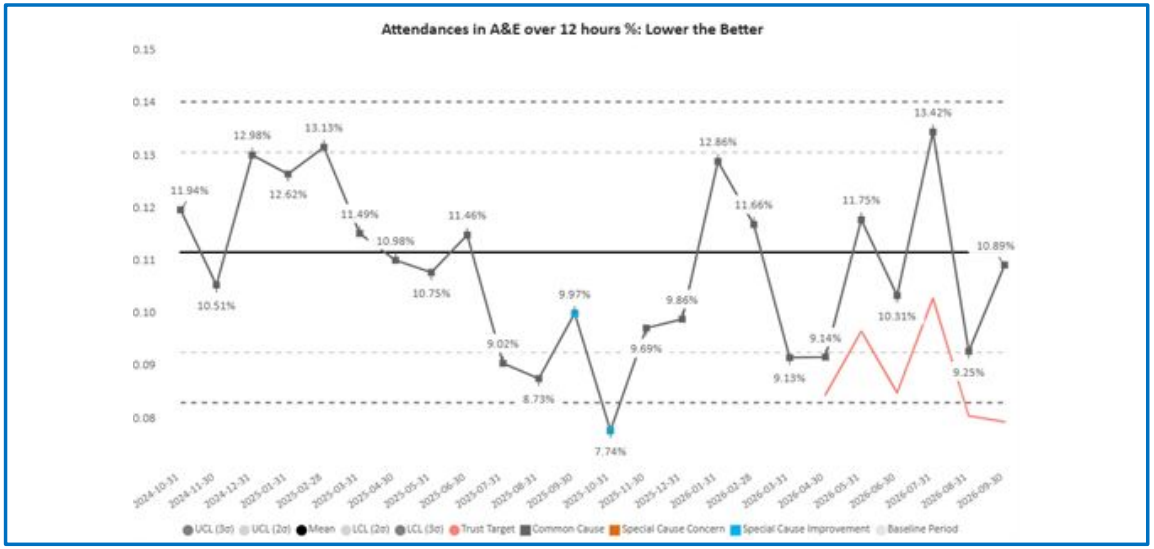
Performance

# 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 |

| September 2026 | Operating Plan September 2026 |
|---|---|
| 10.89% | 7.9% |

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




| Update since previous month | Current Issues | Key Dependencies | Future Actions |
|---|---|---|---|
| • The percentage of patients waiting in ED over 12 hours increased to 10.89%, above the target of 7.9% for the month. | • 12-hour length of stay breaches are mostly attributed to those awaiting inpatient admission to an acute or mental health hospital bed. | • Improved flow for patients with a mental health Decision To Admit (DTA) into partner organisations.<br>• Flow from ED into inpatient admission wards.<br>• Reduction in length of stay across inpatient wards through the site flow programme, particularly in view of predicted challenging winter virus presentations. | • Delivery of improved inpatient flow through the 26-27 flow programme and local care group initiatives.<br>• Extension of LLOS reviews on further wards<br>• Opening of the MH UTC on the Maudsley site<br>• Review of continued operation of LIAA over Q3/4 |

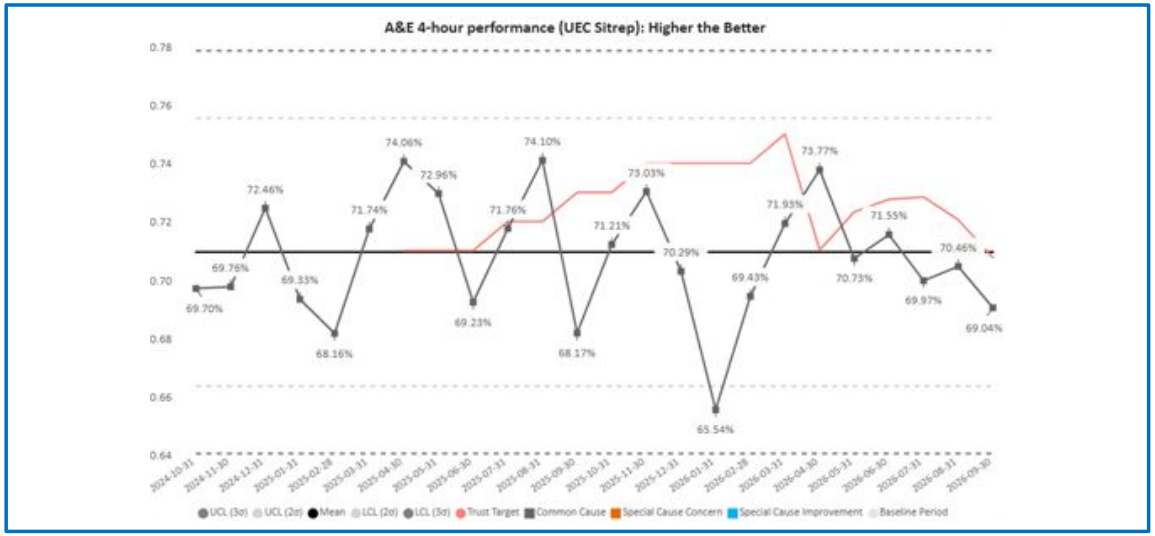
Performance

# 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. |

| September 2026 | Operating Plan September 2026 |
|---|---|
| 69.04% | 70.8% |

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




| Update since previous month | Current Issues | Key Dependencies | Future Actions |
|---|---|---|---|
| • All type performance decreased to 69.04% in September, remaining below the Operating Plan target.<br>• Implementation of Rapid assessment and treatment model 12:00-21:00 | • Type 1 PRUH performance remained in line with the mean of the last 24 months.<br>• Type 3 attendances were higher than accepted variation, however performance remained static<br>• LAS calls to the geriatric SPOA remain low and an unrealised opportunity.<br>• Corridor congestion due to admitted demand continues, but a significant reduction compared to FY2025-26. | • Attendance avoidance pathways in the community and the use of Universal Care Plans (UCP).<br>• Re-direct pathways from ED into out-of-hospital providers.<br>• Optimisation of referral pathways to SDECs to take lower risk presentations.<br>• Flow into MH inpatient wards.<br>• Flow into G&A inpatient wards. | • Focus on increasing pathways out of ED into ADU, MSDEC and SAUU.<br>• UTC implementation of “Hello Dr” model to support triage and treatment<br>• Extended geriatric consultant cover onsite 7 days a week to support SPOA and AGU flow. |

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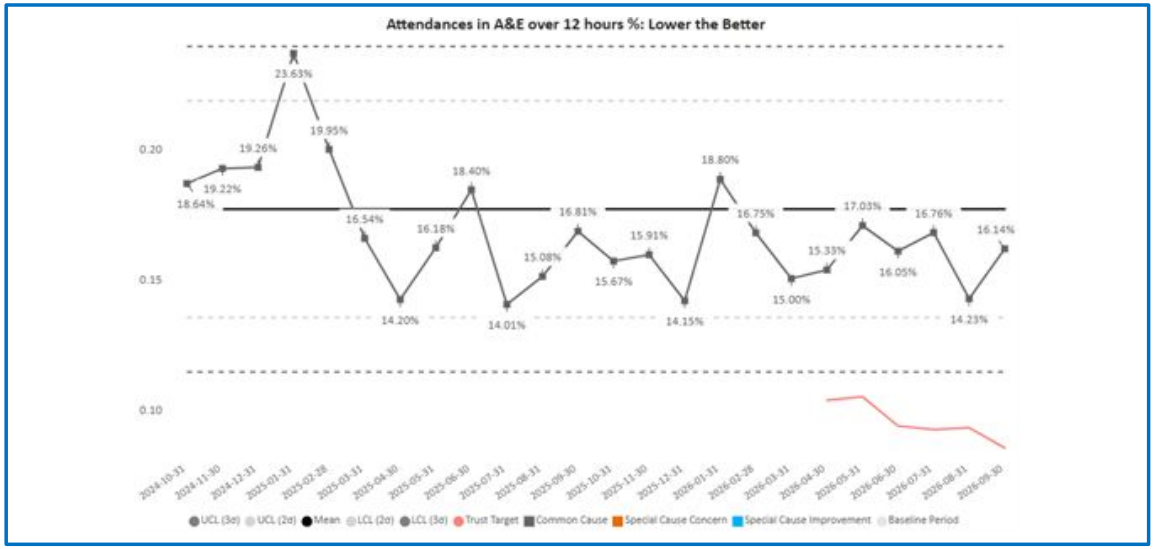
Performance

# 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 |

| September 2026 | Operating Plan September 2026 |
|---|---|
| **16.14%** | **8.5%** |

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




| Update since previous month | Current Issues | Key Dependencies | Future Actions |
|---|---|---|---|
| • Reduction in 12 hour stays in September to 16.14% but remained above the Operating Plan target of 8.5%. | • 12 hour stays for patients requiring admission remain a significant challenge.<br>• 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.<br>• Flow from ED into inpatient admission wards.<br>• Reduction in length of stay across inpatient wards through the site flow programme. | • Exploring discharge ward model to support winter flow.<br>• Extension of LLOS reviews onto further inpatient wards |

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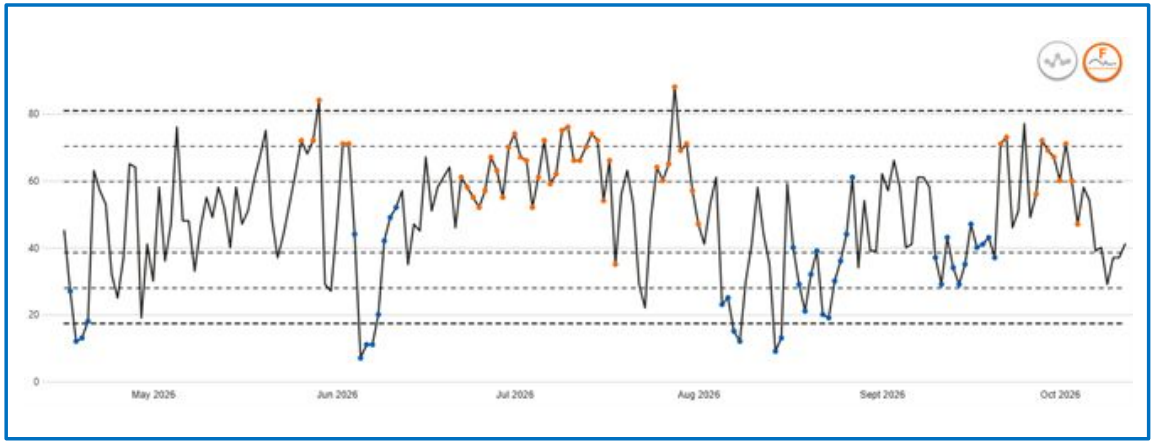
Performance

# 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<br>• This metric counts patients recorded in a location marked as an escalation space in each department. |

| September 2026 |
|---|
| 1550 |

- Executive Owner: Angela Helleur, Chief Delivery Officer
- Operational Leads : 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.<br>• 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.<br>• Improved early flow into G&A beds to support continuous flow through the Trust.<br>• Improved flow into MH beds to support increase assessment capacity. | • Implementation of extended focus of flow programme to support earlier site flow, including adoptions of LLOS review process.<br>• Re-Audit of adherence to Criteria to admit in ED and AMU. |

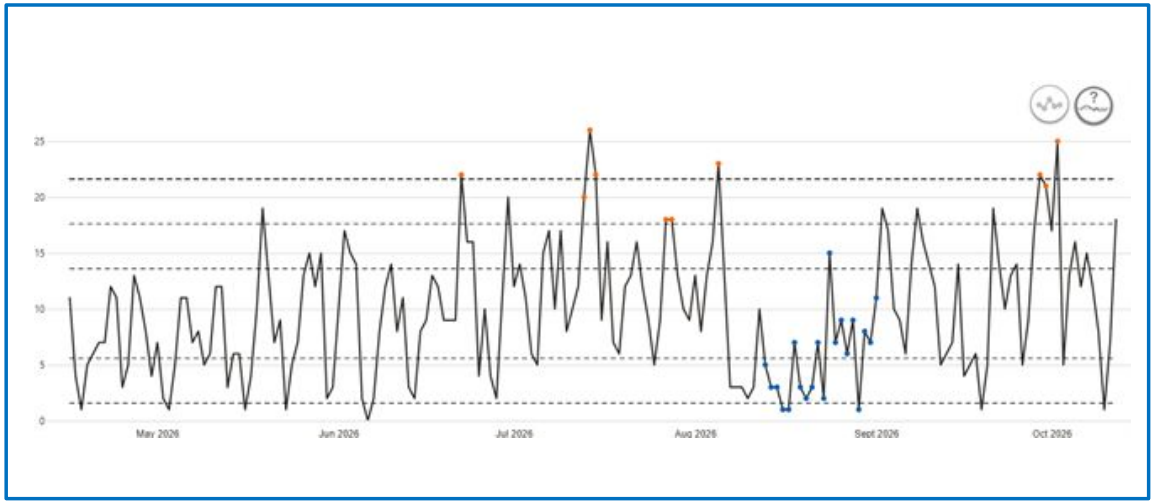
Performance

# 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.<br>• This metric counts patients recorded in surge beds on inpatient wards. |

| September 2026 |
|---|
| 344 |

- Executive Owner: Angela Helleur, Chief Delivery Officer
- Operational Leads : 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.<br>• Insufficient discharges compared to demand result in high bed occupancy. | • Improved discharges before 12 midday and utilisation of discharge lounge.<br>• Increased discharges per day to lower bed occupancy.<br>• 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.<br>• Criteria Led Discharge project being rolled out to support earlier in day discharges.<br>• Long Length of Stay Reviews project to be further rolled out to support reduction in LoS. |

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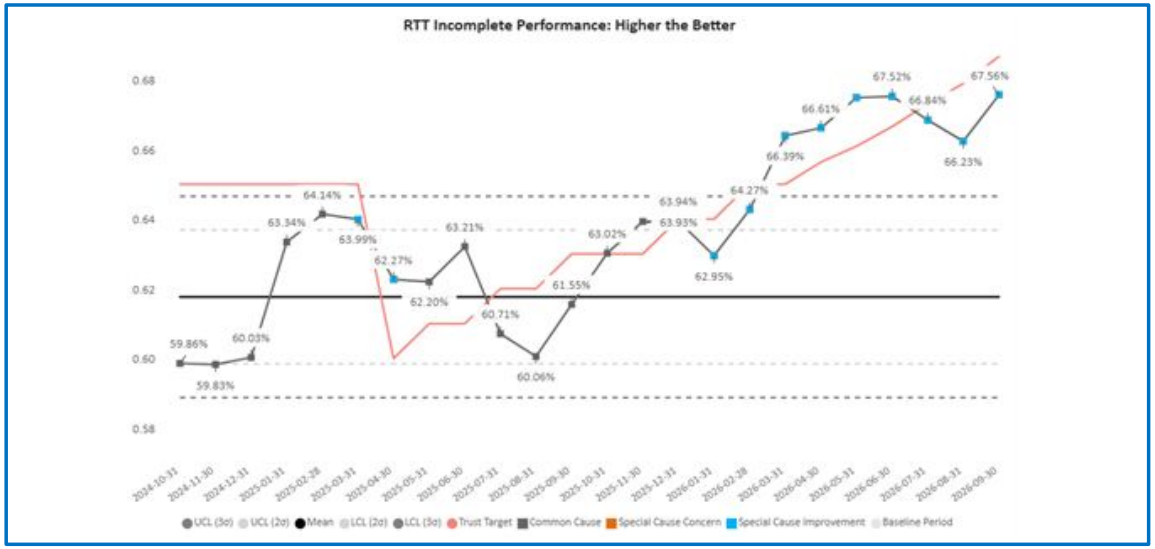
Performance

# RTT Incomplete Performance

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

| September 2026 | Operating Plan September 2026 |
|---|---|
| 67.65% | 68.7% |

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




## Update since previous month

- There has been a run of 10 months RTT Incomplete performance above the mean to September 2026, with an increase to 67.65% in September, but remained below operating plan target.
- However, the revised forecast for September of 67.2% was achieved.
- The total RTT PTL decreased by 2532 patients to 88,570 for September, however it remains above the Operating Plan target.

## 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.
- Additional internal activity and outsourcing taking place.

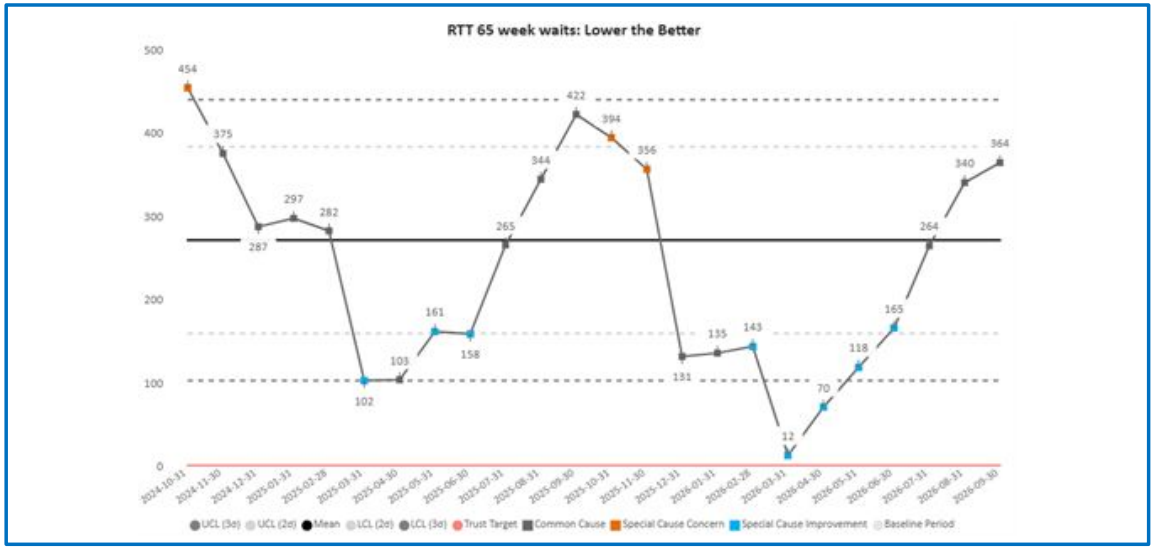
Performance

# RTT – 65 Weeks

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

| September 2026 | Operating Plan September 2026 |
|---|---|
| 364 | 0 |

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




## Update since previous month

- The number of patients waiting over 65 weeks increased by 24 patients in September to 364, remaining well above the zero breaches in the 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.

## Current Issues

- 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.

## Key Dependencies

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

## Future Actions

- Weekend theatre lists, outsourcing and mutual aid to be progressed
- Procurement of external validation support to improve PTL accuracy
- Further use of SIF money to fund additional capacity.

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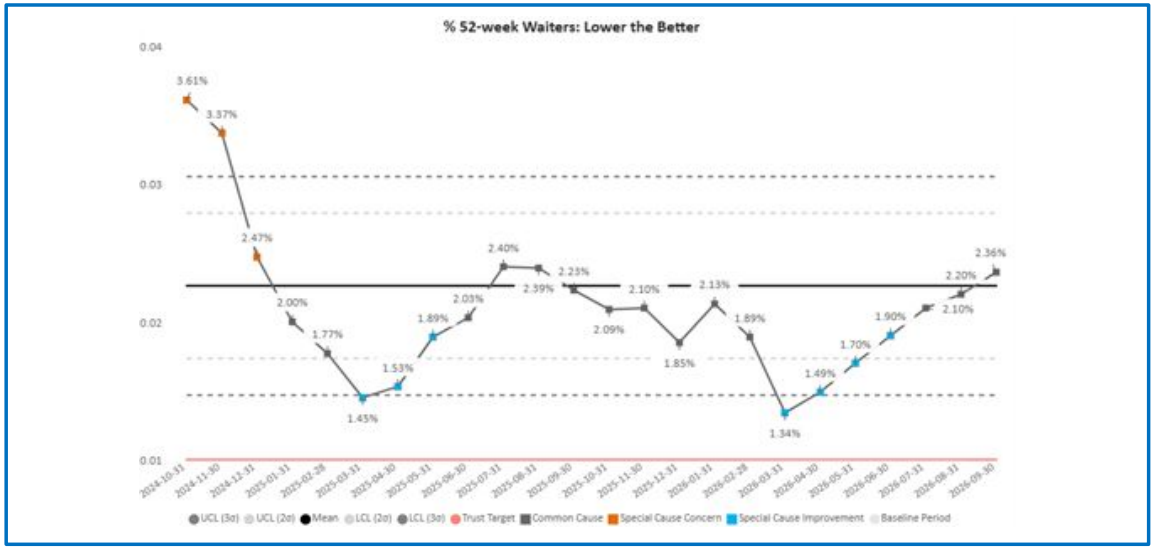
Performance

# RTT – % 52 Week Waiters

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

| September 2026 | Operating Plan September 2026 |
|---|---|
| 2.20% | 0.72% |

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




## Update since previous month

- The number of patients waiting over 52-weeks increased further from 2004 in August to 2091 in September.
- This represents 2.36% of the total PTL and above the target of 0.72%.
- Over 1500 patients are waiting over 52-weeks on an admitted pathway and over 500 on a non-admitted pathway.

## 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

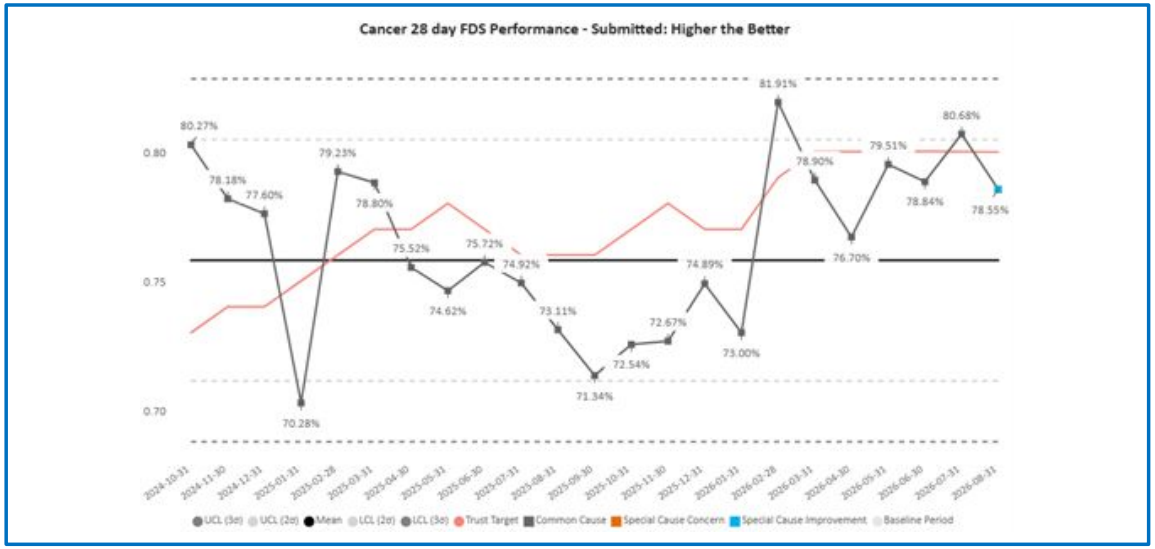
- Enhanced senior clinical and operational oversight continues, with line-by-line review of long wait risks across both admitted and non-admitted cohorts.
- Weekend theatre lists, outsourcing and mutual aid to be progressed
- Procurement of external validation support to improve PTL accuracy

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. |

| August 2026 | Operating Plan August 2026 |
|---|---|
| 78.55% | 80% |



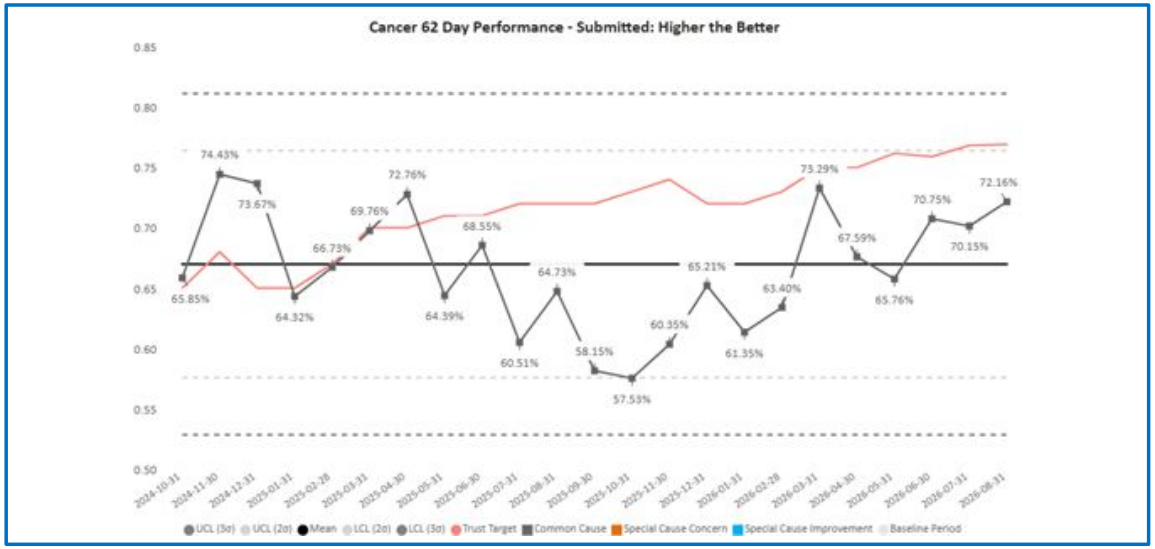

| Update since previous month | Current Issues | Key Dependencies | Future Actions |
|---|---|---|---|
| • Submitted June 2026 28-day FDS performance is 78.55%, above the 80% standard. | • PRUH endoscopy backlog recovery (from new unit opening in April 2026).<br>• PRUH pathology reporting turnaround times.<br>• PRUH GI CT radiology reporting and (Trust wide) urology CT reporting<br>• Other smaller challenges include PRUH breast radiology capacity, Trust wide prostate biopsy capacity, DH head & neck referral triaging and DH gynaecology hysteroscopy capacity | • Backlog recovery from new endoscopy build.<br>• Radiology demand exceeds capacity overall (for both cancer pathways and all Trust standards).<br>• Balance of pathologist workload and demand at DH and PRUH and recruitment to vacant posts. | • PRUH endoscopy backlog recovery (from late September unit will be at full capacity for first time since March but further backlog clearance required- service to provide trajectory recovery plan and SELCA funding bid to deliver by end of September).<br>• Radiology reporting backlog reducing through non-recurrent fund, service to bid for further SELCA funding.<br>• Pathology medical recruitment and cross site reporting integration. |

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. |

| August 2026 | Operating Plan August 2026 |
|---|---|
| 72.16% | 76.9% |




## Update since previous month

- Submitted 62-day performance for August 2026 was 72.16%, below the 76.9% Operating Plan target.

## Current Issues

- Pathology reporting delays.
- Complexities of breast pathways with additional imaging (and breast radiology workforce).
- PRUH endoscopy capacity.
- Lung IR radiology and OPA capacity.
- Prostate biopsy and oncology capacity.

## Key Dependencies

- Synnovis pathology turnaround times.
- Clinical review of breast diagnostic pathway.
- Radiology demand exceeds capacity overall (for both cancer pathways and all Trust standards).
- PRUH endoscopy backlog.

## Future Actions

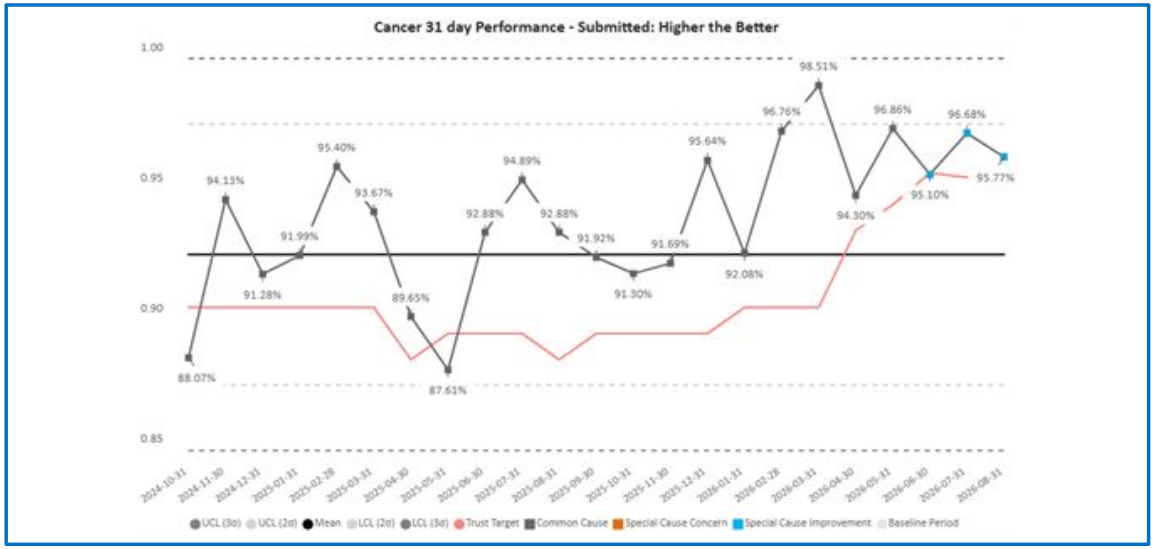
- Pathology review meetings for breast and prostate cancer to fast track local reporting.
- Breast radiology pathway mapping (through GSTT or locally).
- PRUH endoscopy backlog recovery (see previous slide)
- New post to be advertised for urology ANP to perform prostate biopsy.
- New Lung consultant starting November.

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. |

| August 2026 | Operating Plan August 2026 |
|---|---|
| 96.68% | 95.00% |




| Update since previous month | Current Issues | Key Dependencies | Future Actions |
|---|---|---|---|
| • Submitted 31-day performance was 96.7% in June 2026 meeting the NHS Operating Plan target of 96%. | • DH surgical capacity (breast, colorectal, HPB)<br>• IR radiology capacity | • HPB surgical and radiology capacity | • DH colorectal cancer theatre utilisation longer term plan in action (covering anaesthetics, wards, surgery and theatres).<br>• Dh site review required for specific allocation of breast and colorectal theatre list<br>• Liver interventional radiology scheduling process being streamlined.<br>• Additional HPB surgeon not fit to commence operating until end of September. |

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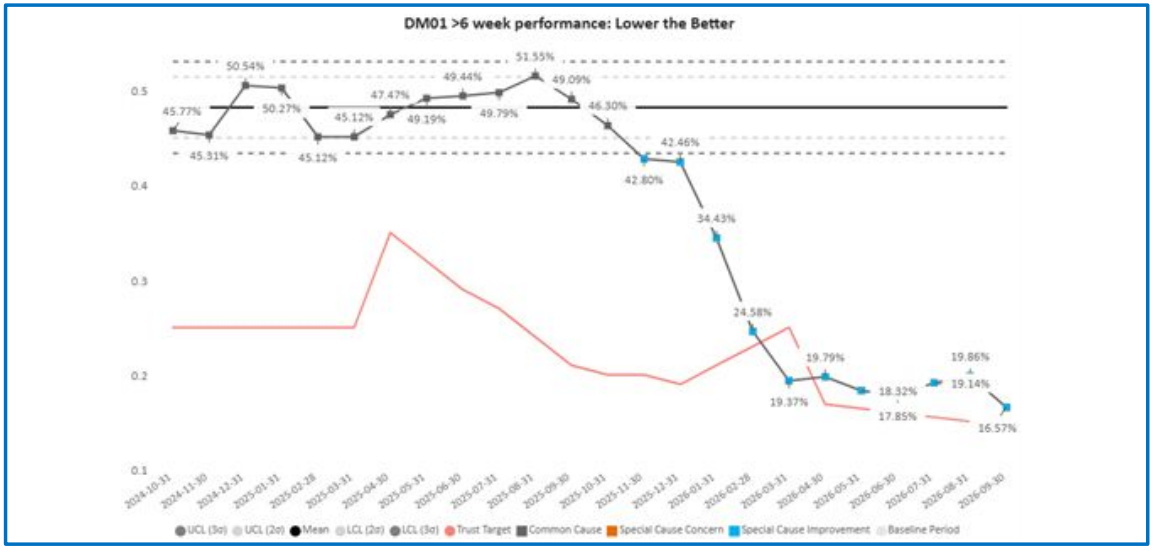
Performance

# 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%.<br>• The target on the chart is incorrect and will be amended |

| September 2026 | Operating Plan September 2026 |
|---|---|
| 16.57% | 14.6% |




| Update since previous month | Current Issues | Key Dependencies | Future Actions |
|---|---|---|---|
| • There has been a run of over 11 months DM01 performance below mean to September 2026.<br>• Performance improved to 16.57% in September but remained above the Operating Plan target of 14.6%. | • The total waiting list increased by 1193 patients. | • 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.<br>• 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. | • Neurophysiology – administrative recruitment and training will improve timely booking.<br>• A revised endoscopy recovery action plan is in place, with additional internal and external capacity being delivered.<br>• 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 - Assurance (August 2026)

| | |
|---|---|
| **Safe** | • 2 new PSIIs commissioned in August<br>• 1 new Never Event reported – retained guidewire with AAR completed September 2026<br>• Incidents awaiting review have remained below the mean for 9 consecutive months & learning responses taking more than five months has improved for 6 consecutive months<br>• 16 ongoing PSIIs (6 MNSI) – none overdue<br>• Audit compliance (slide 13) remains strong at 94.9% |
| **Caring** | • Inpatient and day-case FFT received 1,363 responses in August. Overall performance shows common-cause variation. Waiting, communication, overcrowding and ward temperature continue to feature in negative feedback (Slide 26)<br>• Emergency Department FFT continues to show special-cause variation of concern, with 751 responses. Waiting times remain the principal concern, alongside communication, overcrowding and delays in receiving updates (Slide 27)<br>• Maternity FFT remained high at 93.8%, with birthing services improving to 96.2% from 52 responses, the highest response volume recorded for the service in 2026 (Slide 29) |
| **Responsive** | • 147 complaints were received in August, 51% fewer than the record July position and broadly in line with the recent six-month monthly average. 140 complaints were closed during August (Slide 37) |
| **Well-Led** | • Safer staffing shows positive assurance and special-cause improvement in daytime and nighttime RN/RM and HCSW fill rates |

Quality

# Domain 2 – Quality Summary - Escalation (August 2026)

| | |
|---|---|
| **Safe** | • Duty of Candour remains an area requiring focus – current metrics (slide 8) show our performance below the Trust set target |
| **Caring** | • Outpatient FFT remains below the benchmark and national average, continuing the position seen since February 2026. Ophthalmology remains a particular area of focus, with waiting and communication also reflected in PALS feedback |
| **Responsive** | • Quality Alert volumes remain below the historical average and demonstrate special-cause improving variation. However, overdue alerts remain the principal concern, with performance continuing above the 20% target, requiring sustained focus on timely review and closure (Slide 36)<br>• 107 complaints were overdue by at least one day, representing 26% of open complaints, while 30 were four or more weeks overdue, up from nine in April. Eight complaints were 12 or more weeks overdue |
| **Well-Led** | **Nothing to escalate** |

Quality

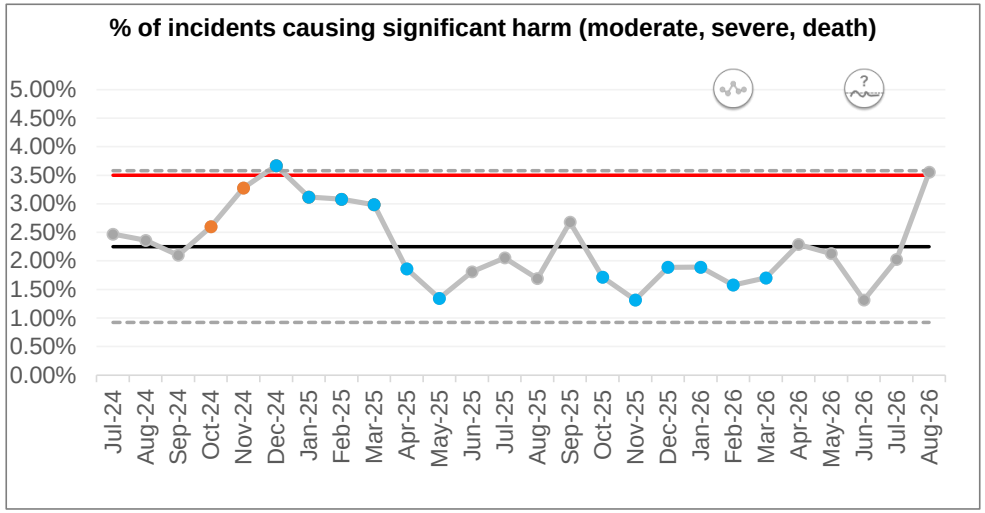
# Safe – Incidents

The Trust commissioned two new PSIIs in August 2026. One related to ED Resus capacity at DH and the other to a deteriorating post-liver transplant patient covering Liver and Critical Care teams. No new MSNI cases were identified.

One new Never Event was identified, a retained guidewire following insertion of a vascath for plasma exchange. This involves services from across Divisions A & C. An after-action review was agreed as a proportionate response.

Whilst the volume of patient safety incidents awaiting review at PSIRF Panels remains above target we have seen special cause variation with nine consecutive months below the mean, although the total remains above target.

Similarly, we have seen improving special cause variation in the proportion of learning responses taking greater than five months to complete, with six consecutive months of improving performance. This also remains above target however, and has impacts both in delayed learning and improvement following incidents, and delays in the compassionate engagement steps which can compound harm for those affected.




**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.

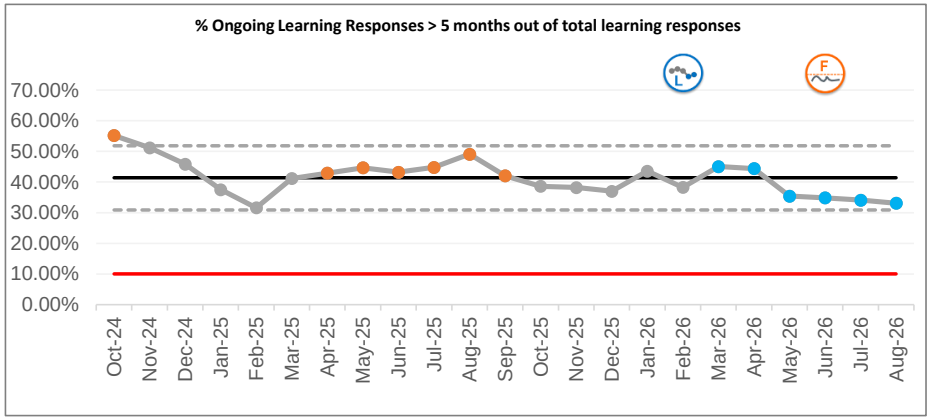
**Actions being taken to improve:**
Positive assurance. Safety culture programme currently being developed and rolled out which should improve psychological safety for staff and therefore further improve reporting culture.

**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

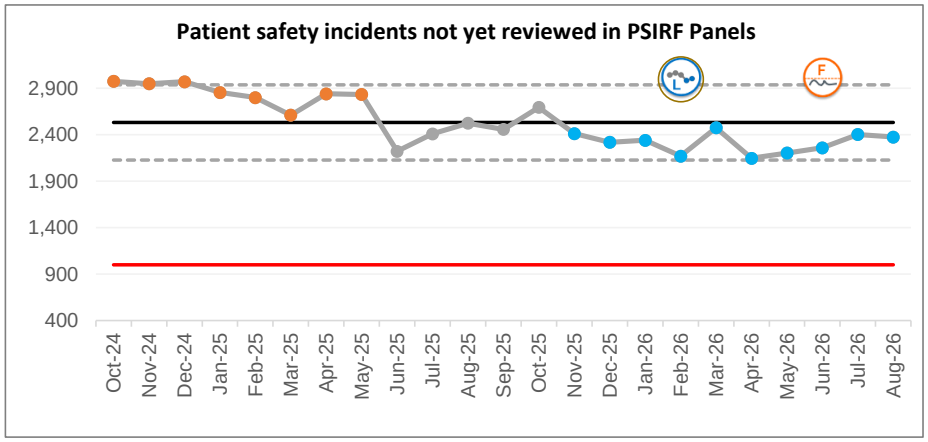
Special cause variation continues to be seen in the proportion of learning responses taking greater than five months to complete. The impact of both on our patients (and staff) is delayed learning and improvement following incidents, and delays in the compassionate engagement steps which can compound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




**What is the data showing us?**
We have seen improving special cause variation in the proportion of learning responses taking greater than five months to complete, with six consecutive months of improving performance. This, however, remains above target.

**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.




**What is the data showing us?**
Whilst the volume of patient safety incidents awaiting review at PSIRF Panels remains above target we have seen special cause variation with nine consecutive months below the mean, although the total remains above 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:**
The impact is both delayed improvement following incidents, and delays in the compassionate engagement steps which can compound harm for those affected.

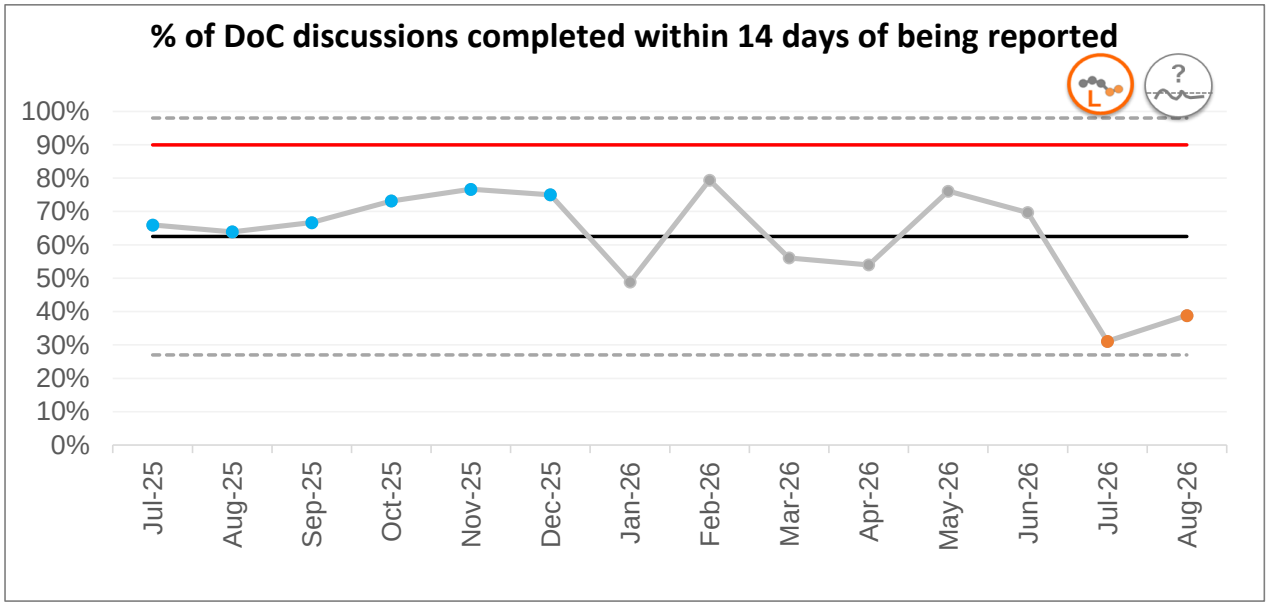
Quality

## Safe – Duty of Candour (DoC)

New 14-and 30-day performance data was agreed at KE has been introduced however is yet to see any improvement in performance. 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.

There are 34 DoC cases from before August with conversations outstanding. These are nearly all in Division B, and predominantly in the Liver and Integrated Medicine Care Groups. As discussed in September's OCB, a deep dive into DoC will be presented in December OCB to identify areas for improvement in the process and management of notifiable safety events.

There are 69 outstanding DoC letters, these are more evenly spread between Division A and B. The oldest cases are from July and August 2025, both in Division A.

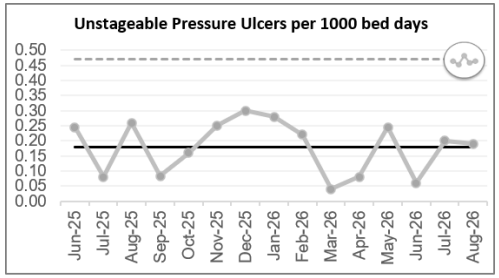


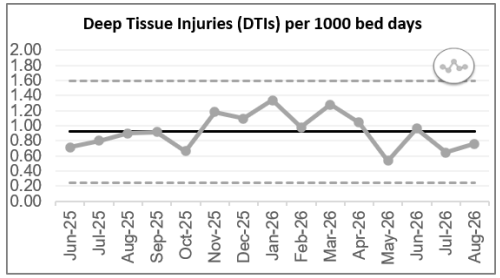
Quality

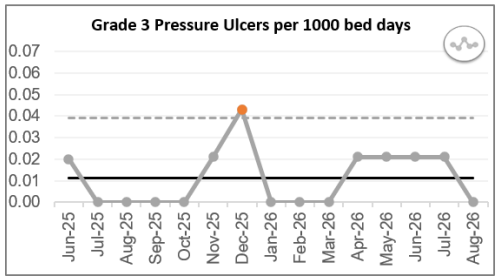
# Safe – Falls & Pressure Ulcers

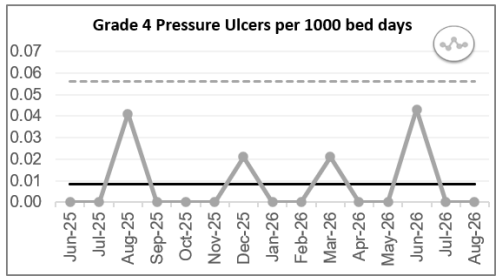
Enhancements are being made to Epic documentation, including improvements to falls and pressure ulcer flow sheets and the introduction of Purpose-T to support standardised skin assessment – delayed to September on current road map. In parallel, a revised Trust Falls Policy and Strategy is being developed, 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. Nurse free transfer SOP is approved and being rolled out. 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 continues to demonstrate special cause variation, which suggests that performance is consistently improving. This is linked to changes in falls documentation in Epic and better oversight of falls documentation completion at a ward level.

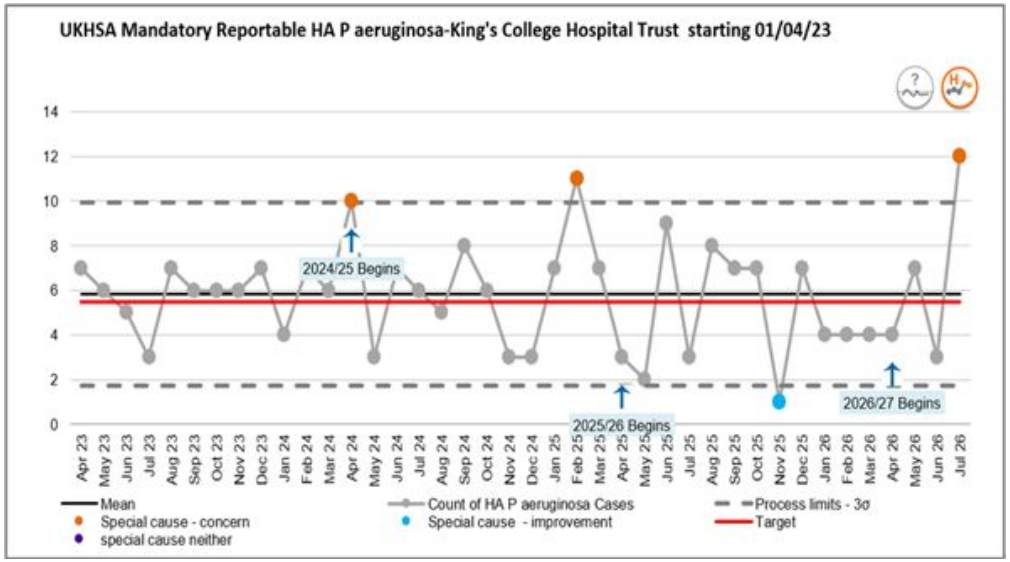
Common cause variation identified for Trust-wide data. 111 pressure ulcers in August. 9 x unstageable and 35 x DTI's

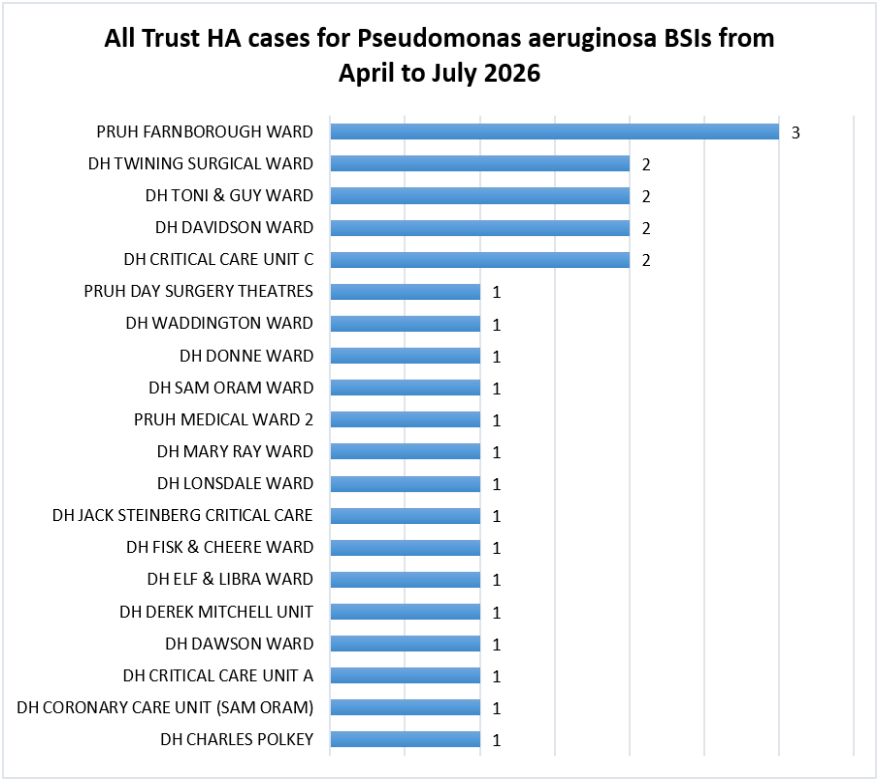
**Actions being taken to improve:**
Enhancements are being made to Epic documentation, including improvements to falls and pressure ulcer flow sheets and the introduction of Purpose-T to support standardised skin assessment – delayed to September on current road map. In parallel, a revised Trust Falls 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; Pseudomonas



Quality

# Safe – Infection Protection Control; Pseudomonas

| Associated Department | Blood Culture - Focus of Infection Assessment | Cases |
|---|---|---|
| DH CHARLES POLKEY | Urinary tract - catheter associated | 1 |
| DH CORONARY CARE UNIT (SAM ORAM) | No identified focus | 1 |
| DH CRITICAL CARE UNIT A | Urinary tract - catheter associated | 1 |
| DH CRITICAL CARE UNIT C | Gastrointestinal or intra-abdominal excluding hepatobili | 1 |
| | Upper respiratory tract and Ear, Nose and Throat (ENT) | 1 |
| DH DAVIDSON WARD | No identified focus | 1 |
| | Other focus - specify in comments | 1 |
| DH DAWSON WARD | No identified focus | 1 |
| DH DEREK MITCHELL UNIT | No identified focus | 1 |
| DH ELF & LIBRA WARD | Intravascular device - central line | 1 |
| DH FISK & CHEERE WARD | Intravascular device - haemodialysis related | 1 |
| DH JACK STEINBERG CRITICAL CARE | Other focus - specify in comments | 1 |
| DH LONSDALE WARD | No identified focus | 1 |
| DH MARY RAY WARD | Urinary tract - not catheter associated | 1 |
| DH TONI & GUY WARD | Other focus - specify in comments | 1 |
| | Skin and soft tissue | 1 |
| DH TWINING SURGICAL WARD | Lower respiratory tract/pleural space | 1 |
| | No identified focus | 1 |
| PRUH FARNBOROUGH WARD | Hepatobiliary | 1 |
| | Skin and soft tissue | 1 |
| | Vascular (with prosthetic material) | 1 |
| PRUH MEDICAL WARD 2 | Urinary tract - catheter associated | 1 |
| DH SAM ORAM WARD | No identified focus | 1 |
| DH DONNE WARD | Skin and soft tissue | 1 |
| DH WADDINGTON WARD | No identified focus | 1 |
| PRUH DAY SURGERY THEATRES | Urinary tract - catheter associated | 1 |

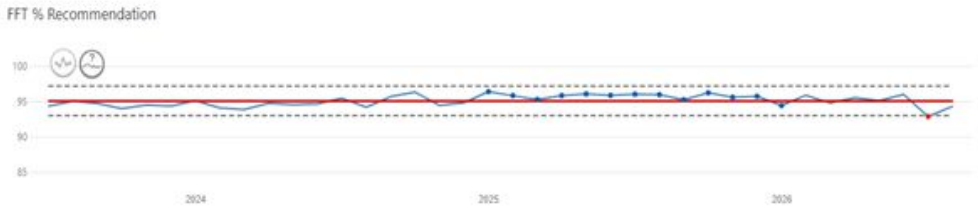
The reason for the increase in pseudomonas BSI in July 2026 is not clear.

Between April – July 2026 there were 26 cases, of which 4 (15%) were urinary catheter related, and 2 (7%) were intravenous line related.

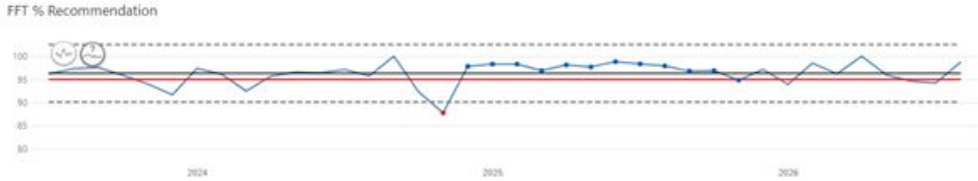
IPC ward round reviews of urinary catheters remains in progress, with results fed back on the day.

Quality

# Caring – Friends & Family Test – Inpatient & Day Case




## Division A




## Division B




## Division C




**What is the data showing us?**
Overall, Common cause variation for Friends and Family Test score across all divisions. Friends and Family Test responses decreased to 1,363 responses in the month of August.

The overall Friends and Family Test score for Division C has statically improved by 3.6% since July 2026.

**Actions being taken to improve:**
Feedback around facilities, particularly around the temperature in the ward will be reviewed as part of Trust's Estates Strategy development.

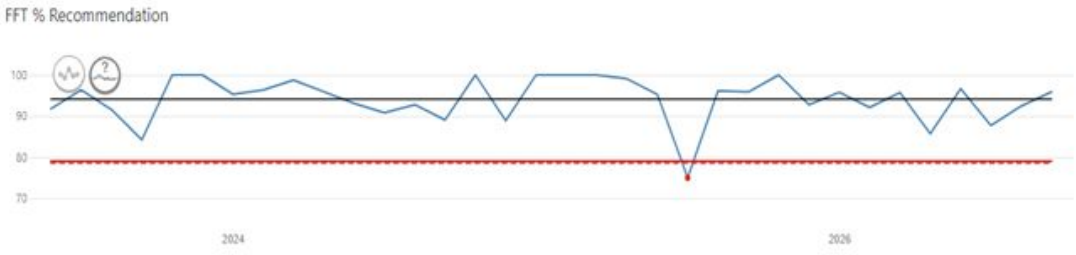
The Patient Experience Team continue to support efforts to increase response rates in wards that have recorded low or no survey responses over the past 12 months. Since June 2026, monthly Care Group reports been shared with teams, providing area-specific patient experience data and insights. Each report includes tailored recommendations and information on the support available from the Patient Experience Team to help improve engagement and response rates. Expected outcomes for this action is increased awareness among ward teams of their patient experience survey performance through regular, area-specific reporting. This approach will also support a stronger culture of listening to and acting on patient feedback across the organisation.
Following the Band 7 away day on the 7th September, the action plan to address the 2025 CQC Inpatient Survey areas of improvement is in development by the Patient Experience and Involvement Lead – Division C to be submitted to the DONs for sign off. The areas focus on communication, up to date and access to information and the increased accessibility of volunteers as and when needed.

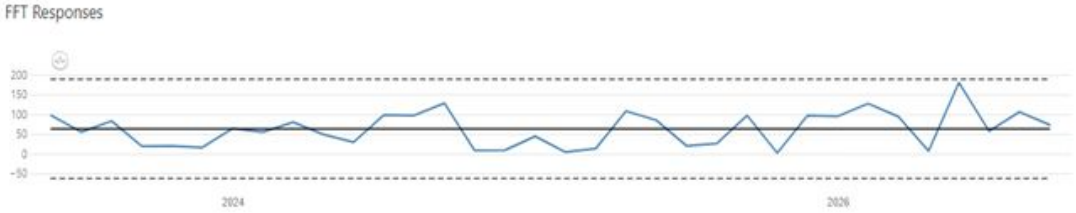
**Positive Feedback:**
67% of the themes identified were positive in sentiment. Patients continue to praise the staff behaviour and the quality of patient care continue to be well received, and a substantial number of feedback provided.

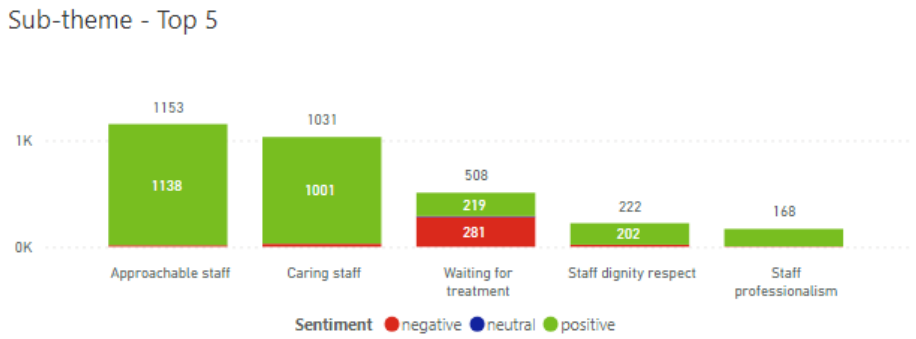
**Improvement Feedback:**
Waiting and communication continues to be the most prominent negative main theme, which included waiting for treatment, appointment and issues with communication with staff. Facilities concerns were commonly mentioned with many patients citing overcrowding, issues with parking and ward temperature as the heatwave continued into August.

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 score continues to decline throughout the year, with a total of 751 responses.

**Actions being taken to improve:**
Requests for feedback on content and design of the ED infographic and pop-up banner for AMA sent to patients, with 17 responses so far. This has included visiting patients in the department, through EPIC patient lists and the collaborators Hub.

Work has begun on the 16th to exercise the outcome toolkit to get a detailed understanding of wait time concerns and update comms for patients which will be carried how people experience these challenges in EAU, SDEC, Majors and AMA. This is in collaboration with Mohamed Elgowini and Ehsan Weidi.

At the PRUH work is underway to evaluate and improve the process of presenting at ED, working collaboratively with UTC and the ED team. Patients will be involved to give their insights and recommendations as well as how to eliminate potential challenges before they arise with the new layout.

Quality of life issues continue to be a focus at the PRUH, targeting water supply, signage and access to hot drinks out of hours.

**Positive Feedback:**
Patients valued the dedication and professionalism of staff, particularly when receiving prompt treatment and clear explanations. Individual examples of compassionate and effective care were noted across emergency services.

**Improvement Feedback:**
Waiting times remained the most prominent concern. Patients also highlighted communication, overcrowding, discharge delays and difficulties obtaining timely updates regarding treatment and care plans

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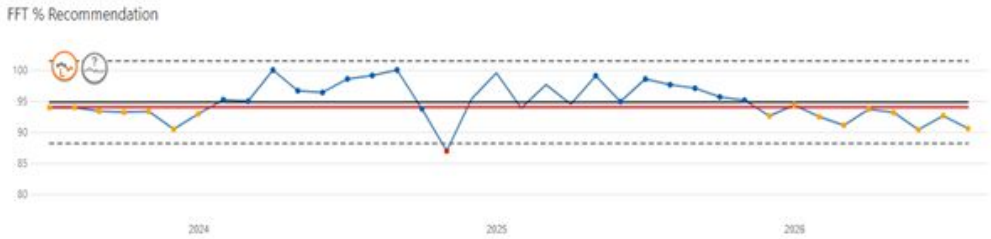
Quality

# Caring – Friends & Family Test – Outpatients

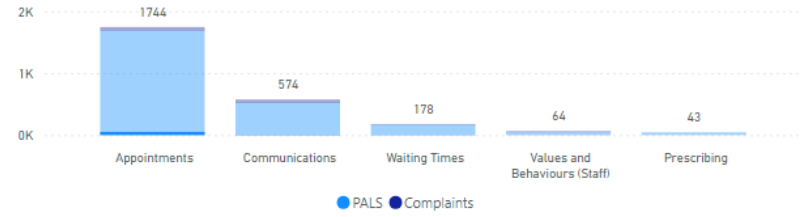
**Outpatients**




**Ophthalmology**




Top PALS & Complaints




**What is the data showing us?**
Special cause of concerning nature has been noted for outpatients overall, with the Trust not obtaining the benchmark and national average since February 2026.

Special cause of improving nature for **Liver, Gastroenterology, Upper Gi, Endoscopy, Neurosciences, Specialist Medicine, Surgery and Women's Health.**

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

**Actions being taken to improve:**
A review of feedback for Ophthalmology during the 12-month period was conducted with the aim to better understand the experience of patients and the area of focus for improvement. The report included FFT and PALS data which highlighted 3 key themes – waiting, communication and patient care. The report will be shared and discussed at the next Division C Quality and Governance meeting.

**Positive Feedback:**
Patients frequently praised staff for being caring, professional and informative. Many reported positive experiences due to thorough consultations, good communication, efficient appointments and confidence in the care provided.

**Improvement Feedback:**
The most common concerns related to appointment delays, waiting times and communication regarding appointments and follow-up care. Administrative issues, signage and navigation across sites were also identified as areas for improvement.

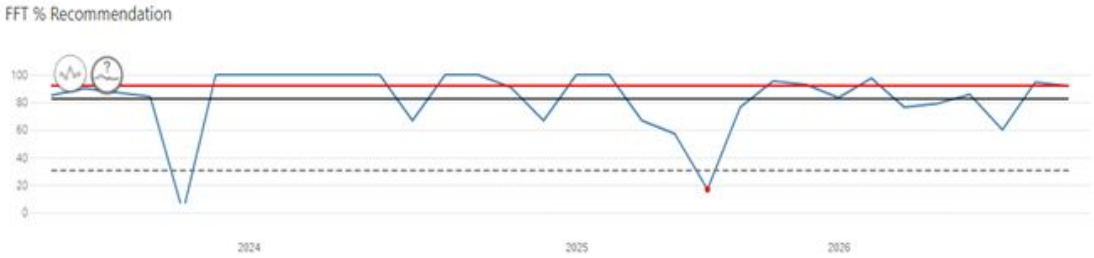
Quality

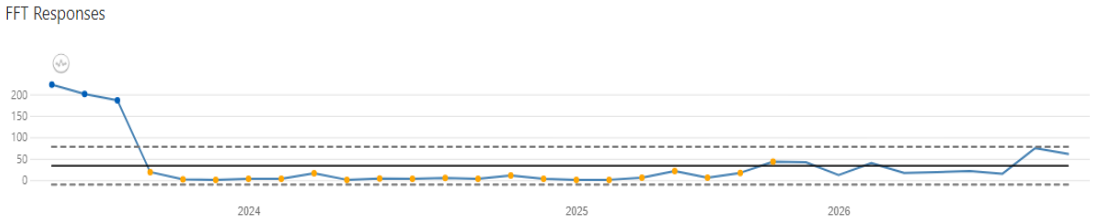
# Caring – Friends & Family Test – Maternity

### Maternity Overall




### Antenatal Services




**What is the data showing us?**
Common cause variation for Friends and Family Tests scores, with a score of 93.8% in the month of August

Improvement from the birthing service, achieving a recommendation score of 96.2% from 52 responses, the highest number of responses in 2026.

**Actions being taken to improve:**
The Patient Experience and Involvement Team is undertaking a programme of service user engagement to better understand experiences of finding, accessing and using information throughout their pregnancy journey. A key focus of this work is ensuring that improvements are co-designed with our service users, including working with the local Voluntary, Community and Social Enterprise (VCSE) organisations to engage with service users from ethnic minority communities and other less well-heard groups. The findings will inform the co-design of information and communication resources in maternity, ensuring they are accessible, relevant and responsive to the needs of the communities we serve.

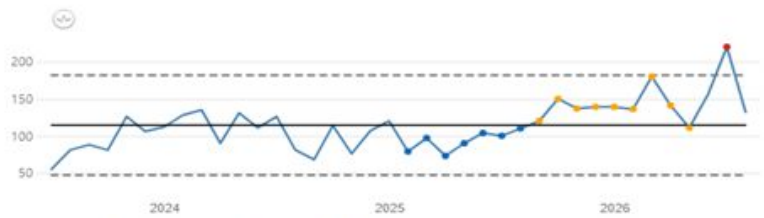
**Positive Feedback:**
Women frequently praised staff for being caring, compassionate and reassuring. Positive comments highlighted emotional support, clear explanations and the professionalism of maternity teams throughout their care.

**Improvement Feedback:**
Areas for improvement included waiting times, communication and patient experience at reception. Some women also highlighted the need for greater consistency in staff interactions and responsiveness to concerns.

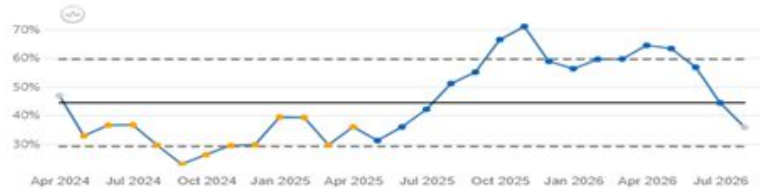
Quality

# Responsive - Complaints

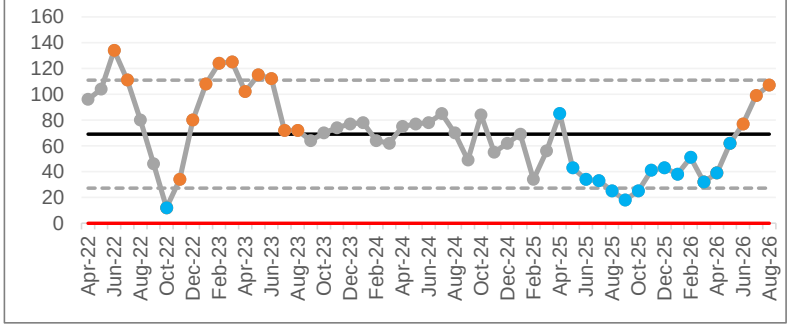
Formal Complaints Opened




Complaints % Closed within due date




**Number of overdue complaints**




147 complaints received in August, this is 51% less than last month and sits at the monthly average over past 6 months. National trend noted across NHS. Annual data will be published in October for benchmarking. Complaints severity ratings at time of for August; 10 Red, 81 Amber, and 56 Green.

**Responding to complaints:**
Considering the increased numbers received last month, 140 were closed in August momentum across care groups is sustained despite August annual leave periods. No special cause variation noted for complaints closed within due date, although this has dropped in previous 3 months, but still within process limits. There are 8 complaints 12 or more weeks overdue, predominantly within Division B. In total, there are 107 complaints one day or more overdue, representing 26% of total open complaints.

**Risk register & mitigations**
Complaints have been added to the local risk register due to declining response times, with mitigations in place to re-recruit to current vacancy to support central team in processing complaints in a timely way. SOP to be drafted and signed off to offer Care Groups local resolution meetings, with consideration to reintroducing informal complaints process.

In July, the main subjects Trustwide are communication (71) – mainly communication with patients followed by communication with relatives, values & behaviours (25) and Patient care (12).*There can be more than one subject logged for each complaint.

**What is the data showing us?**
Special cause for concern variation and consistent target failure shown. The increase in numbers overdue is in part due to central team delays in processing responses whilst the team concentrates on logging and processing new complaints following record numbers in July, and whilst agreeing investigation plans with complainants. However, only 7% of all open complaints are 4 weeks or more overdue , this is reassuring as far as sustaining a grip into Q2.

**Actions being taken to improve:**
Divisional regular care group complaint meetings will continue focus on complaints overdue and due in next 2 weeks to maintain the progress alongside focus from central complaints team and care groups. Risk register details mitigations as outlined above.

**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. For those who remain under our care they will lose Trust which may cause reputational damage.

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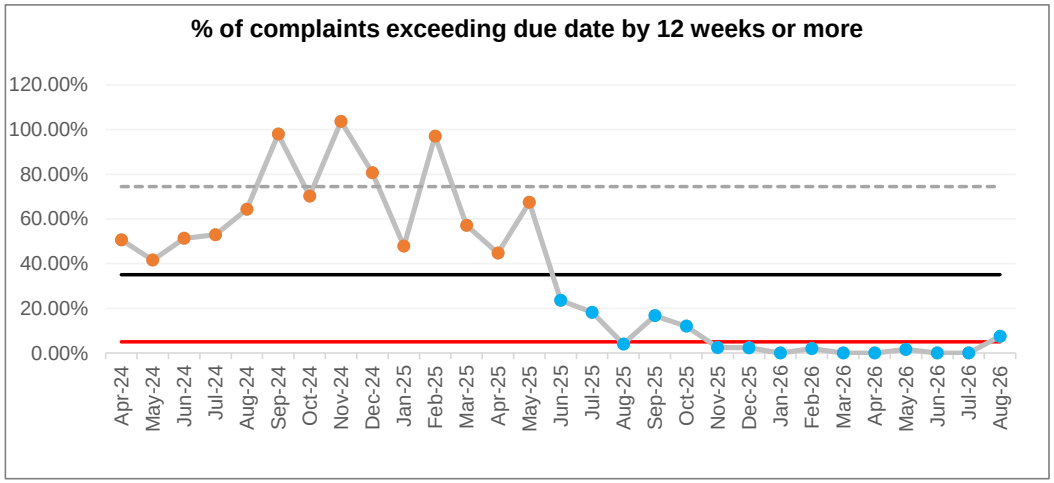
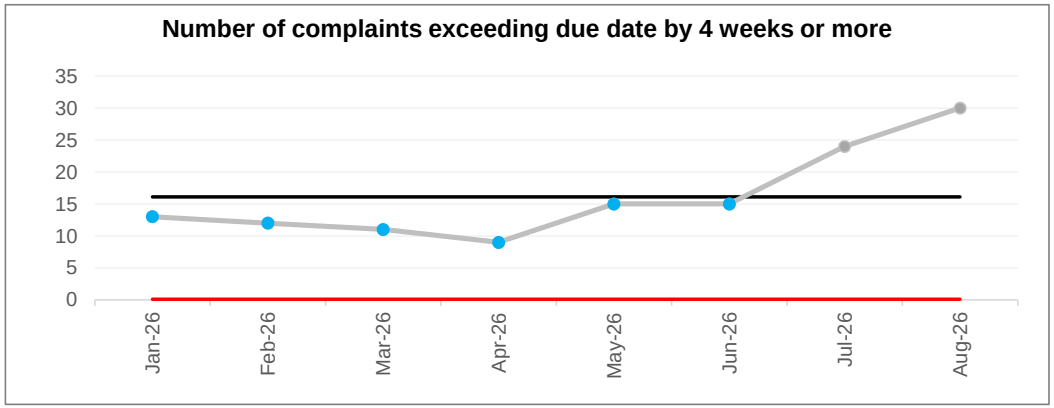
Quality

# Responsive – Complaints




**What is the data showing?**
Performance against the 12-week overdue KPI has improved significantly and has been sustained over the last 12 months. The proportion of complaints exceeding their due date by 12 weeks or more has reduced from consistently high levels throughout 2024-2025 to single-digit performance since late 2025. As of August 2026, only a small number of complaints remain overdue by 12 weeks or more, demonstrating effective management of aged complaints and improved oversight across Divisions.

Conversely, the number of complaints exceeding their due date by 4 weeks or more has increased during Q2, rising from 9 complaints in April 2026 to 30 complaints in August 2026. Suggesting that, although care groups have been successful in reducing the most significantly overdue complaints, pressures relating to complaint volumes, investigation complexity, staff capacity and annual leave have affected the ability to consistently close complaints within shorter timescales.

**Actions being taken to improve**
Care Groups continue to review complaint performance through weekly oversight meetings and divisional tracking processes, with a particular focus on complaints approaching their due date and those exceeding four weeks overdue. Escalation processes are in place for high-risk delays, and targeted support is being provided to teams with increasing backlogs. Additional scrutiny is being applied to complaints due within the next two weeks to maximise opportunities for timely closure and prevent further deterioration in performance.

**What is the impact for our patients?**
Reducing the number of long-overdue complaints supports a more responsive patient experience by ensuring concerns are addressed closer to the point at which they are raised. Timely responses help maintain patient confidence, reduce the need for repeat contact chasing updates, and minimise escalation to external bodies such as the Parliamentary and Health Service Ombudsman. However, the recent increase in complaints highlights the importance of continued focus on complaint resolution, to ensure patients receive prompt, meaningful responses and remain engaged in the local resolution process.

Quality

# Well-led – Safer Staffing

King's College Hospital NHS Foundation Trust

**Safer Staffing Summary:**

Within our nursing ward areas, a range of mitigations have been implemented to maintain safe staffing levels. These include:

- Support from senior divisional team members, such as Matrons, Ward Leaders, and PDNs
- Redeployment of staff from other areas, including CNS roles
- Ongoing monitoring of ward capacity by Operational Matrons and the Flow Team, in conjunction with site staffing huddles
- Within Maternity To maintain patient safety we have x2 safety huddles every day including weekends and bank holidays. At these the acuity is discussed and staff levels in relation to this.

Mitigations include redeploying midwives, booking nurses for surgical cases, and calling in community staff. Twice-daily cross-site huddles review acuity and may divert care to the PRUH site. The OPEL London escalation policy is enacted when required, following MDT and senior midwifery input. A non-rostered ward manager provides daily support, maintaining safe staffing through defined antenatal and postnatal ratios with additional input from specialist and education midwives.

**Care Hours Per Patient Day**

Total staff time spent on direct patient care, including activities such as preparing medicines, updating patient records and sharing care information with other staff/departments. Includes permanent and temporary staff but excludes students.

| | Registered CHPPD | Unregistered CHPPD | Total CHPPD |
|---|---|---|---|
| Division A | 10.4 | 2.5 | 12.9 |
| Division B | 5 | 3.6 | 8.6 |
| Division C | 8.5 | 2.9 | 11.4 |
| Trust | 7.1 | 3.2 | 10.3 |

**Red Flags**

Indicators of inadequate staffing levels that could negatively impact patient care

| | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 | Jun-26 | Jul-26 | Aug-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Division A | 27 | 42 | 24 | 30 | 12 | 57 | 38 | 39 | 31 | 27 | 24 |
| Division B | 104 | 103 | 110 | 126 | 173 | 162 | 115 | 124 | 159 | 176 | 118 |
| Division C | 48 | 57 | 58 | 91 | 51 | 53 | 38 | 69 | 65 | 102 | 66 |
| Trust | 1790 | 202 | 192 | 247 | 236 | 272 | 191 | 232 | 255 | 305 | 208 |

Quality

## Well-led – Safer Staffing

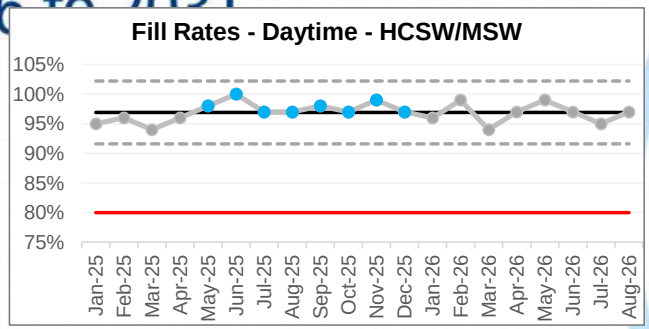
King's College Hospital NHS Foundation Trust

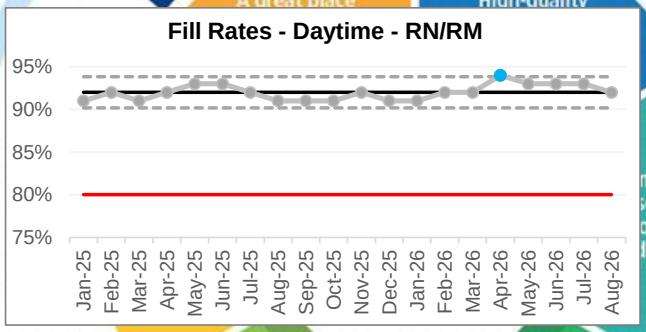
**Fill Rates**

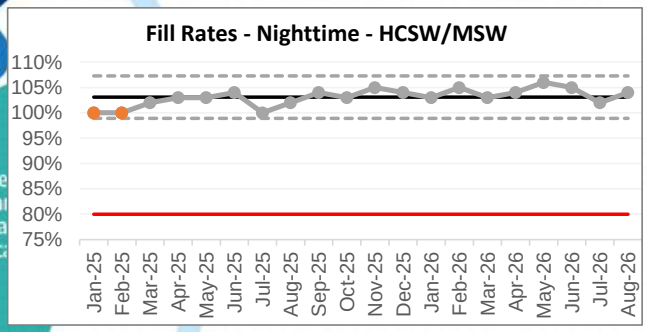
Positive assurance and special cause improvement shown for fill rates for daytime and nighttime for both HCSW and RN/RM.
Low special cause concern noted for fill rates for Daytime Trainee NA, however, this affects a very small number of staff in a few clinical areas only. King's are due to end the Trainee NA programme following the qualification of the latest 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.

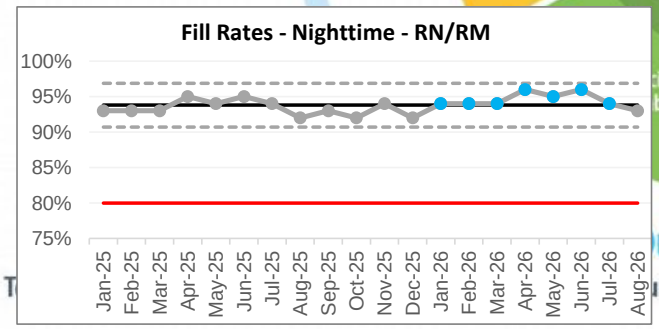
**There were two areas within the organisation that reported a <80% RN/RM aggregate fill rate on either day or night shifts in August:**

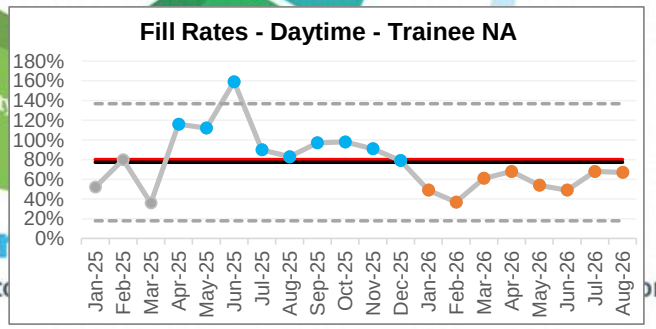
- **Postnatal William Gilliat Ward – RN fill rate 78% Nights**
- **Toni & Guy Ward – RN fill rate 78% Day and 75% Nights**

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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 | 2026-09 | 13326.01 | 13361.13 | No Target | |
| Advert Open to Conditional Offer (AfC) | 2026-09 | 27.7 | 26.2 | Fail | |
| Advert Open to Conditional Offer (Consultants) | 2026-09 | 51.3 | 51.2 | Fail | |
| Agency Cost | 2026-09 | | | | |
| Appraisal % | 2026-09 | 95.04% | 94.47% | Pass | |
| Average days lost to sickness per FTE/employee | 2026-09 | 6.8 | 8.4 | No Target | |
| Bank Cost | 2026-09 | | | | |
| Core Skills % | 2026-09 | 89.03% | 88.57% | Fail | |
| Disciplinary Cases(formal) | 2026-09 | 32 | 27 | No Target | |
| Dismissals | 2026-09 | | 2 | | |
| Early Resolution Cases (formal) | 2026-09 | 19 | 20 | No Target | |
| Establishment FTE | 2026-09 | 14357.12 | 14347.49 | No Target | |
| Flu Vaccination Uptake (%) | | | | | 11/10/26 |
| Gross Salary Bill | 2026-09 | | | | |
| Headcount (Substantive) | 2026-09 | 14352 | 14383 | No Target | |
| Leavers < 12 Mths Service % (voluntary) | 2026-09 | 17.31% | 17.43% | No Target | |
| Leavers Headcount | 2026-09 | 227 | 381 | No Target | |
| Proportion of Apprenticeship levy spent | 2026-09 | 9% | 3% | No Target | |
| Sickness % | 2026-09 | 4.85% | 4.80% | Fail | |
| Sickness Long Term % | 2026-09 | 2.23% | 2.56% | Pass | |
| Staff mix (substantive, honorary and volunteers) | 2026-09 | | | | |
| Starters Headcount | 2026-09 | 217 | 386 | No Target | |
| Turnover Voluntary % | 2026-09 | 7.43% | 7.48% | Pass | |
| Vacancy % | 2026-09 | 6.64% | 6.32% | 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 Trust's sickness absence rate is 4.85%, placing it within the middle quartile when benchmarked against other large London Trusts. This provides a positive foundation from which to build, with the Trust maintaining a stable position against a backdrop of ongoing NHS workforce pressures. The focus remains on sustaining this position while pursuing opportunities to further improve attendance, support staff wellbeing and strengthen workforce productivity.
- A dedicated Sickness Absence Improvement Project Group was established in early September 2026 to lead the development and delivery of a Trust-wide improvement programme. The group has commenced work to identify the key drivers of sickness absence and develop targeted interventions to strengthen management capability, support staff wellbeing and improve attendance outcomes. This provides an important opportunity to embed a more proactive, consistent and supportive approach to attendance management, aligned with the Trust's People and Culture Strategy, workforce productivity and financial recovery objectives.

- Core Skills Training compliance improved from 88.57% in August to 89.03% in September 2026, although performance remains below the Trust's 90% target. This represents a modest improvement following recent fluctuations, but sustained progress is needed to achieve and maintain compliance.
- Medical and Dental staff compliance remains a priority area for improvement, alongside variation across divisions, care groups and individual training requirements. Targeted recovery activity is being progressed with divisional and clinical leaders, supported by strengthened reporting, clearer management accountability and action to address barriers to training completion. Particular focus remains on essential training linked to patient safety, including resuscitation.

- The Trust vacancy rate increased slightly to 6.64% but continues to significantly outperform the 10% Trust target. This reflects continued good progress in workforce stabilisation and vacancy management in line with Trust priorities. Additional controls have now been implemented for the remainder of the financial year in Corporate areas.
- AfC time-to-hire remains within KPI for bands 4-9 and was 0.1 days outside of target for bands 1-3.
- Consultant time-to-hire has increased to 143.9 days against the 100 days KPI. However, It should also be noted that volumes in this group are currently very low (4) with individual cases skewing the metric.

- Voluntary turnover has slightly decreased to 7.43% and remains well below the 13% target. Notably, turnover has consistently remained under target since October 2023, reflecting sustained retention performance.

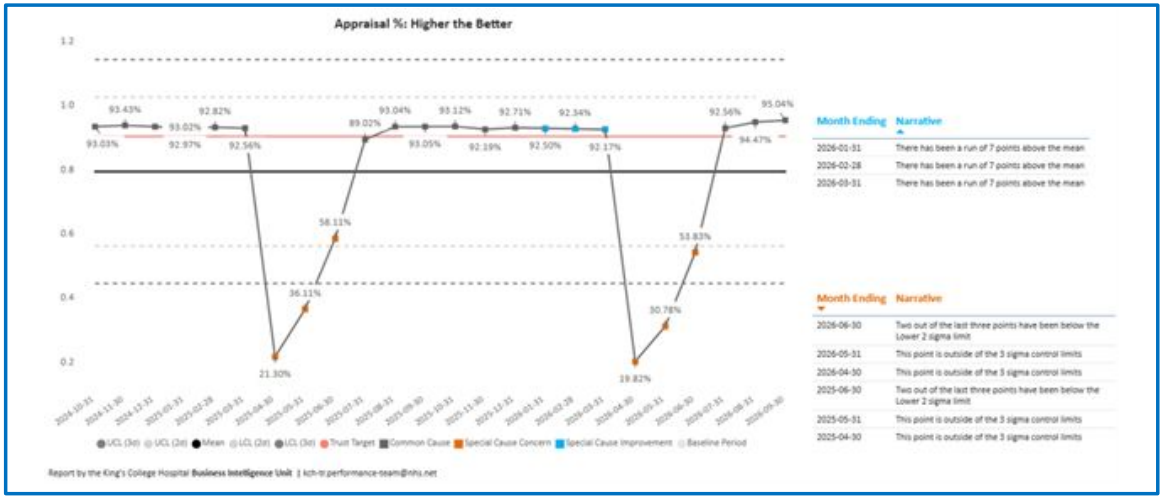
Workforce

# Appraisal Rate

**Background / target description:**

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

| Sep 2026 | Target |
|---|---|
| 95.04% | 90% |




**What is the Data Telling Us**

**Non-Medical:**
Overall appraisal compliance increased from 94.47% in August to 95.04% in September 2026, remaining above the Trust's 90% target.
Non-medical appraisal compliance exceeded the target at the close of the annual appraisal window for the first time in over four years, with all three divisions and Corporate Services achieving at least 90%. This reflects improved organisational focus, local leadership engagement and more consistent monitoring.

**Medical:**
Medical appraisal compliance has increased to **93.41%**, exceeding the Trust target of 90% for the third consecutive month. Engagement with clinical management, 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:**
- Continue regular reporting and targeted follow up with divisions and care groups to maintain compliance and address outstanding appraisals.
- Strengthen data quality and reporting arrangements, including appropriate consideration of staff absence and other circumstances affecting completion.
- Develop a proportionate approach to quality assurance, focusing on the quality of appraisal conversations, development planning and staff experience, alongside completion rates.
- Maintain clinical leadership oversight of medical appraisal compliance and address persistent non-compliance through established processes.

**Medical:**
- Monthly compliance reports are shared with Clinical Directors, People Business Partners, and General Managers.
- The frequency and terms of reference for the medical appraisal & revalidation quality assurance group meetings is currently being reviewed
- 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.
- Appraiser update training compliance & the number of appraisals each appraiser is completing is also being reviewed.

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.

| Sep 2026 | Target |
|---|---|
| 4.85% | 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 0.05% from 4.80% in July 2026 to 4.85% in September 2026, in overall absence performance as the Trust.
- In total, 2,905 staff were reported as absent due to sickness during September, an increase of 398 on the previous month.
- The highest absence reasons based on the number of episodes were due to:
  - Cold, Cough, Flu – Influenza (27%)
  - Gastrointestinal problems (12%)
  - Other musculoskeletal problems (6%)

**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, working closely with managers and Occupational Health to agree actions and support resolution. To help reduce long-term sickness caseloads and improve sustainable return-to-work outcomes.
- In addition, monthly and bespoke training is delivered to further strengthen manager confidence in managing and monitoring sickness absence, with an intended outcome of improved policy compliance and reduced absence.
- A fixed-term post has been established to support sickness absence and workforce wellbeing and will lead and coordinate a Trust-wide programme to improve how sickness absence is understood, reported and managed. Recruitment to the post is currently in progress, with the appointment process underway. The role will strengthen workforce intelligence and translate data and insight into targeted, evidence-based interventions to address the underlying drivers of sickness absence, support staff health and wellbeing, and promote sustainable attendance. This will strengthen the Trust's ability to identify emerging risks, target resources effectively and improve workforce resilience, while supporting organisational workforce, productivity and financial priorities.

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# 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.

| Sep 2026 | Target |
|---|---|
| 89.03% | 90% |

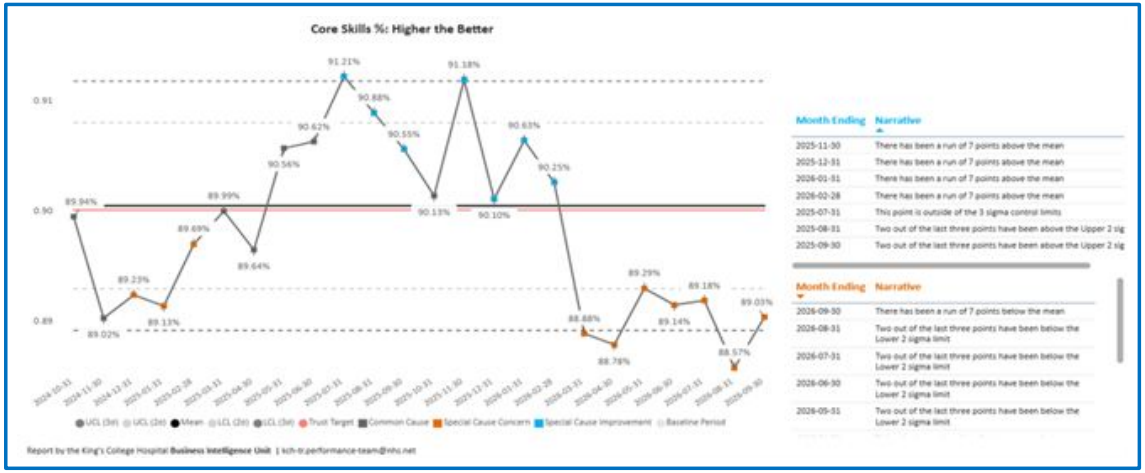
**What is the Data Telling Us**

Trust Core Skills compliance improved to 89.03% in September 2026, an increase of 0.46 percentage points from August (88.57%). Whilst this represents positive movement, performance remains below the Trust's 90% target, and further improvement is required to achieve sustained compliance.

Performance continues to vary across staff groups, divisions and care groups. Medical and Dental compliance remains a particular area of focus, having fallen to 78.0% in August. This continues to present a challenge to overall Trust performance, alongside lower compliance in specific training subjects.

Resuscitation remains a priority area due to its importance to patient safety. The latest detailed subject-level analysis, from August, showed overall resuscitation compliance at 77.20%, with Level 2 Adult Basic Life Support at 77.80%. These areas require continued attention and assurance that appropriate local risk management arrangements are in place.

The September improvement is encouraging, but further work is needed to understand and address the underlying barriers to compliance, including training access, workforce changes, data quality and management oversight. Progress will continue to be monitored through divisional and Trust governance arrangements, with targeted intervention where performance remains below expectations.




**Future Actions**

**Strengthen accountability and oversight**
Continue targeted engagement with divisional, care group and clinical leaders, with clear ownership of local recovery plans and regular review of performance against the 90% target.

**Prioritise areas of greatest risk**
Focus improvement activity on Medical and Dental compliance, lower-performing care groups and essential training subjects, particularly resuscitation. Work with relevant clinical leads to review risks and agree appropriate mitigating actions where compliance remains low.

**Improve data quality and reporting**
Strengthen the accuracy and accessibility of compliance information, including line manager records, learning system reporting and training passporting arrangements, to support effective local management and assurance.

**Address barriers to training completion**
Work with operational and clinical teams to improve access to training, including booking arrangements, protected training opportunities and clearer guidance for staff and managers.

Workforce

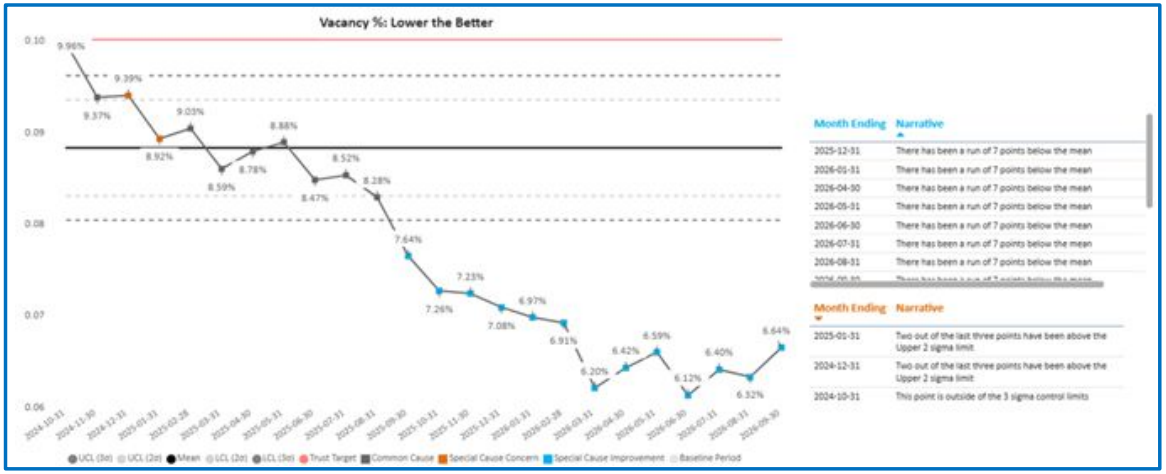
# Vacancy Rate

**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.*

| Sep 2026 | Target |
|---|---|
| 6.64% | 10% |




## What is the Data Telling Us

- The overall vacancy rate has increased slightly to 6.64% this month and remains within the 10% target, reflecting continued improvement in workforce stability.
- AfC time to hire sits above KPI for bands 1-3 & 4-6
  - Band 1–3 at 60.1 days
  - Band 4–6 at 62.8 days (well within 70-day target)
  - Band 7–9 at 75.3 days (well within the 90-day target)
- Medical time-to-hire has increased to 143.9 against the 100 days KPI. However, It should also be noted that this was based on 4 offers being made in this period. With low volumes, individual cases significantly skew the results and are often down to overseas recruits taking longer to complete checks.
- Overall resourcing performance remains stable with strong control on vacancy levels, with all AfC metrics performing well.

## Future Actions

- Following the successful implementation of our new vacancy control process for substantive recruitment, a new app to support the Trust in managing pay-impacting changes outside of recruitment has completed testing . Feedback on the app has been positive and we are moving to a pilot in the Divisions in Q3.
- The Trust's redeployment processes have been updated and strengthened to support staff being displaced as part of the 26/27 CIP programme. Additional support routes have been highlighted in the guidance to ensure staff are fully supported throughout the process. Trac is still being utilised to drive this and will work alongside the revised vacancy control processes.
- The Trust will continue to recruit in line with local and external 'triple lock' processes.
- Implementation of additional vacancy controls for Corporate areas within this financial year.

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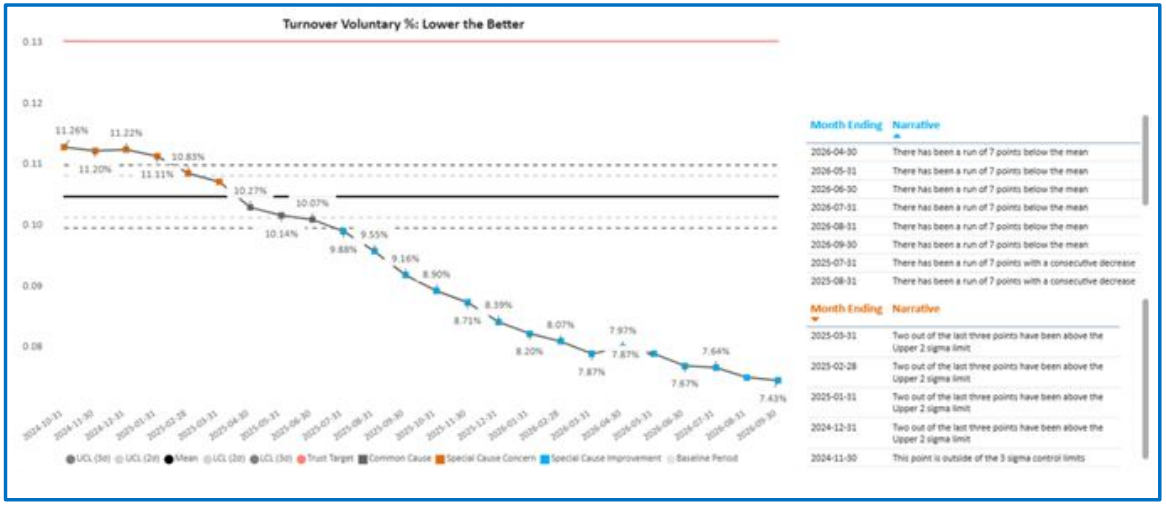
# Turnover Rate

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

| Sep 2026 | Target |
|---|---|
| 7.43% | 13% |




| What is the Data Telling Us |
|---|
| • Voluntary turnover has decreased slightly to 7.43% in September 2026 from 7.48% in August 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.<br>• The three main voluntary reasons for leaving in September were:<br>  • Relocation (11%)<br>  • Promotion (9%)<br>  • Retirement (8%) |

| Future Actions |
|---|
| • Delivery on action plans from the 2025 National Staff Survey has taken place. Action planning sessions are in place to review feedback and agree targeted responses.<br>• 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.<br>• Establishment of the Health & Wellbeing Steering Group to coordinate the implementation of Trust's Health and Wellbeing action plan under WS02.<br>• 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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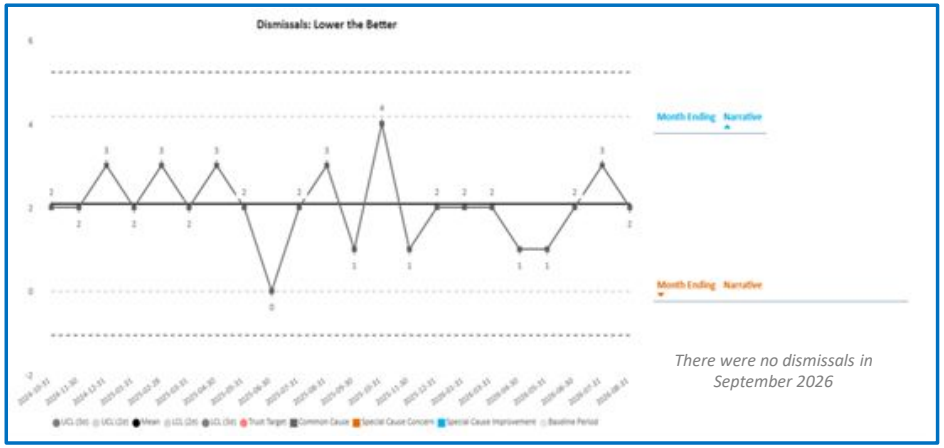
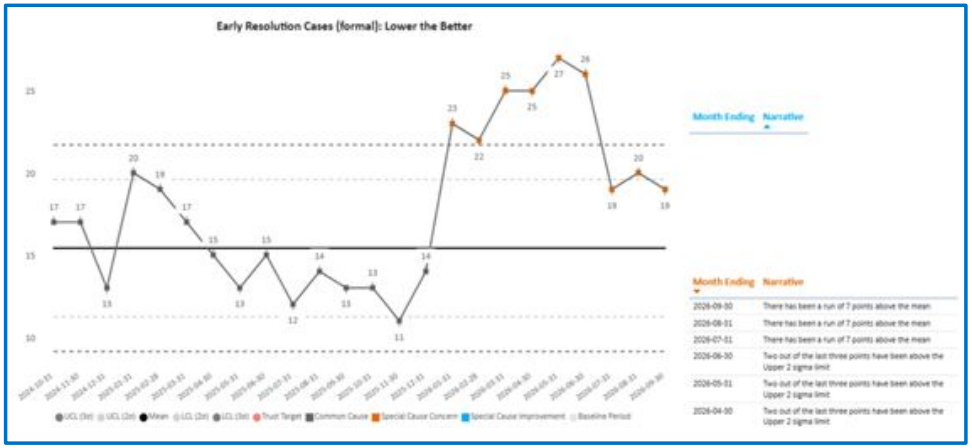
Workforce

# Employee Relations

*These charts have 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.*



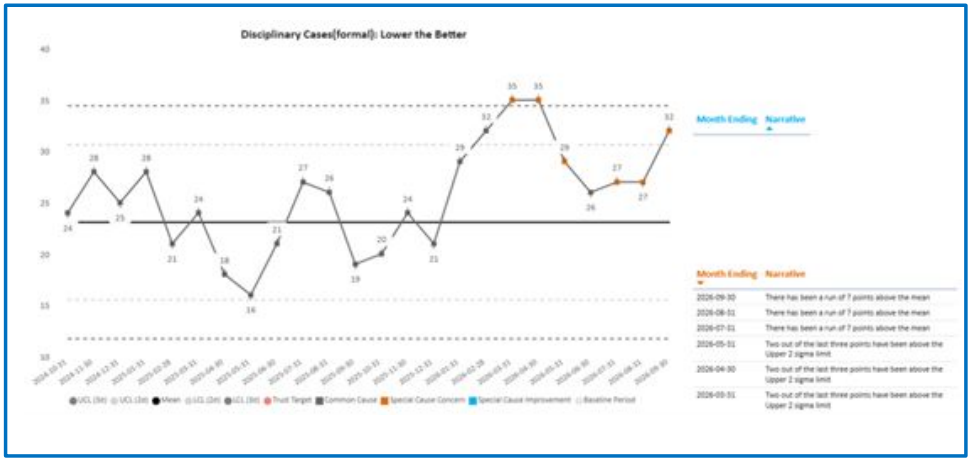

*There were no dismissals in September 2026*




## What is the Data Telling Us

*As of 30 September 2026, there were 32 open formal disciplinary cases, an increase of 5 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, which is the same number as the previous month. Average investigation completion time has exceeded the target of 12 weeks for the first time in 6 months. In September, 4 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.*



Workforce

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

## What is the Data Telling Us

| Sickness Category | Global Majority (BME) | White heritage | Not Stated |
|---|---|---|---|
| Sickness ST % | 2.88% | 2.14% | 3.17% |
| Sickness LT % | 2.17% | 2.28% | 2.65% |
| **Sickness %** | **5.05%** | **4.41%** | **5.82%** |

ST – Short term sickness / LT – Long term sickness

Overall sickness remains higher for Global Majority staff than for White staff, at 5.05% compared with 4.41%, a gap of 0.64 percentage points. The disparity is concentrated in short-term sickness, where the rate for Global Majority staff is 2.88% compared with 2.14% for White staff, a gap of 0.74 percentage points. In contrast, long-term sickness is slightly lower for Global Majority staff at 2.17%, compared with 2.28% for White staff. Staff whose ethnicity is not stated continue to have the highest overall sickness rate at 5.82%, indicating a continuing data quality consideration. Pending the outcome of the commissioned Trust-wide sickness absence review, seasonal flu vaccination campaigns are under way to help mitigate flu-related absence, particularly in frontline services where Global Majority staff are more highly represented.

*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 130**

| Stage | Global Majority (BME) | White heritage | Not Stated | Grand Total |
|---|---|---|---|---|
| Applications | **4,567** | 536 | 98 | 5,201 |
| Shortlisted | **439** | 115 | 15 | 569 |
| Appointed | **82** | 34 | 5 | 121 |
| Appointment from Shortlisting % | **18.7%** | 29.6% | 33.3% | 21.3% |
| **Relative likelihood** | | **1.58** | | |

During this reporting period, 18.7% of shortlisted Global Majority applicants were appointed, compared with 29.6% of shortlisted White applicants. This produces a relative likelihood of 1.58, meaning White applicants were approximately 1.58 times as likely to be appointed following shortlisting. The disparity remains materially above parity at 1.0 and is slightly narrower than the August reporting-period measure of 1.62. The September data covers 130 adverts, compared with 82 in August, and therefore represents a broader volume of recruitment activity. However, this movement should not be interpreted as evidence of sustained improvement without considering the longer-term trend and differences in recruitment activity between reporting periods.
The Q4 recruitment improvement work will focus on understanding where differential outcomes arise across the recruitment pathway, strengthening structured and consistent selection practice, and monitoring outcomes by division, profession and seniority.

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

| Metric | Global Majority (BME) | White heritage | Not Stated | Trust |
|---|---|---|---|---|
| Staff entering the formal disciplinary process (YTD) | **65** | 23 | 6 | 94 |
| Staff in post (month end) | **8,464** | 5,295 | 593 | 14,352 |
| Formal Disciplinaries rate | **0.8%** | 0.4% | 1.0% | 0.7% |

Year to date, 65 Global Majority staff and 23 White staff have entered the formal disciplinary process. The relative likelihood has increased from the August reporting-period measure of 1.76, although the change is small and should be interpreted cautiously. Using the workforce denominator shown, the respective rates are 0.83% and 0.47%, giving a relative likelihood of approximately 1.76. This represents a material disparity and remains above parity. The Trust's published 2024/25 WRES ratio was 2.17. The current YTD measure uses a different reporting period and should therefore not be interpreted as evidence of a sustained improvement without considering the longer term trend. An externally commissioned review continues to examine referral patterns, decision points and potential drivers of disparity. This will inform targeted improvements to Employee Relations practice, including consistent thresholds for formal action, quality assurance of decision making and greater use of appropriate early and restorative approaches.

Workforce

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

## What is the Data Telling Us

**Monthly Sickness by Category and Disability**

| Sickness Category | Disabled | Non-Disabled | Not Declared |
|---|---|---|---|
| Sickness ST % | 3.88% | 2.57% | |
| Sickness LT % | 5.21% | 1.97% | |
| **Sickness %** | **9.09%** | **4.50%** | |

ST – Short term sickness / LT – Long term sickness

Disabled staff sickness remains more than twice the rate for non-disabled staff, at 9.09% compared with 4.50%. The largest disparity is in long-term sickness, at 5.21% compared with 1.97%, although short-term sickness is also higher for disabled staff at 3.88% compared with 2.57%. Both the overall rate and disparity have reduced slightly since August, but the difference remains substantial. The findings should be considered alongside wider WDES evidence on reasonable adjustments, presenteeism and formal capability processes. Staff whose disability status is not declared also have a comparatively high sickness rate of 6.92%, reinforcing the need to improve the completeness of ESR disability data.

Improving the completeness of ESR disability data remains important both for supporting individual staff and for strengthening the reliability of organisational analysis. Work is underway to strengthen and relaunch the workplace adjustment policy and guidance in the organisation, a key driver for preventative sickness absence.

*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 | **146** | 5003 | 52 | 5,201 |
| Shortlisted | **35** | 520 | 14 | 569 |
| Appointed | **4** | 111 | 6 | 121 |
| Appointment from Shortlisting % | **11.4%** | 21.3% | 42.9% | 21.3% |
| **Relative likelihood** | | **1.87** | | |

In September, 11.4% of shortlisted disabled applicants were appointed, compared with 21.3% of shortlisted non-disabled applicants, producing a relative likelihood of 1.87. This is a material movement away from the parity reported in August and a declining trend since July (0.82 relative likelihood.) The number of disabled candidates remains relatively small, with 35 shortlisted and four appointed, so the result should be interpreted alongside the monthly trend. Applicants whose disability status was not declared had the highest appointment rate at 42.9%, although this was based on only 14 shortlisted applicants and six appointments and is therefore highly sensitive to small changes. Further analysis will examine recruitment outcomes by seniority and staff group, including Band 8a and above, to test whether barriers remain within particular parts of the recruitment pathway.

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

| Metric | Disabled | Non-Disabled | Not Declared | Trust |
|---|---|---|---|---|
| Staff entering the formal disciplinary process (YTD) | **4** | 83 | 7 | 94 |
| Staff in post (month end) | **576** | 12,705 | 1,071 | 14,352 |
| Formal Disciplinaries rate | **0.7%** | 0.7% | 0.7% | 0.7% |

Year to date, four disabled staff and 83 non-disabled staff have entered the formal disciplinary process. The reported relative likelihood is 1.1, indicating a position close to parity and an improvement from 1.26 in August. However, the small number of disabled staff involved makes the measure highly sensitive to individual cases and it should be interpreted alongside the longer-term trend. The continuing gap between disability recorded on ESR and disability disclosed through the NHS Staff Survey also limits the completeness of the analysis.

The November Workforce Equalities Report integrated WDES, NHS Staff Survey, Employee Relations and recruitment data to strengthen the Trust's assessment of disability equity. The findings will inform cross-cutting equity workstreams and dedicated reasonable-adjustment activity, supporting the forthcoming People and Culture Strategy and WDES objectives.

Finance

# Domain 4: Finance

As of September, the KCH Group (KCH, KFM and KCS) has reported a £18.3m deficit year to date. This represents a £2.1m 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 £67.3m deficit after removal of non-recurrent items, £8.7m adverse to plan.

**Income £3.0m adverse variance:**

- The Trust is reporting a £1.6m adverse variance against NHS patient care income driven by a £3.2m data quality adjustment and £0.8m activity over performance recognised in September.
- Private Patient income is £1.0m adverse to plan, primarily reflecting the timing of CAR-T cell activity. Given the low-volume, high-value and inherently variable nature of this service, the associated CIP remains forecast to be fully delivered by year-end.
- The adverse position is partially offset by £2.5m favourable variance of Overseas Visitors income reflecting increased activity.
- The £1.6m adverse Other Operating Income variance is primarily driven by £1.2m underperformance in Research & Development income, together with a £0.3m shortfall in Total Pancreatectomy with Islet Auto Transplantation (TPIAT) income within Liver, Gastro, Upper GI and Endoscopy services.

**Pay £13.4m adverse variance:**

- The adverse variance is driven by £15.8m undelivered CIP against plan, with pay expenditure remaining higher than planned.
- Nursing pay is a £5.0m adverse variance mainly due to Bank spend driven by sickness cover, escalation and enhancement.
- Medical pay is £4.4m adverse, primarily driven by bank expenditure. £0.8m relates to vacancy cover, with 35 WTE more booked under this category than the substantive vacancy level. A further £2.5m adverse bank variance is mainly driven by sickness and other cover, Waiting List Initiatives, escalation and elective recovery. The net impact of the Resident Doctors' strike is £0.6m adverse, after a £0.3m pay clawback recognised in August.
- The adverse position was partially offset by £11.8m Administrative & Clerical and Other Staff vacancies.
- The Trust's WTE has decreased by 84 since August, primarily driven by a decrease in Nursing Bank utilisation.

**Non-pay £15.6m favourable variance:**

- The favourable variance is mainly due to budgeted inflation expected to crystallise in future months.
- Private Patient expenditure is £1.0m favourable, consistent with the under delivery of Private Patient income due to lower activity, with a further £0.3m favourable variance reflecting lower business rates charges following a successful challenge with the Council.
- The favourable position partially offset pressures of £1.6m overspend in Patient Transport Services and £5.4m under delivery of CIP.

**CIP**

- The Trust has confirmed plans to deliver £23.3m of Cost Improvement Programme (CIP), a planning gap of £61.6m against the £84.9m target. The Trust has delivered year-to-date recurrent savings of £10.6m (£2.8m pay and £7.8m non-pay), resulting in a £21.2m adverse variance. It must rapidly progress the financial improvement actions approved at September 2026 Trust Board,, with failure to do so risking delivery of the 2026/27 financial plan, loss of £44.0m deficit support funding (DSF) in 2026/27, eligibility for DSF in 2027/28 and delivery of the Trust's financial strategy, including return to breakeven by 2029/30.

| | Current Month | | | Year to Date | | |
|---|---|---|---|---|---|---|
| NHSI Category | Budget £ M | Actual £ M | Variance £ M | Budget £ M | Actual £ M | Variance £ M |
| Operating Income From Patient Care Activities | 156.6 | 159.6 | 2.9 | 935.0 | 933.3 | (1.6) |
| Other Operating Income | (1.3) | 11.6 | 12.9 | 58.6 | 57.2 | (1.4) |
| **Operating Income** | **155.3** | **171.2** | **15.9** | **993.6** | **990.5** | **(3.0)** |
| Employee Operating Expenses | (92.8) | (96.0) | (3.2) | (558.3) | (571.8) | (13.4) |
| Operating Expenses Excluding Employee Expenses | (63.1) | (74.7) | (11.6) | (435.6) | (420.0) | 15.6 |
| Non Operating Expenses | (3.1) | (2.4) | 0.7 | (26.0) | (23.4) | 2.6 |
| **Trust Surplus / (Deficit)** | **(3.7)** | **(1.9)** | **1.8** | **(26.3)** | **(24.6)** | **1.7** |
| **Less Control Total Adjustments** | **(0.3)** | **(0.2)** | **0.0** | **5.9** | **6.3** | **0.4** |
| **Adjusted Financial Performance (NHSEI Reporting)** | **(4.0)** | **(2.1)** | **1.9** | **(20.4)** | **(18.3)** | **2.1** |
| Less: Non-recurent Deficit Support Income (National) | (3.7) | (3.7) | 0.0 | (22.2) | (22.2) | 0.0 |
| Less: Non-recurrent Deficit support income (Local) | (2.7) | (2.7) | 0.0 | (16.0) | (16.0) | 0.0 |
| Less: Non-recurrent benefits and industrial action | 0.0 | 1.2 | 1.2 | 0.0 | (10.8) | (10.8) |
| **Adjusted Financial Performance excluding NR Items** | **(10.4)** | **(7.3)** | **3.1** | **(58.6)** | **(67.3)** | **(8.7)** |
| Cash and Cash Equivalent | 62.0 | 100.9 | 38.9 | 62.0 | 100.9 | 38.9 |
| Capital | 3.7 | 6.2 | 2.5 | 19.3 | 12.9 | (6.4) |
| CIP | 7.1 | 2.1 | (5.0) | 31.8 | 10.6 | (21.2) |

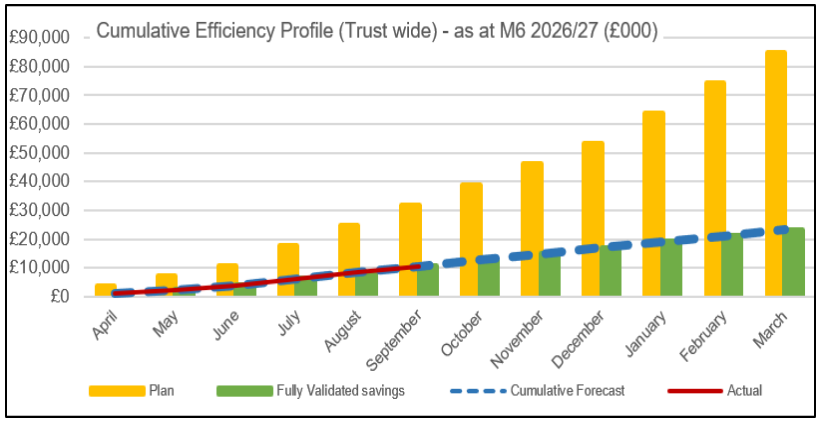



**Figure 1:** Cumulative Efficiency Profile (Trust-wide) as at September 2026

Finance

## Domain 4: Finance - (Continued)

As of September, the KCH Group (KCH, KFM and KCS) has reported a £18.3m deficit year to date. This represents a £2.1m favourable variance to the March 2026 NHSE accepted plan. Excluding non-recurrent support, this results in an underlying deficit of £67.3m, £8.7m adverse to plan.

Employee Operating Expense shows expected variation, driven by temporary staffing costs associated with 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 September WTE position has decreased by 84 WTE, from 14,401 WTE to 14,317 WTE

Temporary staffing utilisation continued to improve during September, with Agency WTE reducing by 3 and Bank WTE by 46 compared to August, primarily driven by reduced enhanced care activity and lower sickness-related cover requirements.

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 £5.3m year to date; largely within Nursing bank staffing (£3.4m). This was exacerbated in April by additional backfill requirements during industrial action. April to September usage was to cover escalation, enhancement and sickness. Agency spend is however £0.3m below the target year to date, the improvement driven by Division A. Both bank and agency spend reduced in September, providing an early but not yet sustained indication of improved divisional grip and control to meet 2026/27 targets (see appendices 3 & 4).

Other Operating Income has returned to expected variation in September following the reset of subsidiary external income budgets.

Operating Expenses Excluding Employee Expenses (non-pay) is within expected variation since September 2024.

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.




**Figure 2:** Key metrics SPC charts April 2024 – September 2026

Finance

# Domain 4: Finance (Continued)

As of September, the KCH Group (KCH, KFM and KCS) has reported a £18.3m deficit year to date. This represents a £2.1m favourable variance to the March 2026 NHSE accepted plan.

**Cash:** Month end cash balances continue to show special cause improvement between August and September and remain within expected levels.

**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 September 2026, Trust confirmed capital sources for 2026/27 core projects stands at £70.4m, a movement of £1.2m as a result of £1.0m provisional Return to Constitutional Standards (RtCS) funding now confirmed by NHS England and £0.2m of charity and national funding, including £0.06m of Frontline Productivity Programme (FPP) funding.

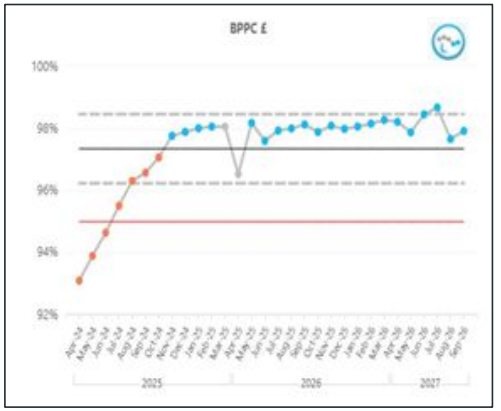
September 2026 year-to-date expenditure is £12.9m, against a year-to-date planned spend of £19.3m, giving a year-to-date variance of £6.4m. All project variances are currently expected to resolve in 2026/27, though concerns remain around the pace of delivery of key programmes including the Sexual Assault Referral Centre (SARC) and Willowfield. Following last month's Board report Finance, Estates and KFM agreed an action plan to tackle risks to capital spend. The year-to-date variance on Estates Safety Funding (ESF) and Backlog Maintenance (BLM) has reduced by £1.2m to £1.6m.

The capital programme is significantly backloaded with 46% of spend (£33.7m) forecast in Q4, with Willowfield, SARC and Denmark Hill NICU particularly backloaded. This increases the risk of unfunded slippage late in the year, resulting in the Trust not getting full value from its capital budget. The action plan developed by Finance, Estates and KFM is making progress, with in-month spend of £3.9m across the identified projects compared with £4.5m year-to-date spend at August 2026. Continued close monitoring of capital programmes is required due to the level of spend required in Q4 to deliver to budget.

**Key Actions**

1. Deliver the interventions approved by the Trust Board on 16 September 2026, as defined in the Trust Board paper and summarised:
   - Progress existing CIP schemes in Gateway 0-2 through movement into Gateway 3 + to increase the approved CIP position. These schemes are expected to improve the position by £19.4m in-year.
   - Take the agreed actions to mitigate the gap through reduced run rate expenditure.
   - Implement additional run rate reduction measures through bank staff reduction.
   - Enable delivery through strengthened improvement leadership, programme delivery capability and organisational focus on delivery.
2. By November 2026, these temporary recovery plans and run rate recovery actions will need to be replaced with recurrent savings to release further recurrent CIP.
3. 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.



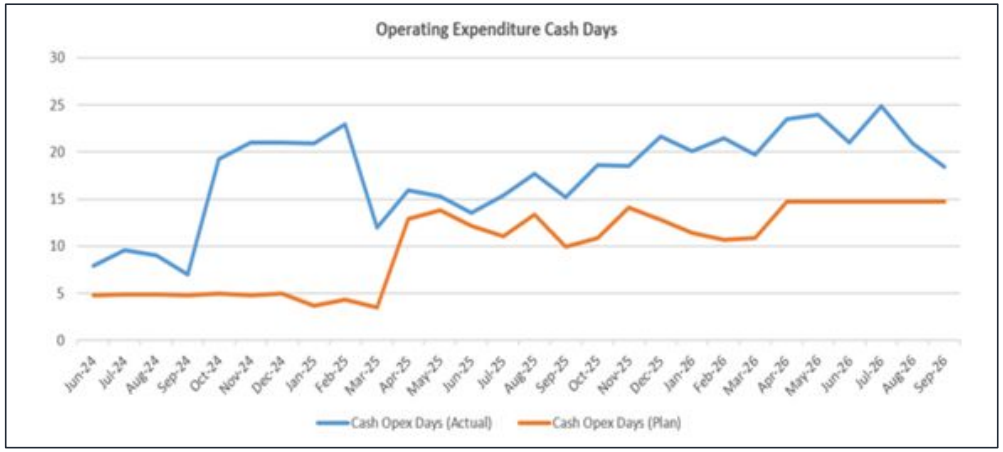




**Figure 3:** Cash and liquidity performance metrics trend to September 2026

Finance

# Domain 4: Finance - 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 September, CIP is £21.2m 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.

Risk H relates to the risk of strategic investments subject to central funding bids not receiving full revenue and capital support.

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. The risk has increased due to the impact of CIP under achievement on the Trust's overall financial performance.

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 £0.6m 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 latest published data (Q1 2026/27). Finance has a combined metric score of 2, which reflects a planned deficit greater than 2% of expenditure, mitigated by a positive variance against plan at Q1. The productivity metric used by NHSE has changed from Implied Productivity in 2025/26 to Relative difference in costs (reference costs) in 2026/27. KCH's performance of 100.7% against the national average of 100% gives a ranking of 72 out of 134 providers.

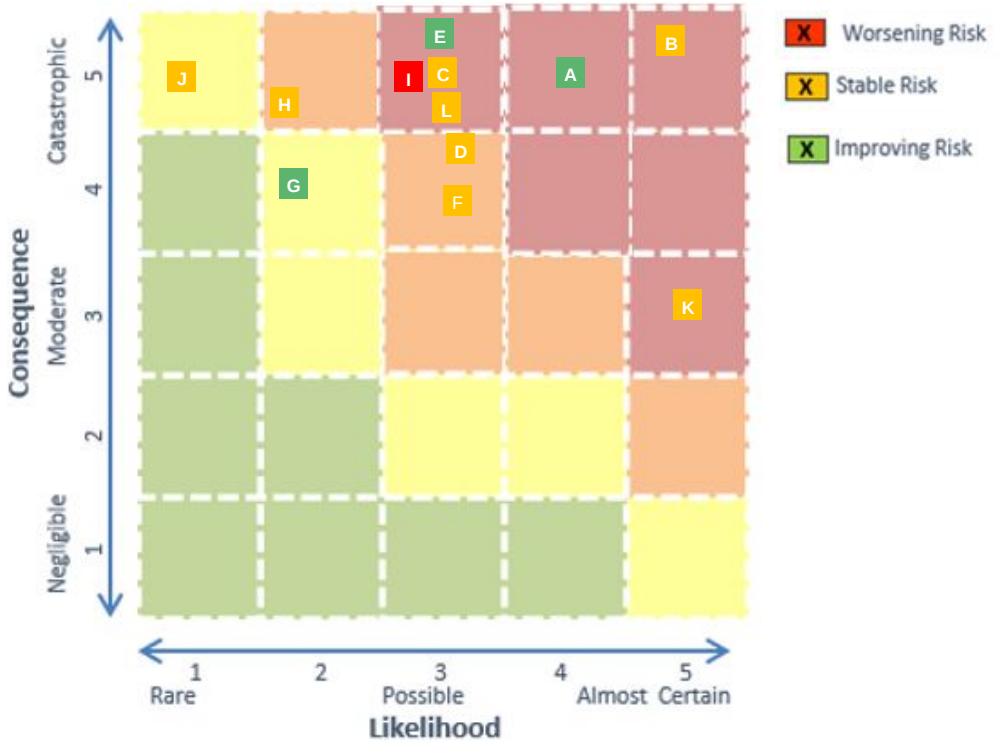



**Figure 4:** Strategic and Operational financial risk assessment September 2026

| Metric Sub-Domain | Description | Reporting date | Metric value | Units | Metric score | Rank |
|---|---|---|---|---|---|---|
| Finance | Planned surplus/deficit | Q1 2026/27 | -2.29 | % | 4.00 | 93 out of 134 |
| Finance | Variance year-to-date to financial plan | Q1 2026/27 | 1.48% | % | 1.00 | 1 out of 134 |
| Finance | Combined finance | Q1 2026/27 | | | 2.00 | |
| Productivity | Relative difference in costs | 2024/25 | 100.7 | % | 2.15 | 72 out of 134 |

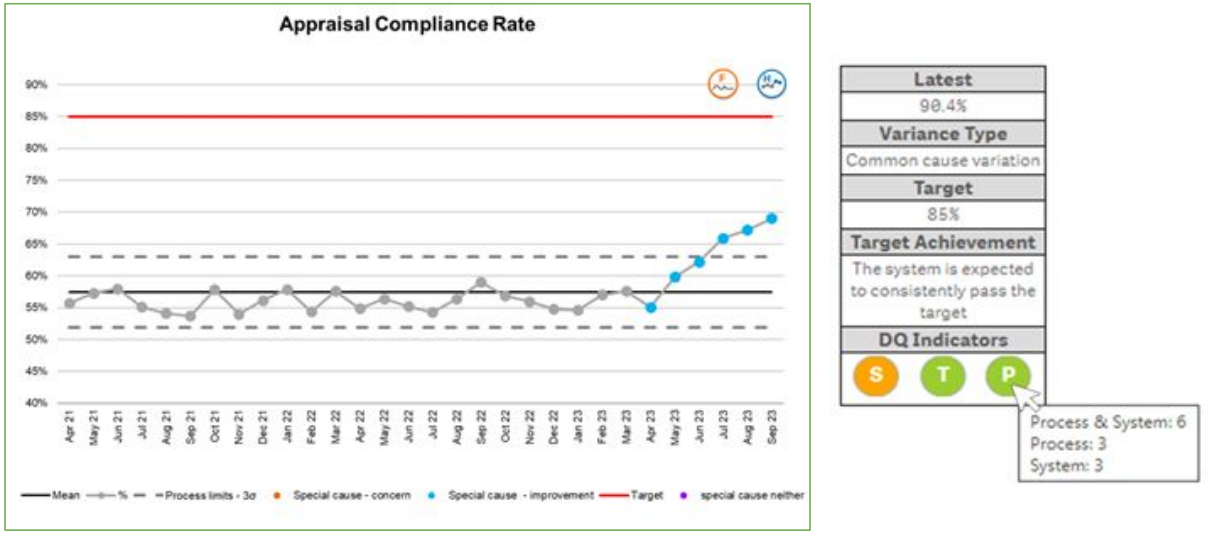
# Interpreting summary icons

| | 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.<br>Is it a one off event that you can explain?<br>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.<br>**Celebrate** the improvement or success.<br>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?<br>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?<br>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?<br>Is data collected in a structured format using an appropriate digital system? |



NHS
King's College Hospital
NHS Foundation Trust

# King's strategy
## 2026 to 2031

## Our vision:
## Transforming healthcare




## Our purpose:
To provide outstanding patient care and experience to our communities and deliver world-leading research, education and training.

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