King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Board of Directors – Public**
Date	**Tuesday 17 November 2026**
Time	**14:00 – 16:30**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill, London SE5 9RS**

No.	Agenda item	Lead	Format	Purpose	Time
STANDING ITEMS					
1.	Welcome and Apologies	Chair	Verbal	Information	**14:00**
2.	Declarations of Interest	Chair	Verbal	Information	
3.	Chair's Actions	Chair	Verbal	Approval	
4.	Minutes of the Meeting held on 16 September 2026	Chair	Enclosure	Approval	
5.	Action tracker	Chair	Enclosure	Discussion	
6.	Patient Story	Chief Nurse and Executive Director of Midwifery	Presentation	Information/ Discussion	**14:05**
7.	Report from the Chief Executive Officer	Chief Executive Officer	Enclosure	Discussion /Assurance	**14:20**
8.	Board Assurance Framework	Director of Corporate Affairs	Enclosure	Assurance	**14:25**
9.	Risk Register Report	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**14:30**
10.	Integrated Performance Report - Quality - Operational Performance - Finance - Workforce	Chief Executive Officer	Enclosure	Discussion/ Assurance	**14:35**
11.	Highlight Reports from Committee Chairs 11.1. Finance & Commercial Committee x2 11.2. Performance, Transformation and Improvement Committee x2 11.3 Quality and Research Committee x2 11.4 People, Inclusion and Education Committee x2 11.5 Academic Committee in Common	Committee Chairs	Enclosure	Assurance	**15:00**
12.	Report from the Chair of the Board	Chair	Verbal	Information	**15:15**

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COUNCIL OF GOVERNORS					
13	Council of Governors' Update	Lead Governor	Enclosure	Information	**15:20**
STRATEGY, PLANNING AND DELIVERY					
14.	King's Strategy 2026-31 Q1&2 Delivery Report *More information in Reading Room (Board Reporting of Strategy Delivery)*	Director of Strategy	Enclosure	Assurance	**15.35**
15.	Acute Services Review	Chief Executive Officer	Enclosure	Assurance	**15:45**
16.	Freedom to Speak Up Guardian Annual Report 25-26	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**15.55**
GOVERNANCE AND ASSURANCE					
17.	Thirlwall Inquiry Report Response	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**16:05**
18.	Maternity & Neonatal Quality & Safety Integrated Report *More information in Reading Room*	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**16.15**
ANY OTHER BUSINESS					
19.	Board Assurance following CQC's Inspection Findings	Chair	Verbal	Assurance	**16:25**
FOR INFORMATION					
20.	Annual Report for Infection, Prevention & Control 25-26	Chief Nurse and Executive Director of Midwifery	Enclosure	Information	*
21.	Vulnerabilities Annual Report 25-26	Chief Nurse and Executive Director of Midwifery	Enclosure	Information	*
DATE OF THE NEXT MEETING					
	Date of the next meeting: The next meeting will be held on Thursday 14 January 2027 at 1400 – 1630.				

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

King's College Hospital NHS Foundation Trust

Board of Directors - Public

DRAFT Minutes of the meeting held on 16 September 2026 at 14:00 – 16:30
Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill, London SE5 9RS

Members:		
Non-Executive Directors:		
	Dame Christine Beasley	Non-Executive Director
	Sir David Behan	Non-Executive Director (Chair of the Board)
	Nicholas Campbell-Watts	Non-Executive Director
	Dr Jane Fryer	Non-Executive Director
	Akhter Mateen	Non-Executive Director
	Gerry Murphy	Non-Executive Director
	Dr Angela Spatharou	Non-Executive Director (via MS Teams)
Executive Directors:		
	Prof. Tracey Carter MBE	Chief Nurse & Executive Director of Midwifery
	Roy Clarke	Chief Financial Officer
	Angela Helleur	Chief Delivery Officer
	Julie Lowe	Deputy Chief Executive Officer
	Damian McGuinness	Chief People Officer
	Matthew Trainer	Chief Executive Officer
	Dr Mamta Shetty Vaidya	Chief Medical Officer
In attendance:		
	Siobhan Coldwell	Director of Corporate Affairs
	Hannah Dyos	Patient Story (for item 6, Patient Story)
	Kat Hughes	Chief of Staff – CEO Office
	Vanisha Mistry	Corporate Governance Officer
	Luke Palmer	Experience and Engagement Manager (for item 6, Patient Story)
	Chris Rolfe	Director of Corporate Communications
	Todd Ward Staff Members	For item 6, Patient Story
	Governors	
	Members of the public	
	Members of Staff	
Apologies:		
	Prof Graham Lord	Non-Executive Director
	Sheena Mackay	Non-Executive Director
	Prof Anthony Schapira	Non-Executive Director

Item	Subject
26/82	**Welcome and Apologies** The meeting was chaired by Sir David Behan, the Chair of the Board. Apologies were received from Professor Graham Lord, Sheena Mackay and Professor Anthony Schapira. Dr Angela Spatharou was attending the meeting on MS Teams.

26/83	**Declarations of Interest** There were no new declarations of interests to declare.
26/84	**Chair's Actions** The Chair noted that there were no substantive updates since the previous meeting. He formally thanked the Chief Delivery Officer, for whom this was final Board meeting, for her extensive NHS service and significant contribution to King's College Hospital across a range of roles. The Board recorded its appreciation for the CDO's commitment, expertise and contribution to the Trust and wished her well for the future. The CDO thanked the Chair and Board colleagues for their kind words and reflected positively on her time with the Trust. The Chair advised the Board that a petition had been received concerning the use of Palantir products within the NHS. The Board noted that the Trust does not currently have, and has no plans to enter into, a contract with Palantir. The Trust has existing functionality within Epic and access to the London Secure Data Environment to support secure use of data. The Chair acknowledged the concerns raised by petitioners and advised that matters relating to existing NHS England contracts should be directed to NHS England as the organisation responsible for those contracts. The Chair acknowledged the right of staff and members of the public to express their views and participate in democratic activity. He reminded staff that NHS email accounts and electronic systems should not be used for external campaigning or representations.
26/85	**Minutes of the meeting held on 15 July 2026** The minutes of the meeting on 15 July 2026 were approved as a correct record.
26/86	**Action tracker** The Board noted that arrangements for the planned population health development session, scheduled for approximately six weeks' time, were progressing as planned. The Board reviewed progress in relation to the Board Assurance Framework (BAF) actions. Workforce-related risks will be considered by the People, Inclusion and Education Committee at its forthcoming meeting, with a review of the relevant workforce risks underway. Initial work has also commenced on risk appetite and tolerance, including development of a BAF manual to support consistent consideration of these matters across Board committees. Further work is required to clarify appropriate risk tolerances. The Board noted that the outstanding action relating to the maternity and neonatal report remained in progress, including work to identify appropriate case studies for the Communications Team. The Board noted that there were no other outstanding actions requiring escalation. Existing actions remain under active management through the relevant committees and workstreams. **The board noted the actions.**

26/87	**Patient story** The Board welcomed Hannah Dyos, a patient of the Trust's Liver Service, who shared her experience of receiving care at King's, including treatment through the liver and transplant pathway. Hannah highlighted opportunities to improve communication and coordination between departments, particularly for outpatient care. She described an experience where inconsistent information regarding a liver biopsy and pre-operative assessment resulted in duplicated arrangements and unnecessary inconvenience. She also shared her experience of complex wound care, noting the high standard of care received but identifying opportunities to strengthen staff training and knowledge in managing less common clinical needs. The Liver and Transplant teams thanked Hannah for her constructive feedback and reflected on the importance of multidisciplinary working and ongoing staff development in caring for complex patients. The Board noted the value of patient stories in identifying practical improvements and understanding the patient journey beyond individual episodes of care. The Patient Experience Team will use the feedback to support learning around communication, coordination and staff development. The Chair and Board thanked Hannah for sharing her experience and for her contribution to improving patient care.
26/88	**Report from the Chief Executive Officer** The Chief Executive provided the Board with an update on key developments across the Trust. The Board noted confirmation that the enforcement undertakings attached to the Trust's licence since 2017 had been removed, reflecting significant improvements in financial and patient governance. The Board also noted the continuing financial challenge, including a £62.9m shortfall against the recurring savings requirement for the current year. The Board noted that the Denmark Hill site's overall CQC rating of surgical services had improved from Requires Improvement to Good, recognising strengths in learning from incidents, patient support and responding to feedback. Urgent and emergency care and children and young people's services remained rated Requires Improvement, with improvement required in areas including infection prevention and control and day-to-day service management. Relevant teams were progressing actions arising from the inspections. The Board noted continued progress in reducing reliance on paper correspondence, with MyChart, Epic and the NHS App increasingly being used for appointment information and patient communications. Alternative communication methods would remain available to support patients unable to access digital services. The Board noted examples of clinical excellence and recognition across the Trust, including achievements in Parkinson's care and the 60-year history of the Liver Service. The Board also noted the service's contribution to highly complex and innovative transplantation, including a recent procedure understood to be only the tenth of its kind globally. **The Board NOTED the report.** *Dr Angela Spatharou left the meeting.*
26/89	**Board Assurance Framework** The Director of Corporate Affairs presented the latest Board Assurance Framework (BAF) and highlighted the principal risks for Board consideration. Regarding Financial sustainability, the risk remained rated 25. While the Trust was currently on track to deliver its in-year financial plan, the underlying recurring savings gap remained a significant concern.

	Capacity and operational performance, the Trust remained off trajectory against some key performance measures. Improvement plans were in place and continued to be monitored by the Performance Committee, with further evidence required before the risk rating could be reduced. Information security and cyber risk, the Audit and Risk Committee had undertaken a detailed review. The Board noted that appropriate controls were in place, but that the description of the control environment within the BAF should be strengthened. The BAF would be refreshed accordingly. The Board noted progress in strengthening BAF risk discussions, committee assurance and the identification and monitoring of actions, while recognising that further work was required to improve the detail supporting individual risks and the articulation of controls and assurance. Capability, talent and leadership was a new strategic risk that had been proposed and incorporated into the BAF, with actions allocated to the relevant areas and progress to be monitored through the committee structure. **The Board noted the updated BAF and the proposed new strategic risk relating to capability, talent and leadership.**
26/90	**Integrated Performance Report** <u>Operational Performance</u> It was noted that Urgent and Emergency Care: July performance against the four-hour standard was 70.2%, below the 76.2% expectation, with attendances increasing by approximately 3% year-on-year. Twelve-hour performance also deteriorated, with mental health assessment delays contributing at Denmark Hill. The SLAM facility was expected to support improvement. The Trust's flow programme was beginning to deliver benefits. Regarding RTT, the waiting list had increased, partly reflecting improved validation and recording of patients. Recovery plans were in place to address long waits, with the longest waits expected to be eliminated in two specialties and the remaining specialty addressed by year-end. Regarding diagnostics, performance had improved significantly over the previous year, although July saw some deterioration in endoscopy and neurophysiology. Recovery plans aimed to restore compliance by December. The Board supported applying the successful demand, capacity and waiting-list validation approach used in ultrasound and echocardiography to other diagnostic services, including the new PRUH endoscopy capacity. The Board noted the impact of mental health pressures on emergency and acute care and the importance of strengthening arrangements with SLAM. <u>Quality</u> It was reported there was an increase in violence and aggression towards staff. The Board noted continued work through the Choose Kindness campaign and the introduction of the Enhanced Care Team, providing additional support for patients with complex behavioural and mental health needs. The Board also noted the use of a digital tool within Epic to support identification and management of complex needs, alongside a review of restraint practices and proposed development of a joint mental health strategy with SLAM. The importance of using data to identify emerging concerns and supporting staff was emphasised. <u>Finance</u>

	The Board noted a £9m adverse financial position for the month, approximately £18m adverse to plan. Work continued to address the Trust's principal financial risks, deliver the improvement programme and identify productivity and efficiency opportunities. The Board congratulated the Finance team on achieving Level 3 NHS finance accreditation, recognising the significant work undertaken across the Trust. <u>Workforce</u> The Board noted that key workforce metrics remained broadly stable. Appraisal completion had reached 94.6% in August, the highest level for more than four years. Vacancy and turnover rates also remained historically low. The forthcoming staff survey was noted as an opportunity to assess the impact of improved appraisal conversations and staff experience. Further consideration of workforce performance and the Trust's ADI position would take place through the People, Inclusion and Education Committee. The Board noted the launch of the national staff survey and activities supporting National Inclusion Week, emphasising the importance of addressing discrimination and racism and supporting staff networks. The Chair highlighted the Staff Recognition Awards and thanked staff across the Trust for their commitment and contribution. The Board welcomed the updates and noted the importance of continued committee oversight and challenge to ensure that recovery plans delivered sustained improvements across operational performance, safety, finance and workforce. **The Board noted the latest position against the performance and quality metrics contained within the report.**
26/91	**Highlight Reports from Committee Chairs** The Chair introduced the summary reports from the Board's sub-committees and invited each Committee Chair to present the key matters discussed at their respective meetings. **Finance & Commercial Committee** Progress was noted on the Estates Strategy, with the strategy expected to return to the Board in November 2026. The Committee also supported the Trust's approach to climate-related financial disclosures and continued oversight of major investment proposals and the Epic programme. The Board noted that Epic had achieved its principal objectives and was now moving into optimisation. **Performance and Transformation Committee** The Committee continued to oversee the Trust's transformation and performance improvement programmes, with a focus on embedding changes, completing actions and ensuring benefits were sustained. **Audit and Risk Committee** The Board noted significant progress in risk management maturity, with the latest assessment indicating improvement from approximately level 2 to level 4. The Committee also reviewed the Standing Financial Instructions, data security and protection, KFM's external audit, fit and proper person testing and data quality. Significant assurance was received in several areas, with an action plan in place to address remaining data security requirements. The Board emphasised the importance of maintaining a clear link between committee work, the BAF and the Trust's strategic risks, ensuring that committee reports demonstrate how assurance is being provided.

	The Board welcomed the progress reported and recognised the important role of the committee structure in providing detailed scrutiny, assurance and follow-up between Board meetings.
26/92	**Report from the Chair of the Board** There was no report from the Chair of the Board.
26/93	**Trust Supporting Strategies** The Deputy Chief Executive presented an update on the Trust's supporting strategies following approval of the 2026–2031 Trust Strategy in summer 2026. The supporting strategies are intended to remain flexible and be updated as priorities and circumstances evolve. Digital Strategy: The Board approved the strategy, noting the opportunities from the implementation of Epic across south-east London and the need for the strategy to cover technology across clinical and corporate services, not just the electronic patient record. Cyber security will remain under review. Given the pace of technological change, the strategy will be reviewed annually. Estate Strategy: The strategy will return to the Board for approval in November 2026, following further consideration of the Trust's wider organisational strategy and site control plan. Financial Strategy: The Board noted that the existing strategy, approved two years ago, remains relevant and supports improved care and financial sustainability. Green Plan: The updated Plan, including removal of outdated organisational references, remains aligned with the wider system strategy. Innovation Strategy: No further consideration was required, as the strategy had been reviewed by the Board in May. People Strategy: The Board approved the strategy, which brings together the previous workforce and people and culture strategies, subject to minor amendments from ongoing staff engagement. The Board welcomed the use of staff feedback and the proposed 18 month delivery plan. The importance of monitoring workforce data, including ethnicity and race, was highlighted to support the Trust's equality, diversity and inclusion responsibilities. Population Health Management and Healthcare Equity Strategy: The Board approved the strategy. Discussion focused on better understanding the needs of local populations, targeting resources towards groups with high healthcare utilisation, and strengthening patient and community engagement. Further work with primary care, academic partners and a forthcoming population health equity workshop will support development. The Board requested a consistent balanced scorecard/dashboard for all supporting strategies, showing measurable objectives, progress, milestones and direction of travel. Key interdependencies between strategies should also be identified. Research and Development Strategy: The strategy is not yet ready for approval. Further work with academic and system partners will continue through the autumn before it returns to the Board. **The Board approved the Digital Strategy, subject to ongoing review and development.** **The Board approved the People Strategy, subject to any further minor amendments arising from ongoing staff engagement.**

	The Board approved the Population Health Management and Healthcare Equity Strategy. **The Board approved the supporting strategies presented for approval, with the exception of those already approved previously or not yet ready for Board approval, and agreed that the strategies should continue to evolve in response to evidence, staff and stakeholder feedback, and changes in the Trust's operating environment.** **ACTION**: To develop a consistent balanced scorecard/dashboard for reporting progress against the supporting strategies. **JL** **ACTION**: To ensure that key interdependencies between the supporting strategies are identified and reflected in future reporting. **JL**
26/94	**Trust Winter Plan 2026/27** The Chief Delivery Officer presented the Trust's Winter Plan for 1 November to 31 March, developed using learning from the previous winter, engagement with divisions, care groups and system partners, and NHS England requirements. The Board noted continued pressure across urgent and emergency care, including a 9.4% increase in PRUH presentations, alongside risks from influenza, workforce pressures and limited bed capacity. The plan assumes no additional winter funding and must therefore be delivered within existing resources. Key priorities are to maintain elective activity and performance, Improve urgent and emergency care flow, Reduce and eliminate corridor care, Strengthen infection prevention and vaccination, Support staff wellbeing and resilience, and Maintain robust escalation and severe weather arrangements. A strengthened four-level escalation model will operate alongside existing site and business continuity arrangements, with clearer triggers, responsibilities and actions at Denmark Hill and the PRUH. Capacity remains a significant risk, with modelling indicating potential deficits of 39 beds at Denmark Hill and 20 at the PRUH before planned mitigations. Other risks include mental health delays, workforce resilience, seasonal illness and the potential need for unfunded beds. The Board highlighted the critical importance of the patient flow programme, including reducing long stays, improving discharge planning, admission avoidance and closer working with system partners. Discharge to assess will be expanded, particularly at the PRUH. The Board also stressed the need to balance urgent and emergency pressures with maintaining elective activity. Delivery will depend on effective flow, data-driven operational management and early escalation rather than additional short-term solutions. The Trust's vaccination programme aims to increase staff uptake to 60 to 65%, supported by peer vaccinators, clinics, targeted engagement, vaccination buses and patient and care home outreach. Governance arrangements have been strengthened to provide clearer oversight of pressures, escalation, mitigations and delivery, while retaining flexibility as circumstances change. **The Board approved the Winter Plan for submission to NHS England and thanked the teams involved in its development.**
26/95	**Board Capability Assessment** The Director of Corporate Affairs presented the Board Capability Assessment, which forms part of the Trust's assessment under the National Oversight Framework. The assessment uses the

	updated Insightful Board framework, meaning direct comparison with the previous year is not appropriate. The Board discussed two areas in particular: • People, despite positive developments, including the new People Strategy, stable workforce indicators and improved staff survey results, wider evidence highlighted ongoing concerns around staff experience, psychological safety, health and wellbeing. The Board agreed that an amber/red rating appropriately reflected the Trust's current position, while recognising the need to demonstrate measurable improvement. • Operational Performance, the Board acknowledged that appropriate infrastructure, resources and improvement plans were in place, but performance remained off trajectory in several areas. The Board agreed that the proposed rating was consistent with the assessment criteria and evidence, emphasising the importance of avoiding optimism bias. The Board agreed that the assessment should be finalised following the discussion and submitted to the regulator by 2 October 2026. Delegated authority was given to the Director of Corporate Affairs to make any necessary amendments, subject to Chair and Chief Executive approval. **The Board approved the Board Capability Assessment for submission under the National Oversight Framework and agreed that any necessary final amendments could be made under delegated authority, subject to Chair and Chief Executive approval.**
26/96	**Standing Financial Instructions** The Chief Finance Officer presented the Standing Financial Instructions (SFIs) for the Board's annual review and approval. The Board was advised that the proposed amendments were minor and reflected changes to the Trust's management structures. The SFIs had also been strengthened in relation to procurement arrangements. The revised SFIs had been considered and endorsed by the King's Management committee and the Audit and Risk Committee. **The Board approved the revised Standing Financial Instructions.**
26/97	**Maternity & Neonatal Quality & Safety Integrated Report** The Chief Nurse and Executive Director of Midwifery presented an update on quality, safety, performance and improvement across maternity and neonatal services. The Board noted no emerging trends in perinatal deaths requiring escalation. Most cases received positive PMRT assessments, with one case graded C highlighting learning around earlier in-utero transfer and communication with the family. The Trust was making good progress against the Year 8 Maternity Incentive Scheme and NHS 10-Point Plan, with confidence that requirements would be met. Neonatal workforce pressures had also improved, with substantive nursing vacancies filled for the first time in around a decade. Key areas for continued improvement included, communication and experience of women and families, waiting times and appointment availability, maternity triage pathways and strengthening the involvement of women and families in service improvement. The Board emphasised the importance of professional curiosity and early identification of emerging risks, combining data with staff and patient experience, operational intelligence and clinical judgement. Developing dashboards should help identify patterns or clusters, but these would need to be supported by contextual discussion.

	The Board also discussed the importance of organisational culture and speaking up, following a recent national report. It agreed that the report's wider implications for leadership, governance and the environment for staff to raise concerns should be considered in detail at a future meeting. The Board welcomed progress across maternity and neonatal services and emphasised the need for robust assurance, professional curiosity and open dialogue to identify and address concerns early. **The Board received and noted the maternity services report and the assurance provided on the ongoing improvement work.** *Matthew Trainer left the meeting.*
26/98	**Risk Register Report** The Chief Nurse and Executive Director of Midwifery presented an update on the Trust's risk management arrangements and ongoing risk refresh programme. The Audit and Risk Committee had recently reviewed the overall risk position and divisional governance arrangements. The Board noted continued progress with the Trust wide risk refresh and movements on the risk register. In particular, data and cyber security risks had reduced in assessed likelihood following strengthened controls and assurance, although the potential impact remained unchanged. Controls and strategies will continue to be monitored, with the revised risk metrics formally reviewed in Quarter 4. The Board also agreed that the risk report should be considered immediately after the BAF in future, to better reflect the links between financial planning, operational delivery and organisational risk. **The Board received and noted the risk update and the continued progress of the risk refresh programme.** **ACTION**: The timing and sequencing of the risk report within the Board agenda will be reviewed, with consideration given to placing it immediately after the BAF item. **SC**
26/99	**Council of Governors' Update** The Lead Governor updated the Board on proposed changes to NHS foundation trust governance and the potential future of Councils of Governors. The legislative position remains subject to Parliament, with Governors highlighting the importance of retaining a strong patient, public and community voice. The Board recognised Governors' significant voluntary contribution and the need for any transition to be handled respectfully. The Board agreed that any changes should not reduce the Trust's understanding of patient and community views. It supported exploring a citizens' panel or similar mechanism to strengthen direct engagement with patients, service users and community groups, complementing existing engagement and population health work. The Board also agreed to maintain dialogue with Governors while the legislative process continues. A report at the Council of Governors meeting in November will be arranged to discuss future arrangements and community engagement options. The Board supported maintaining a strong and appropriately resourced patient, public and community voice at senior level, regardless of the outcome of the proposed legislative changes.

	ACTION: The Chair and Executive team to attend and support the Council of Governors meeting in November 2026 and progress work on potential future community engagement arrangements, including consideration of a citizens' panel. **SDB/ SC/ Execs** **The Board noted the updated.**
26/100	**Any other Business** <u>Question from member of Public</u> The Board considered a question submitted by a member of the public, Belinda Blanchard, regarding the length of time patients were waiting for operations. The question was: "Please could you explain why operations marked URGENT are taking well over a year (in my case), with the assumption made unofficially by some doctors that we should just go to A&E when in pain? Also, being told that you are pushing patients with cancer to the tops of the queues, is unhelpful. Others without cancer may still be suffering from other life threatening diseases, including the reason for the actual operation. What are you doing about this, if you care about patients so very much?" The response to the question was: "We are aware that surgical waiting times at King's are beyond the national target and longer that we would want them to be. Currently we have patients that are waiting over 65 weeks for some types of surgical procedures. A large amount of work was done last year to reduce our waiting times, but unfortunately for various reasons, in a couple of areas they have increased again. There is now a recovery plan to again improve our waiting times and to reduce the maximum waiting time such that only 1% of patients are waiting over 52 weeks, as per national guidance. Patients are classified according to urgency when on the waiting list, and this is reviewed regularly by the clinical teams. Patients are treated by clinical urgency and then by length of wait. Patients categorised as urgent should not be waiting extended periods of time and if there is concern that this is the case then please contact us directly with details. 18 week performance at the trust has been on an upward trajectory for the last year, and at the end of July almost 67% of patients had their treatment within 18weeks. King's has a plan to increase this percentage further over the next two years." The Board acknowledged that the Trust was not currently meeting the constitutional standards for all waiting-time measures and that some patients continued to experience very long waits, including waits of 65 weeks or more for some surgical procedures. The Board noted that significant work had been undertaken to reduce long waits and that further improvement plans were in place. It was confirmed that the Trust had established processes for assessing and prioritising patients awaiting treatment. These processes considered both clinical priority and the length of time a patient had been waiting, with the aim of ensuring that patients were treated according to their clinical need and in a fair and consistent manner. <u>Mortuary Services</u> The Board received a brief verbal update regarding the recent unannounced inspection of the Trust's mortuary services at both Denmark Hill and the PRUH. The Board was advised that the inspection had identified a number of findings requiring action, including critical findings relating to storage capacity and major findings relating primarily to standard operating procedures and documentation.

	The Trust had received the final inspection report and was working through the findings and required actions with the relevant teams. The Board noted that the findings would be considered in greater detail through the Quality Committee at its meeting later in the month. It was agreed that the relevant risk would also be considered for inclusion on the Trust's risk register as appropriate. **ACTION**: The mortuary inspection findings and associated improvement actions will be reported to the Quality Committee, with the relevant risk position reviewed for inclusion on the Trust risk register. **MSV**
26/101	**For Information** The following report was noted: • NHS People Standards
	Date of the next meeting: Date of the next meeting: 17 November 2026 at 14.00 - 16:30 at the Dulwich Room, Hambleden Wing, Denmark Hill, London SE5 8BQ.

Public Board Action Tracker - 17 November 2026

ACTION ID	Date & Ref	Action	Lead	Date Due	Status	Update
N/A	**ACTIONS - PENDING**					
BoDPB2607		**Board Development Session on Population Health** To arrange a Board development session on population health, aligned with King's Health Partners (KHP), to include input from the KHP Executive Director	SC	16/09/2026	Complete	Complete. Session was delivered as board development in Octobe
BoDPB2609	15/07/2026 26/71	**Board Assurance Framework** That the relevant committees should review the workforce related risks to ensure there was clear distinction between them and that the Board Assurance Framework remained appropriately structured.	SC	16/09/2026	Complete	Complete.
BoDPB2610	15/07/2026 26/71	**Board Assurance Framework** It was suggested that the distinction between target risk and risk tolerance should be reviewed. The Audit Committee and relevant risk-owning committees were asked to consider this further and report back as appropriate.	SC	16/09/2026	Open	to be taken forrward in the next round of committees.
BoDPB2611	15/07/2026 26/77	**Maternity and Neonatal report** The Communications and Engagement team to explore opportunities to better showcase positive patient experiences across maternity and other high-volume services, ensuring communications highlight everyday examples of good care and the experiences of patients and families, alongside major service developments.	CR	Ongoing	Open	The team are working with the Director of Midwifery and her team, and are looking at potential case studies to showcase the work they do both internally and externally.
BoDPB2612	16/09/2026 26/93	**Trust Supporting Strategies** To develop a consistent balanced scorecard/dashboard for reporting progress against the supporting strategies.	LS	17/11/2026	Complete	Complete.
BoDPB2613	16/09/2026 26/93	**Trust Supporting Strategies** To ensure that key interdependencies between the supporting strategies are identified and reflected in future reporting.	LS	17/11/2026	Complete	Complete. Agreed an approach to monitoring delivery of the supporting strategies.
BoDPB2614	16/09/2026 26/98	**Risk Register Report** The timing and sequencing of the risk report within the Board agenda will be reviewed, with consideration given to placing it immediately after the BAF item.	SC	17/11/2026	Complete	Complete.
BoDPB2615	16/09/2026 26/99	**Council of Governors' Update** The Chair and Executive team to attend and support the Council of Governors meeting in November 2026 and progress work on potential future community engagement arrangements, including consideration of a citizens' panel.	SC	17/11/2026	Open	Working group has been established and had its first meeting on 22/10. A plan has been agreed and the aim is to have a proposal for the Board and the Council of Governors in March 2027.
BoDPB2616	16/09/2026 26/100	**Any other Business** The mortuary inspection findings and associated improvement actions will be reported to the Quality Committee, with the relevant risk position reviewed for inclusion on the Trust risk register.	MSV	17/11/2026	Complete	Went to the 20 October Quality and Research Committee meeting. Complete.

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

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 7

BOARD/COMMITTEE REPORT COVER PAPER

Report to:	Board of Directors
Date of meeting:	17 November 2026
Subject:	Report from the Chief Executive
Author(s):	Siobhan Coldwell, Director of Corporate Affairs
Sponsor:	Matthew Trainer, Chief Executive Officer
History:	Standing report to this meeting
Status:	

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

Purpose

This paper outlines the key developments and occurrences since the last Board meeting held on 16th September 2026 that the Chief Executive wishes to discuss with the Board of Directors.

Recommendations:

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

Strategy alignment

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

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Key implications

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

King's College Hospital NHS Foundation Trust

Report from the Chief Executive Officer

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King's College Hospital NHS Foundation Trust

1. Introduction

1.1 This paper outlines the key developments and occurrences since the last Board meeting held on 16th September 2026 that the Chief Executive wishes to discuss with the Board of Directors.

2. Senior Management changes

2.1. Julie Lowe, Deputy Chief Executive at the Trust, left the Trust in early November to take up the role of interim Executive Director of Strategy and Strategic Partnerships at Guy's and St Thomas'. Julie will continue as Executive Sponsor of the Maternity Improvement Management Group at King's, which is due to complete at the end of the year.

2.2. Julie joined King's at the start of the COVID-19 pandemic in 2020, and has held a number of roles at the Trust over the last six years, including as Site Chief Executive for our Denmark Hill site. Going forward, there will no longer be a Deputy Chief Executive role here at the Trust, and later this month, Julie's current responsibilities as Deputy CEO will be divided amongst other members of the executive team.

2.3. On behalf of the Trust Board, I would like to thank Julie for the significant contribution she has made during her time at the Trust, and we wish her all the best for the future.

2.4. Board members will be aware that Angela Helleur, Chief Delivery Officer, retired at the end of October. Recruitment is underway for a permanent replacement. In the interim, I am pleased to welcome Dena Marshall to the Board as Chief Operating Officer. The appointment is for six months. Dena has extensive NHS managerial experience, most recently as Chief Operating Officer at Great Ormond Street Hospital NHS Foundation Trust. She has also held executive director roles at Mid & South Essex NHS Trust, Surrey and Sussex Healthcare NHS Trust, Barts Health NHS Trust, and Manchester University NHS Foundation Trust.

3. Industrial Action

3.1. In my last report, I updated that the British Medical Association (BMA) had confirmed that its consultant members have voted in favour of taking industrial action. This mandate will last for 12 months. Since then we have received notification that the strike planned for late November has been paused whilst talks are ongoing.

4. National Oversight Framework 2026/27 Q1 Trust results

4.1. NHS England published the Q1 data on 10th September. A league table provides a ranking for all Trusts, and segmentation. The full results for the Trust can be found at appendix 1, but in summary the Trust position has not change, the Trust remains in segment 3 and is ranked 81 out of 134 acute Trusts. As the Trust is in receipt of deficit support funding, the Trust cannot be higher than segment 3, regardless of performance against the indicators.

4.2. All metrics are grouped by NOF domain and are rated 1-4 (1 being highest). The Trust is rated as follows:

Access to Services	3
Patient Safety	3
Finance, Productivity and Innovation	4
People	3
Experience of Care	3
Effectiveness of Care and Population Health	1

4.3. It should be noted although the dashboard comparisons to Q4 2025/26, this is of limited value given the change to the indicators being used in the framework.

5. Board Committee Meetings since the last Board of Directors Meeting (16 September 2026)

Governor Strategy Committee	17 September 2026
People, Education and Inclusion Committee	24 September2026
Annual Members Meeting	29 September 2026
Quality and Research Committee	30 September 2026
Finance and Commercial Committee	1 October2026
Academic Committee in Common	6 October 2026
Performance, Transformation and Improvement Committee	8 October 2026
Quality and Research Committee	20 October 2026
People, Education and Inclusion Committee	22 October 2026
Finance and Commercial Committee	5 November 2026
Performance, Transformation and Improvement Committee	5 November 2026

6. Good News Stories and Communications Updates

6.1. **King's recruits world's first patient for rare blood cancer trial** The Trust has recruited the first patient globally for a trial exploring treatments for a rare type of blood cancer. Dr Austin Kulasekararaj, Consultant Haematologist at King's and Chief Investigator of the study, said: "The only approved treatment in the UK for 'lower risk' MDS is supportive treatment with erythropoietin (natural hormone) injections and if this fails, patients start needing blood transfusions. This trial could provide a fantastic opportunity for our patients to benefit from this therapy."

6.2. **"I can't believe I am working in one of the hospitals that saved me"** Dr Kai Newton, A former King's cancer patient is now training as a doctor at the hospital that saved his life. Dr Malcolm Tunnicliff, Consultant in Emergency Medicine and Clinical Director for Trauma at King's, said: "There is no doubt that Kai's experience of cancer is one of his greatest strengths. He has a real understanding of how daunting a hospital stay can be at times, and how to put patients at their ease. Seeing him fulfil his potential as a doctor is wonderful to see."

6.3. **King's College Hospital NHS Foundation Trust achieves highest level of Future-Focused Finance Accreditation** The Trust has achieved Level 3 Future-Focused Finance (FFF) Accreditation, the highest level available under the national accreditation framework, recognising the Trust's commitment to excellence, continuous improvement

and innovation within its finance function. Roy Clarke, Chief Financial Officer at King's, said: "Achieving Level 3 Future-Focused Finance Accreditation is an important milestone for our organisation and a testament to the dedication, professionalism and expertise of our finance teams. This recognition reflects the significant progress we have made together and highlights the vital role finance plays in supporting excellent patient care, effective decision-making and long-term sustainability."

6.4. **Tooting MP visits King's to see embedded youth work** Dr Rosena Allin-Khan MP visited the Emergency Department at our Denmark Hill site to discuss how the Trust's long-standing partnership with Redthread helps young people at risk. Dr Lalarukh Asim, Clinical Director for Emergency Medicine and Major Trauma Consultant at King's, said: "Our partnership provides an important bridge between hospital and community services, supporting vulnerable young people with crucial safeguarding and violence-reduction services, alongside any other specialist provision they may need. It's about providing the right access, at the right time."

6.5. **Liver Twins: how a life-saving transplant made two strangers friends for life** Maya Parmer, 24, and Linda Fraser, 74, have developed a life-long friendship following transplant surgery at King's, where they shared the same donated liver. Sarah Coate, Lead Liver Transplant Coordinator at King's, said: "King's Liver Transplant Unit runs one of the largest transplantation programmes in Europe, and it is wonderful for us to see how the lives of our patients like Linda and Maya have been transformed, giving them the chance to make the most of life again.

6.6. **King's nurse wins global nursing award** Dr Agimol Pradeep BEM, Senior Liver Recipient Transplant Coordinator at King's, has been awarded the Aster Guardians Global Nursing Award 2026, in recognition of her campaigning work to improve awareness of organ and stem-cell donation. Helen Fletcher, Deputy Chief Nurse at King's, added: "Congratulations to Agi on this remarkable achievement. The award is recognition of not only her exceptional clinical skills but also her dedication and passion for raising awareness about organ donation. Agi is an inspiration to nurses all over the world and we are incredibly proud she is a member of Team King's."

6.7. **20 years of supporting liver transplant patients** The Listen support network, an organisation helping liver transplant patients at our Denmark Hill site, has marked its 20th anniversary. Elaine Monument, a current Listen member, said: "Listen gives me invaluable access to a community whose help and guidance are priceless. They understand the journey we are on, and the uncertainty of it all. Knowing you can connect with people who have been through it means so much."

6.8. **Clinical trial offers hope for Parkinson's patients** Researchers at King's are investigating whether a new drug could treat the symptoms of Parkinson's Disease. Dr Mubasher Qamar, Senior Movement Disorder and Neurology Clinical and Research Fellow at King's, said:" We are extremely proud that King's was the highest recruiting site for the ARISE study in the UK, one of a number of trials behind our reaccreditation as a Parkinson's Foundation Centre of Excellence."

6.9. **Improving survival rates for patients with chronic liver failure** William Bernal, a Professor of Liver Critical Care at the Institute of Liver Studies at King's, has contributed to a major study that could save the lives of patients with acute-on-chronic liver failure. Professor Bernal said: "These latest findings will help us to identify the patients most likely to benefit from liver transplant, so that we can most effectively use the limited number of donations available."

6.10. **New approach to urology treatment at King's** The Urology Team at King's has become the first in South London to offer treatment for enlarged prostate through a 15-minute outpatient procedure under local anaesthetic. Mr Sanjith Gnanappiragasam, Consultant Urological Surgeon at King's, said: "Delivering this type of treatment within 15 minutes as part of an outpatient clinic appointment has huge benefits for our patients. It makes treatment quicker, simpler and less disruptive, helping people get home sooner and back to everyday life."

6.11. **King's and Guy's and St Thomas' patient record system saves £4.1 million in three years** has teamed up with Guy's and St Thomas' to avoid 3.3 million duplicate and repeat tests for patients over the past three years, as a results of the two trusts' combined use of the Epic electronic patient record. Carmel Curtis, Chief of Division at King's College Hospital, said: "Our staff response to this campaign, which we have called 'Choose Wisely, Test Smartly', has been fantastic, saving time, money, and discomfort for patients."

6.12. **Celebrating ten years of the King's helipad** The helipad at our Denmark Hill site, which is London's only fully operational helipad that is open 24 hours a day, seven days a week, has celebrated 10 years of live saving landings. Dr Malcolm Tunnicliff, Emergency Medicine Consultant and Clinical Director for Major Trauma at King's, said: "We're both excited and proud to celebrate the 10th anniversary of the opening of our helipad. Thousands of patients have been flown to King's in the last 10 years by our pre-hospital partners, such as Air Ambulance Charity Kent, Surrey, Sussex, and have benefitted from more timely access to care from our dedicated major trauma team. "

6.13. **King's Finance team win trio of HFMA London awards** The Finance Team at King's College Hospital NHS Foundation Trust has taken home three Healthcare Financial Management Association (HFMA) London Awards. Roy Clarke, Chief Financial Officer at King's, said: "We are all extremely incredibly proud of our award-winning Finance Team. This triple award win is a remarkable achievement, and testament to the team's hard work and commitment over the past year."

6.14. **King's midwife urges women to attend breast screening after cancer diagnosis** During Breast Cancer Awareness Month, Miriam McCarthy, Midwifery Matron at King's, is sharing her experience of receiving a breast cancer diagnosis, in the hope that others will take up their invitation when called for screening. Dr Juliet Morel, Consultant Radiologist and Director of Screening at King's, said: "We know for many women there can be lots of reasons why they might be reluctant to come forward for their routine breast screening appointment, or why it's not top of the priority list. We hope that by sharing Miriam's story, we can reassure and remind everyone why screening is so important."

6.15. **Baroness Bertin visits The Haven Camberwell** On Thursday 15 October, The Haven Camberwell team welcomed Baroness Bertin to learn about the important work they do, supporting people who have been raped or sexually assaulted. Martin Slack, Service Manager for The Havens, said: "Having Baroness Bertin come to visit was a fantastic opportunity for us to showcase the work that we do to support survivors of sexual assault and abuse and related harm. Raising awareness of sexual assault referral centres and the safe spaces we provide is also a key part of what we do. It is important to us that people know our service is here for them 24/7."

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 8

Report to:	Board of Directors						
Date of meeting:	17th November 2026						
Subject:	Board Assurance Framework (BAF)						
Author(s):	Siobhan Coldwell, Director of Corporate Affairs						
Sponsor:	Matthew Trainer, Chief Executive Officer						
History:	Standing Agenda Item						
Status:							
Decision/Approval	✓	**Discussion**	✓	**Assurance**	✓	**Information**	✓

Purpose

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

Recommendations:

The Board of Directors is asked to :

- to review the BAF and note changes.

Strategy alignment

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

Key implications

Strategic risk - Link to Board Assurance Framework	all
King's Improvement Impact (KIM):	The King's Improvement Method is one tool being used to deliver service improvements and mitigate risk
Quality Impact	Risks to safe and effective care are outlined in the document as well as the controls and assurance framework in place to address them.

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

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

King's College Hospital NHS Foundation Trust

Ref	Risk Summary	Executive Lead(s)	Assurance Committee	Current risk (LxC)	Change	Target Risk Score*	Update September 2026
1	**Workforce** If the Trust is unable to transform the workforce and develop new ways of working in order to deliver the new Trust operating model, financially sustainable services will not be delivered, adversely impacting patient outcomes and staff engagement and patient experience	Chief People Officer	People, Education and Inclusion	**20 (4 x 5)**	↔	16	**Reviewed at P, E&I October 2026** • The committee reviewed workforce KPIs in detail, including the delivery of the 2026/27 workforce plan. Q1 reductions have been achieved, but limited assurance can be provided that Q2 targets are achievable based on current trajectories. • Committee reviewed the People Strategy which will provide the key delivery vehicle for addressing this risk.
2	**Staff Engagement** If the Trust is unable to transform the culture of the organisation to become more inclusive and positive, staff engagement and well-being may deteriorate, adversely impacting our ability to provide culturally intelligent, compassionate care to our patients and to each other.	Chief People Officer	People, Education and Inclusion	**12 (4 x 4)**	↔	12	**Reviewed at P, E&I October 2026** • The committee considered an update from the FSUG, outlining recent activity. The current model is being reviewed to understand whether it is fit for purpose. • Staff networks presented to the Committee in September and October
3	**Capability, Talent and Leadership:** If the Trust is unable to build and sustain leadership and workforce capability (including a robust talent pipeline for critical clinical, operational and corporate roles), it will be unable to deliver the Trust Strategy and Operating Model at pace, leading to variable quality and safety, reduced productivity and financial performance, and poorer staff experience and retention	Chief People Officer	People, Education and Inclusion	**16 ((4x4)**			**Reviewed at P, E&I October2026** • Committee GMC Survey data and noted staff standards implementation (October) • Approved the people and culture strategy (September)
4	**Financial Sustainability** If the Trust is unable to improve the financial sustainability of the service it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future	Chief Finance Officer	Finance and Commercial	**25 (4 x 5)**	↑	20	**Reviewed at FCC 5th November 2026** • The risk is well integrated into financial reporting and was raised to 25 in July 2026, due to the partially identified CIP programme. Some assurance received as recovery plans are in place, but further high priority actions were requested.
5	**Critical Infrastructure** If the Trust is unable to protect and maintain its critical infrastructure (estate, ICT and medical equipment) our ability to deliver safe and sustainable services will be adversely impacted		Finance, Commercial & Sustainability	**16 (4 x 4)**	↔	15	**Reviewed at FCC 5th November2026** • The committee discussed challenges in delivering the capital programme within the financial year. • A draft estates strategy was discussed and an update was provide on general estates issues. Partial assurance was provided by the annual Premises Assurance Model submission.
6	**Research & Innovation** If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre	Chief Medical Officer	Quality and Research	**12 (3 x 4)**	↔	6	**Reviewed at QRC 30 September 2026** • The committee received an update on the delivery of the research strategy, and an update on actions being undertaken to address the findings of a critical MHRA inspection. • Performance against the 150 day target is improving. • A review of the Trust approach to R&D is underway. • Risk score remains under review. • Academic Committee in Common met on 6th October 2026.

King's College Hospital NHS Foundation Trust

Ref	Risk Summary	Executive Lead(s)	Assurance Committee	Current risk (LxC)	Change	Target Risk Score*	Update September 2026
7	**Safe Effective Care** If the Trust does not have adequate arrangements to support the delivery and oversight of high-quality care, this may result in an adverse impact on patient outcomes and patient experience and lead to an increased risk of avoidable harm	Chief Nurse & Executive Director of Midwifery and Chief Medical Officer	Quality and Research Committee	**12 (4 x 3)**	↔	8	**Reviewed at Quality Committee September 2026** • Risk has been comprehensively updated, although no change to the score. • Quality Assurance Framework has been reviewed and updated. • Focused discussions on safety, experience and outcomes including a review of corridor care, medicines safety, maternity services, patient experience and patient outcomes (including mortality).
8	**System Sustainability** If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely on our ability to achieve system transformation in line with the NHS 10-year plan ambition.	Chief Executive	Board of Directors	**9 (3 x 3)**	↔	9	**Reviewed at the Board of Directors on 15 July 2026** • Risk was considered alongside a detailed update on partnership activity.
9	**Demand and Capacity** If the Trust is unable to transform services, improve productivity and sustain sufficient capacity, patient waiting times may increase potentially resulting in an adverse impact on patient outcomes and an increased risk of avoidable harm.	Chief Operating Officer	Board of Directors	**16 (4 x 4)**	↔	16	**Reviewed at Performance, Transformation and Improvement 5th November 2026** • Performance is off trajectory in a number of areas, linked in part to imbalances in demand and capacity and NHSE London Region has increased the risk rating for cancer, RTT and UEC. Rating for DMO1 is reduced as performance is on track. • There was detailed discussion at the committee about drivers, reviews are underway aimed at providing assurance that the risk can be mitigated. The committee will review at its next meeting, and consider whether the risk score should be raised.
10	**Information Security/Cyber** If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data	Chief Executive	Audit	**16 (4 x 4)**	↔	16	**Reviewed at Audit Committee 9 September 2026** • Board cyber training completed in September. • Addition priority in relation to operating systems patching added, with dedicated resource identified • Recognition of the increased threat posed by AI • New head of ICT Cyber Security appointed.

Risk: If the Trust cannot transform the workforce and improve people cost control, it will be unable to deliver sustainable services, impacting quality and safety, staff engagement and patient experience.

Risk Owner: Chief People Officer **Committee** **People, Education Inclusion and Research Committee** **Last review: Oct 2026**

2026/27 Priorities (People Plan):

- Deliver directorate workforce plans aligned to activity, affordability, productivity and safe staffing, avoiding reactive workforce growth followed by unplanned contraction.
- Develop a flexible, multiskilled workforce through service, role and skill-mix redesign, with staff working at the top of their capability across hospital, community and virtual pathways.
- Reduce reliance on temporary staffing through strengthened workforce planning, recruitment pipelines, retention, internal bank capability and SEL system working.
- Use digital innovation, data, automation and AI-enabled workflows to release time, improve productivity and support new ways of working.
- Strengthen workforce planning, recruitment and education partnerships, including hard-to-fill and fragile-service pipelines, apprenticeships and local recruitment.
- Apply the King's people-centred change approach and KIM so workforce transformation includes staff voice, equality, wellbeing, change-readiness and quality impact assessment.

Relevant significant risks on Corporate and Trust RR:

- CRR 36 Bullying and Harassment
- CRR 567Harm from violence, abuse and challenging behaviour

Risk Scoring:

	consequence	Likelihood	Score
Risk score	5	4	20
Mar 26	5	4	20
July 26	5	4	20
Oct 26	5	4	20
Target (Mar 27)	5	3	15

Appetite rating

Averse: Safe staffing levels

Cautious: Wellbeing / Rightsizing

Open: Culture

Eager: Learning and Development

Future Risks

- Financial recovery/CIP under-delivery resulting in grip and control measures.
- Failure of establishment and vacancy controls leading to workforce growth above plan and reduced affordability
- Temporary staffing spend increases due to inadequate controls (rate cards, caps, authorisation) and/or insufficient bank fill, creating financial and safe staffing risk
- Roster / e-rostering non-compliance (including unplanned uplift, sub-optimal skill mix and weak roster governance) driving overspend and variable quality/safety
- Workforce productivity / CIP benefits not delivered or not recurrent (including slippage in workforce redesign and job planning), leading to in-year and recurrent cost pressure
- Cost control measures implemented without effective engagement and equality impact management, leading to industrial relations risk, morale impacts and reduced retention (with consequent cost and capacity effects)
- Retention, wellbeing and sickness absence pressures (burnout/fatigue) reducing available workforce capacity
- Industrial relations/collective disputes impacting delivery and staff engagement (including pay, job planning and local change)
- Medical workforce sustainability risks (rota gaps, exception reporting and job planning capacity) impacting service delivery, training and staff experience
- Workforce redesign and productivity programmes slowed by operational pressures and limited change capacity
- Workforce compliance and governance gaps (mandatory training, appraisal, safer recruitment, professional revalidation and job planning) reducing assurance and increasing regulatory risk
- Failure to meet safe staffing expectations and regulatory requirements, impacting quality and patient safety
- Inadequate leadership and people-management capability leading to variation in experience, performance and turnover

Future Opportunities:

- Productivity-led workforce redesign can create a more flexible, multiskilled workforce and reduce repeated cycles of growth and contraction.
- Digital, data and AI-enabled workflows can reduce administrative burden, release time for care and improve planning and deployment.
- Improved retention, internal progression, apprenticeships and system partnerships can strengthen supply while reducing premium staffing costs.
- People-centred change and KIM can improve adoption, staff experience, productivity and sustainability of workforce transformation.

Controls:

- Workforce Strategy governance through the Workforce Steering Group, King's Executive and People, Education, Inclusion and Research Committee, supported by annual review and quarterly dashboard reporting.

Assurance of Controls:

Positive

- Workforce plan, establishment and vacancy control reporting through KE/Trust Board and the People, Education, Inclusion and Research Committee
- Safer staffing reports to Trust Board

Rationale for current score

- The score of 20 reflects the immediate risk that short-term grip-and-control measures do not convert into the recurrent, productivity-led workforce change required by the People Strategy. Failure would affect financial sustainability, service delivery and regulatory confidence.

• Directorate workforce plans align service demand, establishment, vacancies, skill mix, affordability, productivity and safe staffing, with variance recovery actions. • Vacancy control, temporary staffing, e-rostering, job planning and paybill controls, alongside Trust Improvement Programme benefits tracking. • Safe staffing and medical workforce assurance, including professional standards, roster governance, quality impact assessment and escalation routes. • Digital, data and process-redesign programmes support automation, workforce productivity, improved planning and new models of care. • Workforce supply actions with SEL, King's Health Partners and education partners strengthen apprenticeships, placements, domestic pipelines and recruitment to hard-to-fill roles. • Culture and OD controls support workforce redesign through staff engagement, trade union partnership, inclusive change leadership, wellbeing support and KIM-aligned improvement. **Gaps in Controls** • Temporary staffing grip not yet consistent (authorisation, rate card compliance, bank fill and exception escalation) • Inconsistent roster/job planning and paybill controls (e-rostering compliance, planned vs actual, payroll/ESR exceptions) • Sustained delivery risk where financial recovery requirements constrain ability to invest in substantive workforce, retention and safe staffing mitigations • Limited leadership change capacity may slow workforce redesign/productivity programmes and benefits realisation • Workforce supply pipeline constraints (placements, specialist training routes and competition) may outstrip current mitigations • Industrial relations risk remains where pace/scale of change and job planning requirements exceed local partnership bandwidth • Leadership and people-management capability improvement is not yet consistent at scale across all divisions/care groups		• Quarterly Guardian of Safe Working report (medical safe working assurance) • Bank and agency performance monitoring (spend and fill) through the Integrated Performance Report and workforce governance • Health and wellbeing governance (including NED Wellbeing Guardian) and sickness absence reporting • Workforce compliance reporting (statutory & mandatory training, appraisal and safer recruitment) through established governance routes • People services and workforce data assurance (recruitment/payroll/ESR performance measures) and Trust Improvement Programme benefits tracking **Negative** • Bank and agency spend/fill performance remains above plan in some areas (Integrated Performance Report) • Sickness absence levels remain a capacity risk (Integrated Performance Report and site performance reviews) • Workforce compliance and job planning/rota governance indicators show variable performance and incomplete assurance in some areas • Staff experience measures (National Staff Survey, pulse survey and medical engagement) indicate continuing improvement needs .		• The People Strategy requires King's to break the cycle of reactive workforce growth followed by unplanned contraction, aligning workforce supply and growth to activity, affordability and productivity. Current CIP, pay, bank and workforce trajectories show that this strategic shift is not yet secured. • Delivery depends on all five workforce objectives: a flexible multiskilled workforce; stronger engagement, wellbeing and retention; digital innovation and new ways of working; capable leadership and talent pipelines; and strengthened workforce planning, recruitment and partnerships. • The strategic mitigations are therefore broader than vacancy control. They include service and skill-mix redesign, safe deployment, stronger directorate workforce plans, reduced temporary staffing reliance, digital and AI-enabled productivity, improved internal pipelines and partnership working across SEL and King's Health Partners. • The Culture and OD Strategy is a critical control because workforce transformation will not succeed without trust, staff voice, psychologically safe teams and effective change leadership. Major reductions and redesign must therefore include early engagement, quality and equality impact assessment, workload and wellbeing review, and visible feedback on decisions. • The CQC Well-Led findings on governance, accountability and information flow increase the risk that rapid cost decisions are not consistently translated into sustainable local delivery. Likelihood remains 4 until divisional accountability, benefits tracking and workforce assurance demonstrate recurrent impact. • The target of 15 by March 2027 assumes the consequence remains severe but likelihood reduces to 3 when directorate workforce plans, staffing controls, recurrent CIP, workforce productivity measures, temporary staffing controls and the workforce dashboard show sustained delivery without deterioration in quality, inclusion or staff experience.

Risk: If the Trust cannot transform the workforce and improve people cost control, it will be unable to deliver the Operating Model and sustainable services, impacting quality and safety, staff engagement and patient experience.
Risk Owner: Chief People Officer **Committee** **People, Education Inclusion and Research Committee** **Last review: Oct 2026**

Action Plan

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

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

Risk Owner: Chief People Officer **Committee People, Education Inclusion and Research Committee** **Last review: Oct 2026**

18-month delivery priorities (Sep 2026–Feb 2028):

- **Creation of a Shadow Executive:** strengthen staff voice, diverse perspectives and constructive challenge in strategic decision-making.
- **Getting the basics right:** address working conditions, rest spaces, equipment, digital frustrations, safety concerns and local barriers to staff doing their jobs well.
- **Behavioural Framework:** co-design and embed Caring, Collaborative, Inclusive and Innovative behaviours across recruitment, induction, appraisal, recognition, leadership and performance.
- **Trust-wide listening and engagement forums:** involve staff earlier, strengthen local listening and publish visible "you said, we did, we are still working on" feedback.
- **Strengthen the FTSU offer:** improve accessibility, confidence, triangulation and organisational learning from concerns.
- **King's EDI offer, including conflict management:** use WRES, WDES, workforce and lived-experience evidence to advance race equity, disability inclusion, fair opportunity and consistent conflict resolution.
- **Leadership and manager offer:** build practical capability in inclusive leadership, wellbeing, appraisal, staff voice, employee relations, performance and change.
- **Wellbeing and hotspot support:** deliver targeted action on workload, stress, sexual safety, violence, aggression, bullying, harassment and psychological safety.
- **Culture and workforce dashboard:** provide a single view of People Promise, WRES, WDES, FTSU, ER, wellbeing, absence, turnover and patient-experience variation for executive and Board assurance.

Relevant significant risks on Corporate and Trust RR:

- CRR 36 Bullying and Harassment
- CRR 567Harm from violence, abuse and challenging behaviour

Risk Scoring:

	Consequence	Likelihood	Score
Risk score	4	4	16
Mar 26	4	4	16
July 26	4	4	16
Oct 26	4	4	16
Target March 27	4	3	12

Appetite rating

Averse: Safe staffing levels

Cautious: Wellbeing / Rightsizing

Open: Culture

Eager: Learning and Development

Future Risks

- Deterioration in staff experience, civility and wellbeing (including bullying/harassment and violence at work), impacting retention and patient experience
- Staff health and safety risks (including stress, musculoskeletal injury and occupational health capacity) leading to increased absence, claims and regulatory scrutiny
- Failure to improve representation and career progression for staff with protected characteristics (including senior leadership diversity)
- Poor WRES/WDES, staff survey and medical engagement outcomes reducing confidence in culture and leadership
- Inconsistent leadership behaviours and people-management capability across divisions, limiting sustainable culture change
- Increased employee relations casework (grievance/disciplinary/whistleblowing) and slower resolution impacting trust, morale and management time
- Inconsistent application of policies, procedures and 'just culture' principles across teams increasing perceived unfairness and undermining confidence in leadership
- Change fatigue and competing operational pressures leading to limited engagement with culture/EDI programmes and reduced pace of improvement

Future Opportunities:

- A single values-led framework can reduce variation in leadership behaviour and strengthen trust, fairness and accountability.
- Focused OD support and high-performing-team development can improve psychological safety, team climate, productivity and change delivery.
- Transparent inclusion, talent and progression pathways can improve belonging, retention and leadership representation.
- Integrated staff voice and culture intelligence can identify hotspots earlier and improve Board assurance and local action.

Controls:

- Culture and OD Strategy governance through the Board, King's Executive, People and Culture governance, divisions and corporate functions, with quarterly delivery reporting.
- Trust-wide Behaviour Framework aligned to values and embedded through core people processes and leadership expectations.
- Inclusion, equity and belonging plan using WRES, WDES, pay-gap, workforce and lived-experience data to target inequity and improve representation and progression.
- Phased leadership and management offer, including inclusive leadership, wellbeing, appraisal, employee relations, team climate and change capability.
- Wellbeing and psychological safety programme using absence, stress, violence, FTSU, ER and EDI insight to identify hotspots and target support.
- King's Engagement Approach, staff networks, trade unions and local listening arrangements support early involvement, sense-making and closure of feedback loops.
- Culture dashboard triangulates quantitative and qualitative insight and supports targeted OD intervention where variation or inequity persists.

Gaps in Controls

- Consistency and pace of culture/DEI delivery varies by division/care group, with competing operational priorities contributing to change fatigue
- Employee relations capacity and timeliness (case investigation and resolution) may not be sufficient to prevent deterioration in trust and morale at times of peak demand
- Leadership behaviours and line-manager capability are not yet consistently embedded across all teams to sustain culture change
- Composite culture measurement and triangulation (survey, ER, FTSU, turnover/absence, patient feedback) not yet fully developed as a single consistent view

Assurance of Controls:

Positive

- DEI quarterly progress reporting (including WRES/WDES and gender pay gap actions)
- People & Culture Plan and Staff Experience Performance Committee reporting
- Freedom to Speak Up reporting to Trust Board and triangulation with employee relations themes and learning actions
- Staff health and safety/occupational health and wellbeing reporting (including absence and hotspots) through routine performance and governance routes
- Workforce policy/procedure refresh programme and manager standards to support consistency and 'just culture' behaviours
- Violence and aggression reduction programme monitoring and reporting (incidents and hotspots)

Negative

- National Staff Survey results (including engagement, civility and respect, and speaking up) show continued improvement needs
- Trust pulse survey results indicate variable experience and risk of change fatigue across care groups
- WRES and WDES outcomes show persistent inequality/experience gaps and representation challenges
- Health and safety indicators (e.g., stress/MSK themes, absence) and local feedback indicate continued staff harm risk and variable policy application in some areas
- Employee relations/FTSU indicators (case volumes, themes and resolution times) and violence at work reporting highlight ongoing culture risk in some areas

Gaps in Assurance

- A single, routinely reported composite culture dashboard is not yet in place (triangulating NSS/pulse, ER/FTSU, violence, turnover/absence and patient feedback), including consistent ER timeliness measures.

Rationale for current score

- The score of 16 reflects that a compassionate, inclusive and high-performing culture is a core delivery condition for the People Strategy, not a separate workforce initiative. Deterioration would affect patient safety, retention, wellbeing, employee relations, productivity and regulatory confidence.
- The Culture and OD Strategy aims to make King's a great place to work and achieve top-quartile NHS People Promise performance by 2031, with staff safer, valued, well led, supported to learn and able to contribute to transformation. Current variation between teams, sites and staff groups means this ambition is not yet consistently experienced.
- The CQC Well-Led assessment reinforces the likelihood of 4 through findings on psychological safety, leadership visibility, speaking up, engagement, inclusion and the gap between stated values and lived experience. This aligns directly with the strategy's central task of reducing local variation and embedding Caring, Collaborative, Inclusive and Innovative behaviours.
- The 2025 Staff Survey provides a positive platform, with improvement across all seven People Promise themes and 98 of 110 questions, but persistent differences in discrimination, bullying and harassment, burnout, progression and confidence in leadership demonstrate that improvement is not yet sufficiently equitable or embedded.
- Grip-and-control actions may heighten change fatigue, workload pressure and mistrust unless delivered through the strategy's people-centred change approach: early staff and trade union involvement, honest communication, visible 'you said, we did, we are still working on' feedback, equality and wellbeing impact assessment, and targeted OD support for hotspots.
- Strategic controls include the Behaviour Framework, leadership and manager development, inclusion and belonging priorities, proactive wellbeing and psychological safety support, staff voice and engagement routines, and a culture dashboard triangulating survey, WRES, WDES, FTSU, ER, absence, turnover and patient experience.
- The target of 12 by March 2027 assumes likelihood reduces to 3 when year-one foundations are operational and there is measurable evidence of improved trust, speaking-up confidence, leadership behaviours, wellbeing, inclusion, retention and reduced variation across teams and staff groups.

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

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Creation of a Shadow Executive: strengthen staff voice, broader perspectives and constructive challenge in strategic decisions.	DOC	Design Dec 2026; operate Jan 2027; review Oct 2027	Earlier staff voice and clearer evidence that feedback influences decisions.	Planned
Governance and delivery plan: establish consistent executive, divisional and care-group ownership, milestones and escalation.	DOC	Phase 1, Sep–Dec 2026; quarterly assurance to Feb 2028	Consistent accountability and reporting for staff experience and culture improvement.	In progress
Getting the basics right: address working conditions, equipment, digital systems, rest spaces, safety and local barriers.	DOC/CNO	Priorities Dec 2026; delivery to Oct 2027; sustain Feb 2028	Everyday barriers are identified and resolved more quickly.	In progress
Behavioural Framework: co-design and embed Caring, Collaborative, Inclusive and Innovative behaviours.	DOC	Co-design May 2027; implement Jun 2027; sustain Feb 2028	Reduced variation in behaviours and staff experience.	Planned
Trust-wide listening and engagement forums: involve staff earlier and close feedback loops visibly.	DOC	Approach Dec 2026; delivery Jan 2027; review Oct 2027	More consistent listening and visible “you said, we did, we are still working on” reporting.	In progress
Strengthen the Freedom to Speak Up offer: improve accessibility, confidence, triangulation and learning.	DOC/Deputy CPO	Redesign May 2027; delivery to Feb 2028	Improved confidence and stronger learning from concerns.	In progress
King’s EDI offer, including conflict management: address inequity, progression, representation and conflict resolution.	DOC	Priorities May 2027; delivery to Feb 2028	Reduced disparities and clearer accountability for fair outcomes.	In progress
Leadership and manager offer: develop practical capability in inclusive leadership, appraisal, wellbeing, employee relations, performance and change.	DOC/Deputy CPO	Offer May 2027; delivery Jun 2027; sustain Feb 2028	Managers have practical tools and staff experience more consistent leadership.	Planned
Wellbeing and hotspot support: target workload, stress, sexual safety, violence, aggression, bullying and harassment.	DOC/CNO	Hotspots Dec 2026; delivery across four phases; review Feb 2028	Earlier support and reduced harm in priority areas.	In progress
Culture and workforce dashboard: triangulate Staff Survey, WRES, WDES, FTSU, employee relations, wellbeing, absence, turnover and patient experience.	DOC	Baseline Dec 2026; embedded May 2027; sustain Feb 2028	Earlier hotspot identification and stronger Board assurance.	Planned

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

Risk Owner: Chief People Officer **Committee People, Education Inclusion and Research Committee** **Last review: Oct 2026**

2026/27 Priorities (People Plan):

- Implement a phased leadership and management offer aligned to the NHS Management and Leadership Framework, King's values and KIM, prioritising team and service leaders.
- Build practical capability in inclusive leadership, appraisal, wellbeing, employee relations, finance, workforce, productivity, digital adoption, improvement and change.
- Establish a Trust-wide talent and succession framework for critical clinical, operational, corporate and specialist roles, linked to workforce planning and future skills.
- Create transparent internal career pathways, positive-action, sponsorship, mentoring, apprenticeships and stretch opportunities to strengthen equitable internal pipelines.
- Develop people-centred change, OD and high-performing-team capability to support major workforce redesign, CQC improvement and services under pressure.
- Introduce a capability and pipeline dashboard covering critical roles, succession readiness, bench strength, diversity, time-to-fill, time-to-competence and leadership churn.

Relevant significant risks on Corporate and Trust RR:

- CRR (to confirm) – Leadership / workforce capability
- CRR (to confirm) – Workforce supply / retention dependencies

Risk Scoring:

	Consequence	Likelihood	Score
Risk score	4	4	16
Oct 26	4	4	
Target (Mar 27)	4	3	12

Appetite rating

Averse: Safe staffing levels

Cautious: Wellbeing / Rightsizing

Open: Culture

Eager: Learning and Development

Future Risks

- Insufficient succession for critical leadership roles (clinical, operational and corporate) leading to instability, slower decision-making and variable performance
- Capability gaps in line management (performance, wellbeing, ER, sickness, rostering/job planning) driving variation in staff experience, productivity and cost control
- Talent pipeline and supply constraints in key professions (clinical specialists, diagnostics, theatres, digital, estates) impacting service delivery and transformation, including where educational development, placements and training routes are insufficient
- Insufficient educational development and CPD (including clinical educator capacity, supervision, protected learning time and access to training) leading to slower time-to-competence, variable practice, reduced retention and greater reliance on short-term staffing solutions
- High turnover in leadership and priority roles leading to increased interim reliance, loss of organisational memory and slower delivery of the strategy
- Inadequate leadership development and support for the divisional model leading to inconsistent governance, improvement and patient experience, particularly where funding constraints limit backfill/protected time and investment in development

Future Opportunities:

- A coherent leadership and management pathway can improve day-to-day staff experience, accountability, productivity and change delivery.
- Transparent talent, succession and internal-first pathways can reduce interim reliance, strengthen retention and improve leadership diversity.
- KIM-aligned change capability and targeted OD support can strengthen adoption and sustainability of workforce and service redesign.
- Education, apprenticeship and system partnerships can expand pipelines for critical and hard-to-fill roles and build future digital and improvement skills.

Controls:

- Leadership and management framework aligned to national expectations, King's values, KIM and the practical requirements of leading clinical, operational and corporate services.
- Core manager, divisional and senior leadership development strengthened through coaching, mentoring, action learning, peer support and experiential learning.
- Talent and succession framework links critical roles, future skills, workforce plans, hard-to-fill roles and service redesign, with transparent moderation and equality oversight.
- Internal-first progression, positive action, sponsorship, secondments, acting-up, apprenticeships and career pathways strengthen retention and future supply.

Assurance of Controls:

Positive

- Leadership programme participation and feedback (senior leadership, divisional and manager offers)
- Talent pilot governance reporting (progress, diversity and pipeline metrics) through PEIRC
- Appraisal and mandatory training compliance reporting through performance governance

Negative

- Vacancy and turnover in key leadership and specialist roles remains a risk in some areas
- Staff survey/medical engagement feedback indicates variation in confidence in local leadership and management

Rationale for current score

- The score of 16 reflects that leadership, management, talent and change capability are essential enablers of all five People Strategy objectives and are already affecting the Trust's ability to deliver workforce transformation, the operating model and CQC improvement actions at pace.
- The consequence is 4 because insufficient capability could impair safe workforce redesign, productivity, digital adoption, service transformation, succession, quality governance, staff experience and financial delivery. The current grip-and-control programme increases the need for leaders who can balance pace, affordability, safe staffing, inclusion and service continuity.
- The CQC Well-Led findings support a likelihood of 4 because compassionate and inclusive leadership, accountability, governance understanding and information flow are not yet consistently experienced.

• OD consultancy, change-readiness assessment and high-performing-team support are prioritised for major change programmes, hotspots and services under pressure. • Appraisal, development planning, core skills and leadership participation are tracked alongside outcome measures through the capability and pipeline dashboard. **Gaps in Controls** • Succession planning and talent identification not yet consistently embedded across all divisions/care groups • Limited consolidated view of critical roles, pipeline health and readiness (including time-to-competence and bench strength) • Variation in line manager capability and access to development, with uneven uptake and protected time for learning, exacerbated where funding constraints limit backfill and programme capacity • Interim reliance and vacancy churn can disrupt continuity and reduce time available for development and improvement		**Gaps in Assurance** • A single, routine capability and pipeline dashboard is not yet in place (succession readiness, bench strength, critical roles, time-to-fill/time-to-competence and leadership churn).		This is consistent with the Culture and OD Strategy's emphasis on reducing variation in day-to-day management practice. • The People Strategy response is to build a phased leadership and management offer aligned to the NHS Management and Leadership Framework, King's values and KIM, with practical capability in inclusive leadership, finance, workforce, productivity, wellbeing, appraisal, change and team effectiveness. • The talent and succession response is to establish transparent pathways, internal-first progression, positive action, mentoring, sponsorship and ready-now/ready-soon succession for critical clinical, operational and corporate roles, linked directly to workforce planning, hard-to-fill roles, future skills and service redesign. • Current gaps remain material: succession planning is inconsistent, consolidated pipeline and bench-strength information is incomplete, manager capability and access to protected development time vary, and interim reliance can disrupt continuity. Programmes are positive controls but are not yet embedded at scale. • The target of 12 by March 2027 assumes likelihood reduces to 3 when the leadership and Behaviour Frameworks, core manager offer, talent and succession model, critical-role dashboard, divisional development, KIM-aligned change capability and equitable access to development are implemented with measurable impact on delivery, staff experience and internal pipelines.

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

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Leadership and manager offer: Launch the leadership development strategy and phased manager offer aligned to the NHS Management and Leadership Framework, King's values and KIM, including inclusive leadership, appraisal, wellbeing, employee relations, workforce, productivity and leading change.	DOC/CPO	Offer agreed by May 2027; active delivery from June 2027; sustained through February 2028	Managers have practical tools, clear expectations and support; staff experience more consistent leadership; improved productivity, team climate and change delivery.	Planned
Behavioural Framework: Co-design and embed Caring, Collaborative, Inclusive and Innovative behaviours through leadership expectations, recruitment, induction, appraisal, talent, recognition and performance management.	DOC	Co-design by May 2027; implementation from June 2027; sustained through February 2028	Clear and consistent leadership behaviours, with fair action when standards fall short and reduced variation in staff experience.	Planned
Change, OD and high-performing teams: Provide targeted OD and change support to leadership teams, major transformation programmes, staff-experience hotspots and services under pressure, aligned to KIM and people-centred change.	DOC/CPO	Approach agreed by December 2026; active delivery from January 2027; scaled through February 2028	Leaders involve staff earlier and lead transition with greater confidence; improved team effectiveness, psychological safety, change readiness and delivery.	Planned
Learning, core skills, talent and AI literacy: Move from appraisal compliance to meaningful objectives, development, performance, talent and support conversations, with clearer learning routes and responsible AI capability.	DOC	Foundations by May 2027; active delivery through February 2028	Improved appraisal quality, easier access to learning, stronger core capability and future skills, and more equitable development participation.	In progress
Talent, careers and succession: Implement transparent internal career pathways, talent processes and ready-now and ready-soon succession for critical clinical, operational, corporate and specialist roles.	CEO/CPO	Framework and pilot by May 2027; scaled through October 2027; sustained through February 2028	Clearer progression and succession options, stronger internal pipelines, improved leadership representation and reduced interim reliance.	In progress
Workforce planning, careers, breakthroughs and AI: Link critical roles, hard-to-fill posts, career development, apprenticeships, future skills and responsible AI adoption directly to directorate workforce plans and service redesign.	CPO/CDO	Active delivery by May 2027; scaled through February 2028	Better alignment between workforce plans, career routes and future capability; stronger supply and reduced service fragility.	In progress
King's EDI offer and equitable leadership pipelines: Use WRES, WDES, workforce and lived-experience insight to strengthen positive action, sponsorship, mentoring, fair progression and leadership representation.	DOC	Priorities agreed by May 2027; delivery through February 2028	Fairer access to development and progression, improved representation and reduced inequality within talent and leadership pipelines.	In progress
Culture and workforce dashboard: Establish capability and pipeline measures covering leadership participation, manager confidence, appraisal quality, succession readiness, bench strength, diversity, time to fill, time to competence and leadership churn.	CPO	Baseline by December 2026; embedded reporting by May 2027; sustained through February 2028	Earlier warning of leadership and capability risks, stronger assurance and better-targeted investment and intervention.	Planned
Employee-centred People service: Simplify digital access to leadership development, learning, career and talent information, supported by improved self-service and workforce intelligence.	CPO	Design by May 2027; active delivery through February 2028	Easier access to development and career support, improved user experience and more effective leadership and workforce intelligence.	Planned

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

2026/27 Priorities:

- Grip and control
- Delivery of the 2026/27 Operational plan
- FGR – improvement on the maturity scale
- Delivery of year 2 of the Financial Strategy (inc. component parts)
- Refresh of Financial Strategy and agreement of Medium-Term Financial Plan

Relevant significant risks on Corporate and Trust RR:

3608 Identification & delivery of efficiency requirements
3609 Expenditure Control
3610 Investment decisions
3611 Validity of activity assumptions
3612 Management of activity in line with contract arrangements
3613 Cost of Additional Capacity
3614 Capital programme
3617 Cost Inflation
3618 Strategic investments
3926 Withdrawal of Deficit Support Funding
3975 Changes to COS 45 VAT regulations
4108 Industrial action
4125 Impact of national review of band 5 nurses

Risk Scoring:

	Impact	Likelihood	Score
Gross Risk	5	5	25
Previous mitigated score (August 2026)	5	5	25
Current mitigated Risk score – (October 2026)	5	5	25
Target (Mar 2027)	5	3	15
Target (Mar 2030)	5	2	10

Risk Appetite:

Control environment	Averse
Cost Improvement Programme	Open

Future Risks

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

Future Opportunities:

- Alignment of efficiency development with the King's Improvement Method (KIM) with four key workstreams to support delivery of the 2026/27 CIP, each with assigned Executive Director and SRO.
- Review and reset of transformation programme to strengthen delivery mechanism, implement a new Target Operating Model and accelerate delivery through the gateway pipeline.
- Evolution of the KIM approach and Step Change Projects to support development of plans for the lifetime of the financial strategy with successful delivery against them
- Move from lower quartile to upper quartile Model Health System performance against peers by 29/30
- Delivery of 'frontier shift' across the life of the financial strategy to provide a further step change in productivity

Controls:

- Annual integrated activity and financial plan
- Capital prioritisation process
- Key financial system controls framework
- Investment Board review and challenge of revenue and capital business cases. Board committee review of business cases >£5m
- Strategic Development Review (SDR) / financial performance review meetings – at Care Group and Divisional level.
- Vacancy/Pay controls process reviewed/updated incl. temporary staffing controls with 'break-glass' approvals from April 2026
- Non-Pay control panel
- Monthly ESR and general ledger reconciliations
- Transformation programmes in place to support improvements in efficiency and productivity
- Budget holder training
- Engagement with APC / ICS partners and finance leads to support SEL system financial planning
- Long term energy contracts in place
- King's Executive Improvement Board governance over efficiency programme
- Scheme of Delegation and Standing Financial Instructions (SFIs) (Control)
- Development of remedial plans where budget overspends identified in-year.
- Fully signed contracts for 2026/27

Assurance of Controls:

Positive

- Monthly Financial performance reporting – TMC, FCC & Board
- 2026/27 CIP delivery oversight embedded and reviewed fortnightly by executive and monthly by Board, with weekly flash reports to Executive leads.
- Financial performance reporting – Improved reporting pack implemented including monthly forecasting, care group analysis, SPR and risk update.
- Long-term financial strategy in place
- Subsidiaries review complete and action plans implemented and embedded as BAU.
- Continuation of SEL triple lock oversight of pay and non-pay expenditure (vacancy control and non-pay over £25k)
- Financial Governance Review Follow Up 2024/25: *'Significant assurance with minor improvement opportunities'.*

Negative

- 2026/27 CIP not fully developed with £33.8m developed at Gateway 3+ as 22 October 2026.
- Division recovery actions on overspends not fully identified.

Gaps in Assurance

- None identified

Rationale for current score

- Trust is in National Oversight Framework Segment 3 and exited the Recovery Support Programme in April 2026.
- Internal Audit Annual Conclusion 2025/26 – Financial reporting and management: *Green: Overall findings on design showed controls are effectively designed and our testing showed controls are operating effectively.*
- External Audit value for money rating amber. No significant weakness in arrangements identified. Improvement recommendation raised to progress the earlier identification of recurrent CIP.
- Trust 2026/27 Financial Plan is to deliver a break-even with an underlying deficit of £87.5m.
- £8.7m deterioration in the year to date underlying position against £58.6m plan in September 2026.
- £51.1m CIP planning gap and full year forecast risk against delivery of identified planned schemes at September 2026.
- The Trust's 'do something' forecast indicates a significant deficit without further rectification beyond the current actions being taken.

Gaps in Controls • Multi-year improvement plan				

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

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Delivery of existing CIP schemes in Gateway 0-2 through movement into Gateway 3+ from September onwards to increase the approved CIP position	CFO	By end October 2026	Full CIP in place, underpinned by operational plans, to deliver against 2026/27 efficiency requirement set out in financial strategy and 2026/27 operational plan. All schemes progressed to Gateway 3.	Ongoing
Divisions to implement updated Phase 1 and Phase 2 Financial Interventions actions to reduce budget overspends in line with agreed trajectories. Areas of focus include delivery of elective activity plans, grip and control of bank and agency spend and continued focus on PTS.	CFO	By end August 2026	Consolidated forecast developed with actions to mitigate identified 2025/26 financial risks to be reported in Month 5.	Ongoing
Annual Financial Governance internal audit.	CFO	By end October 2026	Re audit complete with minimum of 'integrated' maturity assessment (level 4 of 5) across all domains and action plan implementation underway.	Ongoing
Complete Operational and Financial Planning cycles 1-4 for 2027/28.	CFO	By end March 2027	An agreed operational and financial plan signed off at Trust, system and NHSE level. Timetable and framework for 2027/28 to be agreed.	Ongoing
Enabling delivery through strengthened improvement leadership, programme delivery capability and organisational focus on delivery	DCEO	By end October 2026	Transformation and improvement capability more closely aligned to delivery of the strategic requirements of the Trust	Ongoing

Update on activity and mitigations since the last meeting:

- Agreed review and reset of transformation programme developed to strengthen delivery mechanism, implementation of a new Target Operating Model and acceleration of delivery through the gateway pipeline approved by the Board in September.
- Progression of CIP schemes through the Gateway pipeline, reducing the CIP planning gap by £12m.
- Further actions identified to mitigate the gap through reduced run rate expenditure, including bank rates and utilisation and further workforce measures.

Strategy Objective: Critical infrastructure
Risk: If the Trust is unable to protect and maintain its critical infrastructure (estate, ICT and medical equipment) our ability to deliver safe and sustainable services will be adversely impacted.
Risk Owner: Deputy Chief Executive **Committee Finance and Commercial Committee** **Last review: October 2026**

2026/27 Priorities:

- Delivery of the 2026/27 Operational plan
- Delivery of year 2 of the Financial strategy (inc. component parts)
- Delivery of the capital programme and equipment replacement plans.

Relevant significant risks on Corporate and Trust RR:

3614 Capital programme (20)
3617 Cost Inflation(8)
3682 PRUH (PFI) building - Estate issues (20)
213 IPC risks associated with estates (12)

Risk Scoring:

	Impact	Likelihood	Score
Gross risk	5	5	25
Previous mitigated risk (Q4 25/26)	4	4	16
Previous Risk Score (Q1)	4	4	16
Current Risk score (Q2)	4	4	16
Target (Mar 27)	4	3	12

Appetite rating

Risk Appetite:

Compliance	Minimal
Experience	Open

Future Risks

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

Future Opportunities:

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

Controls:

Estates Maintenance

- Estates/IPC ward-level risk assessment and prioritisation
- Fire Risk Assessments
- Water safety management service arrangements
- IPC Committee – risk and governance arrangements
- IPC audits and sampling
- Bi-monthly Health & Safety Committee – review of estates H&S risks
- Estates Compliance Programme
- Water Safety, Ventilation, Medical gases, Electrical, Committees in place meeting regularly.
- Fire Action group in place at PRUH
- HTM control process management

Development

- Capital planning and prioritisation process 26/27. Capital Plan in Place
- Backlog maintenance procedure
- Scheme of Delegation and Standing Financial Instructions (SFIs) (Control)

Gaps in Controls

- Estates governance in review

Assurance of Controls:

Positive

- Annual Premises Assurance Model submission
- Designated Persons and Authorising Engineers in place in line with HTM requirements providing audit reports
- IPC BAF
- Health and Safety and fire training compliance
- Annual 6 facet (Condition) surveys
- LFB fire notice lifted

Negative

- LFB notice of deficiency received for PRUH
- CAPITEC reviews
- PFI Lippit Fire report, Trust Capita Fire reports.
- Internal Audit Review of Estates Backlog maintenance found partial assurance with opportunities for improvement.

Gaps in Assurance

- None identified

Rationale for current score

- Backlog Maintenance limitations due to budget and decant capacity
- Improvement in PFI management, particularly at PRUH
- Scope for improvement of estates governance.

Strategy Objective: Critical Infrastructure
Risk: If the Trust is unable to protect and maintain its critical infrastructure (estate, ICT and medical equipment) our ability to deliver safe and sustainable services will be adversely impacted.
Risk Owner: Deputy Chief Executive **Committee Finance and Commercial Committee** **Last review: October 2026**

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Completion of 2026 Premises Assurance Model	Deputy CEO	September 2026	Provision of assurance that robust systems are in place to ensure premises and associated services are safe, efficient, effective, and of high quality, and identification of any gaps.	Completed
Strategic Estates Review	Deputy CEO	November 2026	Set of recommendations that will deliver clear and robust governance arrangements, eradication of any duplication or inefficient working practices; maximise alignment between the contractual arrangements held across estates and facility functions and enable the production of a long-term Estates Strategy that supports King's strategic ambitions	Ongoing
Work to review PFI performance across the PRUH and DH	Chief Delivery Officer	October 2026	Improved management of the Trust's PFI arrangements on both sites:	Provider in place and work is underway.
Delivery of the 2026/27 Capital Programme	Deputy CEO	March 2027	Backlog maintenance plan delivered and equipment replaced in line with prioritised plans.	The business case has been approved and work is underway – FCC Updated

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

Risk Owner: Chief Medical Officer | **Committee Quality and Research Committee** | **Last review:September 2026**

2026/27 Priorities (Research Roadmap):

- strengthen research and innovation leadership and governance
- Increase the number of studies set up and approved.
- Implement a visible innovation route and co-ordinated innovation system
- Expand education and training opportunities for staff, carers and volunteers
- Strengthen the organisational support needed to enable innovation.

Relevant significant risks on Corporate and Trust RR:

TRR422 Reduction in R&D Funds due to CRN and RCF allocation reductions (20)
TRR3836 Unable to complete mandatory paperwork required by regulators (15)
TRR246 Lack of capacity for research scanning(9)
TRR656 Wearing of safety glasses in the sample processing areas of the CRF (6)

Risk Scoring:

	Consequence	Likelihood	Score
Gross score	5	4	20
Mitigated June 26	3	4	12
Sept 26	3	4	12
Target (Mar 27)	3	4	12

Appetite rating

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

Future Risks

- Access to funding and commercial research opportunities.
- Ability to meet the 150-day target for commercial trials by end March 2027.
- Loss of the ARC
- Triple lock impact on recruitment

Future Opportunities:

- Strengthened relationships through KHP and new KHP strategy
- ARC changes.
- Agreement on single sponsorship with KCL
- Increased collaboration through Academic Committee in Common
- Innovation Strategy
- R&D Strategy

Controls:

- KCH Research & Innovation Strategy and annual plans
- Engagement in King's Health Partners (KHP), Academic Health Science Network
- Action plans to improve the diversity of research participants and increase awareness and engagement in research design and delivery within our local community
- Research & Innovation governance and risk management structure in place, led by Chief Medical Officer
- Quality Recovery Plan in place
- Key policy framework including research misconduct policy
- R&D handbook and mandatory induction for all new research staff.

Gaps in Controls

- Physical capacity to participate in drug trials and trials requiring clinical research facilities at PRUH
- Longer-term research workforce model (linked to funding and investment planning)

Assurance of Controls:

Positive

- Annual strategy progress update reported to Board of Directors – progress aligned to key aims
- Research progress metrics reported to Board – e.g. number of approved commercial studies and trends
- KHP Ventures in place.
- Joint Translational Research function agreed through KHP.
- Academic Committee in Common

Negative

- Critical finding by MHRA in a routine inspection (related to KHP)
- Loss of the ARC.
- Internal Audit and LCFS Review of Academic Research Governance – partial assurance with improvements required
- Critical MHRA triggered inspection (March 2026)

Gaps in Assurance

- R&D governance

Rationale for current score

- Trust is the highest recruiter nationally to NHIR portfolio studies
- Innovation portfolio has moved to the CQI team. QI and Innovation Strategies are being developed.
- Challenging economic landscape for research with reduced commercial studies and reduced NIHR funding.
- Trust unlikely to meet 150 target in 2026/27, although some limited additional funding has been secured and a review of approval processes is underway. 2026/27 performance to date showing some improvement
- Negative assurance received from Internal Audit and MHRA reviews

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

Risk Owner: Chief Medical Officer **Committee Quality and Research Committee** **Last review: date September 2026**

Action Plan

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

Strategy Objective: High Quality Care
Risk: If the Trust does not have adequate arrangements in place to support the delivery of safe and effective care, this may have an adverse impact on patient outcomes and lead to an increased risk of avoidable harms.
Risk Owner: Chief Medical Officer and Chief Nursing Officer and Executive Director of Midwifery **Committee Quality and Research Committee** **Last review: date August 2026**

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

- Developing a quality culture
- Improving how we measure the quality of care
- Foster a culture of continuous learning
- Delivery of the Trust Quality Priorities:
  - Implementing and embedding NATSSIPs2 across all areas carrying out invasive procedures
  - Improving the experience of patients with learning disabilities and autism
  - Improving outcomes of acutely unwell.

Relevant significant risks on CRR:
4104 Care of patients requiring therapeutic mental health intervention (12)
3986 Monitoring to prevent patient deterioration (12)
567 Support following harm from violence, abuse and challenging behaviour
3419 Corridor Care (20)
3458 Delayed Diagnosis (12)
3991 Delayed pathology results (12)
387 Water Contamination (10)
36 Bullying & Harassment (12)
4103 Backlog Maintenance projects (16)

Risk Scoring:

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

Risk Appetite:

Safety	Adverse
Outcomes	Minimal
Experience	Cautious

Future Risks

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

Future Opportunities:

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

Controls:

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

Gaps in Controls

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

Assurance of Controls:

Positive:

- CQC patient survey reports and friends and family test
- Quality performance reporting to OCB, KE, QRC and Board
- Safe Nurse & Midwifery staffing reports presented to Board of Directors
- Quarterly patient outcome reporting to QRC
- Internal Audit reports 2025/26 – PSIRF significant assurance with minor improvement opportunities
- Complaints process embedded
- PALS – improvement with no backlog
- External service reviews (ad hoc)
- MIS Incentive Scheme full compliance 2025/6.
- Patient outcomes and national clinical audit results.
- CQC inspection (Surgery at DH) rated as Good.

Partial:

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

Negative:

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

Gaps in Assurance

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

Rationale for current score

- Good controls and assurance in place.
- Improvement in key services such as Maternity as evidenced through MIS and exit from the Maternity Support Programme.
- Patient outcomes as expected or better in most areas
- Reduced score to risk 295 – improved controls in place to maintain safety of patients
- Reduced score to risk 3458
- Positive assurance from KMPG internal audit review of PSIRF
- Assurance received from harm reviews (pathology and Neuro MRI).
- CQC inspections of Children and Young People (DH), Maternity (DH and PRUH) and Adult Medine rated as requires improvement.
- Positive assurance from KPMG internal audit review of MEG
- Recruitment of Patient Expert Partners underway
- Duty of Candour improvement needed
- Corridor Care metrics now reporting
- Aligns with People BAF on transforming workforce and impact on quality & safety.

Strategy Objective: High Quality Care
Risk: If the Trust does not have adequate arrangements in place to support the delivery of safe and effective care, this may have an adverse impact on patient outcomes and lead to an increased risk of avoidable harms.
Risk Owner: Chief Medical Officer and Chief Nurse **Committee Quality and Research Committee** **Last review: date August 2026**

Action Plan

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

Strategy Objective: Strong Successful Partnerships
Risk: System Sustainability - If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely on our ability to achieve system transformation in line with the NHS 10-year plan ambition.
Risk Owner: **Deputy Chief Executive** **Committee** **Board of Directors** **Last review: date SEPT 2026**

2026/27 Priorities:

1. To complete the first year of our partnerships strategic objectives

   Strong Successful Partnerships
   What's our ambition for the next five years?
   - To transfer up to 30% of hospital care to an appropriate, alternative setting by 2031

   What will this mean for our patients and communities?
   - People will get high-quality care closer to home, through virtual appointments and monitoring, meaning fewer hospital visits and less time as an inpatient

2. To develop our role as the integrator host in Bromley

Relevant significant risks on TRR:
- None

Risk Scoring:

	Impact	Likelihood	Score
Gross	4	4	16
Target (Mar 26)	3	3	9
Previous (Q1)	3	3	9
CURRENT Q2	3	3	9
Target March 2027	3	3	9

Risk Appetite
Open

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

Future Opportunities:
- 10 year plan and changes at local level (opportunities to transform service provision.
- Host of the Bromley Integrator
- Part of Southwark Integrator
- Part of Lambeth Integrator
- Lewisham and Greenwich joining EPIC
- Population health work as part of KHP.

Controls:
- Trust relationship leads identified for key partnerships to ensure that the Trust is represented and engaged in relevant ICS and APC forums
- Engagement and leadership of place-based partnerships e.g. One Bromley, Lambeth Together
- KCH CEO is designated CEO lead on SEL ICB
- Active role in existing APC and ICS clinical and operational forums e.g. Clinical, Strategy & Operations, APC Finance, and System Sustainability Group
- Engagement in SEL ICS and APC elective recovery programmes
- Trust's Anchor Programme
- APC governance and decision-making arrangements operational
- Partnership mapping (community & voluntary) completed

Gaps in Controls
- Oversight – improvements in equality of access, experience and outcomes

Assurance of Controls:

- Updates to Trust Board regarding ICS and APC and the Trust's role as a partner
- Workshop delivered on integrators
- APC Committee-in-Common progress reports
- SEL APC Elective recovery performance
- Well-Led Report published in July 2026 provides positive assurance.

Rationale for current score

- Trust well embedded in local partner arrangements.
- 10 year plan creates risk and opportunity
- System sustainability remains a challenge

Bold Objective: cross cutting Team King's: working as 'one Trust' across our sites, and as a good partner in our local ICS and beyond
Risk: System Sustainability - If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely on our ability to achieve system transformation in line with the NHS 10 year plan ambition.
Risk Owner: **Deputy Chief Executive** **Committee** **Board of Directors** **Last review: SEPT 2026**

Action Plan

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

Strategy Objective: Timely and Efficient Care
Risk: Demand and Capacity: If the Trust is unable to transform services, improve productivity and sustain sufficient capacity, patient waiting times may increase potentially resulting in an adverse impact on patient outcomes and an increased risk of avoidable harm.
Risk Owner: Chief Operating Officer **Committee Performance, Transformation and Improvement Committee** **Last review: October 2026**

2026/27 Priorities:
- To meet operational targets agreed in the 2026/27 operational plan
- Deliver clinical services transformation and CIP

Relevant significant risks on CRR:
- Care of patients requiring therapeutic mental health intervention.
- Delayed Diagnosis
- Delivery of elective activity in line with financial plan
- Corridor Care within PRUH
- 3915: Elective Recovery Achievement
- 3991: Delayed pathology results

Risk Scoring:

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

Risk Appetite

Operational	Cautious

Future Risks
- Impact of cost improvement programme and potential workforce reductions.
- Industrial action
- Interdependences with the wider SEL system
- Removal of waiting list initiatives
- Impact of Winter

Future Opportunities:
- Trust transformation programmes to reduce length of stay and improve flow
- Theatres and outpatient transformation
- Operational and clinical service transformation
- Endoscopy unit at the PRUH
- Opportunity to optimise SDEC use
- Review of stroke services
- Increased support from NHSE for demand and capacity modelling
- Participation in the NHSE ECHO demand project
- Acute Services Review across SEL
- External funding to support outpatient transformation and PTL reduction
- Introduction of 'patient not present' tariff
- Non-elective demand and capacity modelling
- Recovery plans reviewed at August Performance Board (cardio-vascular, general surgery, ophthalmology)
- Cancer recovery plan and SEL cancer meeting with NHS England now in place to oversee delivery
- UEC plans in place but have yet to show impact

Controls:
- Trust access policies in place
- Clinical prioritisation and validation of waiting lists and patient engagement and status checks whilst on waiting list to minimise risk to patient safety
- Use of virtual and telephone appointments/PIFU implementation
- Team supporting the use of In/outsourcing arrangements for some clinical services
- Engagement in SEL ICS and APC led programmes e.g. theatre productivity
- Engagement and support from SELCA in relation to cancer targets
- New governance structure in place to track cancer performance
- Performance Board and associated governance within Divisions
- Divisional SDRs and oversight by KE
- Winter plan
- Site management arrangements in place
- Command and Control arrangements to support incident management response – arrangements can be activated as required
- Data dashboard availability in PowerBI

Gaps in Controls
- Improvement plan to deliver RTT targets to be implemented
- Demand and capacity modelling in progress
- Non-elective demand and capacity modelling identified as a gap.

Assurance of Controls:

Positive
- Internal governance and escalation in place
- Patient outcomes
- IQPR report to Performance, Transformation and Improvement Committee and Board of Directors
- SELCA Oversight and accountability
- Internal Audit Review of Data Quality (RTT)– significant assurance with minor improvement opportunities
- National Oversight Framework -
- Tiering for cancer, elective care and DMO1
- Internal Audit Data Quality Review of ECS data ' significant assurance with minor improvement opportunities'

Gaps in Assurance
- Local management of waiting lists

Rationale for current score

- Trust operational performance is off trajectory and but the position may be recoverable.
- Cancer ITT referrals impacting on overall performance
- LPRR Level 2 for DMO1
- LPRR Level 3 for cancer delivery, planned care and UEC
- Capacity issues in core diagnostic nodes, although significant improvements have been achieved.
- Elective recovery funding no longer available, although some funding available to reduce PTL.
- Transformation and GIRFT Opportunities
- PRUH endoscopy and diagnostic centre operational in Q2, but endoscopy backlog undermining DMO1 recovery
- UEC provider delivery failing below contracted performance levels at DH.
- Removal of waiting list initiative funding
- NHSE Joint Improvement Programme
- DMO1 performance off trajectory (although improving)
- SPC assurance failures in key domains

Strategy Objective: Timely and efficient care
Risk: Demand and Capacity: If the Trust is unable to transform services, improve productivity and sustain sufficient capacity, patient waiting times may increase potentially resulting in an adverse impact on patient outcomes and an increased risk of avoidable harm.
Risk Owner: Chief Operating Officer Committee Performance, Transformation and Improvement Last review: Oct 2026

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Demand and Capacity modelling underway for 2027/28 as part of planning for 27/28	OPOG	Q2 206/27	Clear assessment of demand and capacity to drive key planning decisions for 2027/28	Initiated
Delivering an elective Recovery plan – to eliminate 65ww by end March 2026	Chief Delivery Officer	By end January 2026	National target met and removal from tiering	At year end Trust reported 12 65ww breaches.
Flow Programme (Transformation)	Chief Delivery Officer	Ongoing	Reduction in corridor care and length of stay, closure of beds	Ongoing
Pathology Improvement Plan	Chief Delivery Officer	31 March 2027	Improved flow, reduced delays to diagnosis, reduced costs.	Ongoing.
Cancer Recovery Plan as agreed with NHSE England	Chief Delivery Officer	Ongoing	Achievement of key targets including 28-day FDS and 62-day treatment	Ongoing.
DMO1 Sustainability Plan	Chief Delivery Officer	End Q4	Plan that will ensure sustainable waiting times and performance in key DMO1 nodes	In train

Strategy Objective: High Quality Care: Strengthening patient care through better use of digital technology
Risk: If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data
Risk Owner: Deputy Chief Executive **Committee Audit Committee** **Last review: September 2026**

2026/27 Priorities:

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

Relevant significant risks on Corporate and Trust RR:

391R03 Malware such as Ransomware Compromising Unpatched Servers

Risk Scoring:

	Impact	Likelihood	Score
Risk gross score (unmitigated)	5	5	25
Previous risk net score (2025/26 Q3)	4	5	20
Previous Risk net score (2026/27 Q1)	4	4	↓16
Current Risk net score (2026/27 Q2)	4	4	16
Target (Mar 26)	4	4	16
Target (Mar 27)	3	5	15

Risk Appetite:

Information Security	minimal

Future Risks

- External threat actors
- Potential increase in speed of compromise due to use of AI and quantum computing tools. Whole system compromise time frames reducing from hours to seconds.
- Lack of Independent Recovery Environment for Epic
- Below average spend on ICT security
- Loss of key ICT Cyber Security staff

Future Opportunities:

- SEL Cyber-Security Steering Group: coordinated cybersecurity assessments
- Bid to Frontline Productivity Programme for cyber funding (submitted March'26)
- Improve BCP to reduce impact
- Improve resilience of Atos connection.
- Explore Independent Recovery Environment for Epic and dependant systems
- Achieve Cyber Essentials Plus Accreditation
- Achieve certification of PRUH data centre
- Discussion with Synnovis about network segregation at KCH
- Include automated cyber defences as they mature and become affordable.
- National CSOC enabling isolation of devices and compromised accounts.
- Board training on cyber security

Controls:

- 3rd Party firewall purchased and in place with a number of third parties behind the wall
- Monthly contract meeting with senior staff to mandate the following of trust policies and procedures and compliance with SLA
- Multi skilled staff to act on Cyber-attack.
- Request are evaluated through ICT PMO to prevent unauthorized software and hardware being connected to the network/used.
- Unsupported Systems Workstream in place to mitigate against use of out-of-date software and hardware.
- Access rights not permitted to allow 3rd party installation onto the network.
- Communication to staff via top tips published on Kingsweb including:
  - Do not connect unauthorised devices to the Trust Network AND Do not download any software to PCs/devices without explicit authorisation from the ICT Department.
- ICT Systems Procurement -- Any proposed procurement MUST undergo the correct ICT checks and be officially authorised before purchase.
- Password policy is technically applied
- Password policy being brought in line with NCSC recommendations
- Policy in place for the management of cyber-incidents

Assurance of Controls:

Positive

- HIMSS Digital maturity for infrastructure, Level 6 out of 7 achieved, March 2026, valid for 3 years.
- Raised at Digital Board to promote PMO process.
- Penetration Testing of 3rd party systems on Trust network carried out annually. From the latest (November 2025):
  - External Infrastructure: No critical findings noted
  - Internal infrastructure: Two critical findings, of which
  - 1 related to a network vulnerability, which has been remediated
  - 1 related to the existence of a number of unsupported systems; this is being managed by the Unsupported Systems Workstream
- ISO 27001 Annex A controls are A9.1.1, A9.1.2, A9.4.1 and A15.
- KPMG review of Cyber assessment framework aligned data security and protection toolkit provides significant assurance with minor improvement opportunities.

Gaps in Assurance

- 3rd party assurance

Rationale for current score

- Penetration testing assurance
- Increasing external cyber risk (Middle East concerns)
- Funding constraints
- Extensive use of cloud-based or securely managed in KCH or Atos datacentres leading to significant enhancements in cyber-protection.
- Need to integrate cyber security and business continuity approaches.
- KPMG independent review of the Trust's submission of the cyber assessment framework and DSPT.
- Resource constraints within ICT limit speed at which changes can be enabled

• National Cyber-security Cantre Information Sharing partnership registration and adherence to the National Cyber-security Centre (NCSC) "ten steps to cyber-security". • Information security and data protection policy in place. • Joining NHS England in a pilot monitoring medical devices via MDE **Gaps in Controls** • Integration of business continuity and cyber-security • Lack of automatic isolation of devices that generate a high-risk alert out of hours			

Strategy Objective: High Quality Care: Strengthening patient care through better use of digital technology
Risk: If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data
Risk Owner: Deputy Chief Executive **Committee Audit Committee** **Last review: date September 2026**

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Programme to link together the operational impacts of downtime with the security arrangements of the different IT applications to give an aggregated profile of risk and resilience across the Trust	DCE	March 2027	Improved resilience	ongoing
Cyber-security investment programme (2026)	DCE	June 2026	Strengthened control environment	Funding allocated, currently implementing the purchased items.
Clear maintenance window agreed (monthly basis) with the organisation for servers to be rebooted	DCE	30/12/2026	Timely patch application to servers	Initiation
Move non-windows servers under Microsoft Defender	DCE	30/12/2026	Addition protection of non-windows devices on network	On-going
Explore Independent Recovery Environment (IRE) risk assessment and options	DCE	31/06/2026	Digital board agreed to complete risk assessment, then generate options paper	Completed
2026 Frontline Productivity Programme (NHS England) – Year 1 of 4	DCE	March 2027	Improved resilience and cybersecurity in collaboration with SEL ICB partners	Bid submitted
Board training – Cyber security	DCE	By September 2026	Improved understand and awareness	Organised for 16th September 2026

Activity since the last review:

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

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 9

BOARD/COMMITTEE REPORT COVER PAPER

Report to:	Board of Directors - Public
Date of meeting:	17th November 2026
Subject:	Risk Register Report
Author(s):	Samantha Machen, Assistant Director of Quality Governance
Sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery
History:	Regular report
Status:	Risk and Governance Committee, 27/08

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

Purpose

- Assurance of risk management processes in place to address corporate risks
- Overview of progress against the risk management refresh being undertaken
- Detailed overview of the corporate risks and current risk exposure profile

Recommendations:

The Board is asked to receive the report for discussion and evidence of assurance provided regarding the ongoing improvements to the risk management processes.

Strategy alignment

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

Key implications

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

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

Main Report

Between September and October, all corporate risks remain the same score, with full reviews into all corporate risks expected this November. No new risks entered the corporate risk register.

Work to enhance the risk maturity of the organisation has continued, including reporting on metrics relating to actions against risks and target completion dates, and further risk management training sessions. Planning has started to review divisional maturity of risk management and offer bespoke training sessions for care groups – this will be part of the training offer going forward in 2027.

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Risk Management

Report to Trust Board – November 2026

This report provides:

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

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

Risk Refresh | Risk Assurance | Next Steps

Section 1
Risk Refresh -

- Summary overview of progress
- Risk management refresh Gantt chart

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

Risk Refresh | Risk Assurance | Next Steps

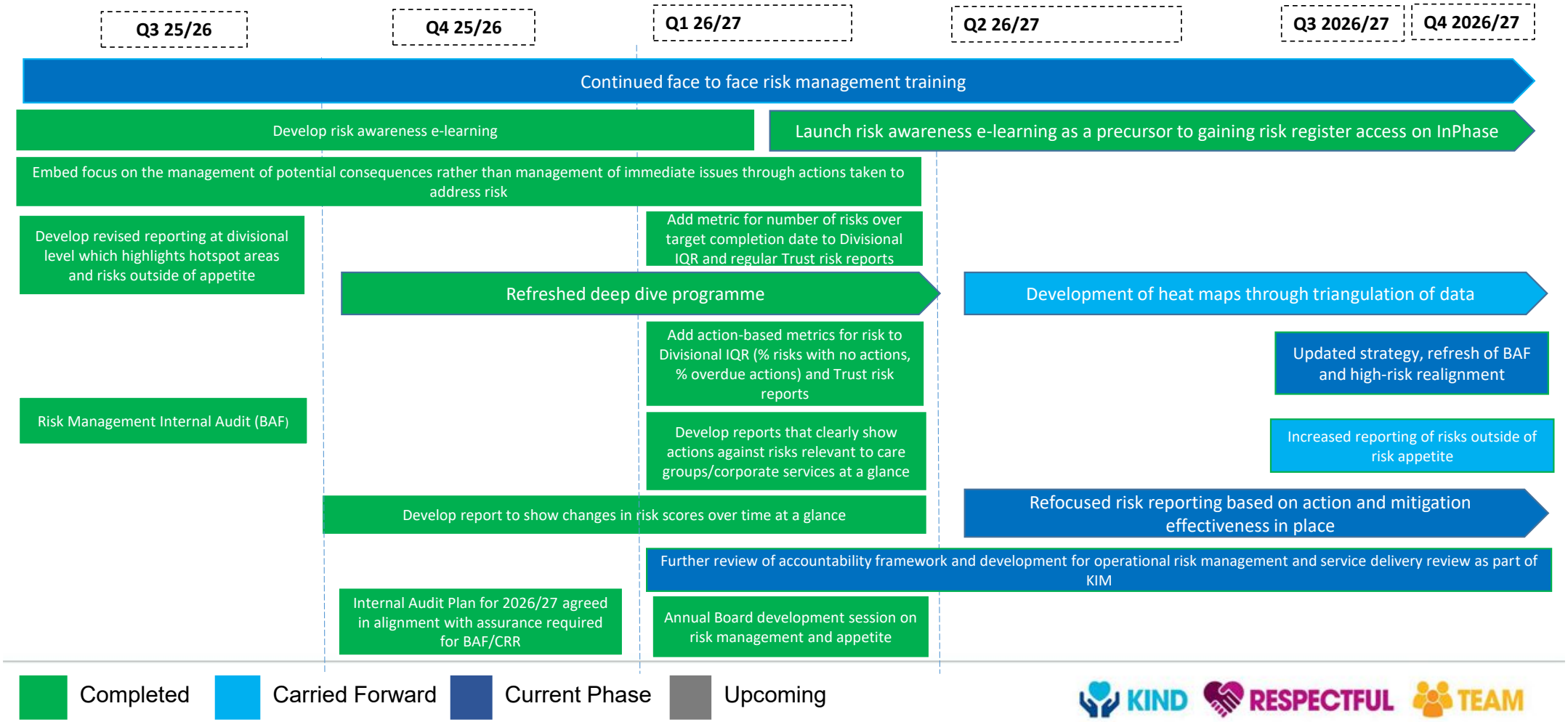
Risk Refresh

Since the last report:

- Further Level 2 training sessions have been held and the e-learning format for Level 1 training has been revised following initial feedback and is now held and undertaken via an InPhase form. This allows for greater tracking of attendance and streamlines the process for system access once the user has passed. We have now trained over 73 staff in Level 2 Risk Management.
- The new metrics for risk (risks with actions underway, high-risk actions overdue, risks past their target date for closure) are embedding and included in divisional IQRs and the report to the Risk and Governance Committee
- These changes will drive a re-focus of discussions towards actions to effectively reduce risk to a level the organisation will tolerate within or outside risk appetite, monitoring these, and where not possible to reduce risk to be clear about the reasons why and mitigation. The next stage is to embed the actions focus and drive improvement. This feeds into the overall improvement in organisational risk maturity

Risk Refresh - Summary

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



KIND RESPECTFUL TEAM

Risk Refresh | Risk Assurance | Next Steps

Section 2
Risk Management Assurance

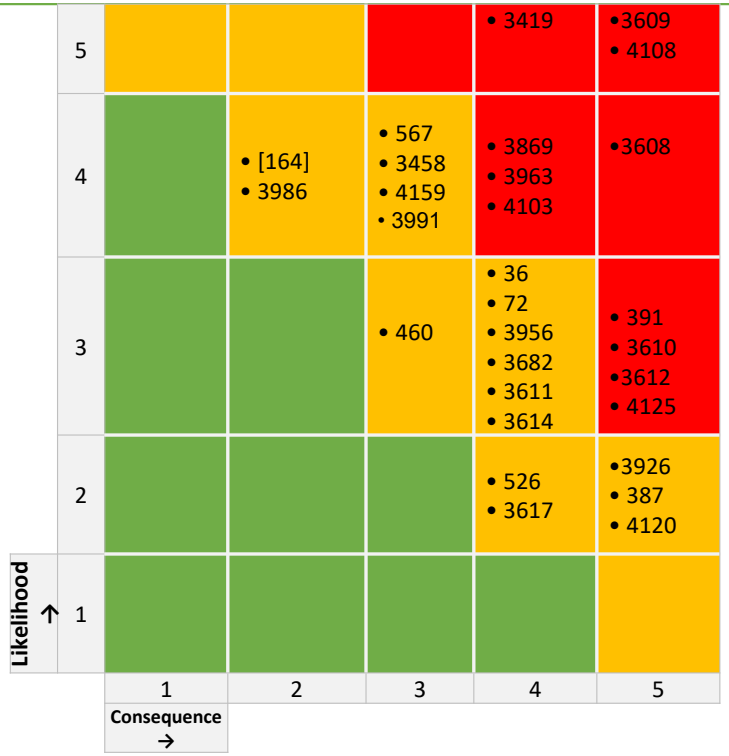
Corporate risk register

Current Risk exposure profile

Risk Register Movement (September-November)

ID	Risk title	Initial	Score	Change (from last board report)	Risk Type
36	Bullying and harassment	*16*	12	=	Workforce
72	Data and Cyber security of third party organisations accessing our network	*20*	12	=	IT
164	Fraud Bribery and Corruption [tolerated risk]	*8*	8	=	Finance
387	Water Contamination	*12*	10	=	Quality
391	R03 Malware such as Ransomware Compromising Unpatched Servers	*15*	15	=	IT
460	Large Scale Staff Shortage	*16*	9	=	Workforce
526	Sustainability and Net Zero	*12*	12	=	Sustainability
567	Harm from Violence, abuse and challenging behaviour	*12*	12	=	Workforce
3458	Delayed Diagnosis	*8*	12	=	Quality
3419	Corridor Care	*25*	20	=	Quality
3608	Identification & delivery of efficiency requirements	*25*	20	=	Finance
3609	Expenditure Control	*20*	25	=	Finance
3610	Investment decisions	*20*	15	=	Finance
3611	Validity of activity assumptions	*20*	12	=	Finance
3612	Delivery of elective activity in line with financial plan	*15*	15	=	Finance
3614	Capital programme	*16*	12	=	Finance
3617	Cost Inflation	*16*	8	=	Finance
3682	PRUH (PFI) building - Estate issues	*20*	12	=	Estates
3869	Elective Performance 2025/26	*16*	16	=	Performance
3926	Withholding of Deficit Support Funding	*8*	10	=	Finance
3963	Radiology Capacity and Performance	*20*	16	=	Finance
3956	Monitoring to Prevent Patient Deterioration	*12*	12	=	Quality
3991	Delayed pathology tests/results	*15*	12	=	Quality
4103	Backlog Maintenance Projects 2026/27	*16*	16	=	Estates
4159	Care of Patients requiring therapeutic mental health intervention	*12*	12	=	Quality
4108	Financial impact of industrial action	*20*	20	=	Finance
4120	Strategic investments	*16*	10	=	Finance
4125	National Review of Band 5 Nurses	*15*	15	=	Finance

November 2026 (following changes agreed at RGC in September 2026)



Risk score increased

Risk score decreased

Risk score stable – no shading

New/newly escalated risk



Next steps

- Review of strategy to make sure changes made in Q1-Q3 are incorporated fully
- Review of impact and effectiveness of revised risk metrics
- A full schedule of deep dive reviews and risk management training continues throughout 2026
- Plans are underway to review training offer in 2027 and opportunities for increased maturity in the care group

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 10

BOARD/COMMITTEE REPORT COVER PAPER

Report to:	Trust Board
Date of meeting:	17 November 2026
Subject:	Integrated Performance Report Month 6 (September) 2026/27
Author(s):	Steve Coakley, Director of Performance & Planning; Simon Lee, Assistant Director of Performance & Planning
Sponsor:	Interim Chief Operating Officer
History:	
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**	✓

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Key implications

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

Main Report

<u>Performance:</u>

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.

NHS
King's College Hospital
NHS Foundation Trust

Integrated Performance Report

Month 6 (September) 2026/27

Trust Board

17 November 2026

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Report to:	*Kings Board Committee*
Date of meeting:	*12th November 2026*
Subject:	*Integrated Performance Report 2026/27 Month 6 (September 2026)*
Author(s):	*Steve Coakley, Director of Performance & Planning;* *Simon Lee, Assistant Director of Performance and Planning*
Presented by:	*Angela Helleur, Chief Delivery Officer*
Sponsor:	*Angela Helleur, Chief Delivery Officer*
History:	*None*
Status:	*For Discussion*

Summary of Report

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

Action required

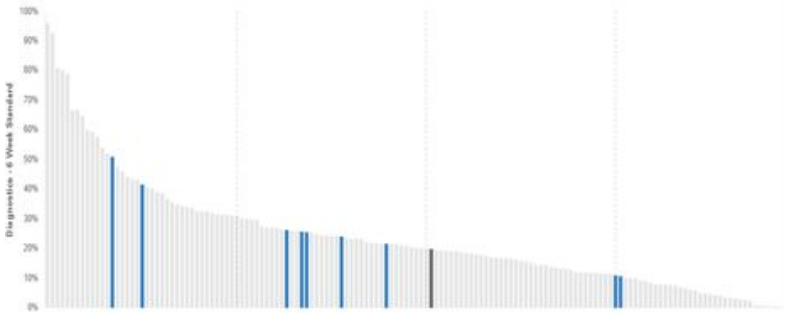
- *The Committee is asked to note the latest available 2026/27 M6 performance reported against key deliverables as set out in the national FY2026/27 Operating Plan guidance.*

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

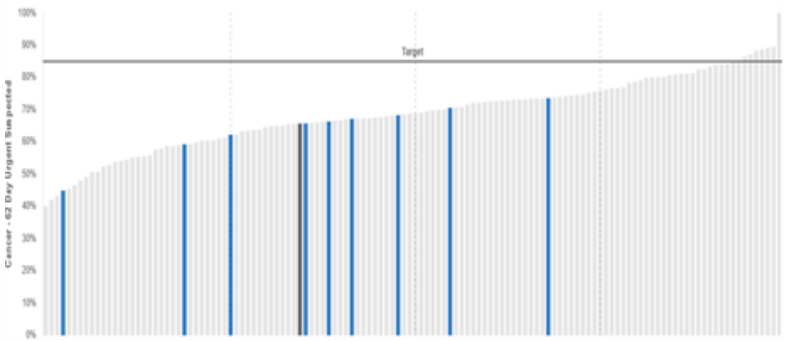
Benchmarked Trust performance
Based on latest national comparative data published



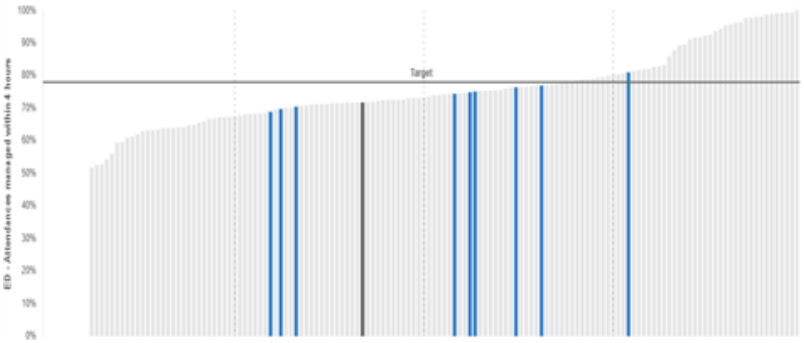
The chart above shows the national ranking against the DM01 diagnostic 6-week standard. **Kings is ranked 75 out of 153 selected Trusts based on August 2026 data published.**



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%.

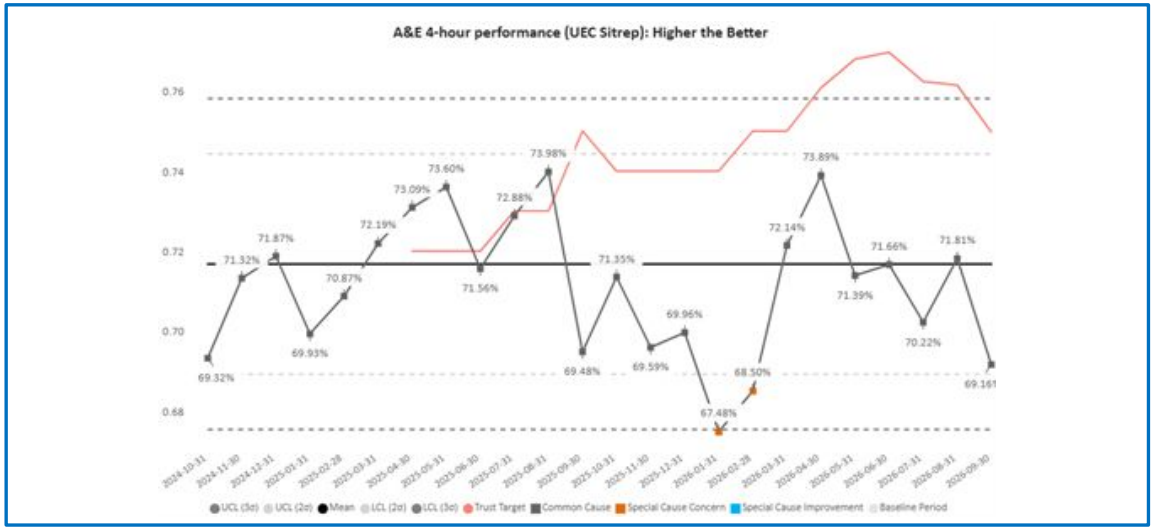
Performance

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

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

Current Issues

- Despite variation and an increase from August, Type 1 attendances remained within expected levels at 16,246.
- High Mental Health demand on both sites resulting in reduced physical and requiring significant staffing resource to maintain safety.
- Slow flow to G&A inpatient wards leading to congestion and extended waiting times.

Key Dependencies

- Utilisation of conveyance and admission avoidance pathways in the community.
- Optimisation of referral pathways to SDECs to take lower risk presentations.
- Flow into G&A inpatient wards.

Future Actions

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

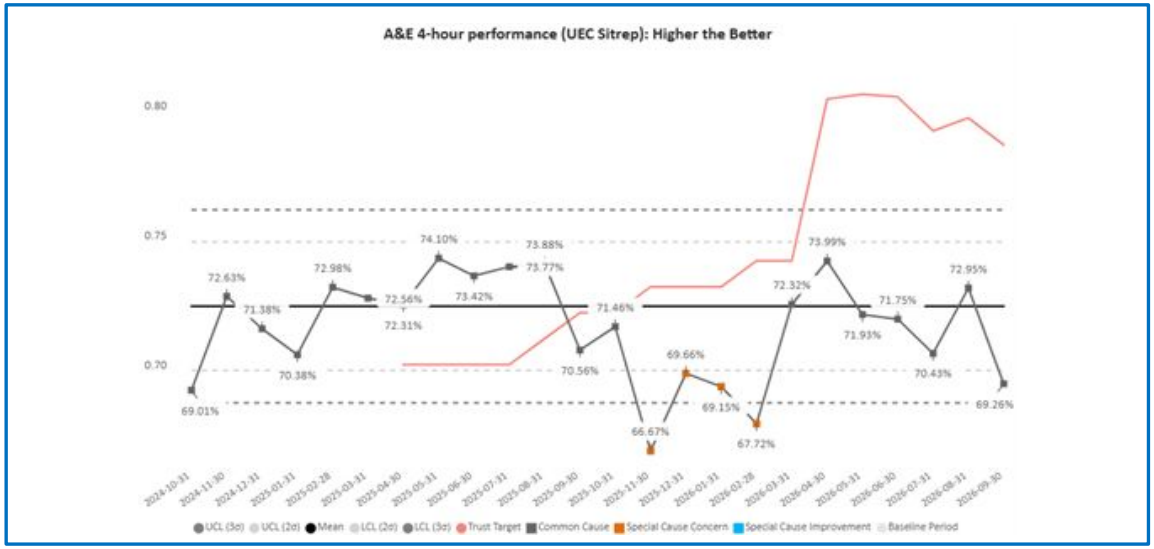
Performance

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. • DH Type 3 performance remains static at 92.45% • Significant challenges with long Mental Health patient stays in ED, leading to cubicles being blocked for assessment.	• Utilisation of conveyance and admission avoidance pathways in the community. • Optimisation of referral pathways to SDECs to take lower risk presentations. • Flow into General & Acute (G&A) inpatient wards. • Flow into MH inpatient wards.	• Working with UTC provider to optimise pathways and improve performance. • Re-focusing on ED triage process and wait for 1st clinician through AMA. • Expansion of ambulatory frailty capacity and medical SDEC throughput. • Implementation of POCT and AVT.

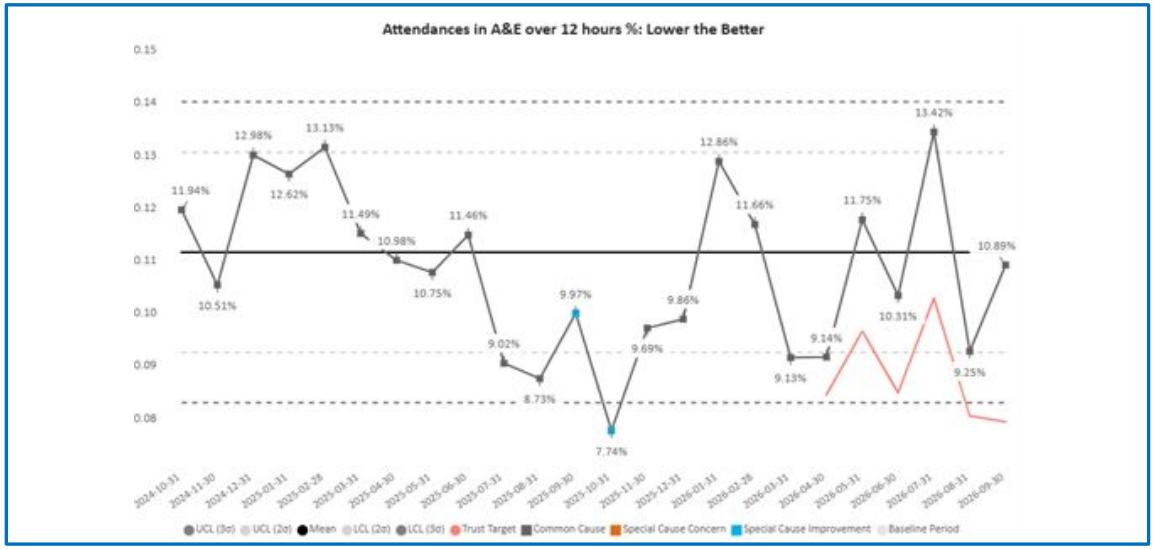
Performance

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. • Flow from ED into inpatient admission wards. • Reduction in length of stay across inpatient wards through the site flow programme, particularly in view of predicted challenging winter virus presentations.	• Delivery of improved inpatient flow through the 26-27 flow programme and local care group initiatives. • Extension of LLOS reviews on further wards • Opening of the MH UTC on the Maudsley site • Review of continued operation of LIAA over Q3/4

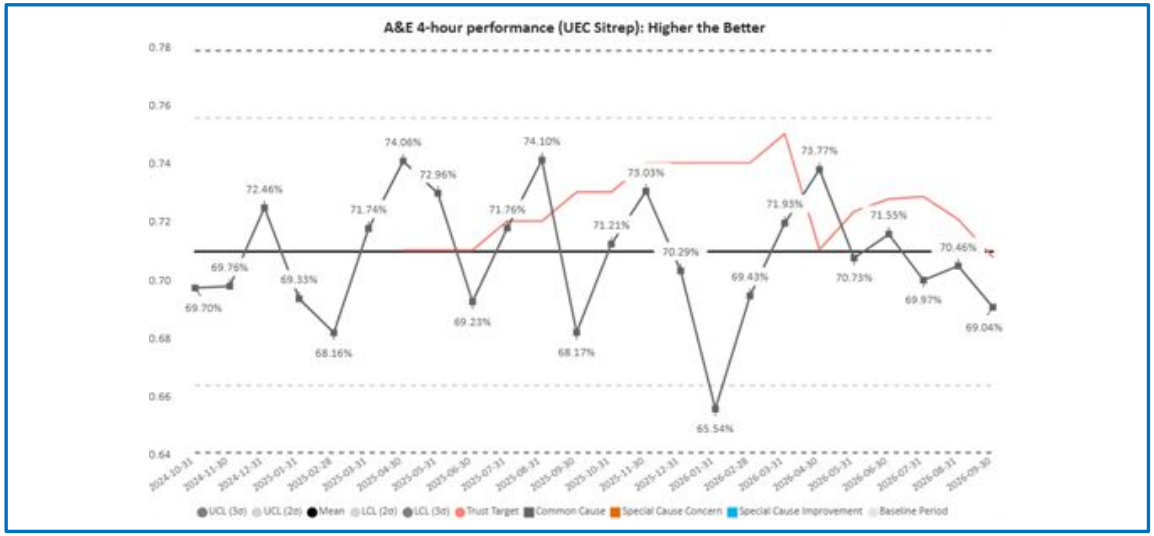
Performance

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

- All type performance decreased to 69.04% in September, remaining below the Operating Plan target.
- Implementation of Rapid assessment and treatment model 12:00-21:00

Current Issues

- Type 1 PRUH performance remained in line with the mean of the last 24 months.
- Type 3 attendances were higher than accepted variation, however performance remained static
- LAS calls to the geriatric SPOA remain low and an unrealised opportunity.
- Corridor congestion due to admitted demand continues, but a significant reduction compared to FY2025-26.

Key Dependencies

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

Future Actions

- Focus on increasing pathways out of ED into ADU, MSDEC and SAUU.
- UTC implementation of “Hello Dr” model to support triage and treatment
- Extended geriatric consultant cover onsite 7 days a week to support SPOA and AGU flow.

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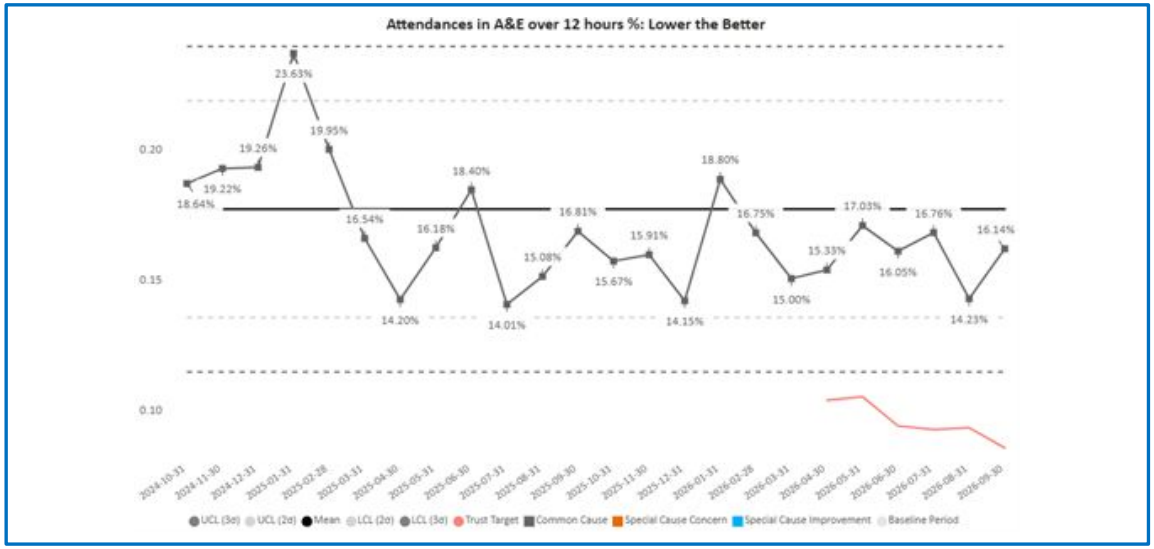
Performance

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. • Patient requiring mental health input (and onward care) are a significant contributor to non-admitted and admitted breaches.	• Improved flow for patients with a mental health Decision To Admit into partner organisations. • Flow from ED into inpatient admission wards. • Reduction in length of stay across inpatient wards through the site flow programme.	• Exploring discharge ward model to support winter flow. • Extension of LLOS reviews onto further inpatient wards

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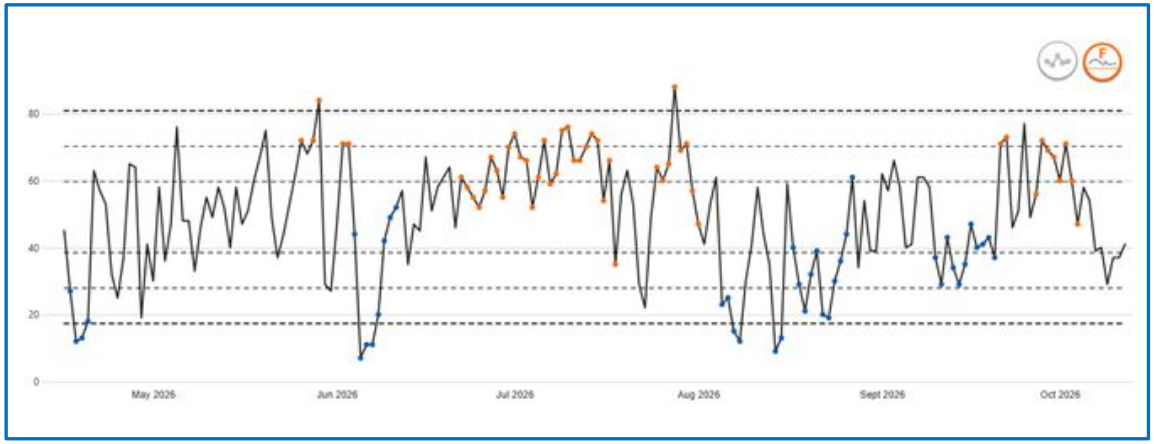
Performance

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 • 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. • Enhanced audit of corridor care patient appropriateness implemented.	• Corridor care levels remains high, resulting from insufficient early and consistent flow and/or acute pressures from high conveyances.	• Increases conveyance avoidance to reduce pressure on ambulance offload. • Improved early flow into G&A beds to support continuous flow through the Trust. • Improved flow into MH beds to support increase assessment capacity.	• Implementation of extended focus of flow programme to support earlier site flow, including adoptions of LLOS review process. • Re-Audit of adherence to Criteria to admit in ED and AMU.

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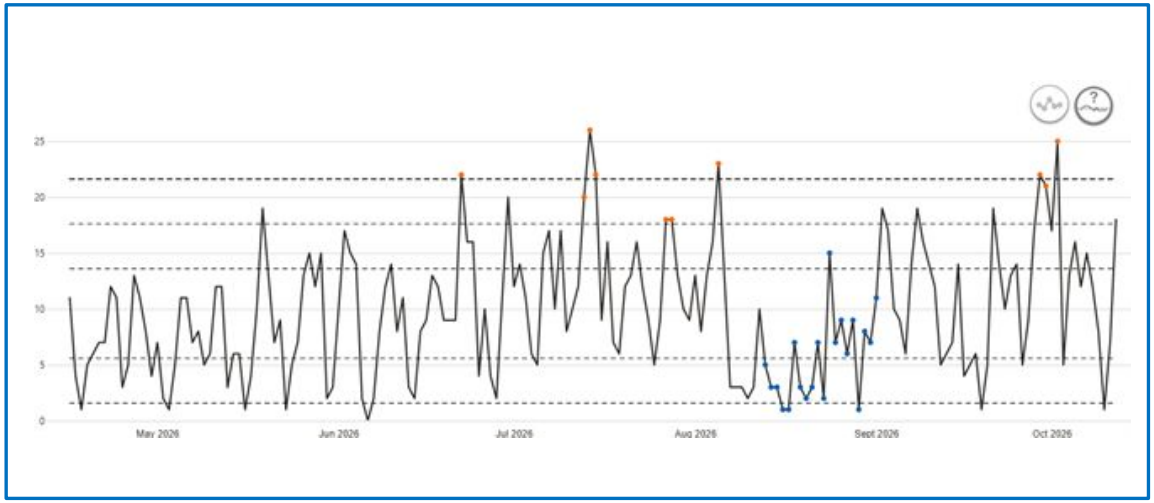
Performance

Inpatient Corridor Care – Trust Level

Background/national target description
• A count of the number of patients who are receiving care for more than 45 minutes on a ward outside of a bed space. This is limited to general and acute beds and excludes ED. • This metric counts patients recorded in surge beds on inpatient wards.

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. • Insufficient discharges compared to demand result in high bed occupancy.	• Improved discharges before 12 midday and utilisation of discharge lounge. • Increased discharges per day to lower bed occupancy. • Reduction in delays for patients who require support to enable discharge.	• Board round optimisation programme to support R2G and reduce delays that impact on patient LoS to be rolled out across all wards. • Criteria Led Discharge project being rolled out to support earlier in day discharges. • Long Length of Stay Reviews project to be further rolled out to support reduction in LoS.

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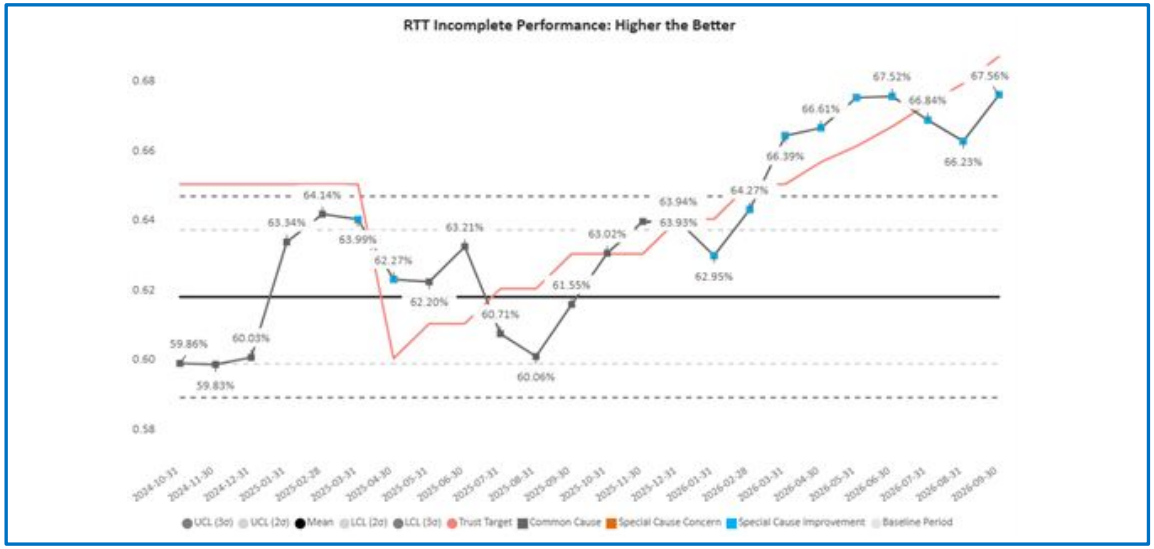
Performance

RTT Incomplete Performance

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

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.

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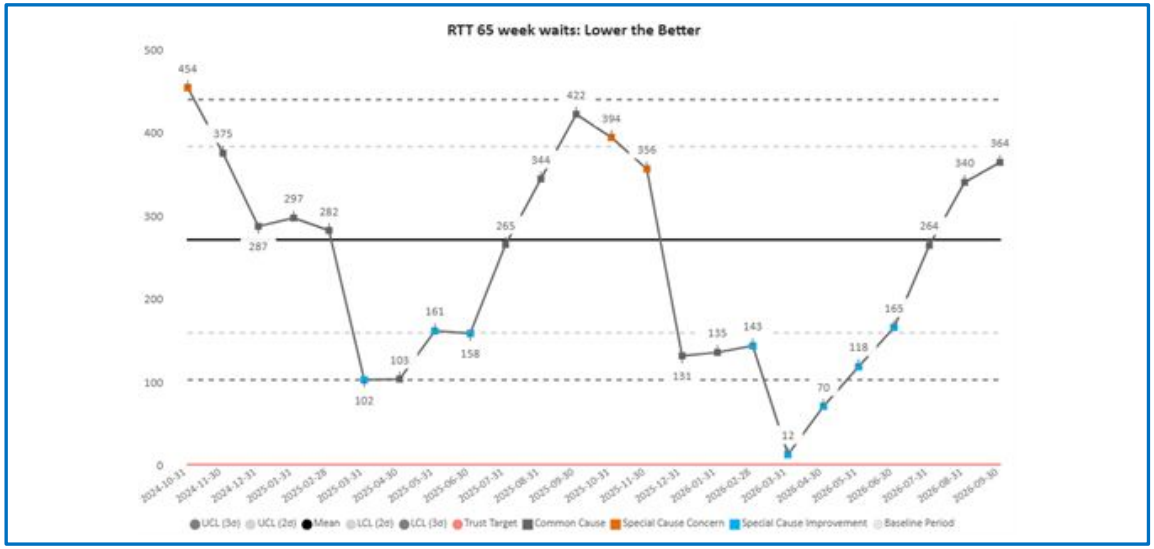
Performance

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.

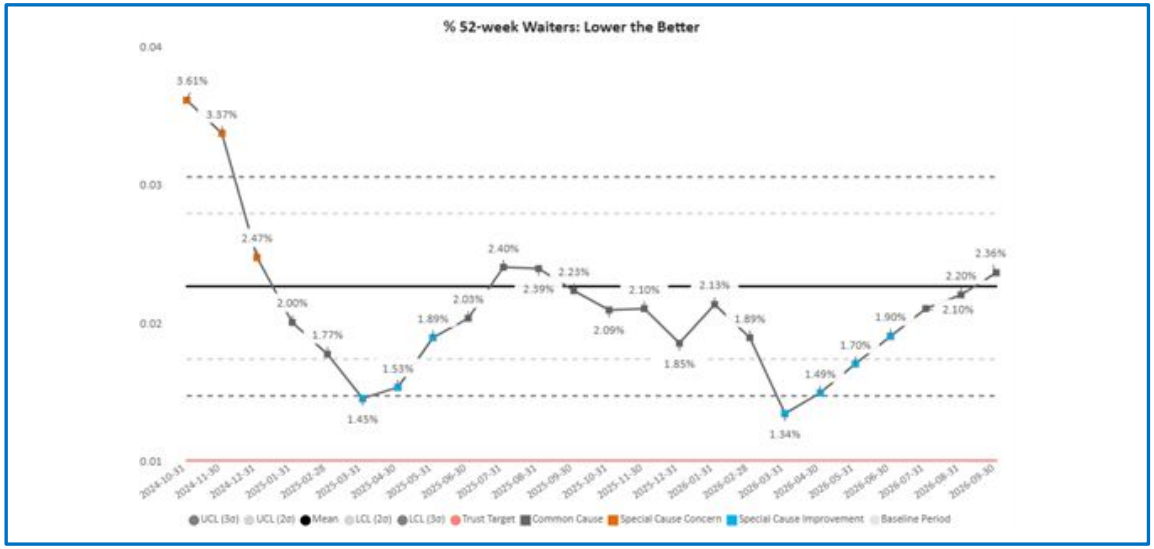
Performance

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.



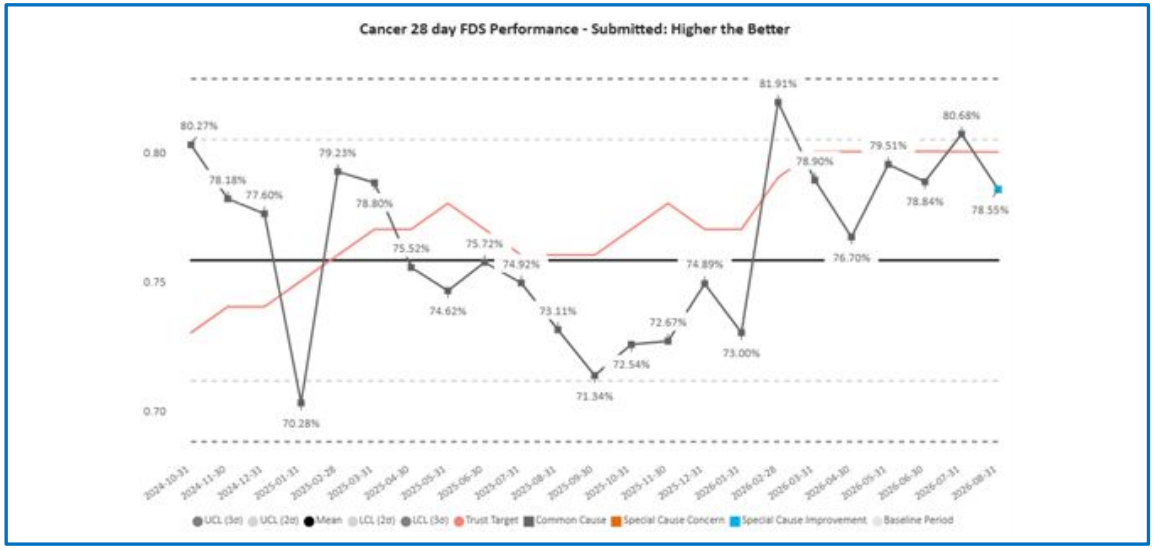
Update since previous month	Current Issues	Key Dependencies	Future Actions
• The number of patients waiting over 52-weeks increased further from 2004 in August to 2091 in September. • This represents 2.36% of the total PTL and above the target of 0.72%. • Over 1500 patients are waiting over 52-weeks on an admitted pathway and over 500 on a non-admitted pathway.	• 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.	• Delivery of Trust activity plan in key areas of operational challenge within standard Trust capacity available.	• 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%



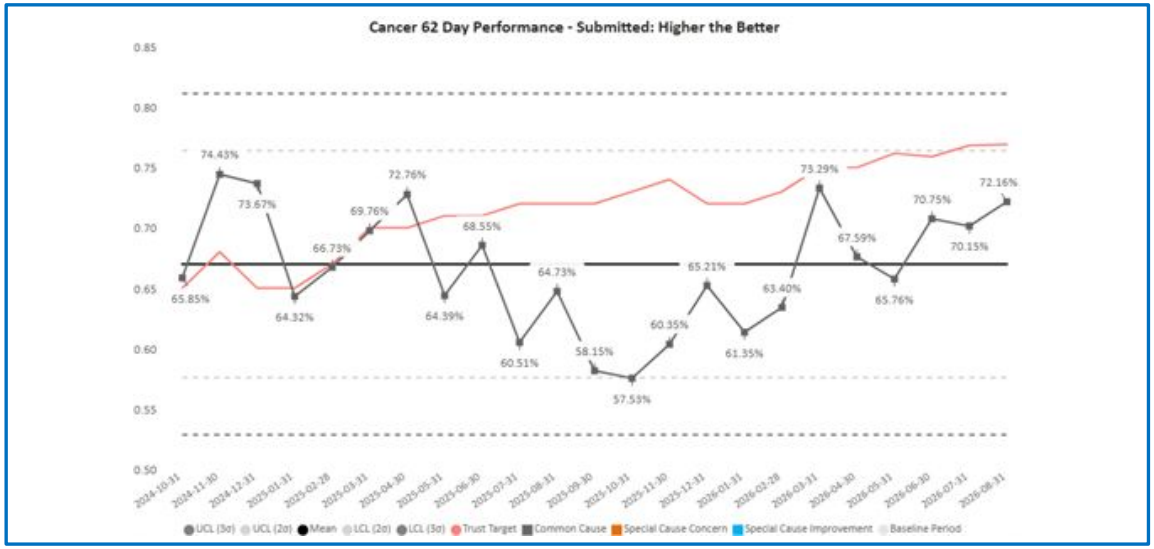
Update since previous month	Current Issues	Key Dependencies	Future Actions
• Submitted June 2026 28-day FDS performance is 78.55%, above the 80% standard.	• PRUH endoscopy backlog recovery (from new unit opening in April 2026). • PRUH pathology reporting turnaround times. • PRUH GI CT radiology reporting and (Trust wide) urology CT reporting • 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. • Radiology demand exceeds capacity overall (for both cancer pathways and all Trust standards). • 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). • Radiology reporting backlog reducing through non-recurrent fund, service to bid for further SELCA funding. • 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%



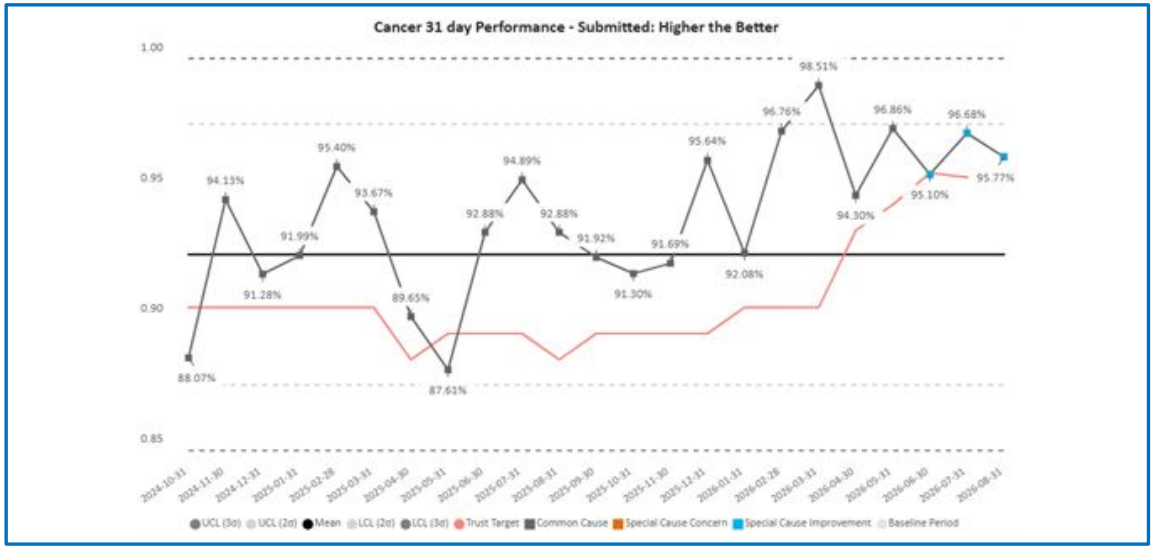
Update since previous month	Current Issues	Key Dependencies	Future Actions
• Submitted 62-day performance for August 2026 was 72.16%, below the 76.9% Operating Plan target.	• Pathology reporting delays. • Complexities of breast pathways with additional imaging (and breast radiology workforce). • PRUH endoscopy capacity. • Lung IR radiology and OPA capacity. • Prostate biopsy and oncology capacity.	• 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.	• 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) • IR radiology capacity	• HPB surgical and radiology capacity	• DH colorectal cancer theatre utilisation longer term plan in action (covering anaesthetics, wards, surgery and theatres). • Dh site review required for specific allocation of breast and colorectal theatre list • Liver interventional radiology scheduling process being streamlined. • Additional HPB surgeon not fit to commence operating until end of September.

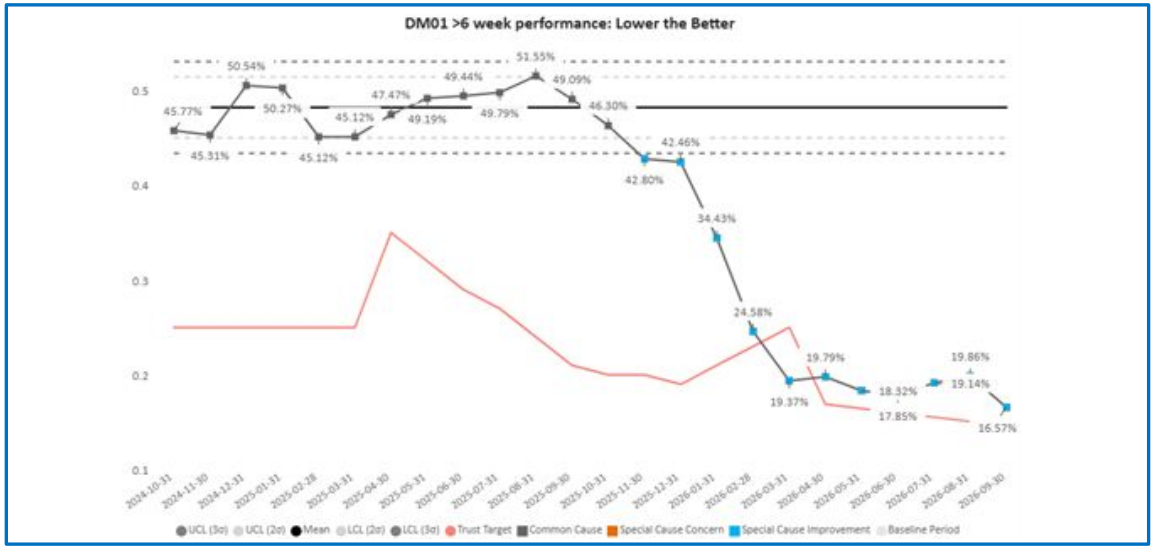
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Performance

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%. • 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. • 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. • 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. • A revised endoscopy recovery action plan is in place, with additional internal and external capacity being delivered. • External validation team has completed their diagnostic DM01 and planned pathway validation work with a ca 40% validation removal/update rate.

Quality

Domain 2 – Quality Summary - Assurance (August 2026)

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%
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) • 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) • 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) • 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

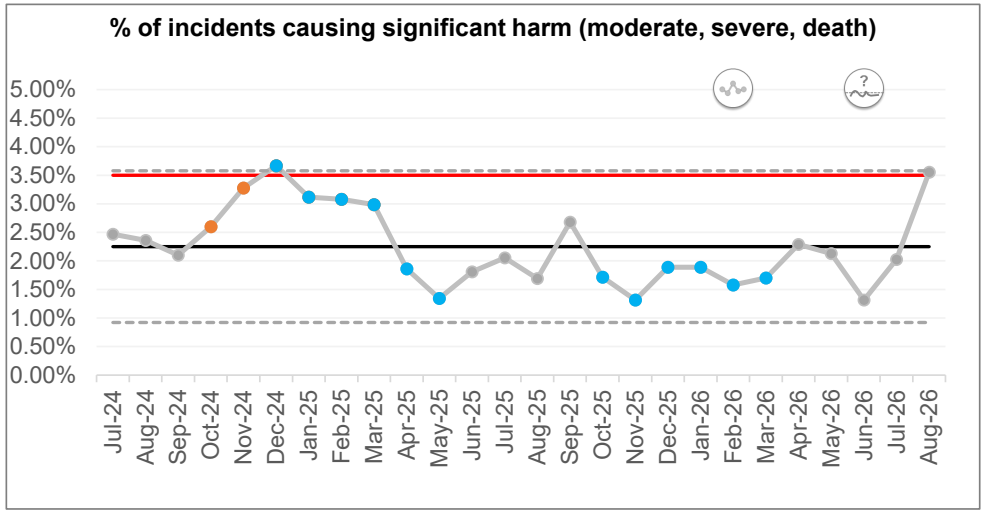
Safe – Incidents

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.

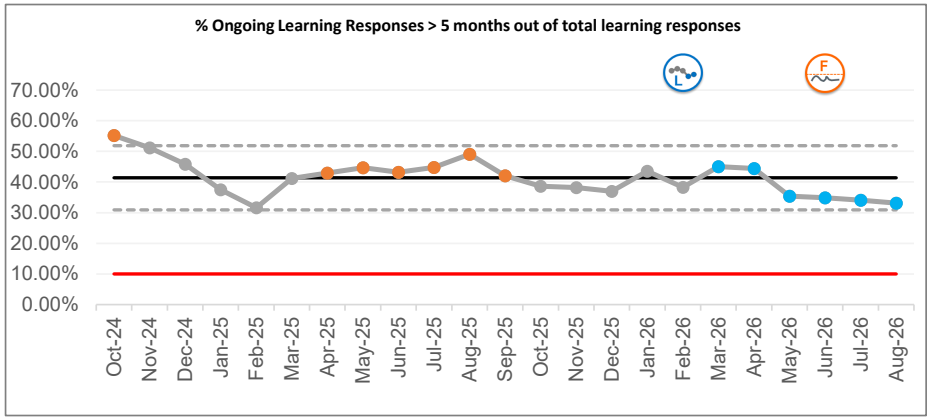
Actions being taken to improve:
Positive assurance. Safety culture programme currently being developed and rolled out which should improve psychological safety for staff and therefore further improve reporting culture.

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

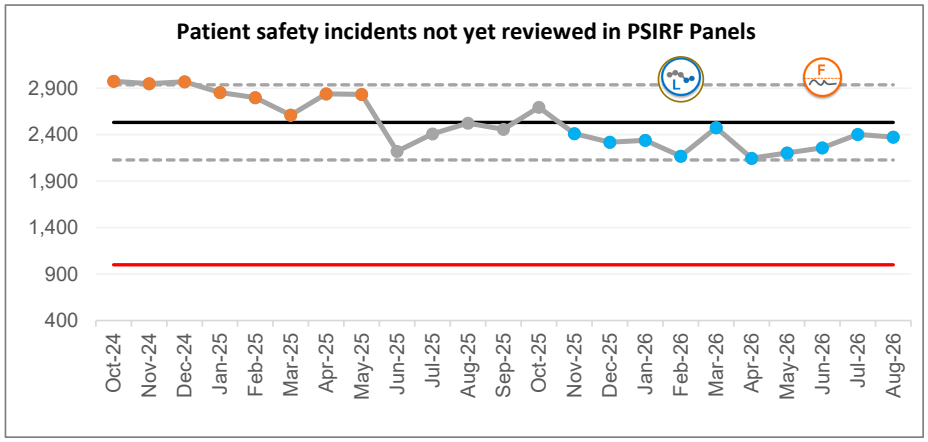
Special cause variation continues to be seen in the proportion of learning responses taking greater than five months to complete. The impact of both on our patients (and staff) is delayed learning and improvement following incidents, and delays in the compassionate engagement steps which can compound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

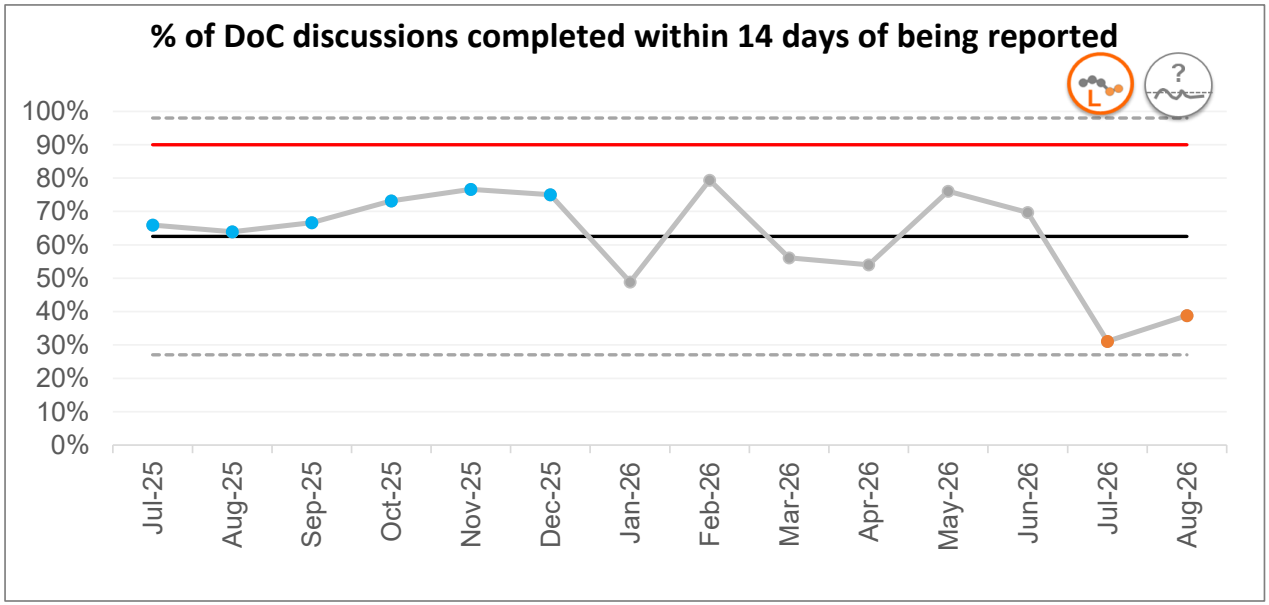
Quality

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.

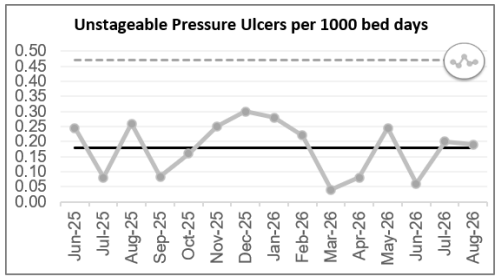


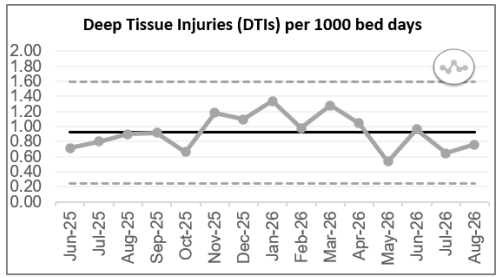
Quality

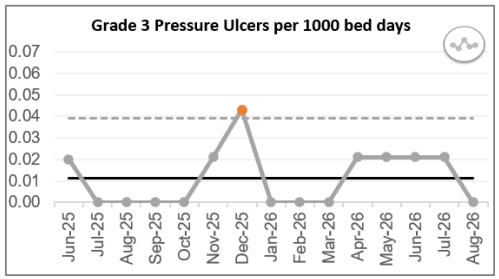
Safe – Falls & Pressure Ulcers

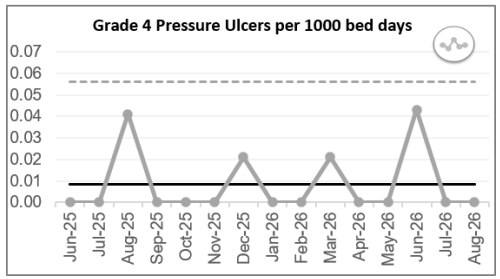
Enhancements are being made to Epic documentation, including improvements to falls and pressure ulcer flow sheets and the introduction of Purpose-T to support standardised skin assessment – delayed to September on current road map. In parallel, a revised Trust Falls Policy and Strategy is being developed, 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.

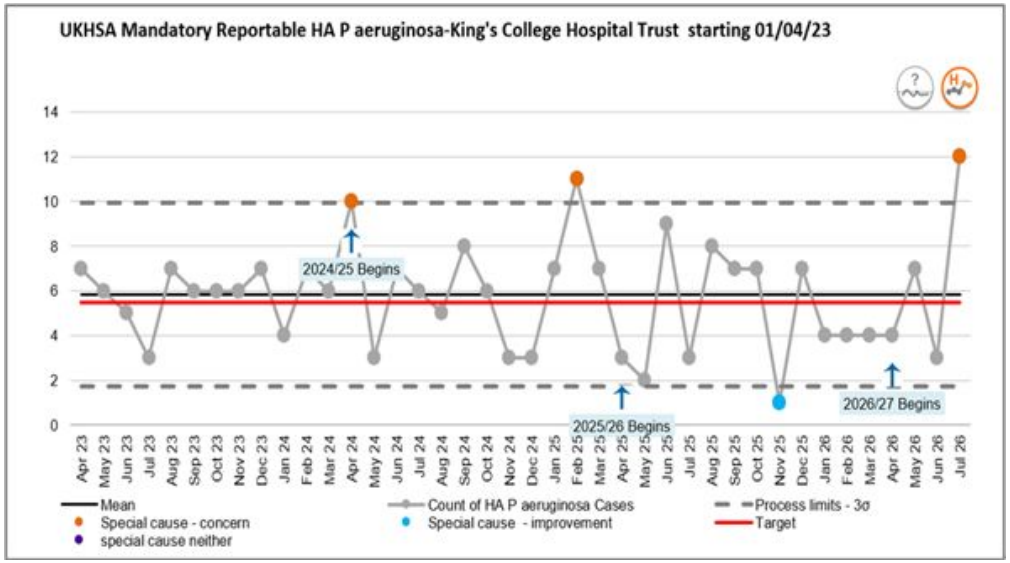
Common cause variation identified for Trust-wide data. 111 pressure ulcers in August. 9 x unstageable and 35 x DTI's

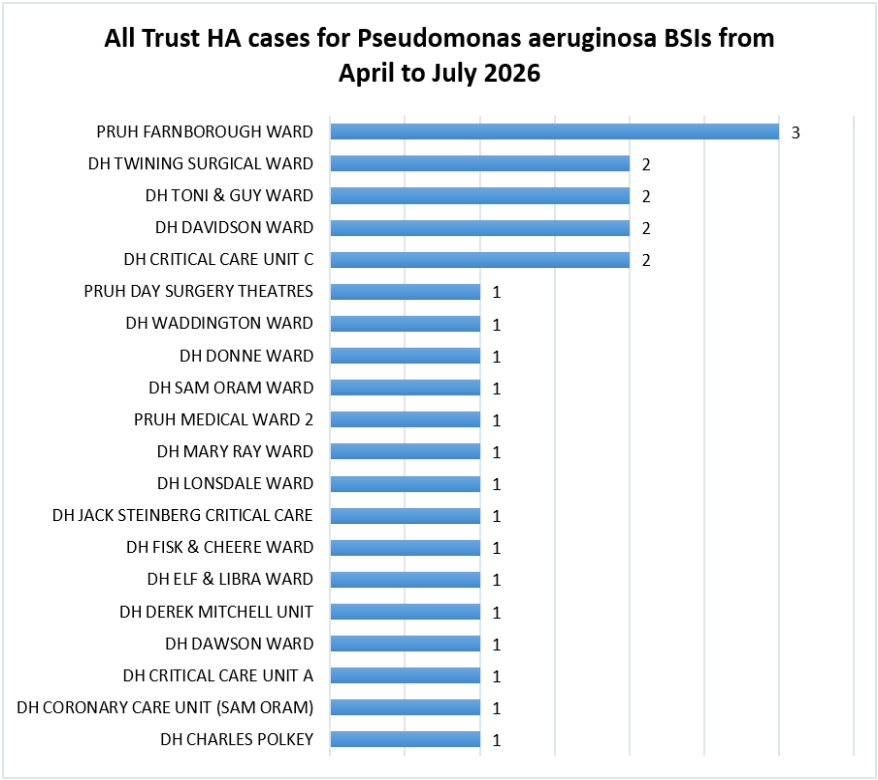
Actions being taken to improve:
Enhancements are being made to Epic documentation, including improvements to falls and pressure ulcer flow sheets and the introduction of Purpose-T to support standardised skin assessment – delayed to September on current road map. In parallel, a revised Trust Falls Policy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

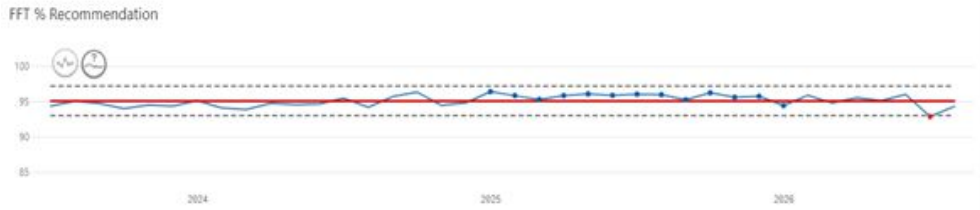
The reason for the increase in pseudomonas BSI in July 2026 is not clear.

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

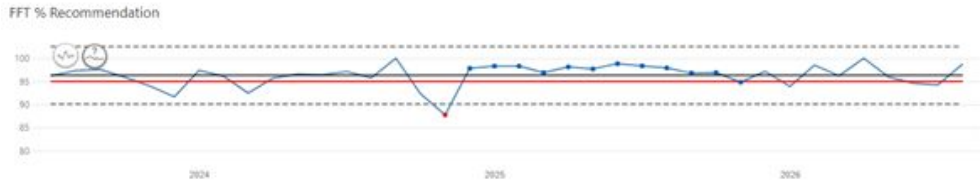
IPC ward round reviews of urinary catheters remains in progress, with results fed back on the day.

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.

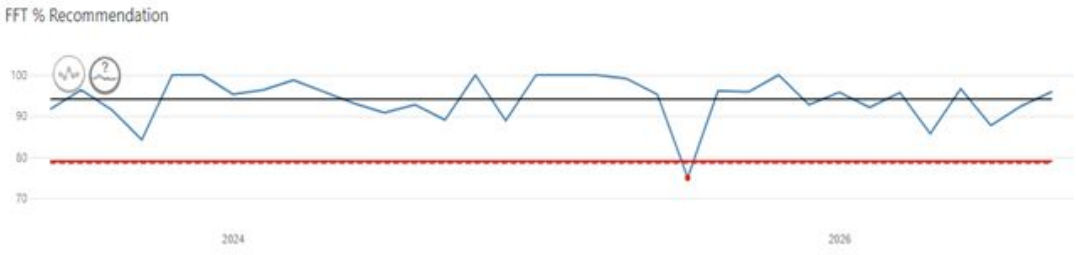
The Patient Experience Team continue to support efforts to increase response rates in wards that have recorded low or no survey responses over the past 12 months. Since June 2026, monthly Care Group reports been shared with teams, providing area-specific patient experience data and insights. Each report 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.

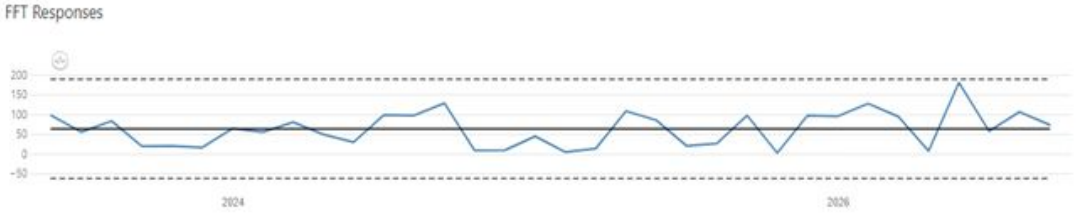
Positive Feedback:
67% of the themes identified were positive in sentiment. Patients continue to praise the staff behaviour and the quality of patient care continue to be well received, and a substantial number of feedback provided.

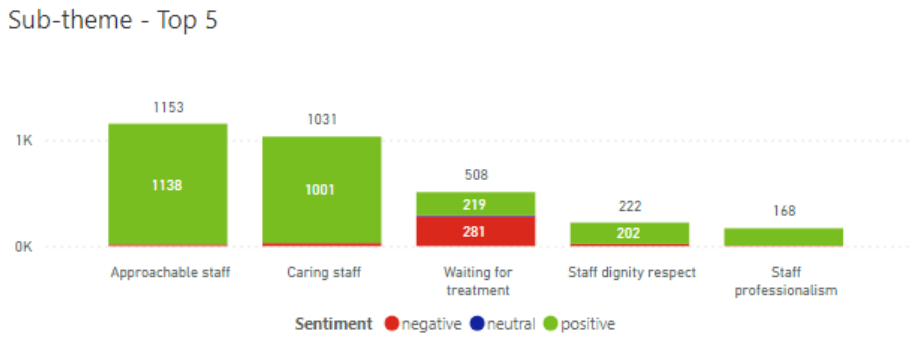
Improvement Feedback:
Waiting and communication continues to be the most prominent negative main theme, which included waiting for treatment, appointment and issues with communication with staff. Facilities concerns were commonly mentioned with many patients citing overcrowding, issues with parking and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

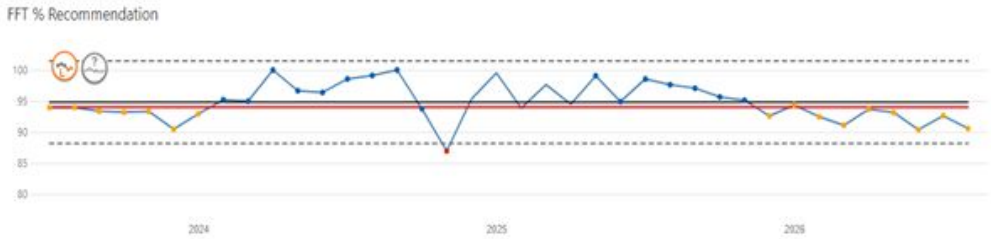
Positive Feedback:
Patients valued the dedication and professionalism of staff, particularly when receiving prompt treatment and clear explanations. Individual examples of compassionate and effective care were noted across emergency services.

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

Quality

Caring – Friends & Family Test – Outpatients

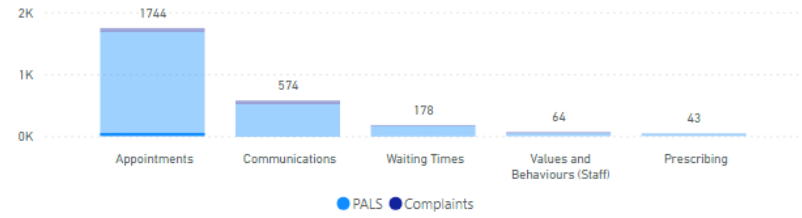
Outpatients



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.

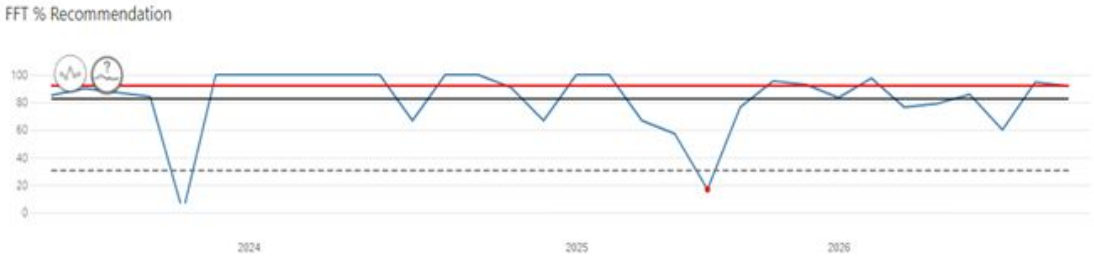
Quality

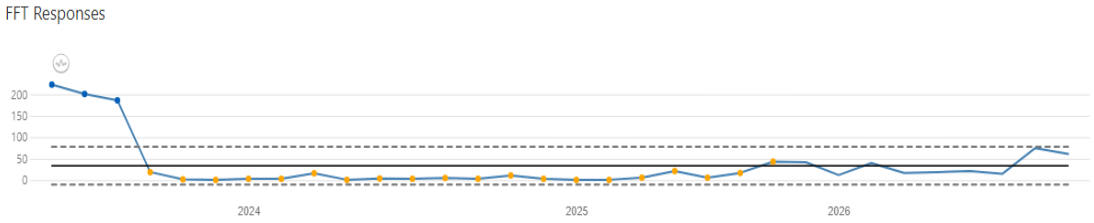
Caring – Friends & Family Test – Maternity

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.

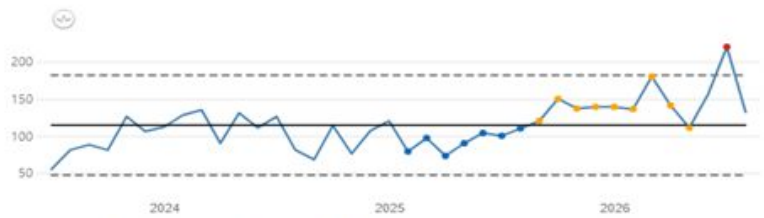
Positive Feedback:
Women frequently praised staff for being caring, compassionate and reassuring. Positive comments highlighted emotional support, clear explanations and the professionalism of maternity teams throughout their care.

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.

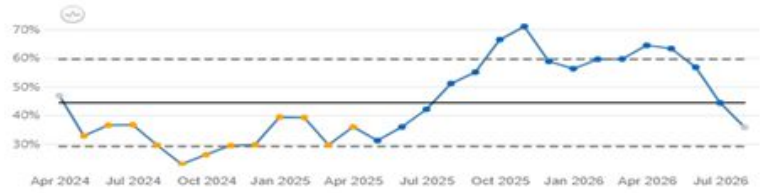
Quality

Responsive - Complaints

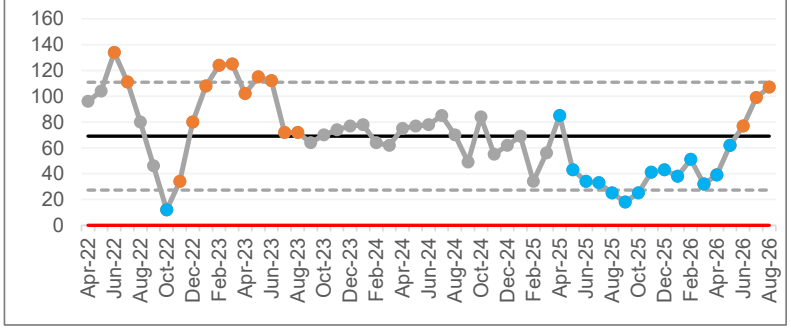
Formal Complaints Opened



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.

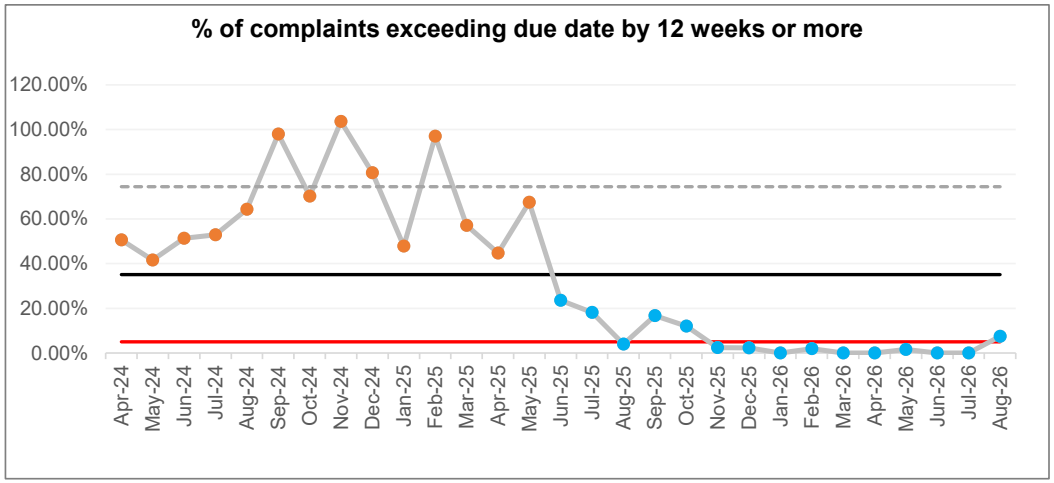
Actions being taken to improve:
Divisional regular care group complaint meetings will continue focus on complaints overdue and due in next 2 weeks to maintain the progress alongside focus from central complaints team and care groups. Risk register details mitigations as outlined above.

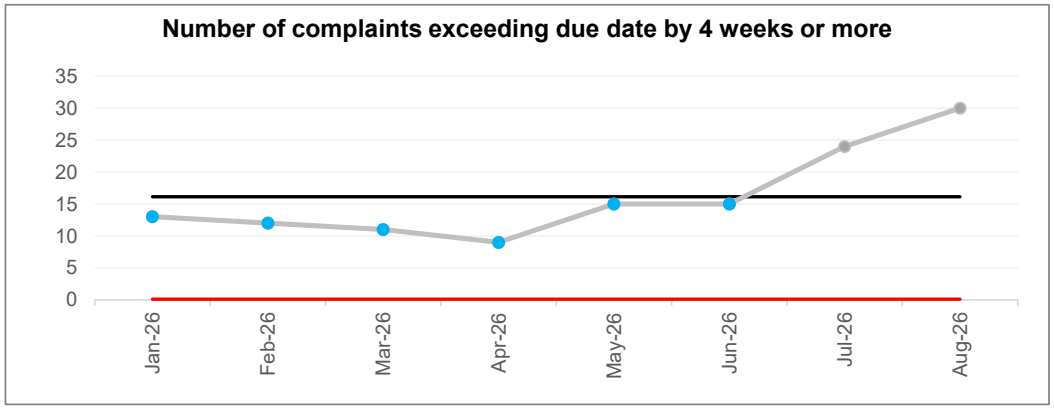
What is the impact for our patients?
Less timely response will make complainants feel unheard and that their concerns are not valid or feedback valued. For those who remain under our care they will lose Trust which may cause reputational damage.

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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

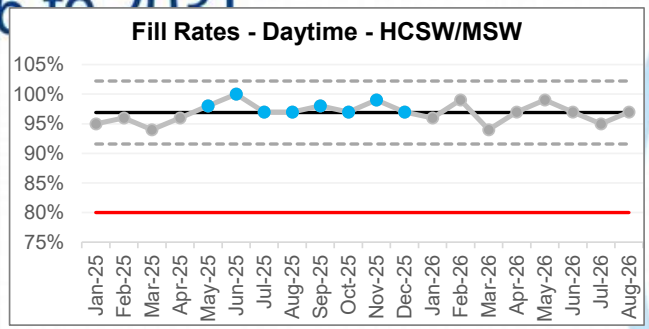
King's College Hospital NHS Foundation Trust

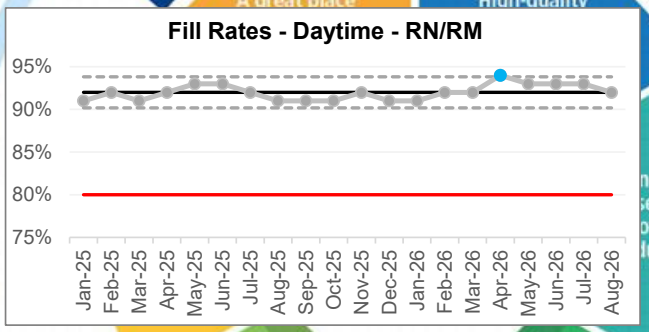
Fill Rates

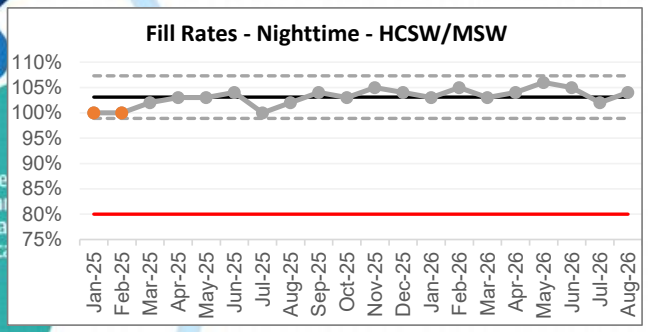
Positive assurance and special cause improvement shown for fill rates for daytime and nighttime for both HCSW and RN/RM.
Low special cause concern noted for fill rates for Daytime Trainee NA, however, this affects a very small number of staff in a few clinical areas only. King's are due to end the Trainee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

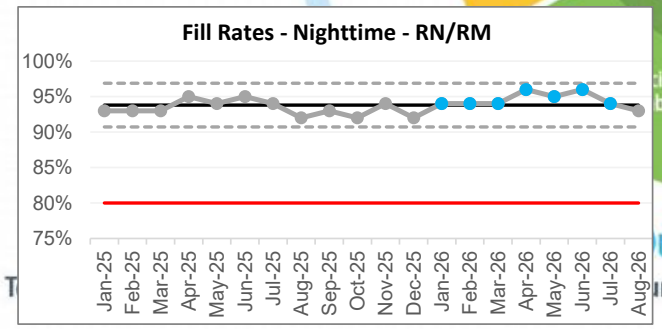
There were two areas within the organisation that reported a <80% RN/RM aggregate fill rate on either day or night shifts in August:

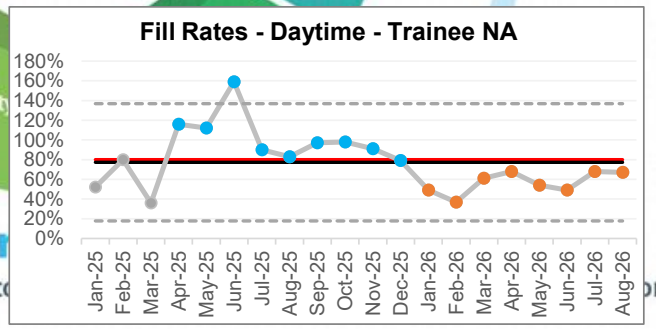
- **Postnatal William Gilliat Ward – RN fill rate 78% Nights**
- **Toni & Guy Ward – RN fill rate 78% Day and 75% Nights**











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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.

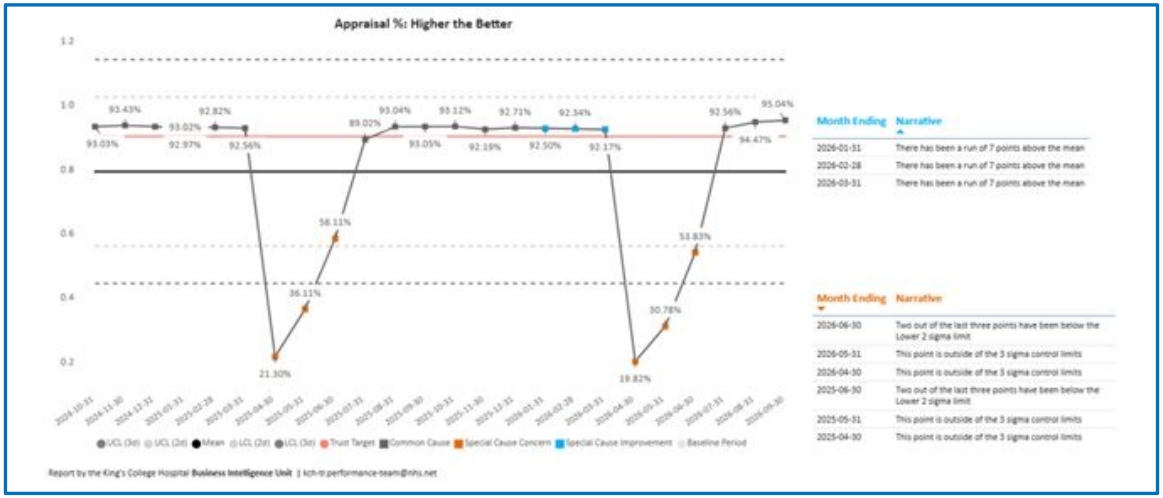
- Voluntary turnover has slightly decreased to 7.43% and remains well below the 13% target. Notably, turnover has consistently remained under target since October 2023, reflecting sustained retention performance.

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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Workforce

Statutory and Mandatory [Core Skills] Training

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

Background / target description:

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

Sep 2026	Target
89.03%	90%

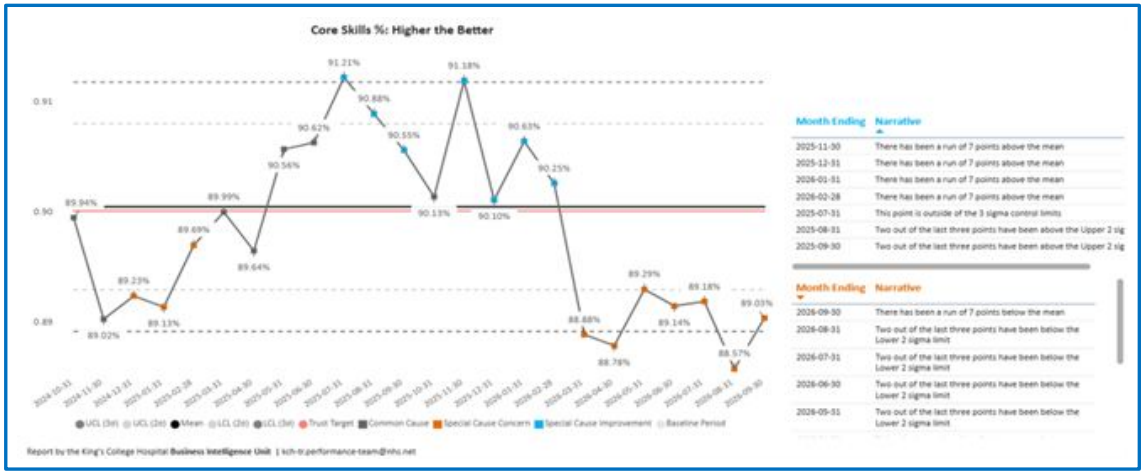
What is the Data Telling Us

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.

King's values Caring Collaborative Inclusive Innovative

Workforce

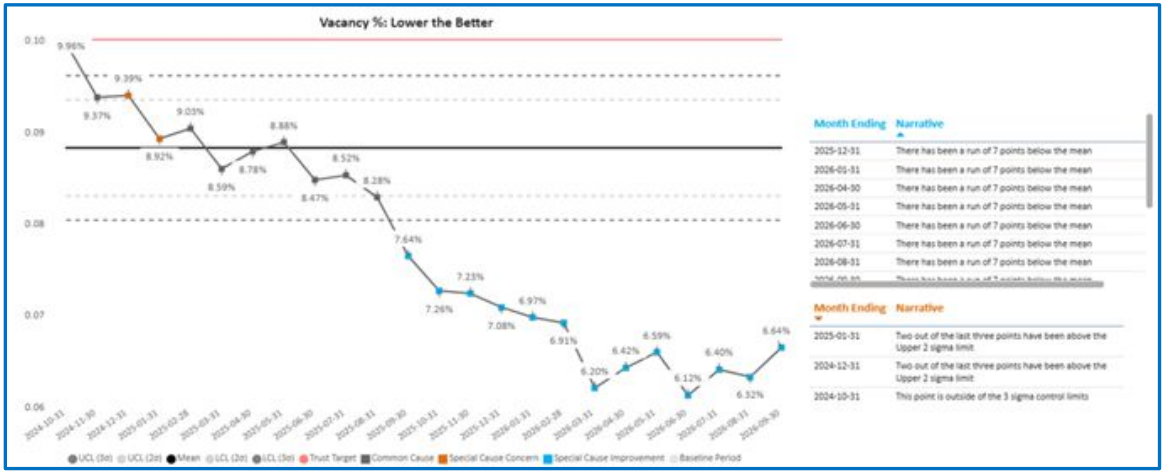
Vacancy Rate

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.

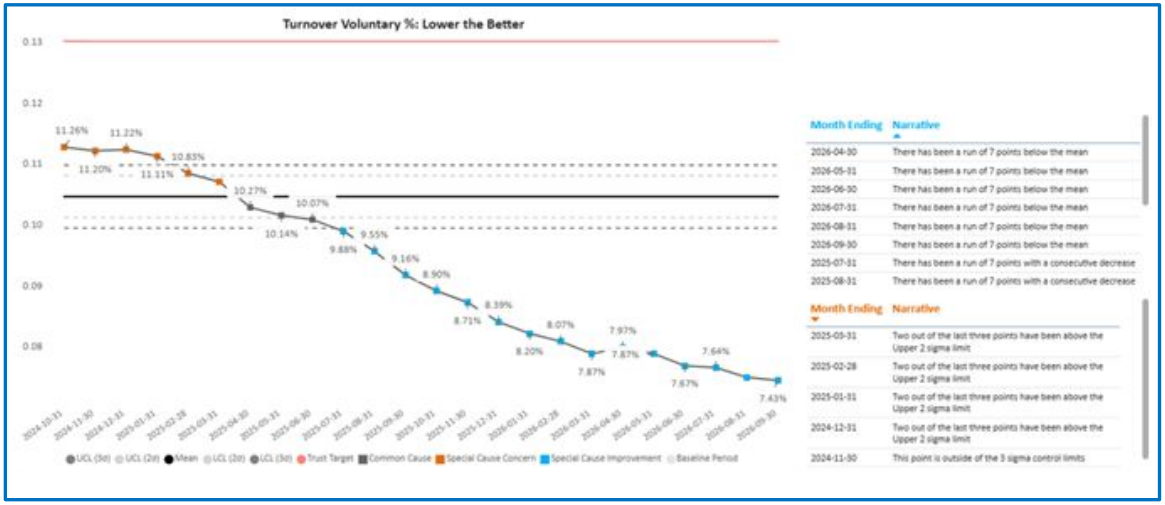
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Workforce

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.
- The three main voluntary reasons for leaving in September were:
  - Relocation (11%)
  - Promotion (9%)
  - Retirement (8%)

Future Actions

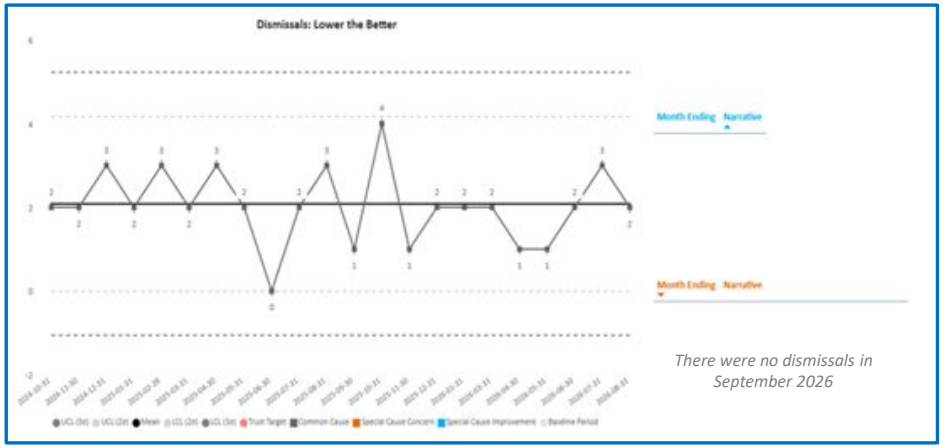
- Delivery on action plans from the 2025 National Staff Survey has taken place. Action planning sessions are in place to review feedback and agree targeted responses.
- Workforce priorities are progressing, including review of flexible working options, review of the reward and recognition offer, and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

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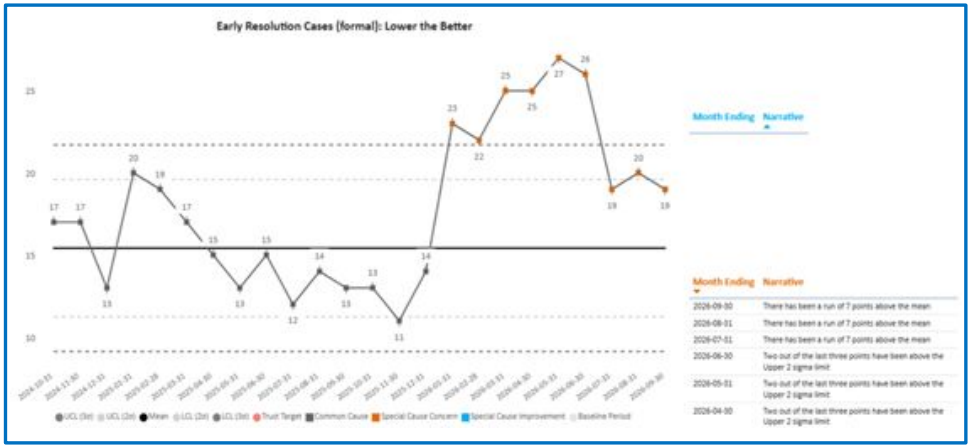
Workforce

Employee Relations

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.



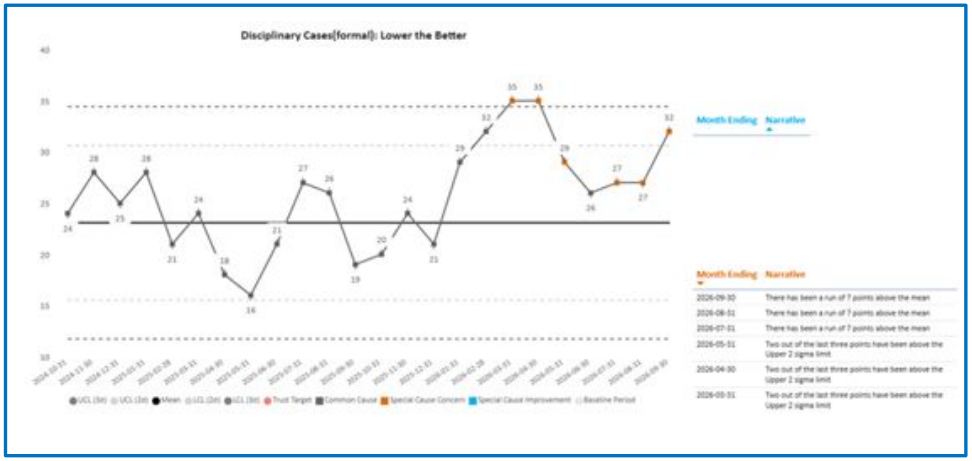
There were no dismissals in September 2026



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

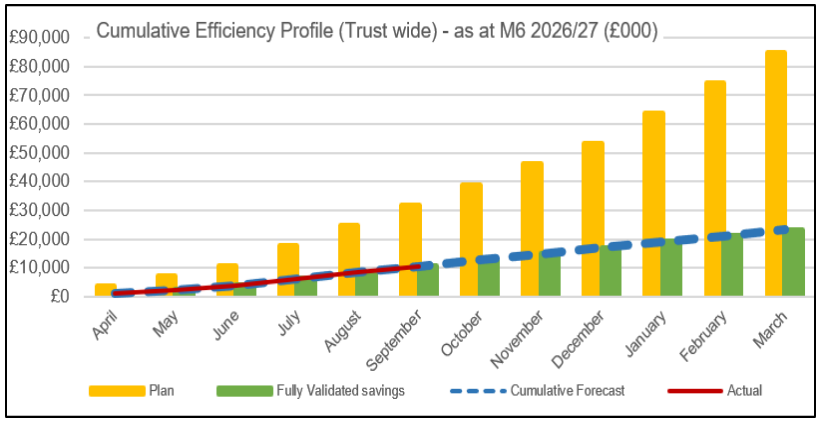
Domain 4: Finance

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.

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	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
Non-recurrent Deficit support income (Local)	(2.7)	(2.7)	0.0	(16.0)	(16.0)	0.0
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)



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.

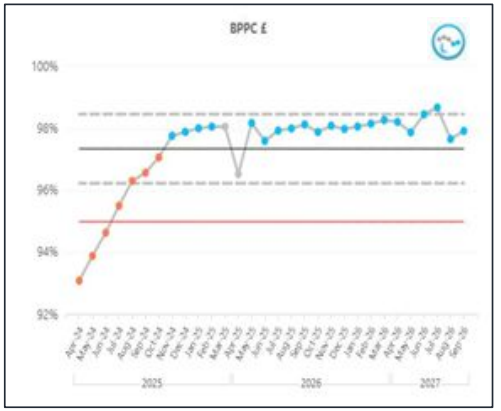
BPPC: performance remains above 90% for both invoice volume and value for the year to date. NHS invoices are around 3-4% of the total invoices processed.

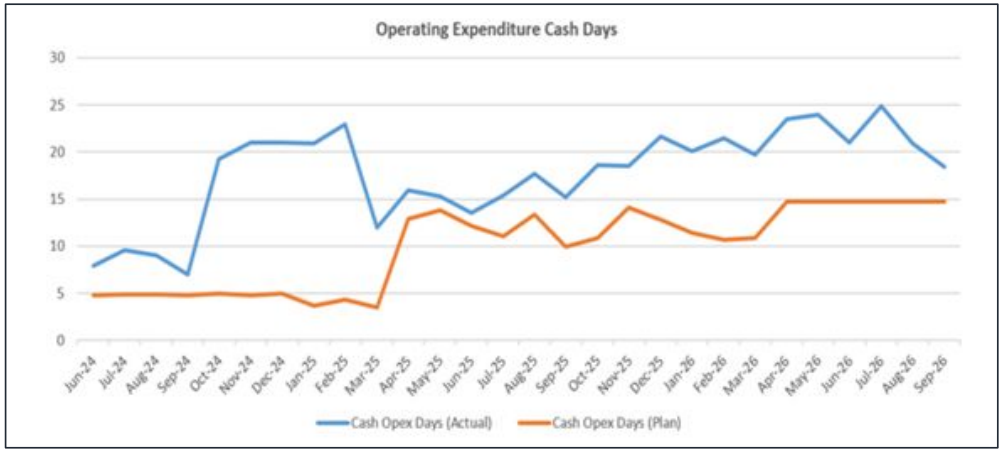
Capital: As at September 2026, Trust confirmed capital sources for 2026/27 core projects stands at £70.4m, a movement of £1.2m as a result of £1.0m provisional Return to Constitutional Standards (RtCS) funding now confirmed by NHS England and £0.2m of charity and national funding, including £0.06m of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

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.

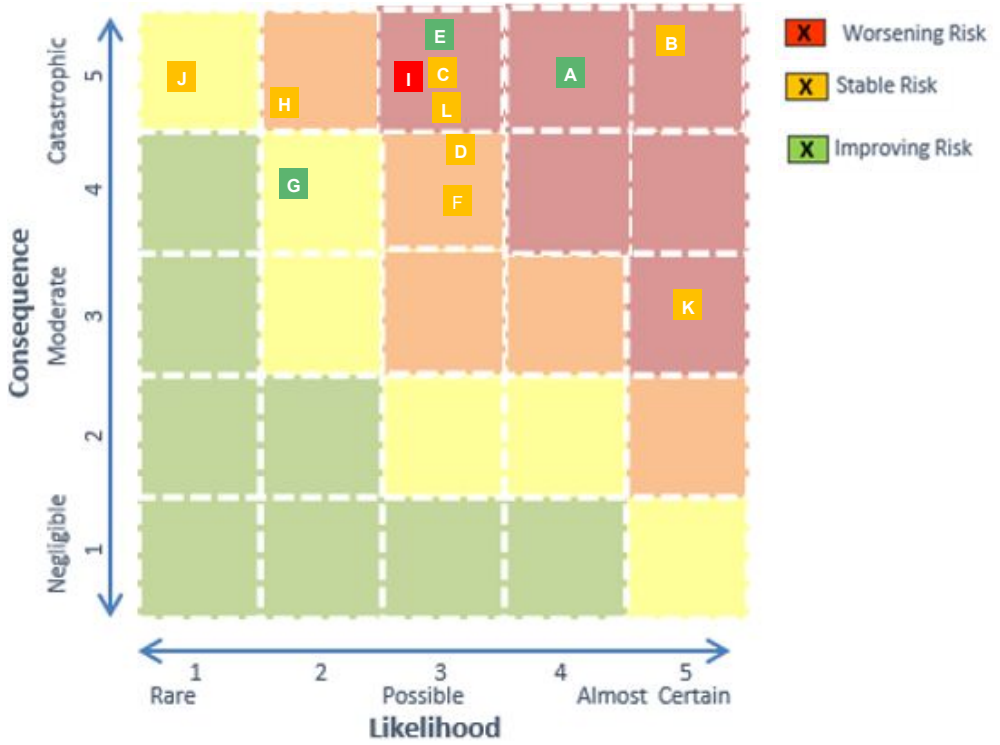
Risk I relates to the risk that Trust and the System's financial performance means national team withholds part of £44.5m deficit support funding in future quarters. If it was to materialise, it would worsen the Trust's deficit and negatively impact the Trust's cash position. The risk has increased due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



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

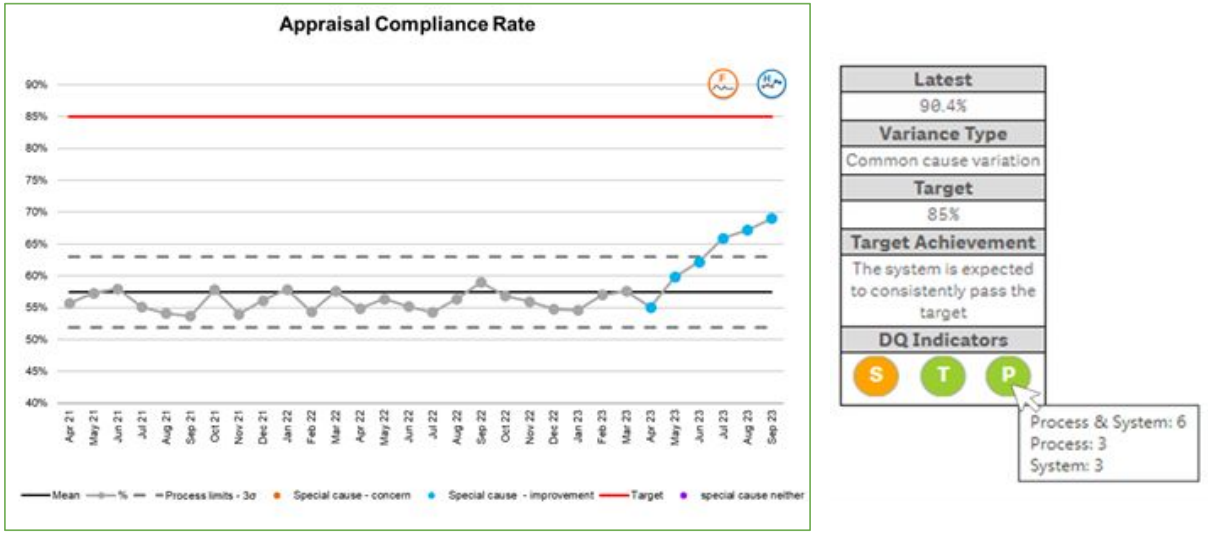
Interpreting summary icons

	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. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	**Something good is happening!** Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening / has happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Assurance icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Interpreting the Data Quality Indicator

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

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



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

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 11

BOARD/COMMITTEE REPORT COVER PAPER

Report to:	Trust Board meeting – Public
Date of meeting:	17 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

This is a summary of the discussions held at the Board subcommittee meetings since 16 September 2026. The following reports are included:

1. Finance and Commercial Committee (1 October and 5 November 2026 meetings),
2. Performance, Transformation and Improvement Committee (PTIC) (5 October and 5 November 2026 meetings),
3. Quality and Research Committee (30 September and 20 October 2026 meetings),
4. People, Inclusion and Education Committee (24 September and 22 October 2026 meetings),
5. Academic Committee in Common (6 October 2026)

Recommendations:

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

Strategy alignment

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

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Key implications

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

King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Finance and Commercial Committee – Chair's Report to the Board**
Date	**Thursday 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 Apologies were received from Non-Executive Director Angela Spatharou.	FI	Verbal	Chair	
	1.2. Declarations of Interest No new declarations were made.	FI	Verbal		
	1.3. Chair's Actions 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 The minutes were approved.	FA	Enc.		
	1.5. Action Tracker The Committee noted the action tracker updates.	FA	Enc.		
	1.6. Matters Arising There were no matters arising.	FD	Verbal		
2.	**FINANCIAL REPORTING 2026 / 27**				
	2.1. Finance Performance Report – Month 5 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**.

	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 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 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 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 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**				

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	5.1. Subsidiary Update 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 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 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) 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				

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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 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 There were no new declarations of interests.	FI	Verbal		
	1.3. Chair's Actions There were no Chair's actions.	FI	Verbal		
	1.4. Minutes of Previous Meeting The minutes from the 1 October 2026 meeting were approved.	FA	Enc.		
	1.5. Action Tracker The Committee noted updates to the action tracker.	FA	Enc.		
	1.6. Matters Arising There were no matters arising.	FD	Enc.		
2.	**FINANCIAL REPORTING 2026 / 27**				
	2.1. September 2026 Financial Position 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	

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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 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 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 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	

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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 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 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 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	

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	settlement, with no future liabilities or counterclaims, and approved the proposal.				
5.	**COMMERCIAL**				
	5.1. Trust-wide commercial activity 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 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) 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				

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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 The Committee noted the apologies received from: Sir David Behan, Chair Dr Mamta Shetty-Vaidya, Chief Medical Officer	FI	Verbal	Chair	
	1.2. Declarations of Interest There were no declarations of interest over and above those on record.				
	1.3. Minutes of the previous meeting and action tracker The minutes of the meeting held on 15 September 2026 were approved as an accurate record.	FA	Enc.	Chair	
OPERATIONAL PERFORMANCE					
2.	Integrated Performance Report 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 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 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 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 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 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 No specific matters were identified for escalation from this meeting to the Board. 8.2 Any Other Business 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 Apologies received from: Prof. Tracey Carter, Chief Nurse and Executive Director of Midwifery Anna Clough, Deputy Chief Operating Officer, and Dr Angela Sparharou, Non-Executive Director.	FI	Verbal	Chair	
	1.2. Declarations of Interest There were no declarations of interest over and above those on record.				
	1.3. Minutes of the previous meeting and action tracker The minutes of the meeting held on 8 October 2026 were approved as an accurate record.	FA	Enc.	Chair	
OPERATIONAL PERFORMANCE					
2.	Integrated Performance Report 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 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 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 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 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 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 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. 8.2 Any Other Business 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.				

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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 **Apologies were received from Matthew Trainer, CEO.**	FI	Verbal	Chair
	1.2. Declarations of Interest **No new declarations of interest were made in relation to the agenda items under consideration.**	FI	Verbal	
	1.3. Chair's Actions **There were no Chair's Actions.**	FI	Verbal	
	1.4. Minutes of the previous meeting **The minutes of the meeting held on 8 July 2026 were approved as an accurate record.**	FDA	Enc.	
	1.5. Action Tracker **The Committee reviewed the action tracker, closed the completed actions and noted that all other actions remained pending.**	FD	Enc.	
	1.6. Matters Arising **There were no additional matters arising.**	FI	Verbal	Chief Nurse & Executive Director of Midwifery/ Chief Medical Officer
	1.7. Immediate Items for Information **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			

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

	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) **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 **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 **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 **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 **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 **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 ▪ Vulnerability Annual Report & IPC Annual Report **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 **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) **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 **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 **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

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 **Apologies were received from non-executive directors, Dame Christine Beasley and Nicholas Campbell-Watts.**	FI	Verbal	Chair
	1.2. Declarations of Interest **No new declarations of interest were made in relation to the agenda items under consideration.**	FI	Verbal	
	1.3. Chair's Actions **No Chair actions were recorded in the meeting notes.**	FI	Verbal	
	1.4. Minutes of the previous meeting **The minutes of the meeting held on 30 September 2026 were approved as an accurate record.**	FDA	Enc.	
	1.5. Action Tracker **The Committee reviewed the action tracker, closed the completed actions and noted that all other actions remained pending.**	FD	Enc.	
	1.6. Matters Arising **There were no additional matters arising.**	FI	Verbal	Chief Nurse & Executive Director of Midwifery/ Chief Medical Officer
	1.7. Immediate Items for Information **No separate immediate item was recorded in the meeting notes.**	FD	Verbal	Chair
2.	**COMMITTEE REFLECTIONS & EMERGING CONCERNS**			
	2.1. Committee Reflections & Concerns **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 **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 **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 **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 **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 **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**

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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 **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 **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 **The report was received for information.**
7.	**ANY OTHER BUSINESS**
	7.1. Issues to be escalated to the Board **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 **Committee Effectiveness and Meeting Format** **Members supported the discussion-led format and reduced use of presentations.** **Members reflected positively on the revised meeting approach while requesting clearer reporting of impact, key data and governance follow-through.** **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

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 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 There were no declarations of interest.	FI	Verbal	Chair	
1.3	Chair's Actions There were no actions from the Chair.	FI	Verbal	Chair	
1.4	Minutes of the previous meeting The minutes of the meeting on 1 July 2026 were approved.	FA	Enc.	Chair	
1.5	Action Tracker The Committee reviewed and noted the updates to the action tracker.	FD	Enc.	Chair	
2.	**PART ONE – Highlight Report**				
2.1	Workforce Performance Report 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 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) 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 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	

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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 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 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 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	

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No.	Item	Purpose	Format	Lead & Presenter	
	promote equitable access to learning and development, and expand widening participation opportunities to support future workforce development.				
4.2	Guardian of Safe Working 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 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) 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 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	
	further discussion, using the existing staff network slot flexibly.				
6.	**ANY OTHER BUSINESS**				
6.1	Location of future People committee meetings 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 There were no issues for escalation to the Board of Directors other than this report	FD	Verbal	Chair	
6.3	Any Other Business 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

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 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 There were no new declarations of interest.	FI	Verbal	Chair	
1.3	Chair's Actions There were no actions from the Chair.	FI	Verbal	Chair	
1.4	Minutes of the previous meeting The minutes of the meeting on 24 September 2026 were approved as a correct record.	FA	Enc.	Chair	
1.5	Action Tracker The Committee noted the updates to the action tracker.	FD	Enc.	Chair	
2.	**PART ONE – Highlight Report**				
2.1	Workforce Performance Report 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	

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No.	Item	Purpose	Format	Lead & Presenter	
	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 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 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 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 The Committee noted that flu vaccination	FA	Enc.	Chief Nurse & Executive Director of Midwifery	

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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 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) 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) The Women's Network highlighted priorities around women's health, sexual	FD	Enc.	Chief People Officer	

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

No.	Item	Purpose	Format	Lead & Presenter	
	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 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 The Committee noted the report.	FD/A	Enc	Chief Medical Officer	
5.	**GOVERNANCE**				
5.1	NHS Staff Standards Implementation 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 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	

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

No.	Item	Purpose	Format	Lead & Presenter	
	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 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 There were no issues for escalation to the Board of Directors.	FD	Verbal	Chair	
6.2	Any Other Business 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**.

ACADEMIC COMMITTEE IN COMMON
6th October 2026, 9am -12pm
Robben Suite, Guy's Hospital

Chair's Report

1.	Welcome, introductions, apologies *Apologies were received from: Steve Weiner (KCL Council), Steve Davies (GSTT CFO), Roy Clarke (CFO KCH), Damian McGuiness (KCH CPO), Mamta Shetty Vaidya (KCH CMO).*	*Verbal*
2.	Declarations of interest *None over and above those already provided.*	*Verbal*
3.	Minutes from the previous meeting (8 July 2026) *Approved*	*Paper*
4.	Review of the action log *Noted.*	*Paper*
5.	Matters arising • A summary of the September KHP Board meeting was provided, including updates on the BRC applications, approval of the terms of reference for the executive group and the clinical academic integration model. An update on SC1 London was also provided. KHP will be hosting the EUHA presidency from November 2027. • An update on the implementation of the clinical academic MOU was provided. A comprehensive update will be provided at the January meeting. • Issues relating to the KHP passport were discussed including inconsistencies in approval processes between organisations. • An update on Biobanking was provided. The importance of transparent, consistent and proportionate governance was underlined. A task and finish group is being established to review arrangements. • The committee noted the NHS Research Framework has been published. An assessment of the impact on current arrangements, including how the University supports research in both Trusts will be brought to a future meeting.	*Verbal*
6.	Education and the future clinical academic workforce The Committee received a finance update focused on education funding, noting projected 2026/27 education income of £54.1m for KCH and £86.4m for GSTT, with nursing education funding of £3.7m and £5.4m respectively. Members reviewed priorities including clinical academic recharges, nursing education funding, research infrastructure bids and grant cost-effectiveness. Discussion highlighted the need to recognise differing financial pressures and governance arrangements between the university and NHS trusts, while exploring more strategic partnership approaches such as co-designing curricula to meet workforce needs. Questions were raised about whether funding information adequately demonstrated its impact on teaching and placement capacity.	Paper

	The Committee then considered capacity building and education, focusing on areas where joint strategic oversight by GSTT, KCH and KCL would add value. Priority areas included student and placement experience, education funding and educator capacity, workforce planning and curricula, and clinical academic careers. Members emphasised the importance of better visibility and use of student feedback, recognised the reputational risk arising from strong QS rankings but weaker NSS results, and agreed to develop a small set of shared measures using existing data. The Committee endorsed using existing governance structures, avoiding duplication, and commissioned further work to refine priorities, map governance and funding flows, and develop a concise proposal for future oversight arrangements	
7.	Research Update	
	Two NIHR Biomedical Research Centre (BRC) outline applications linked to KHP were successfully submitted by the September deadline: the GSTT-hosted Life Course BRC and the SLaM-hosted Maudsley Mind & Brain BRC. The Committee noted that the bids are scientifically distinct but complementary, supported by shared KCL/KHP infrastructure and collaborative working. Feedback is expected in December 2026, with successful applicants invited to submit full applications by March 2027.	*Paper* *Paper*
	Members recognised the significant contribution of academic, finance and governance teams and agreed to promote the achievement across the partnership. Given the competitive nature of the funding round, the need for contingency planning in the event of unsuccessful bids was also highlighted.	
	The Committee also reviewed progress against the 150-day research study set-up target. KCH reported improvements across key set-up metrics through its Research Performance Improvement Programme, while GSTT demonstrated stronger NIHR portfolio and commercial study performance alongside positive participant feedback. Members welcomed the progress but noted that delays can still arise from dependencies on wider clinical and corporate services. Discussion emphasised the importance of balancing speed with research quality, regulatory compliance and participant experience. The Committee also considered challenges around studies that are strategically important but may struggle to meet target timelines, agreeing that ACiC should take a strategic view on these issues and identify common themes for future discussion with NIHR.	
	The committee received the KCH Research Strategy for information.	
8	Any other business • Date of next meeting: Tuesday 19 January 2027 9am to 12noon (Robens Suite, Guy's Hospital)	*Verbal*

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 13.

BOARD/COMMITTEE REPORT COVER PAPER

Report to:	Public Board
Date of meeting:	17th November 2026
Subject:	Report from Governors
Author(s):	Jane Lyons MBE, Lead Governor
Sponsor:	Chair of the Board of Directors
History:	Not previously considered by Board/Committee/KE
Status:	

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

Purpose

To brief on the evolving situation regarding status of Council of Governors.

Recommendations:

The Board is asked to support any efforts to ensure that patient and community voice is resourced such that it is heard, acted upon and supported at the highest level within the Trust.

Strategy alignment

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

Key implications

Strategic risk - Link to Board Assurance Framework	This paper aims to describe how any potential risk of loss of patient and community representation through the removal of Councils of Governors might be mitigated.
King's Improvement Impact (KIM):	KIM has not been applied.
Quality Impact	Removal of Councils of Governors reduces the routes for patients to raise concerns or suggestions
Health Equity Impact	No EqIA has been undertaken on the potential impact of removal of Councils of Governors.
Workforce Impact	Engagement levels would drop.
Research/Innovation Impact	It does not support any of above.
Digital Impact	These have not been considered.
Financial Impact	It is understood that there will be a cost saving from within the Foundation Trust Office because of the removal of the need to support Governors administratively through elections, meeting attendance and dealing with any queries raised by Governors. However there is an increasing understanding that community engagement and accountability need to develop within KCH so it is likely that some cost implications will need to be included in any proposals improve on outreach.
Legal/ regulatory compliance	There will if current proposals go through be a shift in statutory responsibilities as those currently with Governors will need to be allocated elsewhere.
Communications and Engagement	There is a need to further communicate and engage on any plans emerging to succeed the current Council of Governors model. A new working group has been set up to discuss plans for the future, and this group should look to include onward communications both internally and externally.
Use of Artificial Intelligence Tools	No AI used is preparing this paper.
Committee that will provide relevant oversight Board of Directors	

King's College Hospital
NHS Foundation Trust

Main Report

Governors are pleased to submit a written report to the Public Board.

The majority of Governors are elected by their local communities, patients and staff working at King's College Hospital NHS Foundation Trust and currently have statutory and public accountability and patient engagement roles within the Trust. All are volunteers and therefore give of their time freely.

In summary Governors contribute to the work of the Trust currently through holding Non-Executive Directors to account and participation in committees, the raising of concerns or suggestions and visiting wards and other functions within the Trust.

The Board recognises Governors' significant voluntary contribution.

The role of Governors is currently under question with a proposal within the NHS Bill that Councils of Governors are removed from NHS Trusts from the end of March 2027.

There is a clear concern amongst Governors at the Trust of what may be lost in the removal of the Council of Governors, and a belief that we need to retain and indeed build the patient and community voice at a meaningful level within the Trust.

At time of writing (4th November 2026) this NHS Bill is under discussion at committee stage at the House of Lords, but the core proposal has not changed since the September board, though some proposals opposing abolition of Council of Governors have been tabled.

As discussed at the last Board in September work has now started through the creation of a Working Group within King's comprising representation from within the executive team, non-executive directors, and governors to plan what might succeed the current Council of Governors model. The first meeting has taken place, and three further meetings planned such that a proposal is brought to the March 2027 public board.

Whilst this discussion and planning is underway, Governors continue to contribute to the work of the Trust.

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 14

BOARD REPORT COVER PAPER

Report to:	Trust Board
Date of meeting:	17th November 2026
Subject:	King's Strategy 2026-31 Q1&2 Delivery Report
Author(s):	Evelyn Oyebanjo – Deputy Director of Strategy
Sponsor:	Matthew Trainer – Chief Executive Officer
History:	KMC - 3rd November 2026
Status:	

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

Purpose

The purpose of this paper is to provide an update on progress in delivering the King's Strategy – 2026 to 2031. The report outlines performance against the agreed five-year strategic measures and the agreed annual breakthrough objectives, together with key delivery activity undertaken during Quarter One and Quarter two of 2026/27.

Recommendations

Trust Board is asked to note progress against delivery of the Trust's Strategy, including key delivery activity, risks and priorities for the next quarter.

Strategy alignment

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

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

Key implications

Strategic risk - Link to Board Assurance Framework	Provides oversight of progress against the Trust's strategic ambitions, highlighting delivery challenges and risks that may affect achievement of the 2031 goals.
King's Improvement Method (KIM):	Applies KIM methodology through strategic metrics, breakthrough objectives, A3s and SDRs, providing a consistent approach to monitoring progress and improvement.
Quality Impact	Provides oversight of progress against strategic priorities that directly influence quality, access, patient experience and outcomes.
Health Equity Impact	Supports consideration of health inequalities and equity within the delivery of relevant strategic priorities and programmes.
Workforce Impact	Monitors progress against the Trust's workforce ambition, including staff experience, culture and the delivery of the People and Culture Strategy.
Research/Innovation Impact	Monitors progress against the Trust's Research, Innovation and Education ambition, including the development and delivery of supporting plans and priorities.
Digital Impact	Reliable and consistent data and digital capability are important enablers of strategic delivery and the effective monitoring of progress and outcomes.
Financial Impact	Monitors progress towards financial sustainability and the financial position as a key enabler of delivery across the wider strategy.
Legal/ regulatory compliance	Supports the Trust's governance and accountability arrangements by providing the Board with regular oversight of delivery against the approved strategy.
Communications and Engagement	Provides a consistent basis for communicating progress against the strategy, including achievements, areas requiring further improvement and examples of impact.
Use of Artificial Intelligence Tools	AI tools were not used to prepare this report.
Committee that will provide relevant oversight Trust Board	

NHS
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King's Strategy – 2026 to 2031 | Quarterly Strategy Delivery Report | Q1 & Q2 2026/27

Executive Summary

1. Purpose

1.1 This report provides an update on progress in delivering the King's Strategy - 2026 to 2031. It outlines performance against the five-year strategic measures and agreed annual breakthrough objectives, together with key delivery activity undertaken during Q1 and Q2 of 2026/27. The report includes Statistical Process Control (SPC) charts, where appropriate, to support the monitoring of progress and identify sustained improvement over time.

2. Recap: Monitoring Delivery of the King's Strategy 2026-31

2.1 Progress towards delivery of the strategy is monitored through a combination of:

- Five-year strategic measures that describe the outcomes the Trust aims to achieve by 2031;
- Annual breakthrough objectives that focus organisational effort on a number of priorities capable of driving significant improvement over the next 12 months; and
- Narrative updates on key programmes of work and activities, recognising that progress towards the strategy is not captured solely through quantitative measures and that qualitative updates provide important context on delivery, achievements and challenges.

2.2 Four breakthrough objectives have been launched through the SDR process to support delivery of a number of our Strategic Ambitions:

- Improving care for acutely unwell patients – High-Quality Care for Patients;
- Reducing length of stay – Timely and Efficient Patient Care;
- Improving cancer performance – Timely and Efficient Patient Care; and
- Improving adjusted financial position (surplus/deficit) – Financial Sustainability.

2.3 A further three breakthrough objectives are ready for implementation (highlighted in amber in Table 1:

- Keeping patients better informed about their care, appointments and waiting times – High-Quality Care for Patients;
- Improving the "We Are a Team" score in the NHS Staff Survey – A Great Place to Work; and
- Improving implied productivity – Financial Sustainability.

2.4 Not all strategic ambitions lend themselves to a single annual breakthrough objective. For example, for Pioneering Research, Innovation and Education and Strong Successful Partnerships, progress will be driven primarily, initially, through corporate-led programmes rather than a single objective that can be cascaded and monitored through SDRs.

2.5 These ambitions will instead be supported by an agreed set of annual priorities and programme milestones to monitor delivery and ensure continued progress towards the Trust's strategic goals.

2.6 Table 1 below sets out the strategic five-year measures and annual breakthrough objectives currently being used as part of the KIM, in the SDRs (included in black font below) and those that are currently being proposed for rollout (contained in amber font below). They will in turn be used to monitor delivery of the King's Strategy – 2026 to 2031.

Strategic Ambition	**High-Quality Care for Patients**	**Great Place to Work**	**Pioneering Research, Innovation and Education**	**Strong Successful Partnerships**	**Timely and Efficient Patient Care**	**Financial Sustainability**
Five-Year Metric	**98% FFT recommendation score across all services**	**Top performance in the NHS staff survey**	**Increase activity with each area growing by 10%**	**Transfer up to 30% of activity into an appropriate, alternative setting**	**Top 25% performance for all national standards**	**Breakeven by 2030 and maintain breakeven position**
Annual Breakthrough Objective (Y1)	Keeping patients better informed about their care, appointments and waiting times	Improved "We are a team" score in the Staff Survey - People Promise			Improved LoS by one day	Adjusted Financial Position (Surplus / Deficit)
Annual Breakthrough Objective (Y1)	Improving care for acutely unwell patients				Improved cancer performance	Improved Implied Productivity

3. Summary of Q1 and Q2 Progress

3.1 In summary, the following progress has been made against the six strategic ambitions in the first six months of delivery.

3.2 The attached PowerPoint gives more detail of the actions taken, progress and development of breakthrough objectives and step change projects.

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Delivery across the six strategic ambitions

Strategic Ambition	Delivery	Outcome	Movement	Headline progress
High-quality patient care	R	R	▼ Off Track	FFT recommendation rate remains below trajectory. Developed an improvement plan which sets out actions to address three key drivers (communication, waiting and appointments) to patient experience. Ready to launch as part of KIM. Acutely unwell patient breakthrough objective (timeliness of observations) shows consistent improvement since launch as part of KIM in March 2026.
A great place to work	G	A	▲ Improving	Staff experience is improving across all People Promise themes, although further progress is needed to achieve the Trust's ambition for top performance. Focus is now on translating the People and Culture Strategy into visible improvements for staff.
Pioneering research, innovation and education	G	G	• Stable	Improvement in 150-day target performance alongside development of Trust-wide research, innovation and education strategies ambitions.
Strong, successful partnerships	G	G	• Stable	Work continues with partners in developing a unified approach to brining care closer to home.
Timely and efficient care	A	A	• Stable	Performance is showing improvement in RTT and diagnostics, supported by targeted recovery actions. However, urgent care and cancer remain challenged, with continued focus required to improve performance
Financial sustainability	A	A	• Stable	While there is a favourable variance to plan and a forecast breakeven position, there remains a significant underlying deficit and recurrent efficiency gap to address.

3.3 During the first half of 2026/27, the Trust has established foundations for delivering the King's Strategy – 2026 to 2031, with progress across all six strategic ambitions.

3.4 Under **High-Quality Care for Patients**, the Friends and Family Test recommendation rate remains below trajectory and has fallen to 87% since April 2026. However, good progress has been made on the first breakthrough objective 'Improving care for acutely unwell patients' with a promising improvement in the timeliness of observations since its launch in April 2026. In addition an analysis of more than 62,000 patient feedback contacts has informed an improvement plan focused on communication, waiting and appointments which is now due to launch as part of the SDR.

3.5 **A Great Place to Work** has seen improvement across all seven People Promise themes in the 2025 NHS Staff Survey, with the People and Culture Strategy now providing a framework for targeted improvement. Work is being finalised with the Team to establish the use of the Culture Dashboard as the breakthrough objective for this strategic ambition.

3.6 **Pioneering Research, Innovation and Education** has seen improved performance against the national 150-day target, alongside sustained achievement of study set-up and recruitment targets in recent months. A major focus for this strategic ambition has been to continue the development of the Trust's strategic direction for research, innovation and education.

3.7 Under **Strong, Successful Partnerships**, work with partners in Bromley is progressing towards a shared approach to measuring and delivering the ambition to shift appropriate care closer to home. This work will be shared and integrated into a wider approach with partners in Lambeth and Southwark over the next couple of quarters.

3.8 **Timely and Efficient Care** has seen improvement in RTT and diagnostic performance, both supported by targeted recovery plans, although urgent care and cancer performance remains challenged.

3.9 Finally, under **Financial Sustainability**, the Trust is forecasting delivery of its in-year breakeven plan but this remains dependent on further remedial action. The underlying deficit and significant recurrent efficiency gap remain key risks to achieving sustainable financial balance.

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NHS Foundation Trust

King's Strategy – 2026 to 2031

Delivery Report – 2026 to 2027 (April to June and July to September)



Caring Collaborative Inclusive Innovative

King's Strategy – 2026 to 2031 | Delivery Report – 2026 to 2027 (April to June and July to September)

Summary

Progress

Amber

Confidence in delivery to 2031

Overview: The Trust has established foundations for delivering the King's Strategy – 2026 to 2031, with encouraging progress in staff experience, research performance and planned care recovery. However, significant challenges remain: the Friends and Family Test recommendation rate has fallen to around 87%, urgent care and cancer performance remain under pressure and the forecast in-year breakeven position depends on further remedial action to address the underlying deficit and recurrent efficiency gap. The next phase will focus on translating strategic priorities into measurable improvements in patient and staff experience, operational performance and financial sustainability.

Delivery across the six strategic ambitions

Strategic Ambition	Delivery	Outcome	Movement	Headline progress
High-quality patient care	R	R	▼ Off Track	FFT recommendation rate remains below trajectory. Developed an improvement plan which sets out actions to address three key drivers (communication, waiting and appointments) to patient experience. Ready to launch as part of KIM. Acutely unwell patient breakthrough objective (timeliness of observations) shows consistent improvement since launch as part of KIM in March 2026.
A great place to work	G	A	▲ Improving	Staff experience is improving across all People Promise themes, although further progress is needed to achieve the Trust's ambition for top performance. Focus is now on translating the People and Culture Strategy into visible improvements for staff.
Pioneering research, innovation and education	G	G	• Stable	Improvement in 150-day target performance alongside development of Trust-wide research, innovation and education strategies ambitions.
Strong, successful partnerships	G	G	• Stable	Work continues with partners in developing a unified approach to brining care closer to home.
Timely and efficient care	A	A	• Stable	Performance is showing improvement in RTT and diagnostics, supported by targeted recovery actions. However, urgent care and cancer remain challenged, with continued focus required to improve performance
Financial sustainability	A	A	• Stable	While there is a favourable variance to plan and a forecast breakeven position, there remains a significant underlying deficit and recurrent efficiency gap to address.

Risks and Opportunities

Key risks to delivery

- Sustained operational pressures may limit improvements in communication, waiting times and patient experience.
- Ongoing challenges in urgent care and cancer, alongside diagnostic capacity constraints, may affect delivery of access standards.
- Delivery of the in-year breakeven plan remains dependent on further remedial action, with a significant underlying deficit and recurrent efficiency gap to address.

Key Opportunities

- Support building a culture of continuous improvement and embed improvement priorities through the Kings Improvement Method, particularly around communication, patient flow and quality.
- Use partnership work in Bromley to create a scalable model for shifting care closer to home across all partnership geographies.

High-quality care for patients – Five-Year Stretch Target [1]

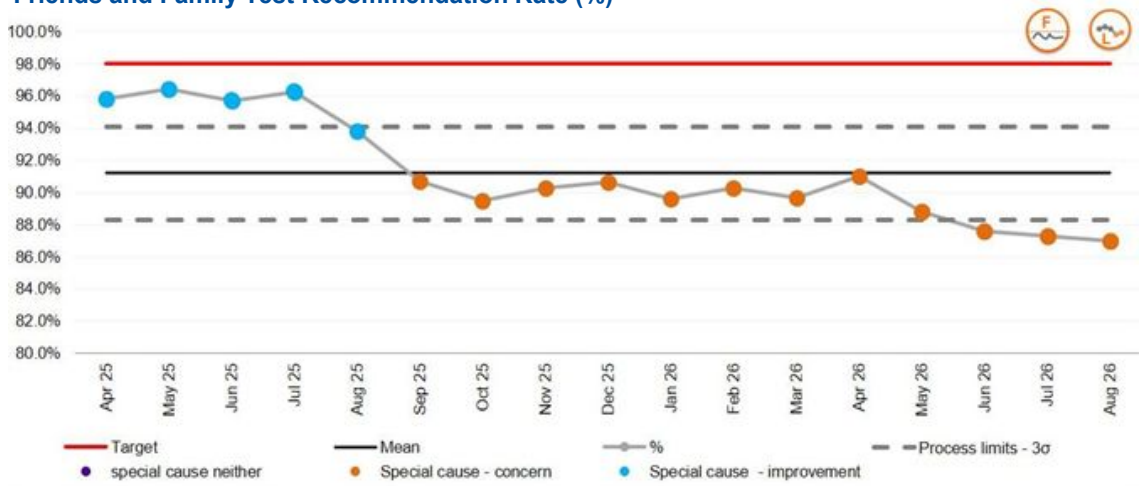
Exec Sponsor: Tracey Carter
SRO: Patricia Mecinska
Board Sub-Committee: Patient Experience and Safety

Our Ambition: People will receive care and treatment that feels safe and personal and is clearly communicated. We will be known as a place that truly puts patients first.

2031 Goal: 98% Friends and Family Test (FFT) recommendation score across all services by 2031.

Delivery	Outcome	Vs last quarter
R Red	R Red	▼ Off track

Friends and Family Test Recommendation Rate (%)



Key Updates

- **Headline:** 62,211 instances of feedback between April 2025 and March 2026 (PALS contacts, FFT responses and formal complaints) consistently point to communication, appointments and waiting as the strongest trust-wide opportunities for improvement.
- **What patients tell us:** Of these 60,000+ patient contacts, communication ranked first and accounted for 34% of PALS concerns and enquiries. Appointments were the most frequently reported theme in PALS. Waiting was the leading negative FFT theme (2,817 mentions) and among the top three negative themes in every service.
- **Friends and Family Test:** The FFT recommendation score has fallen from about 96% (Apr–Jul 2025) to about 87% (Aug 2026), against a goal of 98% by 2031.
- **Our plan:** An improvement plan sets out actions under three key drivers (communication, waiting and appointments), including the King's Communication Standard, Care Navigator service supporting patients with waiting well, and patients managing their appointments more effectively via MyChart.
- **Gaps:** Emergency Department patients are least likely to recommend us (70.3% vs 92–95% in other services). The plan sets a steeper path for Emergency: 72% in year 1, rising to 98% by 2031.

Key risks to delivery

Risk: Consistent adoption of the Communication Standard across all services may be challenging given competing operational pressures and demands.
Mitigation: Consistent adoption through the KIM by embedding standard into routine practice
Risk: Emergency care is furthest from target (70.3% vs 98%), requiring sustained commitment from both EDs at a busy time of year.
Mitigation: Agree targeted improvement plans with both ED teams, supported through the KIM
Risk: Improving communication and patient experience directly relates to wider improvements in patient flow, planned care and corridor care.
Mitigation Work with operational teams to address the underlying causes of poor patient experience, ensuring communication improvements are supported by tangible improvements in flow, waiting times and care delivery.

Next quarter: top priorities

Priority	Owner	Due	Expected result
Launch 'improving communication' as the breakthrough objective in KIM	P. Mecinska	Dec-26	Adopted by most divisions and care groups; baselines set
Interview for the Care Navigator Lead and enable volunteers to access EPIC	P. Mecinska	Dec-26	Establish initial steps to enable the launch of the Standard and Care Navigator

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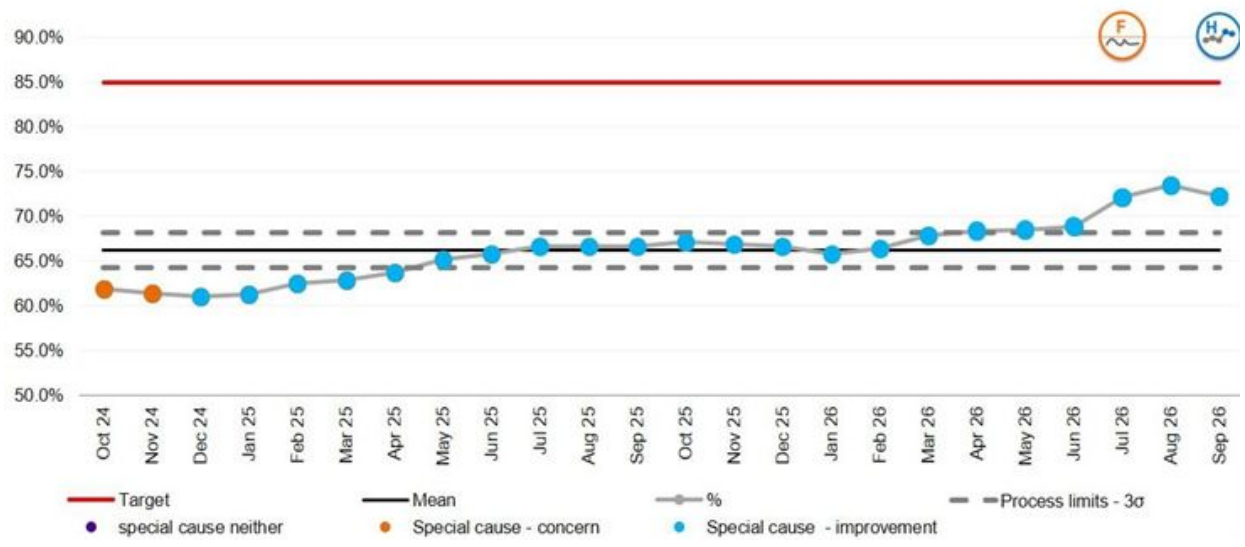
High-quality care for patients - Breakthrough Objective [2]

Exec Sponsors: Tracey Carter
SRO: Sophie Hadfield
Board Sub-Committee: Patient Experience and Safety

Breakthrough Objective (26/27 annual goal): Improve care for acutely unwell patients via improving the completeness and timeliness of patient observations

Delivery	Outcome	Vs last quarter
G Green	A Amber	▲ Improving

Timeliness of Patient Observations (%)



Key Updates

- **Current Situation:** Completeness of observations: 88.3% (Adults), 53.75% (Maternity), 33.4% (Paediatrics); no data for ED. Timeliness of observations: 59.4% (Adults), 28.3% (Maternity), 25.6% (Paediatrics); no data for ED.
- **Prioritised Concerns:** Inconsistent use of early warning scores, no available data to measure response, and a lack of robust metrics.
- **Our plan:** A monitoring toolkit is being rolled out to all wards to sustain improvement. Adult dashboards will be reviewed locally and at 3-4 monthly Quality and Safety meetings with nursing leads.
- **Scope:** Trust-wide. Inpatients only. ED is not yet measured; dashboard being validated by clinical team.
- **Patient benefit**: Improved timeliness of vital signs monitoring may be associated with reduced NEWS trigger scores, suggesting fewer patients are experiencing higher levels of clinical deterioration. This is further supported by lower APACHE II scores (indicate severity of illness) on admission to critical care. However, as other factors may have influenced these outcomes, findings should be interpreted with caution in the absence of formal statistical analysis.

Key risks to delivery

Issue: Monitoring standards vary across the Trust because there is varied use of EWS

Mitigation: The monitoring toolkit is being rolled out based on SEIPS model to set a standard method for monitoring compliance and ensure that improvement is sustained.

Issue: NEWS in adults has shown greatest improvement, PEWS and MEWS are less established tools than NEWS. Data on response to deterioration (time to escalation and review) is not available due to no consistent template for documentation in EPIC

Mitigation: For adults, review monitoring through a dashboard, locally and at the 3-4 monthly Quality and Safety meetings with nursing leads for local areas. PEWS and MEWS improvement plans being developed locally. Data being explored looking at critical drug prescription timestamp as a surrogate marker for time of review.

Next quarter: top priorities

Priority	Owner	Due	Expected result
Monitoring toolkit – rollout across all inpatient areas	Sophie Hadfield	March 2027	Standard monitoring method in use
Adults: Exploring critical drugs prescription as a timestamp for timeliness of review following elevated NEWS Maternity and Paediatrics: Improvement plan MEWS and PEWS timeliness	Sophie Hadfield / Child health leads	March 2027	Improvement from baseline
NEWTT – neonatal EWS dashboard	Sophie Hadfield	March 2027	Dashboard validated for use

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A great place to work – Five-Year Stretch Target [1]

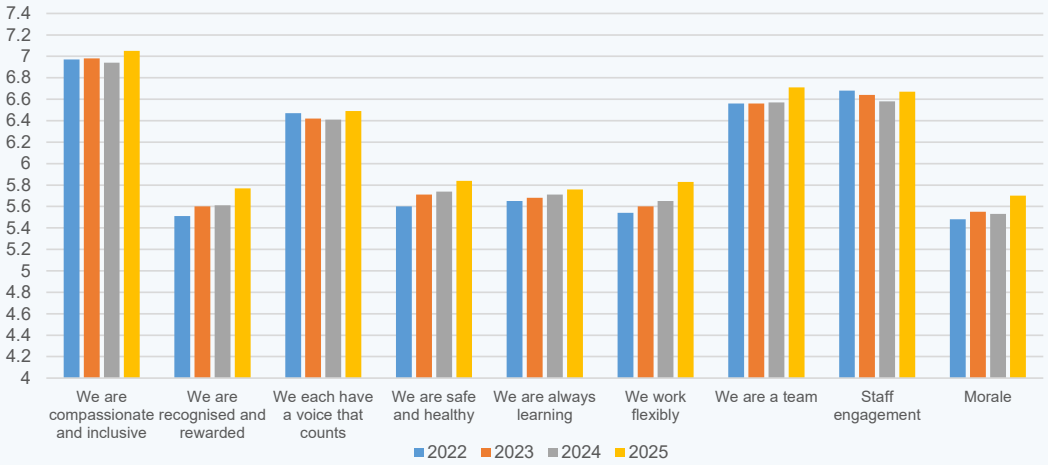
Exec Sponsor: Damian McGuinness
SROs: Dayo Ajibola and Harprit Hockley
Board Sub - Committee: People, Inclusion & Education

Our Ambition: Patients will feel cared for by proud, motivated staff who work seamlessly together to provide compassionate, inclusive care.

2031 Goal: Top performance in the NHS Staff Survey by 2031

Delivery	Outcome	Vs last year*
G Green	A Amber	▲ Improving

NHS Staff Survey* 2022-25
People Promise and Theme Comparisons



Key Updates

- Strategic direction established, with delivery now moving from engagement to implementation.
- The 2025 NHS Staff Survey showed improvement across all seven People Promise themes and 98 of 110 questions. However, no themes are currently in the top quartile, with variation in staff experience across teams, sites and staff groups.
- The Strategic A3 identifies inconsistent leadership and management practice, workforce pressures, wellbeing, inclusion and access to development as key areas requiring sustained improvement.
- The People and Culture Strategy 2026–2031 has been developed and taken through engagement, supported by an initial 18-month delivery plan. Six priority areas have been identified from the Staff Survey, with equity deep dives underway to better understand disparities and target interventions. The next phase will focus on translating this analysis and engagement into visible improvements for staff.

Key risks to delivery

- Operational and financial pressures: Continued service and financial pressures may limit the capacity to prioritise and sustain culture and workforce improvements.
- Leadership and organisational capacity: Competing priorities and variable management capacity may affect the pace and consistency of implementation.
- Delivery at scale: Improvements will depend on translating Trust wide programmes into locally owned action, particularly in areas experiencing poorer staff outcomes.

Next quarter: top priorities

Priority	Owner	Due	Expected result
Finalise the People and Culture Strategy and initial delivery plan	Dayo Ajibola and Harprit Hockley	Q3	Agreed priorities, milestones and governance
Mobilise the six Staff Survey improvement programmes	Dayo Ajibola and Harprit Hockley with exec sponsors	Q3	Clear programme ownership, actions and delivery plans
Progress equity deep dives and develop integrated assurance measures	Dayo Ajibola and Harprit Hockley	Q3	Priority hotspots identified and targeted interventions informed by evidence

**As this measure is derived from the annual NHS Staff Survey, results are only available once each year. Work is in progress to identify a suitable quarterly metric to track progress between survey cycles.*

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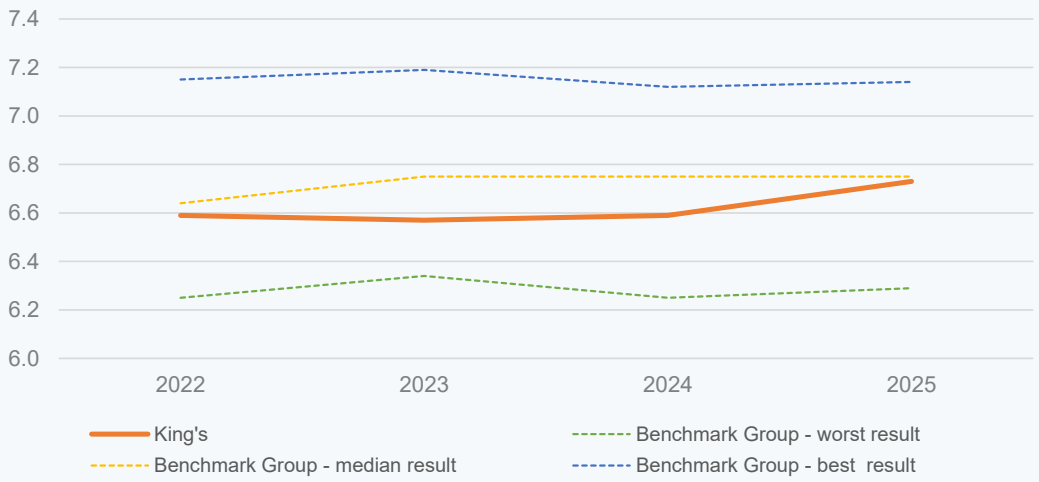
A great place to work - Breakthrough Objective [2]

Exec Sponsor: Damian McGuinness
SROs: Dayo Ajibola and Harprit Hockley
Board Sub-Committee: People, Inclusion & Education

Breakthrough Objective (26/27 annual goal): Improve the "We Are A Team" score in the staff survey

Delivery	Outcome	Vs last year*
G Green	A Amber	▲ Improving

"We Are a Team" People Promise Score*, 2022–2025



Key Updates

- A focused programme of improvement will strengthen teamwork, leadership and staff experience.
- The 2025 Staff Survey showed improvement in the "We Are a Team" score, providing a positive baseline for the 2026/27 Breakthrough Objective.
- However, analysis highlights continuing variation in leadership, team experience, psychological safety and staff confidence that concerns lead to action.
- The Breakthrough Objective will bring together a small number of Trust wide programmes, aligned to the first 18 months of the People and Culture Strategy. Initial priorities will include clearer leadership and behaviour expectations, strengthened staff engagement and voice, targeted support for teams experiencing difficulties, and more consistent approaches to inclusion, wellbeing a development

Key risks to delivery

- Competing operational priorities: Limited capacity for leaders and teams to engage in improvement alongside service and financial pressures.
- Inconsistent local implementation: Trust-wide initiatives may not result in a consistent experience unless care groups and managers actively own the changes.
- Demonstrating impact: The principal outcome measure is annual, requiring interim indicators and qualitative feedback to assess whether interventions are making a difference.

Next quarter: top priorities

Priority	Owner	Due	Expected result
Launch the "We Are a Team" Breakthrough Objective	Dayo Ajibola and Harprit Hockley	Q3	Agreed improvement approach, programme ownership and measures
Progress leadership, behaviours and staff engagement programmes	Dayo Ajibola and Harprit Hockley	Q3	Initial delivery plans and interventions to strengthen team experience
Establish baseline measures and targeted OD support	Dayo Ajibola and Harprit Hockley	Q3	Improved insight into team variation and a targeted support approach
Develop a Culture Dashboard to establish key measures and enable regular monitoring of culture and staff experience at divisional level.	Dayo Ajibola and Harprit Hockley	Q3	Agreed set of culture and staff experience metrics, providing divisional level insight to identify areas of concern, target interventions and monitor progress over time.

As this measure is derived from the annual NHS Staff Survey, results are only available once each year. Work is in progress to identify a suitable quarterly metric to track progress between survey cycles.

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6

Pioneering research, innovation and education – Five-Year Stretch Target

Exec Sponsor: Mamta Shetty-Vaidya
SRO: Vadivelam Murthy
Board Sub-Committee: Quality and Research

Our Ambition: People will have faster access to new treatments, care from expert staff and the confidence that every innovation at King's helps improve lives.

2031 goal: To achieve a Trust-wide increase in research, innovation and education activity, with each area growing defined activity by at least 10% by 2031.

Breakthrough Objective (26/27 annual goal): Unlikely to be captured by a single breakthrough objective, as delivery is not readily cascade-able and will initially require coordinated delivery by corporate teams

Delivery	Outcome	Vs last quarter
G Green	G Green	• Stable

Key Updates

- Performance against the national 150-day target continues to improve, with sustained achievement of the 60-day study set-up target and the 30-day recruitment target in recent months. However cumulative performance against both recruitment metrics remains below the required national thresholds. Delivery continues to be impacted by recruitment restrictions affecting the appointment of externally funded R&D staff. Immediate priorities are to maintain improvements in study set-up performance, strengthen early recruitment planning and address the operational factors contributing to delays.
- Work continues to develop the Trust's strategic ambitions for research, innovation and education:
  - Innovation: Work has commenced to establish a clearer and more coordinated strategic direction for innovation across King's, strengthening alignment with research and education and creating a more cohesive approach to innovation activity across the Trust.
  - Research: Following further consultation with Trust leadership and partners, work is progressing to finalise the Trust's Research and Development Strategy, setting out how King's will deliver its research ambition to 2031. The strategy is being refreshed to strengthen the integration of research and clinical care, enhance internal structures that support greater autonomy and independence for research teams, and expand commercialisation opportunities and strategic partnerships.
  - Education: An emerging ambition is to establish a single, Trust-wide King's Academy, bringing together education, training and workforce development functions within a more coordinated framework. This could support workforce retention and career development, improve the consistency and efficiency of training provision, and create opportunities to share expertise and generate external income. Further work is required to assess the operating model, governance, costs and benefits.

Key risks to delivery

Risk: The breadth and complexity of the education portfolio may make it challenging to develop a coherent, integrated Trust-wide model that meets the needs of all professions and functions.

Mitigation: Map existing provision, identify duplication and gaps and co-design a single integrated Academy model that brings education functions together around shared priorities, clear accountability and measurable benefits. Bring in proven expertise.

Next quarter: top priorities

Priority	Owner	Due	Expected result
Finalise Trust's R&D Strategy	V. Murthy	31/12/26	Strategic ambition for Research at Kings
Finalise strategic ambition for education	V. Murthy	31/12/26	Clarity of the vision going forward

Strong, successful partnerships – Five-Year Stretch Target

Exec Sponsor: Julie Lowe
SRO: Liz Shutler
Board Sub-Committee: Finance and Commercial

Our Ambition: People will get high-quality care closer to home, through virtual appointments and monitoring, meaning fewer hospital visits and less time as an inpatient.

2031 goal: To transfer up to 30% of hospital care to an appropriate, alternative setting by 2031.

Breakthrough Objective (26/27 annual goal): TBC (unlikely to be captured by a single breakthrough objective but will instead require an agreed set of service developments, supported by a suite of measures to track delivery, impact and outcomes.)

Delivery	Outcome	Vs last quarter
G Green	G Green	• Stable

Key Updates

- Two workshops have been held with a focused group of partners in Bromley to develop a shared approach to delivering and measuring this important ambition. Bromley has been selected as the starting point because King's is leading the local Integrator work, providing an established partnership platform and strong local relationships through which to develop and test the approach collaboratively.
- Starting in Bromley offers an opportunity to build on this existing momentum, learn from local experience and establish a practical, robust approach that can be applied more widely. This is an initial phase rather than an exclusive focus on Bromley. Following the second workshop, the intention is to extend engagement to GSTT and partners across Lambeth and Southwark, ensuring the approach reflects the wider system context and supports a consistent ambition across our partnership geographies.
- The second workshop aims to conclude the services that will form the balanced scorecard in Bromley and agree an approach to measuring the 30% shift. The options being looked at include: a single headline activity measure (total hospital activity); a different measure with reductions by type of activity (i.e. IP / OP /DC); a weighted activity measure (reflecting relative resource use or cost); a measure of activity per head of population; a measure that shows the shift in care, alongside hospital activity (i.e. it track reductions in hospital activity alongside increases in appropriate community-based care); and a combined approach with a balanced set of measures.

Key risks to delivery

Risk: The approach developed in Bromley may not fully translate to the differing partnership arrangements and local priorities in Lambeth and Southwark.

Mitigation: Engage GSTT and partners in Lambeth and Southwark early to adapt and validate the approach to reflect local contexts, while maintaining a consistent overarching ambition and measurement framework.

Next quarter: top priorities

Priority	Owner	Due	Expected result
Conclude discussions on balanced scorecard in Bromley	Liz Shutler	31/12/26	Local scorecard for Bromley with a baseline set of measures
Agreed approach to measuring the 30% shift	Liz Shutler	31/12/26	Baseline performance from April 2026 available
Informal discussion with GSTT on approach	Liz Shutler	31/12/26	Risk mitigation

Timely and efficient care – Five-Year Stretch Target [1]

Exec Sponsor: Angela Helleur
SRO: Anna Clough
Board Sub - Committee: Performance, Transformation and Improvement

Our Ambition: People will have faster and more reliable care, with shorter waits, smoother treatment journeys and services they can trust to deliver excellent care every time.

2031 Goal: Top 25% performance for all national and constitutional standards by 2031

Delivery	Outcome	Vs last quarter
A Amber	A Amber	• Stable

NHS Oversight Framework Access Standards: Performance and National Ranking (Q1 2026/27)



Key Updates

- RTT Incomplete performance has improved since April-26, meeting the revised trajectory in September, but remaining below the operating plan. Continued delivery of long-waiters action plan, SIF activity and PTL validation aims to support further improvement to Mar-27.
- Diagnostic performance has improved since April although remains behind operating plan at M6. Several initiatives are in place, with a recovery plan in place for Endoscopy and performance improvements occurring across modalities.
- Urgent Care performance remains challenged and significantly behind the operating plan target. Paediatric performance has remained variable but below target, with significant challenge in September. Strong dependency on Flow programme to delivery required inpatient improvement. Work continues with urgent care providers to improve type 3 performance alongside department pathway and streamlining improvements and use of SDEC pathways.
- Cancer FDS performance achieved in July but was not sustained in August, with endoscopy and pathology delays the main drivers of breaches; recovery plans are in place, with pathology improving and cancer recovery from endoscopy forecast for Q3. 62-day performance improved in Q2 but remained below the August recovery trajectory target of 73.9%, with diagnostic capacity and reporting delays affecting multiple tumour groups; recovery plans are underway, supported by non-recurrent funding for additional capacity.

Key risks to delivery

- PTL volatility makes forecasting RTT performance and required actions challenging
- Industrial action resulting in reduced elective activity delivery
- Winter demand and inability to affect UEC activity levels

Next quarter: top priorities

Priority	Owner	Due	Expected result
UEC Delivery	James Eales	31/03/2027	Improvement of 4hr performance
RTT Incomplete improvement	Anna Clough	31/03/2027	Continued improvement through the remainder of 26/27
62-day Cancer	Rachel Keeley	31/03/2027	Improved performance to Mar-27

NB: [1] Rank is out of 134 NHS trusts. [2] Performance score: This is the average score across all metrics within the domain which determines the organisation's rating for that domain. Organisations are grouped into four quartiles based on their domain average scores: Segment 1: Up to and including the 25th percentile. Segment 2: Above the 25th and up to and including the 50th percentile. Segment 3: Above the 50th and up to and including the 75th percentile. Segment 4: Above the 75th and up to and including the 100th percentile

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Timely and efficient care - Breakthrough Objective [2]

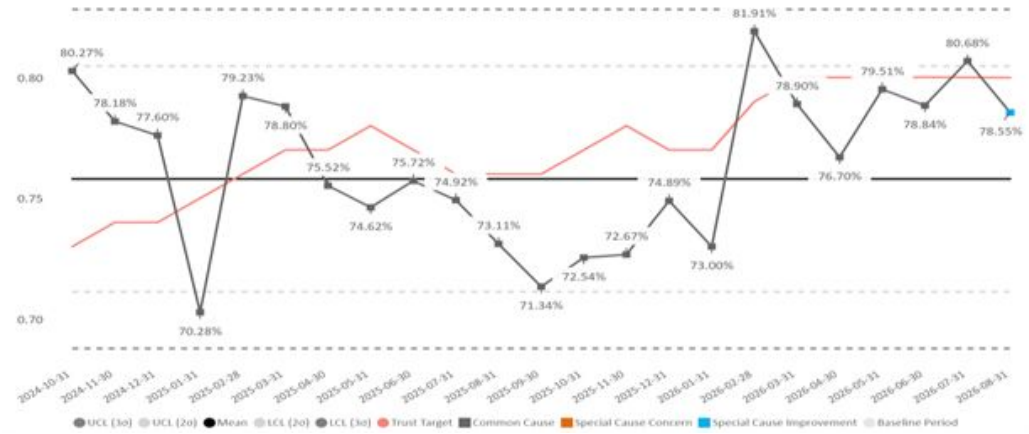
Exec Sponsor: Angela Helleur
SRO: Anna Clough
Board Sub - Committee: Performance, Transformation and Improvement

Breakthrough Objective 2 (26/27 annual goal): Improve wait times for cancer pathways

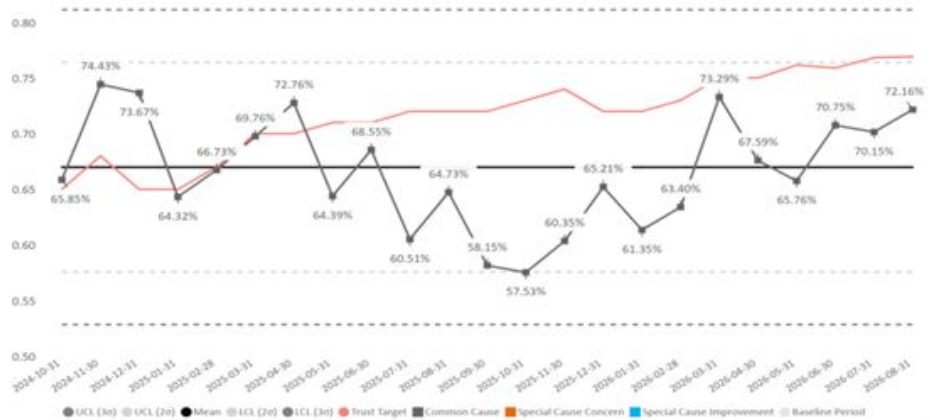
- 28-Day Faster Diagnosis Standard: Achieve =≥80% of patients informed of diagnosis within 28 days of referral
- 62-Day Referral-to-Treatment: Achieve =≥80% of patients starting treatment within 62 days

Delivery	Outcome	Vs last quarter
A Amber	A Amber	● Stable

Cancer 28-day FDS Performance



Cancer 62-day RTT Performance



Key Updates

- FDS performance achieved in July but recovery not sustained in August. Endoscopy delays are the primary driver of FDS breaches, followed by pathology delays. Recovery plans in place for both areas, with Pathology showing consistent improvement through Q1 & 2. Endoscopy capacity being balanced with DM01 demand, but cancer recovery forecast for Q3.
- 62-day performance has improved in Q2 but remained just below the recovery trajectory target for August (73.9%). Delays in diagnostic stages across multiple tumour groups impacted 62-day performance, including scan capacity shortage, reporting delays (pathology and radiology) and complex pathways with multiple diagnostic had the greatest impact on performance. Recovery plans are in place, supported by non-recurrent funding to provide additional capacity

Next quarter: top priorities

Priority	Owner	Due	Expected result
Endoscopy Recovery	James Eales	Nov	Return to 7-10 day wait
Radiology Reporting Recovery	Mark Allen	Nov	Return to cancer reporting turnaround time

Key risks to delivery

- Workforce: Additional capacity for recovery plans dependent on workforce – recruitment and staff willingness to take extra sessions.
- Funding: Additional capacity funded through non-recurrent external funding.

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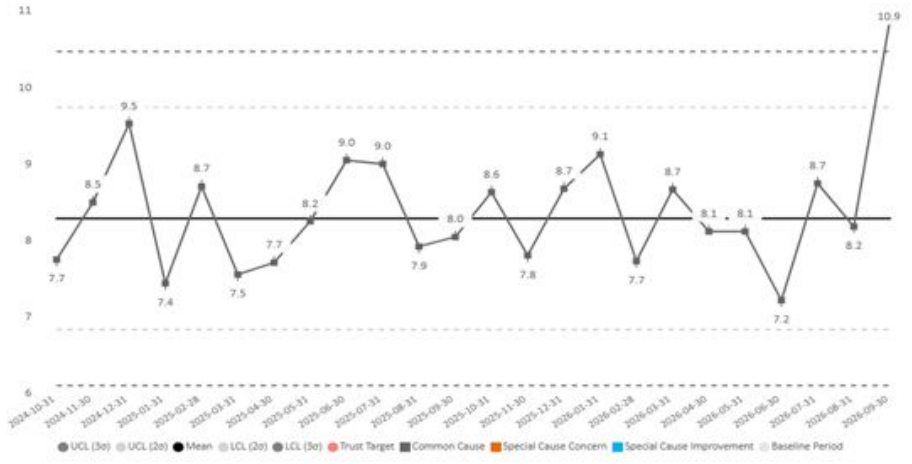
Timely and efficient care - Breakthrough Objective [3]

Exec Sponsor: Angela Helleur
SRO: Anna Clough
Board Sub - Committee: Performance, Transformation and Improvement

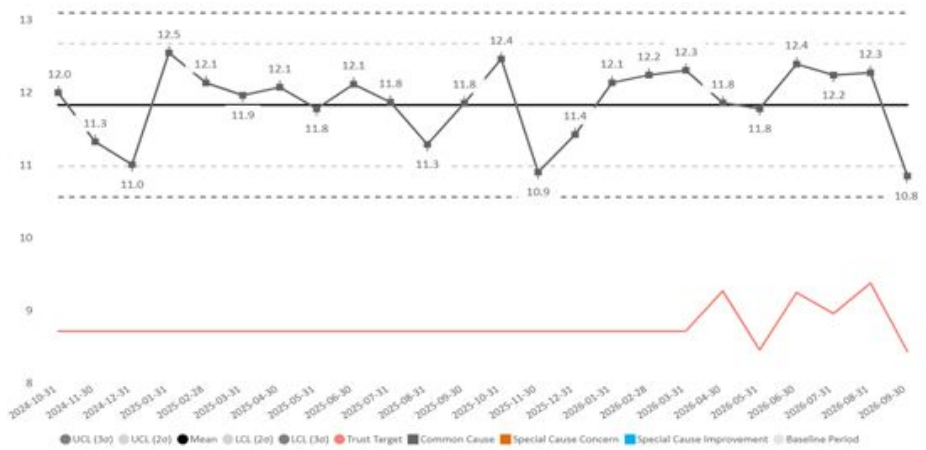
Breakthrough Objective 2 (26/27 annual goal): Improve length of stay

Delivery	Outcome	Vs last quarter
A Amber	A Amber	• Flat

Average Length of Stay (Elective) – Model Hospital Definition



Average Length of Stay (Non - Elective) – Model Hospital Definition



Key Updates

- Non-elective average length of stay fell to 10.8 days in September, the lowest in two years and below the Trust target; this is driven by strong engagement from the medical care groups at both sites.
- Time in ED beyond 12 hours has returned to baseline despite closure of a ward at each site.
- Elective length of stay rose to 10.9 days, the highest in the period. Part of the increase in elective ALOS in September is driven by the discharge of some extremely long stay patients in Maternity/Paediatric Neurorehabilitation affecting the overall trust position. The biggest improvements were in elderly and respiratory medicine at DH, reporting their best ALOS position for NEL care in two-years.
- Morning discharges fell to 17.8%, also a two-year low, while G&A bed occupancy remained at 98.5%; earlier discharge is therefore critical to releasing beds when ED demand is highest.
- Long length-of-stay reviews are live across medical beds at both sites, with expansion to surgery and orthopaedics; criteria-led discharge is establishing and will be pushed in next quarter..
- Delivery risk remains high: September A&E four-hour performance was 69.2%, corridor care rose to 1,851 episodes and early flu and COVID circulation is increasing winter pressure.

Next quarter: top priorities

Priority	Owner	Due	Expected result
Sustain reduced non-elective LoS and extend 21+ day reviews	Flow Programme / Care Groups	Q3	Embed reviews in medical wards and expand to surgery and orthopaedics
Improve early discharge through CLD and discharge lounge	Clinical and site flow teams	Q3	Increase morning bed release, supported by prioritised ward implementation and 10 patients by 10am

Key risks to delivery

- Leadership capacity for the programme.
- Winter demand: flu and COVID activity is running earlier and higher than in recent years.
- Capacity: occupancy at 98.5% leaves little resilience and links delayed morning discharge to ED waits and corridor care.
- Pace and adoption: CLD, SDEC pathways and clinical operational standards require consistent embedding across sites.

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Financial sustainability – Five-Year Stretch Target [1]

Exec Sponsor: Roy Clarke
SRO: Caroline Clarke
Board Sub-Committee: Finance and Commercial

Our Ambition: People will feel confident knowing King's uses its resources wisely to provide great, sustainable care.

2031 Goal: Break even by 2030 and continue to break even to 2031.

Delivery	Outcome	Vs last quarter
A Amber	A Amber	● Stable

Annual reported/planned financial position (£m)

Financial year	Reported / planned financial position[1]	Commentary
2021/22	£0.2m	King's exits Financial Special Measures.
2022/23	(£20.0m)	Deficit begins to re-emerge in reported financial position, whilst underlying deficit persists.
2023/24	(£78.7m)	Peak reported deficit following 2021/22 exit from Financial Special Measures.
2024/25	(£33.7m)	King's enters NHSE's Recovery Support Programme. 15-year financial strategy developed (approved May 2025).
2025/26	£5m	Trust delivers to its financial strategy and financial plan, supported by non-recurrent support funding.
2026/27 (plan)	£0	Ongoing non-recurrent financial support is dependent on delivery against financial plan.
2028/29 (Horizon 1)	(£29.6m)	Continued focus on improved underlying financial position. Current planned deficit subject to approval through future planning rounds.
2029/30 (Horizon 2)	£0	Breakeven without support funding, focussed on a sprint to be in the top 25% most efficient NHS hospitals.
2039/40 (Horizon 3)	£0	Ongoing focus on innovation and transformation enabling the Trust to maintain break-even without support from 2029/30 and to fully address its underlying deficit.

Notes:
1: Reported financial position to 2025/26, planned financial position to 2026/27
2: Cells highlighted in grey represent the period examined for the financial strategy's diagnostic, light blue cells represent the current implementation of the strategy and dark blue cells set out the financial strategy's plans at the end of three future strategic horizons: 2028/29 (Horizon 1); 2029/30 (Horizon 2); and 2039/40 (Horizon 3).

Key Updates

- As of September, the KCH Group (KCH, KFM and KCS) has reported an £18.3m deficit year to date, 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. Without this further remediation a £109.8m deficit would crystallise.
- The underlying position year to date is a £67.3m deficit after removal of non-recurrent items, £8.7m adverse to plan.
- The Trust must close its £61.6m planning gap recurrently to mitigate the risk of loss of DSF in 2026/27 and 2027/28 and deliver its financial strategy including breakeven by 2029/30.

Next quarter: top priorities

Priority	Owner	Due	Expected result
Deliver the interventions approved by the Trust Board on 16 September 2026	Chiefs of Division	31/12/26	£3.45m run rate reduction per month by 31 October and £5.6m addition CIP in G3+ by 31 December.
Identify full £84.9m recurrent CIP, closing £61.6m planning gap.	Chief Delivery Officer	30/11/26	Return to planned £87.5m underlying deficit.

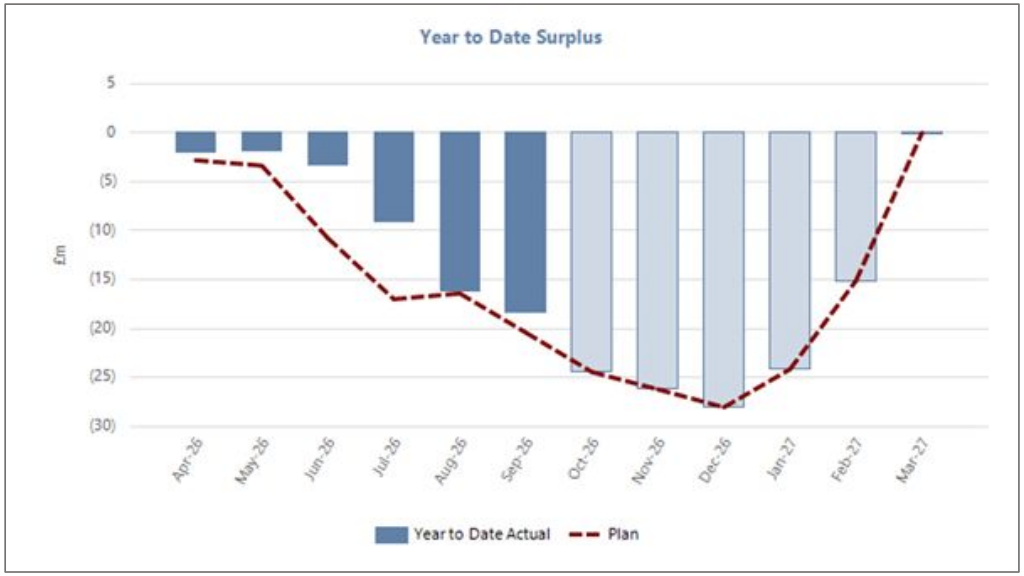
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Financial sustainability - Breakthrough Objective [2]

Exec Sponsor: Roy Clarke
SRO: Caroline Clarke
Board Sub-Committee: Finance and Commercial

Breakthrough Objective 1 (26/27 annual goal): Achieve zero variance to budget

Delivery	Outcome	Vs last quarter
A Amber	A Amber	▲ Improving (in year) ▼ Off track (recurrently)



Year to date and forecast monthly surplus / (deficit) at September 2026

Key Updates

- As of September, the KCH Group reported a £18.3m deficit year to date, a £2.1m favourable variance to the March 2026 NHSE accepted 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. It has delivered £10.6m year-to-date recurrent savings, resulting in a £21.2m adverse variance.
- The Trust must deliver the interventions approved by the Trust Board on 16 September 2026, as defined in the Trust Board paper and summarised:
  - Progress £19.4m existing CIP schemes in Gateway 0-2 through movement into Gateway 3+ to increase the approved CIP position.
  - Take agreed action 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.

Top Risks:

- If the efficiency requirements are not identified and delivered on annual basis, then the Trust is at risk of significantly failing it's I&E and cash plans, alongside delivery of the Trust's financial strategy.
- If the Trust fails to control expenditure in line with the plan, then the Trust will fail to deliver the plan, negatively impacting on financial performance and liquidity.

Next quarter: top priorities

Priority	Owner	Due	Expected result
Deliver £4m identified run rate reduction schemes and additional £16.7m bank run rate reduction.	Chiefs of Division	31/10/26	Schemes identified and approved by KMC. £3.45m run rate reduction per month.
Progress £19.4m existing CIP schemes to Gateway 3+.	Chiefs of Division	31/12/26	£5.6m addition CIP in G3+ by 31 December 2026.

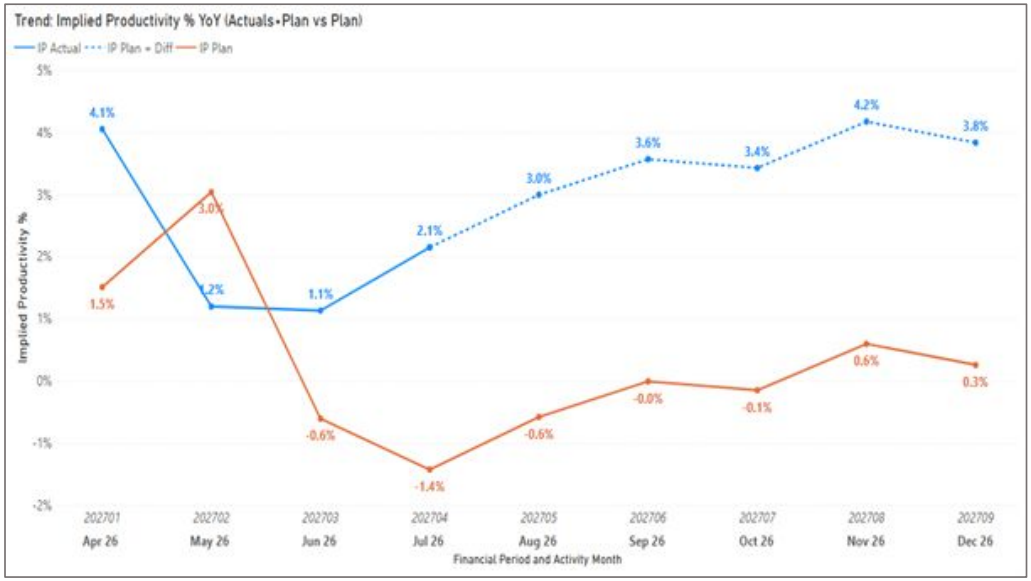
Financial sustainability - Breakthrough Objective [3]

Exec Sponsor: Roy Clarke
SRO: Caroline Clarke
Board Sub-Committee: Finance and Commercial

Breakthrough Objective 2 (26/27 annual goal): Deliver implied productivity growth

The Implied Productivity measure compares the cost of running our services with the amount of care we provide. Costs are adjusted for inflation so that different years can be compared fairly, while activity is adjusted to reflect the complexity cost of the care provided.

Delivery	Outcome	Vs last quarter
G Green	G Green	▲ Improving



Key Updates

- Compared with the same period in 2024/25, King's implied productivity has improved by 3.8%, driven by activity growth of 2.9% continuing to outpace cost growth of 0.7%.
- Growth has been supported by strong performance care, while non-elective activity remains an area of focus. in outpatient procedures (+4.2%), A&E (+2.1%) and outpatient follow-ups (+1.4%), off-set by lower activity in in inpatient elective (-3.3%), inpatient non-elective (-3.0%), outpatient first attendances (-1.0%) and diagnostics & adult critical care (-9.4%).
- Performance varies significantly across care groups, with the Trust-level implied productivity position at +2.1%. The strongest improvements are seen in Integrated Medicine (+26.7%), Emergency Care (+14.9%), Orthopaedics (+13.6%) and Women's Health (+12.0%), while the largest deteriorations are seen in Planned Medicine (-9.1%), Critical Care (-8.6%) and Surgery, Theatres & Anaesthetics (-7.0%).

Top Risks:

- If the Trust does not manage activity in line with contract arrangements, then the Trust will increase the deficit either through carrying out more activity than the commissioners will pay for, or by not meeting contractually required activity leading to commissioners clawing back expected income.

Next quarter: top priorities

Priority	Owner	Due	Expected result
Continue to work with care groups and divisions to develop care group productivity reporting aligned with SDR reporting.	Deputy CFO	31/12/26	Productivity reporting as standard in all care group monthly finance reports.

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 15

BOARD COVER PAPER

Report to:	Board of Directors
Date of meeting:	17 November 2026
Subject:	Acute Services Review
Author(s):	Carnall Farrar
Sponsor:	Matthew Trainer Chief Executive Officer
History:	Acute Provider Collaborative
Status:	

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

Purpose

To brief the Board of Directors on the finding of the Acute Services Review.

Recommendations:

- The ASR has provided the system with a shared understanding of current and future challenges, and how they might realistically be addressed. As a result, providers are able to consider further opportunities for collaboration.
- Recommendations around investing in prevention and shifting to proactive models of care align with the priorities set out in the Five Year Strategic Commissioning Plan and reinforce the commitment to deliver this at pace and scale.
- Delivering cross provider programmes can help mitigate the risk associated with very challenging efficiency targets.
- Focus will now turn to designing a delivery approach which sets us up for success.

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	Financial sustainability, demand and capacity and partnership working.
King's Improvement Impact (KIM):	*N/A*
Quality Impact	*Developing an appropriate response to current and future challenges should protect quality of services. The aim is to better organise care around patient need. Consolidation of services aims to improve outcomes.*
Health Equity Impact	*Improving population health is a key driver for the review. Further work is needed to develop an impact assessment. This is addressed in the report*
Workforce Impact	*Not specifically, but service reconfiguration will inevitably have workforce implications.*
Research/Innovation Impact	*n/a*
Digital Impact	*n/a*
Financial Impact	*One of the key objectives of the review was to establish the case for change through population health and financial modelling of the medium to long term do-nothing position for SE London, to identify the productivity opportunity for each provider and to align on key cross-provider transformation programmes that unlock value beyond individual Trust efficiency programmes.*
Legal/ regulatory compliance	*n/a*
Communications and Engagement	*Pathway changes may require stakeholder engagement.*
Use of Artificial Intelligence Tools	*Not known.*
Committee that will provide relevant oversight Acute Provider Collaborative	

King's College Hospital NHS Foundation Trust

Main Report

Background

The South East London acute system is under significant financial pressure. The ICB and acute providers jointly commissioned Carnall Farrar (CF) to undertake an Acute Services Review (ASR) to identify the system-wide transformation needed to move from structural deficit to financial balance.

Over a number of months, CF undertook extensive data analysis, interviewed dozens of senior staff and held three system-wide workshops to identify care pathway, service transformation and reconfiguration options which would reduce overall spend on hospital-based services. The final report is now available and is presented to each organisation's Board for formal consideration.

Overview of findings

The case for change outlines the impacts of an ageing population and deteriorating health. The over 65 population is expected to increase by 24% in the next 10 years, making up 15% of the population by 2036. Without any major transformation, patients with moderate and high will increase due to poor health from 43% to 54% of the population. In a do-nothing scenario, emergency attendances rise by 15% between 2025/26 and 2035/36, outpatient appointments by 21% to 5.4 million a year, and non-elective and elective bed days by around 25%.

This in turn increases the financial pressure on the ICB and providers. According to the projected counterfactual financial position, the acute system deficit will rise to rise to £1 billion by 2030/31 before efficiency delivery. The report sets out the interconnected role of commissioner-led transformation, productivity improvements, and cross-provider service change to achieve sustainability.

A number of actions are proposed:

- **Invest in prevention** – Expand targeted programmes on obesity, cardiovascular disease, diabetes, respiratory disease, and anxiety and depression
- **Shift to proactive models of care** – Implement proactive and community-based models of care, delivered through the integrator agenda
- **Close the efficiency gap** – Extend CIPs across the full five years and identify where productivity will come from, individually or through additional system collaboration
- **Deliver three cross-provider programmes** – Outpatient transformation, elective surgical hubs, and breast surgery consolidation
- **Scope wider services** – Aim for a smaller acute footprint for oral and dental, review maternity, general paediatrics and non-tertiary cancer surgery in South East London and specialised services on a London footprint.

Taken together, the commissioner-led transformation and full efficiency delivery move all three acute providers closer to financial sustainability by 2030/31. The cross-provider transformation programmes are intended to close that residual gap and to reduce the delivery risk attached to efficiency requirements that remain unidentified in the outer years.

Rationale for cross provider programmes

1. Outpatient transformation

The three acute providers in South East London delivered 4.2m outpatient appointments in 2025/26 and demand is growing at around 4.5% a year. Modelling of reducible activity identifies approximately 500,000 appointments that could be avoided or shifted through redesigning models of care.
A collaborative programme, underpinned by the shared Epic platform, should deliver standardised pathways, single points of access and streamlined diagnostics, better organising care around patient need.

2. Elective surgical hubs

Several surgical specialties delivered in SEL are below the national average and recommended targets for theatre utilisation, cases per list, utilisation of treatment rooms, and day case rates. Establishing high volume and complex surgical hubs is a critical enabler to improve productivity, utilisation of resources and potentially lower unit costs. A detailed change management process is required to explore and agree options to reconfigure surgical services.

3. Consolidate breast surgery

Four separate sites deliver inpatient and day case breast surgical services, some with low volumes. Consolidation of breast surgery may contribute to overall improvements in quality and outcomes and could be delivered in conjunction with the development of surgical hubs. Consideration would need to be given to other parts of the pathway (screening, diagnostics, plastics) which could be explored through a full change programme.

Implementation and next steps

SEL ICB and providers have agreed to give further consideration to the recommended areas of opportunity. We already have programmes of work underway to improve population health through prevention and to support people with long term conditions in the community through developing neighbourhood health, as set out in our strategic plans. Providers have plans in place to improve productivity and efficiency. To establish the scope for further opportunities, formal work programmes will be set up, with a named SRO and an agreed mandate outlining objectives, success metrics and an implementation plan. This will inform resourcing, with the expectation that existing resource will be redeployed to these priorities where possible. The System Sustainability Group will provide strategic direction, and the executive members are responsible for ensuring alignment across and within organisations. Legacy collaborative arrangements will be reviewed and streamlined where possible. Any formal decisions will be taken through existing governance structures and any changes to service configuration would follow a formal change process as set out in NHSE guidance and legislation.

South East London Integrated Care System

South East London Acute Services Review

Summary Report

8 October 2026

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1. Introduction

Context

The South East London acute system is under significant pressure with an underlying financial deficit of £256m in 2025/26.[1] Approximately 52% of ICB spend is on acute services and current efficiency programmes are carrying delivery risk, with CIPs largely unidentified for the next five years and unlikely to bridge the financial gap.[2] Within this context, the Acute Services Review was jointly commissioned by the ICB and acute providers to identify the system-wide transformation needed to move from structural deficit to financial balance.

The Acute Services Review builds on existing system-wide work, including by the System Sustainability Programme, Acute Provider Collaborative, and South London Office of Specialised Services. Aligned with the NHS 10 Year Plan, the Acute Services Review sets out the case to fundamentally shift and transform the way that care is delivered to improve outcomes and ensure future sustainability. The findings span commissioner-led population health planning, provider productivity, and collaborative transformation that extends beyond individual trust boundaries.

Scope and purpose

This report outlines the findings and recommendations of the Acute Services Review. Its purpose is to define the system-wide action required to deliver the long-term financial sustainability of acute services in South East London.

There were five core components to the Acute Services Review:

1. Establishing the case for change through population health and financial modelling of the medium- to long-term do-nothing position for South East London;
2. Scoping the opportunity for commissioner-led transformation and the potential impact of prevention initiatives and new models of care;
3. Identifying the productivity opportunity within each acute provider;
4. Aligning on key cross-provider transformation programmes that unlock value beyond individual trust efficiency programmes; and
5. Exploring wider opportunities for transformation and the appropriate geographical planning levels for future review.

Approach and limitations

The Acute Services Review draws on quantitative analysis from the CF Health Strata© patient-level segmentation model, provider and ICB financial plans, NHS England productivity assessments, and demand and capacity modelling. Quantitative analysis has been supplemented by extensive engagement across the system.

The following areas have not been considered in the Acute Services Review and should form part of future phases of work:

- Detailed design of transformation programmes and potential service configurations;
- Assessment of the workforce, estate, technology, resources, and capital required to deliver service change; and
- Options appraisal and impact assessments that form part of formal service change processes.

[1] SEL ICB and acute provider financial modelling 2025/26 – 2030/31, (July 2026).
[2] Ibid; Acute provider CIPs (May 2026).

2. Making the case for change

The case for change underscores the impact of deteriorating health, growing activity, and financial pressures across South East London. It establishes the need to transform the way services are planned, commissioned, and delivered to improve health outcomes and achieve future financial sustainability.

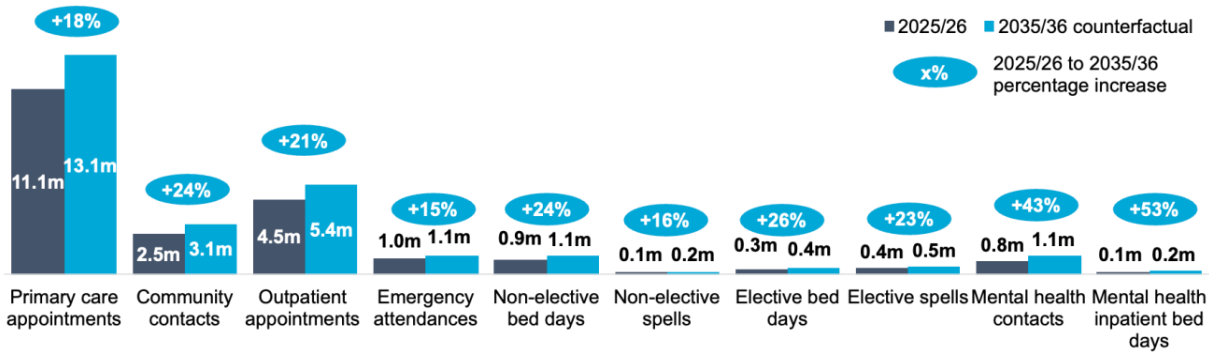
Impact of ageing and deteriorating health

While the population in South East London is projected to grow by 4% over the next decade,[3] the over-65 population will increase by 24%, with the fastest growth in the inner boroughs, which currently have the youngest populations.[4] With the over-65 population currently accounting for almost four times the per-person cost of working-age residents, this shift in the age profile will increase financial pressures for South East London.[5]

In combination with an ageing population, demand for healthcare services will further increase in response to the projected deterioration of health. In 2025/26, the 43% of the total population in moderate and high need cohorts accounted for 82% of total commissioner spend of £4.9 billion.[6] This included people with long term conditions, cancer, severe mental illness, frailty or dementia, and end of life care needs. By 2035/36, these cohorts are projected to reach 54% of the population and 87% of spend, with total healthcare spend rising to £6.2 billion.[7]

In the do-nothing scenario, demand grows across every point of delivery (**Figure 1**). Emergency attendances rise by 15% between 2025/26 and 2035/36, outpatient appointments by 21% to 5.4 million a year, and non-elective and elective bed days by around 25%.[8] This outpaces population growth of 4%, indicating that rising health needs rather than demographic change is the principal driver. The modelled bed requirement for the GP registered population reaches 4,572 by 2035/36 against 3,914 general and acute beds currently open, a shortfall of around 650 beds that cannot be met within current capacity without major transformation to deliver service change.[9]

Figure 1: Projected do-nothing activity volumes by point of delivery, 2025/26 – 2035/36



Source: © Carnall Farrar Limited, Health Strata segmentation model of SEL GP-registered population based on proprietary methods, SEL database, (July 2026).

[3] ONS, Population projections 2025 – 2035, (2022-based edition).
[4] Ibid.
[5] © Carnall Farrar Limited, Health Strata segmentation model of SEL GP-registered population based on proprietary methods, SEL database, (July 2026).
[6] Ibid.
[7] Ibid.
[8] Ibid.
[9] Ibid; NHS England, Bed availability and occupancy – KH03, Quarter 4 2025-26.

Do-nothing financial position

In the do-nothing scenario, the South East London ICB financial position deteriorates to a £293 million deficit by 2030/31 even after the impact of deconstruction of the block and system efficiency requirement.[10] This is driven by a combination of factors, including demographic growth, non-demographic growth, and cost inflation. South East London is also 3.62% above target for core services and 18.32% above target for specialised services, and annual convergence will reduce the allocation growth while demand rises.[11]

The combined deficit for the acute providers is projected to rise from £256 million in 2025/26 to £1 billion by 2030/31 before CIP delivery.[12] Further, deficit support funding is to be phased out from 2026/27 and the acute providers will be required to navigate the income impacts of deconstruction of the block.

These pressures are encountered nationally, but three factors amplify them locally: the case-mix complexity of a largely tertiary and specialised provider base, significant productivity gaps against peers estimated by NHS England across the three trusts,[13] and higher pay and estate inflation as London providers.

Returning acute services to sustainability will require system-wide change that extends beyond existing programmes. The following pages of this report set out the interconnected role of commissioner-led transformation, productivity improvements, and cross-provider service change to achieve sustainability. It builds on national policy, and the body of improvement work already underway in South East London with the aim of increasing the scale and pace of change.

[10] SEL ICB and acute provider financial modelling 2025/26 – 2030/31, (July 2026).
[11] NHS England, ICB allocations 2026/27 – 2028/29, (December 2025).
[12] SEL ICB and acute provider financial modelling 2025/26 – 2030/31, (July 2026).
[13] NHS England, Productivity Improvement Packs, (2025).

3. Maximising the value of the NHS allocation

In the new operating model for the NHS, the ICB is accountable for securing the best value from its allocation. The South East London ICB Strategic Commissioning Plan sets the direction for delivering allocative efficiency in line with the three shifts outlined in the NHS 10 Year Health Plan: sickness to prevention, hospital to community, and analogue to digital. There is the opportunity for commissioner-led transformation to improve health outcomes and system sustainability.

Opportunity to reduce the growth in prevalence and progression of ill health

Targeted focus and investment in prevention is key to long-term health gain, slowing the growth in avoidable ill health, and reducing the demand it places on the system. Five conditions were prioritised for modelling in the Acute Services Review, based on the forecasted increase in burden and the available evidence on modifiable risk factors: cardiovascular disease, diabetes, respiratory disease, anxiety and depression, and obesity.

The South East London Prevention Framework is built on three interconnected tiers of universal prevention, targeted early detection and intervention for high-risk communities, and at-scale secondary and tertiary prevention for the population.[14] The modelling covers the NHS-deliverable elements, including case finding, pharmacological management, structured behavioural and digital programmes, and smoking cessation pathways.

The prevention modelling targets a 15% decrease in transition rates to higher-needs segments to reduce future incidence of disease. On that basis, 13,800 fewer residents develop anxiety and depression by 2035/36, 9,300 fewer respiratory disease, 6,600 diabetes, 6,100 cardiovascular disease, and 4,200 obesity, resulting in a gross saving of £160 million.[15]

Opportunity to improve care for the population

The NHS 10 Year Health Plan establishes the case for shifting towards more community-based and digitally enabled care to achieve sustainability. The Acute Services Review builds on that ambition by examining variation in the cost of meeting similar needs across South East London. Commissioner-spend per person varies materially across the six boroughs after controlling for age, health need, deprivation, and inner or outer London. Where that variation is unwarranted and addressable, scaling proactive and integrated community-based care offers a means of meeting the same level of need at lower cost.

Core20 and non-Core20 populations were benchmarked separately, in each case against the inner or outer London borough with the lowest spend per person that also scores at or above average on an index of quality and outcome measures. Fifteen non-Core20 cohorts agreed with the ICB represent a potential gross variation opportunity of £375 million, and fourteen Core20 cohorts has an opportunity of £110 million.[16]

The scale of the variation indicates substantial potential to improve value from existing commissioner spend. Realising it depends on the shift from hospital to community, delivered largely through the integrated neighbourhood team model set out in the ICB's Strategic Commissioning Plan. Care that is proactive, integrated and digitally enabled will meet need earlier and in lower-cost settings, reducing demand and cost pressure on acute providers.

Impact of commissioner-led transformation

Delivering targeted prevention initiatives and transforming models of care to address variation generate a gross potential opportunity of £645 million in terms of commissioner spend

[14] SEL ICB Strategic Commissioning Plan, (February 2026).
[15] © Carnall Farrar Limited, Health Strata segmentation model of SEL GP-registered population based on proprietary methods, SEL database, (July 2026).
[16] Ibid.

(**Figure 2**).[17] Realising it requires an estimated investment of £230 million, giving an annual net opportunity of £415 million when implemented and realised at full scale.

Delivery of commissioner-led transformation depends on population health management analytics to target intervention, digital tools and shared care records, workforce development for cross-organisational and enhanced roles, and contracting and financial mechanisms that support multi-year change. Acute providers are central to this, contributing specialist expertise to integrated neighbourhood teams and, in all cases in South East London, hosting the integrator function that allows partners to operate them at scale.

Figure 2: Opportunity size of commissioner-led transformations

	Potential gross opportunity	Investment required*	Investment rate	Potential net opportunity
Reducing the growth in prevalence and progression of ill health	£160m	£62m	39%	**£99m**
Transforming models of care: non-Core20 population	£375m	£122m	33%	**£252m**
Transforming models of care: Core20 population	£110m	£45m	41%	**£65m**
Total	**£645m**	**£230m**	**36%**	**£415m**

Note: *Investment calculations are estimated based on prior work conducted by CF in other systems where similar cohorts and conditions have been selected for allocative commissioning opportunities.

[17] Ibid.

4. Targeting provider productivity improvements

The 2025 Spending Review settlement requires the NHS to deliver annual productivity improvement of at least 2% over the next three years.[18] This section of the report outlines the productivity targets for the purposes of the Acute Services Review, developed with provider finance teams, and the potential delivery risk attached to them.

Productivity targets and current CIPs

Each provider's Medium Term Financial Plan sets a productivity requirement over three years, in line with the national shift from annual to multi-year planning. Working with each finance team, these plans have been extended across the full five-year period and expressed as a percentage of operating expenditure:

- GSTT with 3.7% in 2026/27 declining to 2.0% by 2030/31;
- KCHT with 4.3% in 2026/27 declining to 3.3% by 2030/31; and
- LGT with 5.0% in 2026/27 declining to 3.4% by 2030/31.

These trajectories meet the national requirement for at least 2% annual productivity improvement and reflect both confirmed plans for year one and assumptions agreed with finance teams for subsequent years.

Current trust CIP plans do not extend across the full five-year period, and the outer years are largely unidentified. Confirmed 2026/27 CIPs across the three providers total £185 million as at March 2026: GSTT £143 million, KCHT £26 million and LGT £16 million.[19]

Closing this gap will require further productivity opportunities to be identified in each year. This may be partly achievable through individual provider efforts to reduce length of stay, headcount or band/agency spend, and non pay costs. However, system-level transformation will be required to address structural challenges and unlock additional productivity opportunities beyond what is achievable by individual trusts.

[18] NHS England, Productivity plan – update, (February 2026).
[19] Provider CIPs, (March 2026). Note these figures have likely increased or changed since the development of this report.



5. Delivering cross-provider transformation

The purpose of cross-provider transformation is to address structural challenges across the system, including sub-scale services, workforce fragility, fragmented pathways, and inefficient use of resources. By collaborating as a system, the ambition is to drive productivity and quality beyond the level achievable locally.

Engagement and workshops identified four cross-provider opportunities that are explored further in this section of the report:

- Transforming outpatient care into a new model of planned specialist care, which has the potential to deliver material savings for the acute system through avoiding or shifting first and follow-up appointments;
- Establishing elective surgical hubs for high volume specialties, which has the potential to mitigate projected capacity shortfalls through productivity improvements and could deliver savings by releasing bed and theatre session capacity if commissioner-led transformation is also achieved;
- Consolidating breast surgery to strengthen service quality and resilience, which should be explored alongside other surgical consolidation to ensure the appropriate distribution of system capacity; and
- Pursuing alternative ways forward for oral and dental care that have less significant capital implications (e.g., consolidation of specialist activity where possible and shifting of residual and non-specialist activity into the available community estate).

Outpatient transformation

Outpatient services are the largest single point of acute contact in South East London, with 3.0 million appointments delivered in 2025/26 to the GP-registered population.[20] While there has been some improvement in recent years, the providers in South East London still perform inconsistently against the national median for key performance metrics:[21]

- Pre-referral specialist advice is used at 5.1 to 6.4% against a median of 7.8%;
- Missed appointment rates of 8.0 to 9.7% compare with a national median of 6.3%;
- Patient-initiated follow-up rates are above the national median at GSTT, but below it at KCHT and LGT; and
- Remote consultation rates are above the national median at GSTT and KCHT, but below it at LGT.

There is scope to build upon the work of individual trusts and embark on a significant transformation programme to define the future model of planned specialist care for South East London. The move to a shared Epic platform across South East London makes this a timely opportunity to design once and deliver new models for the three providers that is tailored to patient need and consists of:

- Standardised pathways and guidelines;
- Single points of access (SPOA) into planned specialist care, standardised, and in some cases shared, across providers; and
- Straight to test model for harmonised clinical pathways.

The potential impact of redesigning planned specialist care was analysed using the population health segmentation model, grouping appointments by patient need and applying reducibility assumptions to each group. The modelling identifies 506,000 appointments that

[20] © Carnall Farrar Limited, Health Strata segmentation model of SEL GP-registered population based on proprietary methods, SEL database, (July 2026).
[21] NHS England, Model Hospital – Outpatients, (February 2026).

could be avoided or shifted in 2025/26, comprising 217,000 first appointments and 289,000 follow-ups, and a gross annual saving of £80.0 million on National Cost Collection basis.

Undertaking a cross-provider outpatient transformation programme presents additional opportunity to address sub-scale or fragmented medical specialties that would benefit from consolidation to strengthen service resilience and quality. Further financial benefit may also be realised through rationalising the estate in which outpatient services are delivered.

Elective surgical hubs

Currently, surgical activity is delivered across multiple sites for six elective specialties: orthopaedics, gynaecology, urology, ENT, ophthalmology, and general surgery. The configuration of this activity across South East London is associated with several sites performing below the national average or recommended productivity targets for:

- Theatre utilisation where the majority of sites fall below the 85% target (e.g., urology ranges from 53% to 78% between South East London sites);[22]
- Cases per four-hour session which are below the national median for 17 of 34 site-specialty combinations;[23] and
- Daycase rates which are below the national mean for high volume, low complexity (HVLC) ENT, urology, and general surgery.[24]

In the do-nothing scenario, growth in demand is projected to become increasingly unsustainable. By 2030/31, South East London is estimated to be short of 52 weekly theatre sessions for elective orthopaedics, gynaecology, urology, ENT, ophthalmology, and general surgery.[25] The projected bed and theatre session deficits establish a clear case for change as the acute system in its current configuration will be unable to financially sustain the capacity shortfalls in the six specialties.

Significant transformation will therefore be required to change the way services are delivered across the system to ensure future sustainability. Surgical hubs are a national priority supported by GIRFT that concentrate elective activity and ring-fence capacity to deliver significant productivity improvements. GIRFT sets out the conditions for realising the benefits, including separating high volume from complex work, day case surgery as the default, standard case durations, and theatre utilisation of 85%.

Illustrative scenarios were modelled to test the plausibility and impact of establishing high volume and complex surgical hubs in South East London by 2030/31. Reconfiguring and delivering the productivity improvements associated with surgical hubs move the system from a shortfall of 52 theatre sessions to a surplus in the strongest scenario.[26] The modelling demonstrates that establishing surgical hubs can mitigate the projected capacity shortfalls, with further system-wide transformation required in parallel to close the remaining gaps.

Within this context, additional surgical hub scenario modelling was undertaken that incorporates the impact of commissioner-led transformation and broader productivity improvements. System-wide transformation delivered in tandem with surgical hubs moves every scenario into surplus on beds and theatre sessions, with an indicative annual opportunity between £16 and £28 million from released bed and theatre session capacity.[27] However, achieving these benefits are conditional on prevention initiatives and community-based care models reducing acute demand growth in the next five years, and the system working together to drive productivity beyond the level achievable locally.

[22] NHS England, Model Hospital – Theatre utilisation by speciality and site, (February 2026).
[23] NHS England, Model Hospital – Average number of cases per equivalent 4-hour valid elective session by speciality and site, (February 2026).
[24] HES APC, Daycase rates by speciality and site, 2025.
[25] SEL demand and capacity modelling, (September 2026).
[26] Ibid.
[27] Ibid.

As next steps, further work is required across South East London to assess the suitability of the theatre estate against GIRFT standards. Any change to the configuration of services would then need to follow a service change process in compliance with NHSE guidance, HM Treasury Green Book, and legal duties. More detailed demand and capacity modelling is also required that accounts for patient complexity and extends to wider surgical specialties including cancer, as these have not been included in the above demand and capacity outputs.

Breast surgery consolidation

The breast service pathway has challenges spanning screening, referral, one-stop diagnosis, surgery and plastics, and follow-up. In particular, screening coverage in inner South East London sits around 10 percentage points below the England average,[28] and breast cancer mortality has risen in Bexley and Greenwich over the last decade.[29] Sixty-two day combined performance has remained below the 85% standard at GSTT and KCHT since April 2023.[30]

Noting the performance and quality challenges, work is currently being led across the system to redesign of the wider breast pathway, covering mastalgia, one-stop triple assessment and a single plastics pathway. The Acute Services Review examined the specific opportunity to consolidate breast surgery only. Its findings sit alongside existing redesign programmes and do not substitute broader work.

Breast surgery is delivered from four sites, with around 1,700 admitted spells in 2025: 762 at Guy's, 367 at the PRUH, 297 at Denmark Hill and 294 at QEH.[31] Delivered as a single service, that volume would rank fifth nationally and sit above the top decile of 1,300 spells, against a national median of 634 per provider.[32] Three of the four sites operate at less than half the national median provider volume. Stakeholders further reported workforce fragility challenges at the sites, with reliance on insourcing.

Scale is the foundation for establishing service excellence and delivering high quality care, training, and research.[33] Three of the four current breast surgery sites are sub-scale in South East London, which limits the patient population, workforce resilience, and infrastructure. Consolidation of breast surgery to achieve scale may therefore support improvements in quality, and together with the surgical hubs, simplify the organisation of surgical activity across South East London.

Illustrative scenarios were modelled to test the plausibility and potential financial benefits of consolidating breast surgery, with complex activity consolidated onto one or two centres, routine day case activity retained locally, and screening and diagnostics maintained locally in every scenario. Modelling of potential reconfiguration scenarios and assumed productivity benefits suggest a possible saving of up to £1 million a year when delivered in conjunction with commissioner-led transformation.[34] Although this is a small figure, there are also potential benefits in terms of improving service resilience and quality. It should also be considered alongside other surgical consolidation to ensure the appropriate distribution of system capacity.

In line with the next steps for elective surgical hubs, an assessment of estate suitability and detailed demand and capacity modelling should be undertaken for breast surgery alongside plastics. Any change to the configuration of services would then need to follow a service change process in compliance with NHSE guidance, HM Treasury Green Book, and legal duties.

[28] Fingertips (OHID), Indicator: breast cancer screening coverage, 2015 – 2025.
[29] Fingertips (OHID), Mortality rate from breast cancer, 2012-14 – 2022-24.
[30] NHS England, Cancer Waiting Times Statistics, April 2023 – May 2026.
[31] HES APC, Breast surgery spells by site, 2025.
[32] Ibid.
[33] CF, World Leading Services Framework, (July 2026).
[34] SEL demand and capacity modelling, (September 2026).

Oral and dental health

Specialist dental, oral surgery and maxillofacial services are delivered from two acute sites two miles apart, in partnership with King's College London. Combined admitted activity is more than nine times the national median, and GSTT is the largest provider of oral and dental outpatient care in England.[35] Estate condition is the primary driver for change: the Denmark Hill Dental Institute retains limited serviceable life and Guy's Tower is constrained in space and suitability for high-footfall ambulatory care.[36]

A 2023 Strategic Outline Case preferred a purpose-built centre with community satellites at an outturn capital cost of £226.1 million, identifying the capital requirement but deferring value for money testing.[37] Modelling for the Acute Services Review applies an indicative cost per dental chair to the reduction in chairs under each option, giving a cost reduction of £10.5 million a year for the preferred option. Consolidation onto a single existing site was costed at £86.6 million[38] and modelled to deliver £9.7 million, within 8% of that saving for just over a third of the capital. Both figures depend on chair reductions that assume an extended working pattern already piloted and judged unsustainable, so should be treated as indicative.

The scale of capital requirement has halted progress on this programme, and a lower capital route is needed. Changing models of care would allow the service to be delivered from a materially smaller acute footprint, with specialist activity consolidated where clinically appropriate and residual activity moved into community estate. This releases acute estate and avoids further capital spend on facilities that are not fit for purpose.

Planning should begin now that involves assessing estate suitability, developing a full set of options, and undertaking detailed demand and capacity modelling. Any change to the configuration of services would then need to follow a service change process in compliance with NHSE guidance, HM Treasury Green Book, and legal duties.

[35] HES APC and OPS, 2024/25.
[36] SEL, Dentistry 2030 Strategic Outline Case, (2023).
[37] Ibid.
[38] Ibid.

6. Analysing the impact of transformation

Without transformation and service change, the acute system deficit is projected to rise from £256 million in 2025/26 to £1 billion by 2030/31 before efficiency delivery.[39] As outlined in this report, returning acute services to sustainability will therefore require system-wide change that extends beyond existing programmes.

Commissioner-led transformations generate substantial financial benefit for the system. These transformations impact the activity profiles by suppressing demand for acute services and result in income and cost effects across the system. For the ICB, the transformation opportunities close the do-nothing position almost entirely. Applying the prevention, inequalities and models of care opportunities, net of the investment each requires, returns the commissioner from a £293 million deficit to a £3 million surplus in 2030/31.[40]

For the providers, the significance of the transformation opportunities is not only the financial impact, but their mechanism in reducing activity. Prevention and new models of care reduce the growth in demand rather than reducing below the current baseline levels of activity, so the majority of the income and cost reduction offsets forecast growth. The providers are committed to delivering £1.1 billion of efficiency over the period, most of which remains largely unidentified, and a significant proportion of which is currently absorbed to meet the costs associated with rising demand. By flattening the growth line, commissioner-led transformation reduces the volume of activity that the demand related provider efficiency programmes must absorb, allowing those programmes to deliver genuine reductions in the costs associated with care rather than holding the position against demand. The two are complementary rather than additive: commissioner-led transformation creates the headroom in which provider productivity plans become credible and deliverable.

Taken together, the commissioner-led transformation and full efficiency delivery move all three acute providers closer to financial sustainability by 2030/31. They move from do-nothing deficit positions of £440 million at GSTT, £369 million at KCHT, and £201 million at LGT to a residual position of a £29 million deficit, breakeven (with a remaining £149 million residual disaggregation), and a £18 million deficit respectively.[41]

The cross-provider transformation programmes are intended to reduce that residual gap and to mitigate the delivery risk attached to efficiency requirements that remain unidentified in the outer years. Outpatient transformation presents gross opportunity of £80 million on National Cost Collection basis, with the financial benefits distributed between the commissioner and the providers. Elective surgical hubs deliver £16 and £28 million from released bed and theatre session capacity when delivered in conjunction with commissioner-led transformation and productivity improvements. Similarly, consolidation of breast surgery to improve overall quality has an opportunity of £0.8 million to £0.9 million. The reconfiguration of oral and dental services delivers a gross annual opportunity of £9.7 million to £10.5 million through chair based cost-reduction, depending on the option pursued.

Unlike the commissioner led opportunities, which are phased over the planning period, these figures are stated as in-year values when delivered at full scale, as no delivery timescale has been assumed. Realisation will depend on investment and the pace at which each programme is implemented, and earlier delivery would generate a greater recurrent benefit over the period to 2030/31.

[39] SEL ICB and acute provider financial modelling 2025/26 – 2030/31, (July 2026).
[40] Ibid. Note: Includes net impact of outpatient transformation.
[41] Ibid. Note: Includes net impact of outpatient transformation.

7. Considering wider opportunities for future review

The Acute Services Review explored five further areas where scale or changing demand indicates a case for change. These areas provide direction for future sustainability review programmes and their appropriate geographical level for planning.

Maternity

Maternity is spread across ten sites in South London. Deliveries have decreased by 14% since 2019 and fertility rates continue to decline. As volumes decline, more sites will fall below viable scale, and over half are projected to drop under the 2,500-delivery sustainability threshold by 2035.[42] This will further exacerbate the current financial challenge as every maternity site in South London is loss-making, with a combined deficit of over £140m.[43]

While there is need to review maternity in both the South East and South West London systems, any changes in South East London should derive from planning on a South East London footprint. This mitigates the risk of delay in both systems that joint planning could create, and recognises that South West London already has work underway.

General paediatrics

Acute general paediatric activity is predominantly addressing local needs, with limited flow between South East and South West London. Around 89 beds are needed across 7 sites in South East London, with the PRUH, UHL and QEH each requiring less than 15 beds almost entirely for non-elective activity.[44] At these volumes, the cost of 24/7 consultant cover may not be proportionate to activity. Overall, there is opportunity to plan general paediatrics and maternity together across South East London to address the sustainability challenges given the clinical interdependencies between the services.

Non-tertiary surgery for cancer

Surgical treatment for cancer shows a long tail of low-volume provision, with sub-scale services scattered across South London. However, admitted cancer activity is predominantly local, with South East London patients making up 78% of activity across the three trusts and most South West London providers serving their local populations.[45] As such, it should be planned on a South East London basis, with consideration of inward flows from Kent, Medway and Sussex.

Specialised paediatrics, cancer and cardiothoracic

Specialised paediatrics, cancer and cardiothoracic services have significant activity flows across London and wider catchments (e.g., in specialised paediatrics, GSTT draws 65% of activity from outside of South East London).[46] Activity is also concentrated in a few large providers with long tails of sub-scale services (e.g., in specialised cancer, 60% of providers in London make up 7% of activity).[47] The London Specialised Services Review was commissioned in 2026 to review the case for planning services to improve quality of care and sustainability of services. Within this context, planning of these specialised services should occur collaboratively across London's ICSs, rather than at a South London footprint.

Major trauma

Specialised major trauma services are delivered by four London providers: Barts (727 spells), KCHT (654), St George's (493) and Imperial/St Mary's (1.5k).[48] The co-dependency requirements for major trauma are resulting in potentially unsustainable services at the four major trauma sites, including vascular surgery. These sustainability challenges should be considered through a London-wide review of the co-dependency framework.

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[42] HES APC, (2025); National Advisory Team, Guidance on reconfiguration of maternity and children's services, (2015).
[43] HES APC and OPS, (2025).
[44] HES APC, (2025).
[45] Ibid.
[46] SUS, (2025/26).
[47] Ibid.
[48] Ibid.

8. Conclusions and recommendations

South East London has a significant financial and demand challenge that is growing and beyond what existing improvement programmes can close. System-wide action is required to deliver the long-term financial sustainability of acute services in South East London. This spans commissioner-led transformation, neighbourhood health, provider productivity, and collaborative change programmes that extend beyond individual trust boundaries.

Recommendations

1. The ICB should expand investment in targeted prevention programmes and work in collaboration with local authorities to deliver initiatives focussed on obesity; CVD; diabetes; respiratory disease; anxiety and depression.
2. The ICB and each integrator should collaborate to transform models of care to deliver proactive, integrated, and community-based care in alignment with the neighbourhood health agenda.
3. Each provider should extend CIPs across the full five-year period and identify where there is opportunity to deliver productivity improvements either individually or through system-wide collaboration.
4. The three providers and the ICB should mobilise system-wide transformation and service change in the following areas:
    - Outpatient transformation programme to design planned specialist care once and deliver it across all three organisations, leveraging the shared Epic platform and embedding standardised pathways and single points of access.
    - Elective surgical hubs to determine feasibility to concentrate activity, ring-fence capacity, and deliver productivity improvements and financial benefits for the system. This must start from development of a detailed demand and capacity modelling exercise covering all specialties and be associated with a theatres and estates review to confirm the ability for GIRFT standards to be met.
    - Breast surgery to consolidate surgical activity to strengthen service resilience and improve quality.
5. The ICB and acute providers should work to address other services identified through this review to ensure high quality care and system sustainability:
    - Oral and dental health should be explored for a smaller acute estate footprint, consolidating specialist activity where clinically appropriate and moving residual and non-specialist activity into community estate.
    - Maternity and general paediatrics should be jointly explored for transformation in South East London.
    - Non-tertiary surgery for cancer should be considered as part of the above mentioned elective surgical hubs and breast surgery consolidation.
    - Specialised services transformation, including specialised paediatrics, cancer, and cardiothoracic, should be considered as part of the London Specialised Services Review.

South East London Integrated Care System

Acute Services Review

Findings and next steps

South East London Integrated Care System

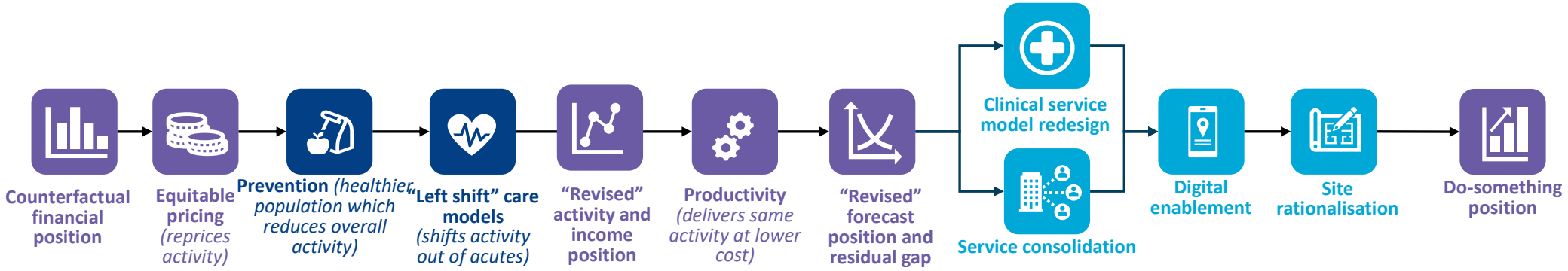
Summary recommendations

Context of the review

South East London Integrated Care System

A sequence of analytical steps underpins the findings and conclusions of the Acute Services Review

Counterfactual	ICB-led transformation	Individual provider productivity	Cross-provider transformation	Do-something
The counterfactual sets the financial position for each provider and the ICB before any transformation	ICB-led transformation impacts the income, activity and cost forecast for providers	Provider productivity impacts predominantly the cost base by each provider delivering activity more efficiently	Provider transformation addresses the residual financial gap through structural change predominantly in the cost base	The resulting financial position once opportunities are delivered



Financial projections over the next five years were developed for each provider and the ICB	Deconstruction of the block was applied to the financial projections and impacted the pricing of activity for each provider	Population health segmentation modelling was leveraged to understand the opportunities that could be realised for preventing deteriorating health status and delivering new models of care	Commissioner transformation impacted the activity, income and cost scenarios for each acute provider	CIPs were triangulated alongside NHSE data and targeted analysis on patient flow, workforce and non pay	The cost base forecasts were updated for productivity improvements and the revised gap was determined	Service transformation opportunities across acute providers are core to the review findings and represent a dominant focus of the review. We are focused on determining the service models, digitalisation and site rationalisation opportunities to bridge the residual financial gap for the acute providers	The impact of the opportunities was determined by considering investment, phasing and benefits

Making the case for change

South East London must transform the way services are planned, commissioned, and delivered to achieve financial sustainability

South East London Integrated Care System

Population needs are growing

- **The population is growing older:** The over 65 population is expected to increase by 24% in the next 10 years, with over 65s making up 15% of the population by 2036
- **People's health is deteriorating:** Without any major transformation, the moderate and high need patient cohorts will increase due to poor health from 43% to 54% of the population

Demand is projected outstrip capacity

- **Do-nothing scenario:** Emergency attendances rise by 15% between 2025/26 and 2035/36, outpatient appointments by 21% to 5.4 million a year, and non-elective and elective bed days by around 25%. The modelled bed requirement for the GP registered population reaches 4,572 by 2035/36 against 3,914 general and acute beds currently open, a shortfall of around 650 beds.

Financial pressures are increasing for the ICB and providers

- **Impact of convergence:** South East London is 3.62% over target for core services with convergence of -0.50%; and 18.32% over target for specialised services with convergence of -0.37%.
- **Income and cost pressures:** Deficit support funding is to be phased out from 2026/27 and the acute providers will be required to navigate the impacts of deconstruction of the block and cost inflation

Current work has not found savings of sufficient scale

- **Projected deficits:** In the do-nothing scenario, the ICB is projected to deteriorate to a £791 million deficit by 2030/31 (excl. efficiency), and the acute providers to a deficit of £1.0 billion (excl. CIP delivery).

The Acute Services Review sets out the interconnected role of commissioner-led transformation, productivity improvements, and cross-provider service change to achieve sustainability

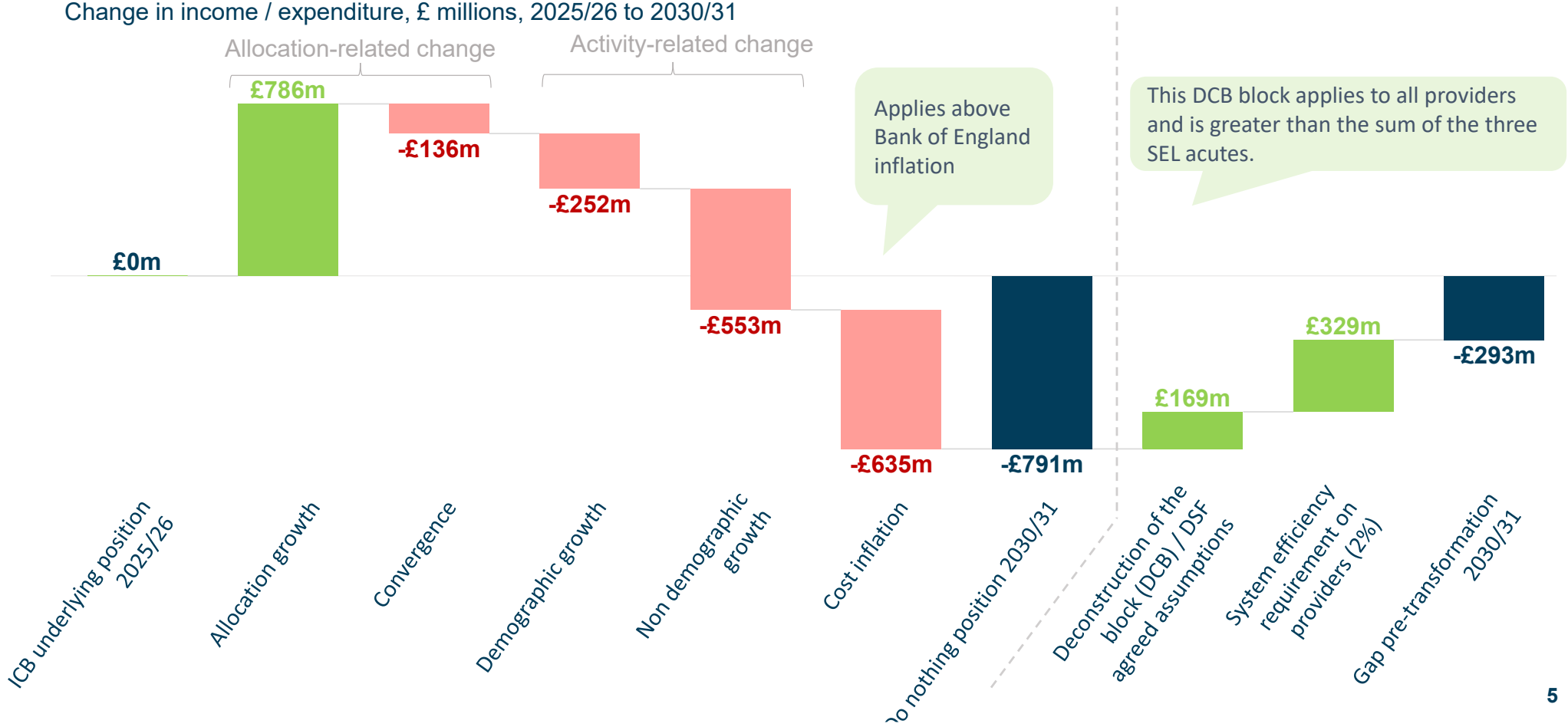
Making the case for change

South East London Integrated Care System

The SEL ICB financial position would deteriorate to a £791m deficit by 2030/31 (excluding efficiency)

SEL commissioner financial waterfall – DO NOTHING

Change in income / expenditure, £ millions, 2025/26 to 2030/31



5

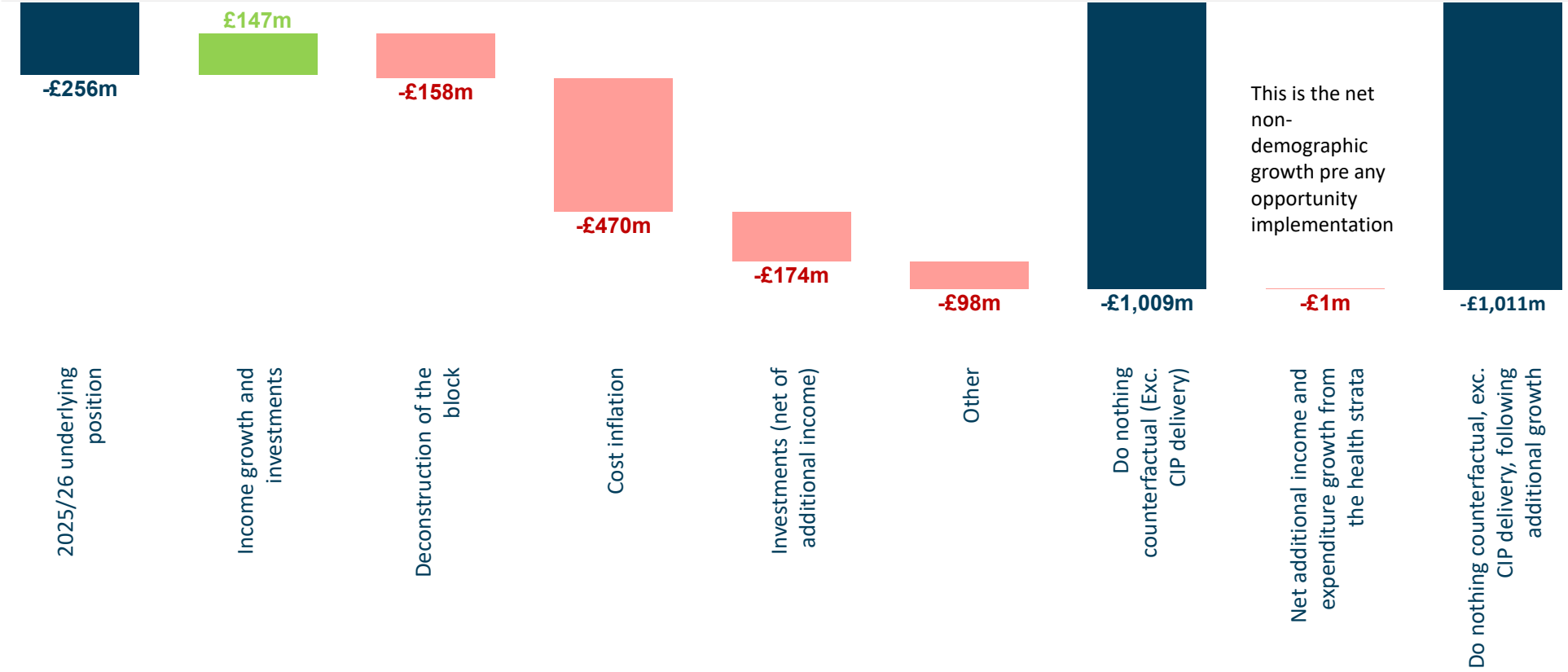
Making the case for change

South East London Integrated Care System

The combined provider financial position would deteriorate to a deficit of £1.0b by 2030/31 (excluding CIP delivery)

Acute provider combined counterfactual – DO NOTHING

Change in income / expenditure and closing position, £ millions, 2025/26 to 2030/31



6

SUBJECT TO REVISION – NOT FOR CIRCULATION

Maximising the NHS allocation

A range of transformative opportunities underpin improvements in healthcare value in South East London

South East London Integrated Care System

Opportunity to reduce the growth in prevalence and progression of ill health

Delivering proactive prevention and early intervention

This opportunity focuses on **proactive prevention and early intervention** to reduce disease prevalence and slow the progression of ill health. This approach increases healthy life years and reduces long-term costs by limiting growth in higher-need cohorts.

The maximum potential opportunity is calculated based on the **financial impact of preventing people from transitioning to higher needs segments** (compared to 2025/26) due to worsening health by 2035/36.

Potential net opportunity: £99m
(investment of £62m)

Opportunity to improve care for the population

Transforming models of care

This opportunity focuses on **implementing proactive models of care** to improve quality and outcomes. It reduces unwarranted variation between places by scaling effective models of care.

The maximum potential opportunity for the non-Core20 population are calculated based on the **value of 'place variation opportunity'**, which is the financial impact if boroughs delivered care at the cost per capita level of the **'best value place'** for non-Core20 population for each population segment, adjusting for inner and outer South East London.

Potential net opportunity: £252m
(investment of £122m)

Reducing health inequalities and improving outcomes for underserved population

This opportunity focuses on **reducing health inequalities and improving outcomes for underserved populations**. By targeting resources and interventions where they are most needed, the system can address disparities.

The maximum potential opportunity for the Core20 population are calculated based on the **value of 'place variation opportunity'**, which is the financial impact if boroughs delivered care at the cost per capita level of the 'best value place' for Core20 population for each population segment, adjusting for inner and outer South East London.

Potential net opportunity: £65m
(investment of £45m)

Source: © Carnall Farrar Limited, Health Strata Population health stratification based on proprietary methods, SEL database

Targeting provider productivity

Annual efficiency targets were extended with trust finance teams to 2030/31, but are largely unidentified and carry delivery risks

South East London Integrated Care System

The Medium Term Financial Plans (MTFPs) set out each provider's efficiency requirement over the medium-term planning period, in line with the national shift from annual to multi-year planning and the requirement to deliver at least 2% productivity improvement a year. Working with each trust's finance team, these plans have been extended across the full five-year period.

Each provider's productivity for the purpose of the modelling is expressed as a percentage of operational expenditure, giving a consistent basis for application across providers. That percentage is applied year by year across the planning period to determine how much productivity each provider is assumed to deliver in each year.

Overview of approach to identify and model productivity improvements

Assumption		25/26	26/27	27/28	28/29	29/30	30/31
CIP as % of operational expenditure	GSTT	—	3.7%	3.1%	2.2%	2.0%	2.0%
	KCH	—	4.3%	4.1%	3.9%	3.4%	3.3%
	LGT	—	5.0%	4.4%	4.2%	4.3%	3.4%

Note: Efficiency targets to 2028/29 are drawn from each provider's Medium Term Financial Plan, consistent with the national medium-term planning framework. Targets for the later years are an extension agreed with trust finance teams to align with the five-year horizon

CIP plans do not extend across the full five-year period, and the outer years are largely unidentified and carry delivery risks. Closing this gap requires further productivity opportunities to be identified in each year. The system transformation opportunities set out later in this pack are potential routes to addressing structural challenges and closing the unidentified gaps.

Source: Provider MTFPs; Five-year financial modelling (June 2026)

Cross-provider transformation

South East London Integrated Care System

Four cross-provider opportunities have been prioritised, worth around £110m a year at full scale

Engagement and workshops have identified four cross-provider transformation programmes to prioritise and pursue. These build on collaboration already underway and fall into four areas: transforming outpatient care into a new model of planned specialist care, establishing elective surgical hubs, consolidating breast surgery and exploring alternative ways forward for oral and dental care.

			Gross size of annual opportunity*
	**Outpatient transformation**	Transform outpatient services into a **new model of planned specialist care** that is designed collaboratively by the system and consists of: • Standardised pathways and guidelines • Single points of access (SPOA) covering planned specialist care for all services • Straight to test model for harmonised clinical pathways For small/fragmented services**,** consolidation or shared SPOAs designed and delivered once for the system	**£80 million**
	**Elective surgical hubs**	Establish **elective surgical hubs** covering: • ENT • Orthopaedics • Gynaecology • Urology • General surgery • Ophthalmology	**£18.1m to £19.8m**
	**Breast surgery consolidation**	**Consolidate breast surgery** to address fragmentation and improve quality with the ambition of establishing a centre of excellence	**£0.8m to £0.9m**
	**Oral and dental**	**Explore alternative ways forward** for oral and dental that have less significant capital implications	**£9.7m to £10.5m**

Excludes estate savings from exiting sites and any required capital investments

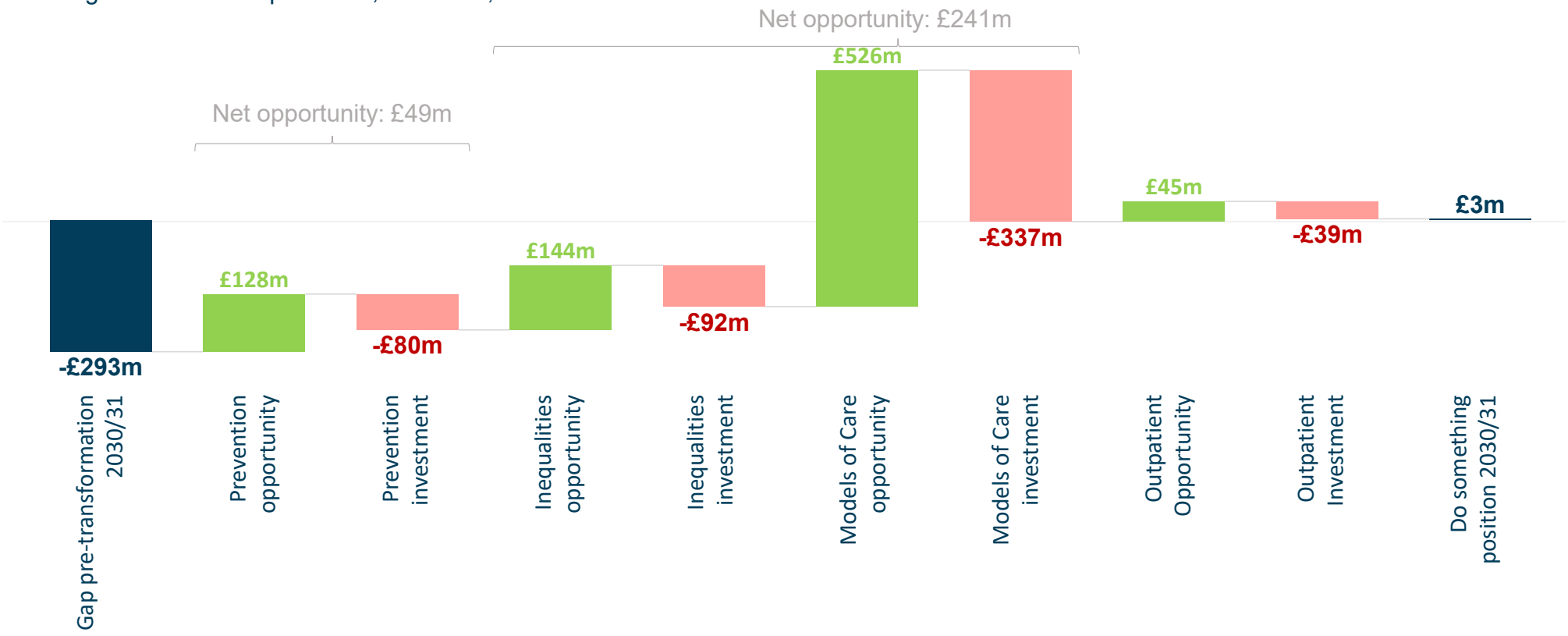
9

Assessing financial impact

The South East London ICB returns to £3m surplus in the do-something scenario

SEL commissioner financial waterfall – DO SOMETHING

Change in income / expenditure, £ millions, 2025/26 to 2030/31



10

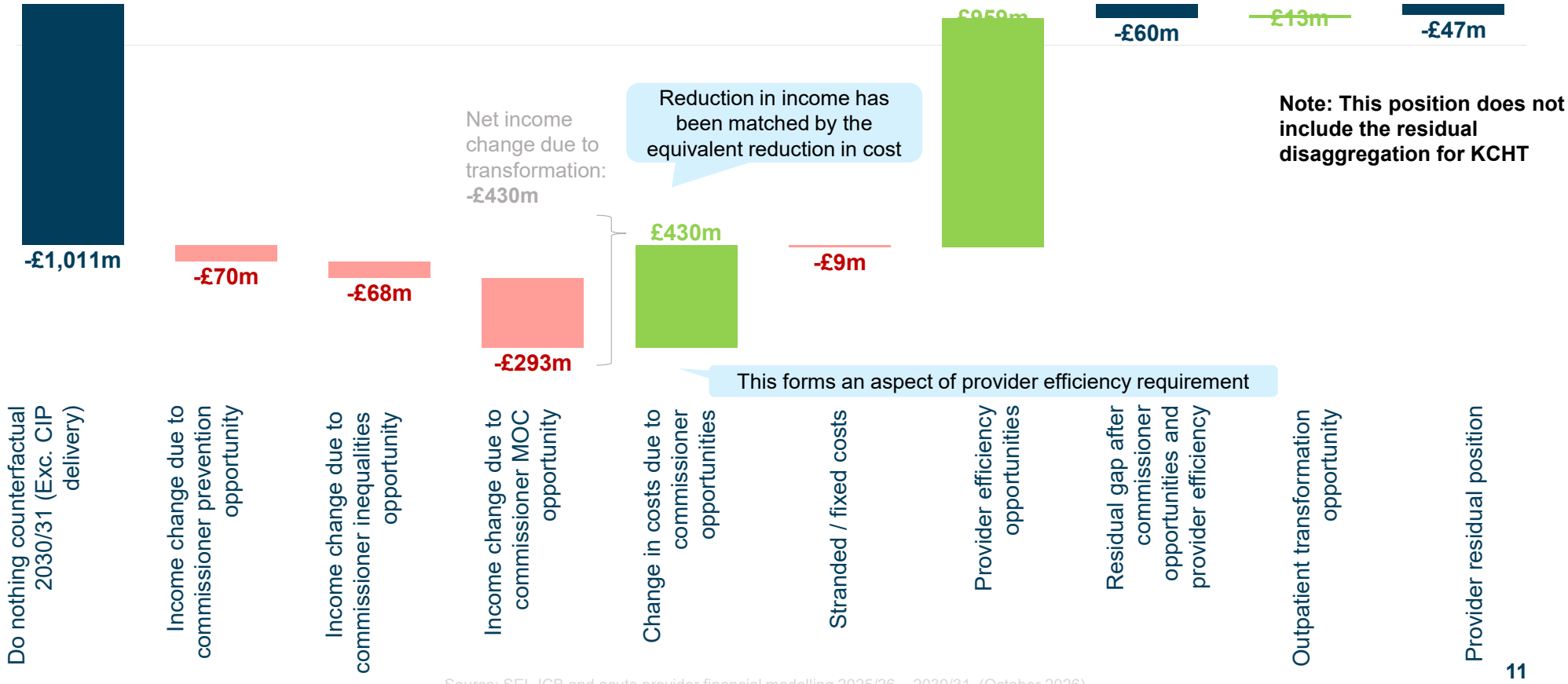
Assessing financial impact

Under the do something scenario, transformation opportunities would leave a (£47m) deficit for the acute providers

South East London Integrated Care System

Combined acute provider financial waterfall – Do something

Change in income / expenditure, £ millions, 2025/26 to 2030/31



Note: This position does not include the residual disaggregation for KCHT

Source: SEL ICB and acute provider financial modelling 2025/26 – 2030/31, (October 2026).

Wider considerations

There is opportunity to review and transform further services should there be appetite and capacity to do so

South East London Integrated Care System

Specialty	Appropriate planning footprint	Rationale
Maternity	**South East London**	Outer-SEL sites have unsustainably low volumes that will further decline with the falling fertility rate. Service reconfiguration could improve the care model to align it with a changes in the demographic profile of demand and improve financial sustainability
General paediatrics (both elective and non-elective)	**South East London**	There are small units in both SEL (and SWL) that would benefit from review to secure quality and efficiency over the longer term. This could be done along side maternity.
Specialist paediatrics	**London-wide**	Activity flows span the whole London and GSTT/Evelina's catchment includes the South East region. Sub-scale services exist across London in a range of subspecialties. This could be addressed through the London specialised services review
Non-tertiary surgery for cancer	**South East London**	Surgical cancer shows a long tail of low-volume provision**,** with sub-scale services scattered across SEL and SWL. However, activity flows are largely local to the SEL trusts (78%), with some cross-border flows from South East England (e.g., Kent).
Specialised cancer	**London-wide**	Activity flows for specialised cancer services cross every London ICB. There is high concentration of activity in a few providers (RMH, UCLH, GSTT, Imperial, Barts) with long tail of other sub-scale providers.
Cardiothoracic (combined due to coding reasons)	**London-wide**	Providers across London draw activity from beyond their catchments. A few large London providers account for most cardiothoracic bed days, with a long tail below 5%.
Major trauma	**London-wide**	The co-dependency requirements for major trauma sites are resulting in potentially unsustainable services across London.

Returning services to sustainability requires action on five fronts, from the ICB and all three providers together

South East London Integrated Care System

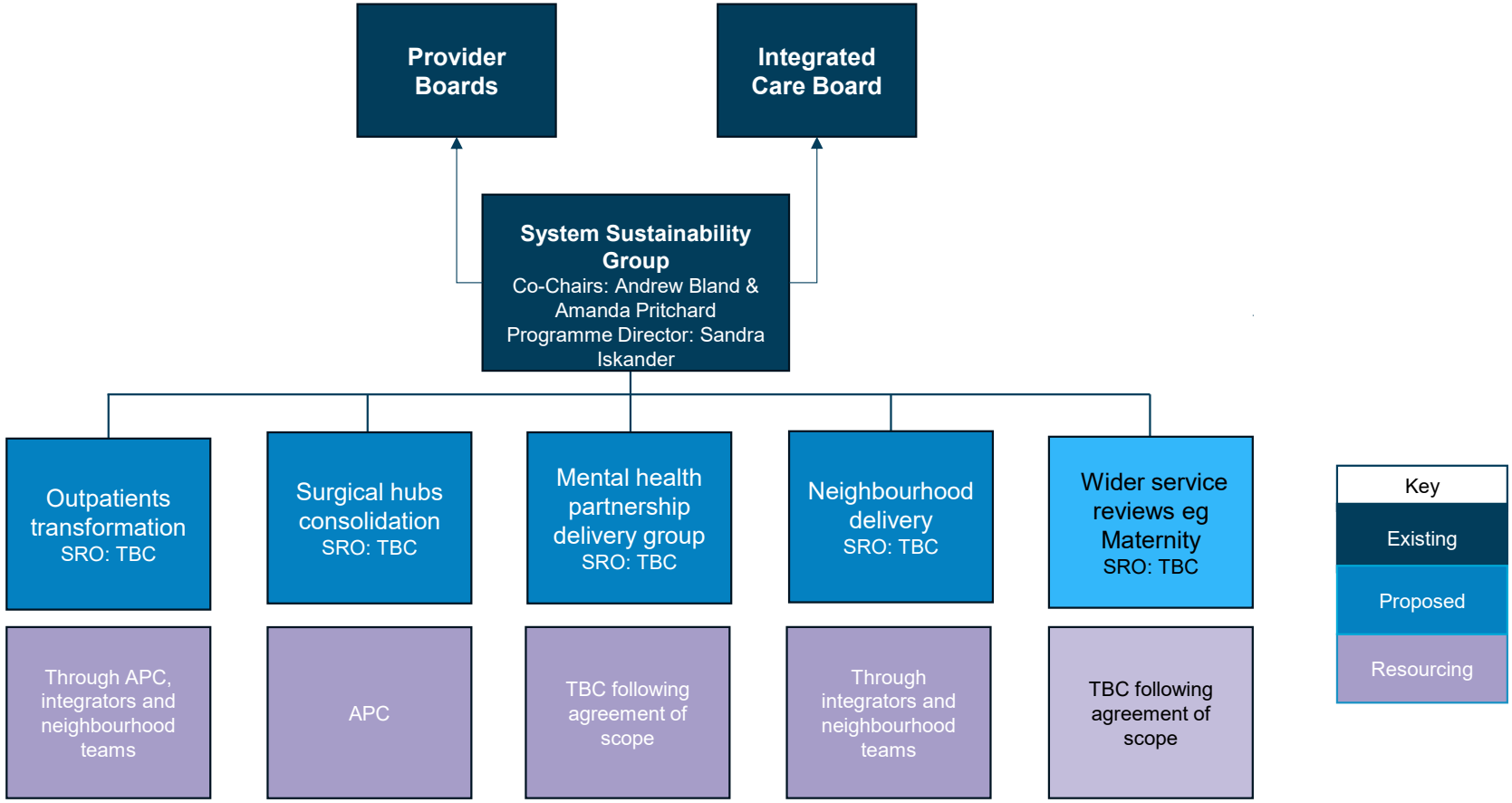
The demand and financial challenge in South East London is growing and is beyond what existing programmes can close. Long-term sustainability requires system-wide action, spanning commissioner-led transformation, neighbourhood health, provider productivity, and change that extends beyond individual trust boundaries.

1. **Invest in prevention** – Expand targeted programmes on obesity, cardiovascular disease, diabetes, respiratory disease, and anxiety and depression
2. **Shift to proactive models of care** – Implement proactive and community-based models of care, delivered through the integrator agenda
3. **Close the efficiency gap** – Extend CIPs across the full five years and identify where productivity will come from, individually or through additional system collaboration
4. **Deliver three cross-provider programmes** – Outpatient transformation, elective surgical hubs, and breast surgery consolidation
5. **Scope wider services** – Aim for a smaller acute footprint for oral and dental, review maternity, general paediatrics and non-tertiary cancer surgery in South East London and specialised services through the London review

South East London Integrated Care System

Governance and oversight

Proposed governance structure



Next steps

- Detailed governance arrangements to be worked through and confirmed with SSG
- Summary report and overview of delivery approach to be agreed by each organisation's Board
- Each programme to have an SRO and agreed mandate outlining scope, implementation plan and resourcing
- Include delivery expectations in commissioning intentions

In conclusion

- The ASR has provided the system with a shared understanding of current and future challenges, and how they might realistically be addressed
- Recommendations around investing in prevention and shifting to proactive models of care align with the priorities set out in the Five Year Strategic Commissioning Plan and reinforce the commitment to deliver this at pace and scale.
- Providers are now able to agree collaborative medium term transformation programmes which can be reflected in commissioning intentions
- A broader set of analysis and evidence is available to direct future phases of work

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 16

BOARD/COMMITTEE REPORT COVER PAPER

Report to:	Trust Board
Date of meeting:	17 November 2026
Subject:	Freedom to Speak Up Guardian Annual Report 2025-2026
Author(s):	Sally Khawaja, Deputy Freedom to Speak Up Guardian
Sponsor:	Tracey Carter, Chief Nursing Officer and Executive Lead for Freedom to Speak Up
History:	Annual report presented through the Trust's governance arrangements. The report provides the annual review of Freedom to Speak Up activity, themes, outcomes, risks, learning and organisational assurance for 2025-2026.
Status:	

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

Purpose

To provide the Board with assurance on the effectiveness, accessibility and impact of the Trust's Freedom to Speak Up (FTSU) arrangements during 2025–26, including the themes and risks identified through concerns raised by staff, the extent to which the organisation is fostering a culture where people feel able to speak up, and the actions required to strengthen organisational learning, leadership, workplace culture and confidence that concerns will be acted upon.

Discussion at Quality & Research Committee asked for examples of how speaking up has led to resolution and improvement. This has been included in the report and will be considered for future reports.

The People, Inclusion and Education Committee sought assurance on the 10 alleged detriment cases, which are being reviewed by the Chief People Officer and Chief Nurse & Executive Director of Midwifery, and will confirm the findings in a report to the committee.

In summary: the report seeks to assure the Board that the FTSU service remains visible and accessible, whilst highlighting the areas where further improvement is needed to ensure concerns raised by staff lead to meaningful action, learning and cultural change.

Recommendations:

The Board is asked to note the key themes, risks and learning arising from Freedom to Speak Up activity during 2025–26 and take reasonable assurance that the service remains visible, accessible and actively used across the Trust, whilst recognising the need for continued action to strengthen organisational response, staff confidence, psychological safety and demonstrable impact from concerns raised.

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	Supports assurance against strategic risks relating to organisational culture, leadership, workforce experience, staff wellbeing, psychological safety and patient safety. The report identifies areas where further improvement and oversight are required and provides intelligence to support risk management and organisational learning.
King's Improvement Impact (KIM):	The report supports continuous improvement through the use of triangulated intelligence, thematic analysis, red-flag methodology, benchmarking and identification of improvement opportunities arising from staff feedback and concerns.
Quality Impact	Positive impact on patient safety, quality of care and organisational learning through identification and escalation of concerns. The report includes analysis of patient safety and safeguarding concerns and supports ongoing quality improvement activity.
Health Equity Impact	Freedom to Speak Up arrangements aim to provide equitable access to all workers regardless of role or background. The report supports inclusion, fairness, psychological safety and equal opportunity to raise concerns.
Workforce Impact	Significant workforce implications. The report highlights themes relating to workplace culture, leadership behaviours, bullying and harassment, team dynamics, staff wellbeing, retention, inclusion and

	psychological safety. Findings support targeted workforce and cultural improvement activity.
Research/Innovation Impact	The report introduces red-flag thematic analysis and enhanced triangulation methodology to support organisational learning, assurance and improvement.
Digital Impact	Supports development of enhanced data quality, reporting and intelligence arrangements following the transfer of FTSU reporting responsibilities to NHS Trusts from July 2026. No significant cyber security implications identified.
Financial Impact	Early identification and escalation of concerns may contribute to reduced organisational costs associated with unresolved workplace issues, employee relations cases, turnover, formal investigations and patient safety incidents. The report itself has no direct financial implications. (Professional judgement based on report purpose rather than a stated report finding.)
Legal/ regulatory compliance	Supports compliance with NHS Freedom to Speak Up policy requirements, NHS England reporting requirements, CQC Well-Led expectations and broader statutory obligations relating to worker voice, patient safety and organisational governance.
Communications and Engagement	Findings will be shared through relevant governance structures and used to inform organisational learning, leadership discussions, workforce improvement activity and staff engagement.
Use of Artificial Intelligence Tools	Microsoft Copilot was used to support drafting and editing of report content. No patient identifiable, confidential or commercially sensitive information was entered. All content has been reviewed by the author for accuracy, governance compliance and confidentiality prior to submission.
Committee that will provide relevant oversight Quality & Research Committee, People, Inclusion & Education Committee	

King's College Hospital NHS Foundation Trust

Board Briefing: Freedom to Speak Up Annual Report 2025–26

Purpose of the Paper

This report provides the Board with assurance on the effectiveness, accessibility and impact of the Trust's Freedom to Speak Up (FTSU) arrangements during 2025–26. It sets out the volume and nature of concerns raised, key cultural and organisational themes emerging from those concerns, staff survey findings, benchmarking information, organisational learning and areas requiring further improvement.

Key Messages for the Board

- The Trust's FTSU service remains **visible, accessible and actively used**, with 262 concerns raised during 2025–26.
- Although reporting activity reduced by 18.4% compared with the previous year, concerns continued to be raised consistently throughout the year. Reporting volumes alone should not be used as a measure of organisational culture.
- **People and Behaviour** remained the largest category of concern, while **Management and Leadership concerns increased**, highlighting continuing challenges relating to workplace culture, leadership behaviours and staff experience.
- The most common themes raised by staff were workplace culture, leadership concerns, inappropriate behaviour, bullying and harassment, and employment processes.
- NHS Staff Survey results show improvement across all speaking-up measures; however, the Trust remains below national averages, particularly in staff confidence that concerns raised will be acted upon.
- Only **54.3% of staff reported feeling safe to speak up**, and **43.0% expressed confidence that concerns would be addressed**, representing the Trust's most significant cultural challenge.
- Patient safety, quality of care and safeguarding concerns continue to be raised through the FTSU service, providing valuable intelligence to support organisational learning and improvement.
- Red-flag analysis identified **teamwork culture, bullying, intimidation and poor team dynamics** as the most significant recurring themes across the Trust.
- Concerns relating to actual or perceived detriment following speaking up remain low but continue to require close oversight due to their potential impact on psychological safety and staff confidence.
- Nursing & Midwifery staff were the highest users of the service, administrative & Clerical staff accounted for a proportion evenly distributed throughout the year. With 34 contacts from medical and dental staff.
- **Referrals to the FTSU service were received from staff across a diverse range of backgrounds, with women accounting for the majority of concern raisers (64%).** Where ethnicity was disclosed, referrals reflected a broad mix of ethnic

groups, demonstrating engagement with the service across different staff communities.

- **The ability to undertake meaningful equality analysis is limited by high levels of non-disclosure of protected characteristic information**, particularly for disability (94% not stated), religion or belief (96% not stated), sexual orientation (78% not stated) and ethnicity (62% not stated).
- The Board can take **reasonable assurance** regarding the visibility, accessibility and utilisation of the FTSU service.
- The Board can take only **partial assurance** regarding organisational response and impact, particularly in relation to leadership behaviours, workplace culture, confidence that concerns will be addressed, and demonstrable evidence of learning and improvement arising from concerns raised.

Strategic Implication

The key priority for 2026–27 is to move beyond supporting staff to speak up and strengthen confidence that concerns lead to visible action, organisational learning and measurable improvement, whilst continuing to address themes relating to leadership, workplace culture, psychological safety and detriment.

King's College Hospital NHS Foundation Trust

Freedom to Speak Up Annual Report 2025-2026



Author: Sally Khawaja. Deputy Freedom to Speak Up Guardian

Confidentiality Statement

Confidentiality is fundamental to the Freedom to Speak Up process. Concerns are managed sensitively, and information is shared only where necessary and, wherever possible, with the knowledge and consent of the individual raising the concern.

To minimise the risk of identification, this report presents concerns, themes and outcomes in aggregated or high-level form where appropriate. This supports transparency, accountability and organisational learning while protecting the privacy, wellbeing and psychological safety of workers who speak up.

Purpose

This report provides the Board with assurance on the visibility, accessibility, utilisation of the Trust's Freedom to Speak Up arrangements during 2025 - 2026. It presents activity, themes, risks, outcomes and learning arising from concerns and triangulates this intelligence with workforce, staff experience, organisational culture and patient-safety indicators. The report also identifies areas where assurance remains partial and where further action, ownership of evidence of impact is required.

Executive summary

This report provides assurance to the Board regarding the accessibility, effectiveness and impact of the Trust's Freedom to Speak Up (FTSU) arrangements during 2025-2026. FTSU remains an important mechanism through which workers can raise concerns, contribute to organisational learning and support improvements in patient safety, staff experience and culture. The service continues to provide valuable intelligence relating to leadership, workplace behaviours, employment processes and patient care.

During 2025-2026, 262 concerns were raised through the FTSU service, compared with 321 during 2024-2025, representing a reduction of 18.4%. Concerns continued to be raised throughout the year, demonstrating sustained use of the service. Reduced reporting volumes should not be interpreted in isolation as evidence of improved culture and must be considered alongside workforce, safety, staff-experience and culture indicators.

The profile of concerns raised provides important insight into the experiences of workers across the Trust. People and Behaviour remained the largest category of concern, accounting for 43.5% of all cases, whilst Management and Leadership concerns increased despite the overall reduction in case activity. This suggests that organisational culture, workplace relationships and leadership behaviours continue to influence staff experience and remain key areas for executive focus.

The NHS Staff Survey demonstrated positive movement across all speaking up indicators. However, the Trust remains below the national average across key measures relating to confidence to raise concerns and confidence that concerns will be acted upon. Most notably, 54.3% of staff reported that they felt safe to speak up, whilst only 43.0% were confident that concerns would be addressed. This continues to represent a principal cultural challenge for the organisation.

The Board can take reasonable assurance that the FTSU service remained visible, accessible and actively used during 2025-2026. Partial assurance is available regarding organisational response and impact. Continued improvement is required to strengthen confidence that concerns will be acted upon, demonstrate learning and measurable change,

address leadership and workplace-behaviour themes, and maintain oversight of detriment and psychological safety.

The Board is asked to:

· 1. Note the activity, themes, risks and learning arising from FTSU concerns during 2025-2026.

· 2. Take reasonable assurance regarding the visibility, accessibility and continued utilisation of the FTSU service.

· 3. Note the partial assurance regarding organisational response and impact, particularly in relation to leadership, workplace behaviours, detriment and confidence that concerns will be addressed.

· 4. Support continued triangulation of FTSU intelligence with workforce, equality, employee-relations, staff-survey, patient-safety and culture information.

· 5. Receive progress assurance during 2026-2027 on accountable ownership, actions taken, intended outcomes and evidence of impact.

Introduction

Freedom to Speak Up (FTSU) plays a vital role in fostering a culture of openness, transparency and continuous improvement across the Trust. The service provides workers with an independent and confidential route to raise concerns where they may feel unable or unwilling to use existing management channels. By supporting staff to speak up, the service contributes to patient safety, staff wellbeing, positive workforce experience and organisational learning.

During 2025-2026, the Trust's FTSU service was delivered by two full-time Freedom to Speak Up Guardians working across all Trust sites. The Guardians remained accessible through a range of channels, including face-to-face engagement, telephone, email and virtual appointments, ensuring equitable access for all workers.

Throughout the year, the service continued to support the Trust's commitment to listening to staff, promoting psychological safety and strengthening compassionate and inclusive leadership. These priorities are reflected within the NHS People Promise, the Trust Strategy and the findings of the CQC Well-Led assessment. The concerns and themes raised through FTSU activity during the year demonstrate the ongoing importance of staff voice in identifying risks, informing improvement and supporting a culture where learning and accountability can thrive.

National Context and Reporting Responsibilities

The national Freedom to Speak Up framework continues to emphasise the importance of local accountability, transparency and organisational learning. The FTSU service supports this by providing independent oversight of concerns raised and ensuring that emerging themes inform governance and improvement processes.

Future Considerations for 2026-2027

Although outside the reporting period covered by this report, from 1 July 2026 NHS Trusts assumed direct responsibility for the submission and quality assurance of FTSU data. This change places increased emphasis on local governance, data quality, executive oversight, and the effective use of speaking up intelligence to support organisational learning and improvement. During 2026-2027, arrangements to support these responsibilities will continue to be developed and embedded, with progress reported through the Trust's established governance structures.

How to interpret the data

FTSU data reflects concerns reported by workers and should not be interpreted as substantiated findings or as a direct measure of the prevalence of harm. Higher reporting may indicate awareness of and confidence in speaking-up routes, while lower reporting may reflect fewer concerns, use of alternative routes or barriers to speaking up. Volumes should therefore be considered alongside workforce size, service context, staff-survey results, employee-relations information, safety intelligence and qualitative feedback.

Activity and analysis

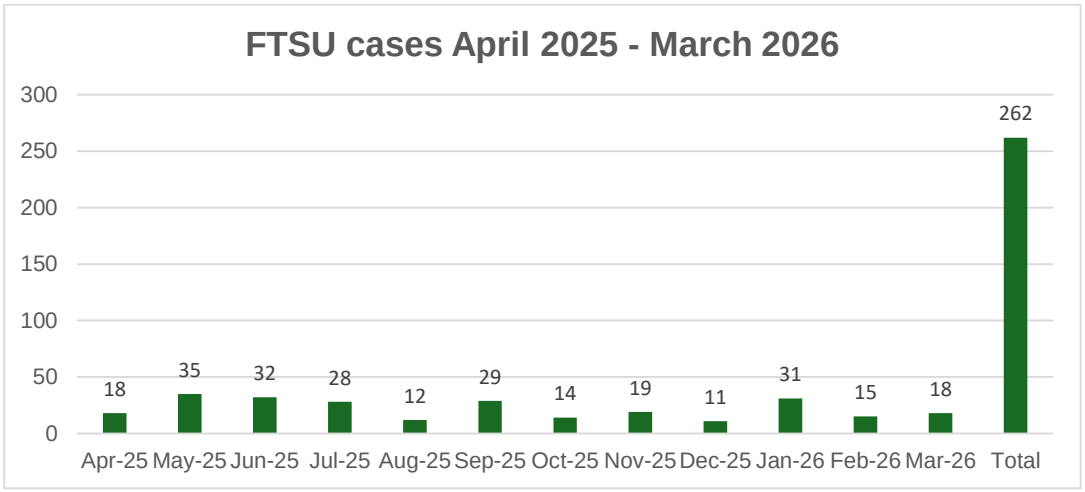
A total of 262 concerns were raised during 2025-2026, representing a decrease from the previous reporting year. Concerns were received throughout the year, demonstrating continued use and accessibility of the Freedom to Speak Up service. Peaks in activity occurred during May, June and January.

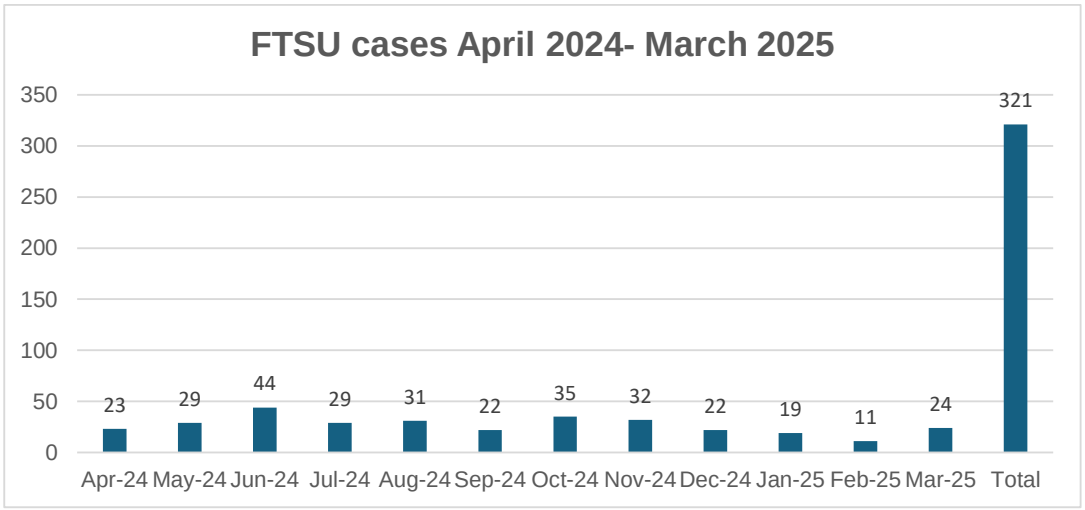
Review of the concerns raised during these periods identified multiple contacts relating to similar issues within the same working areas. The concerns predominantly related to workplace culture, behaviours and team dynamics. The recurrence of similar concerns provided additional thematic intelligence and indicated that the issues raised may extend beyond individual experiences. Relevant themes were escalated to the appropriate teams to support further review, intervention and organisational learning.

The reduction in overall case numbers should not be regarded as either positive or negative in isolation. An effective speaking-up culture is characterised by workers feeling able to raise concerns when needed, rather than by a predetermined level of reporting. More meaningful indicators are whether concerns are heard, responded to appropriately and used to inform learning and improvement.

The FTSU service continues to provide an accessible route for workers to raise concerns and a valuable mechanism for identifying recurring and emerging issues affecting workforce experience, patient safety and organisational culture. However, continued oversight is

required to ensure that thematic concerns are triangulated with wider workforce intelligence and result in visible and measurable action.





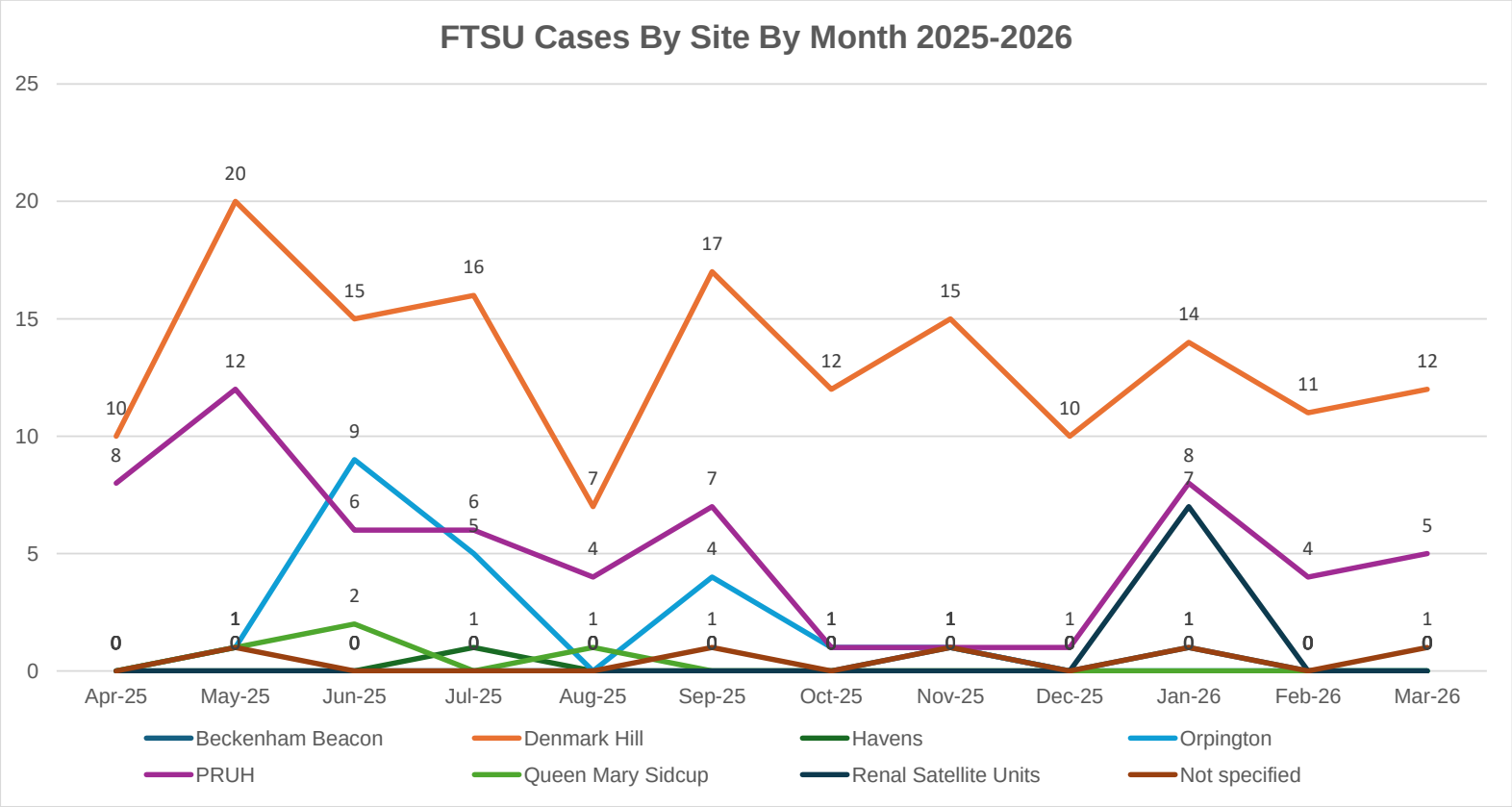
Site Analysis

Concerns were raised across all Trust sites during 2025–2026, demonstrating that the FTSU service remains accessible to staff throughout the organisation. Denmark Hill accounted for the largest proportion of concerns (60.7%), followed by the Princess Royal University Hospital (PRUH) (24.0%) and Orpington Hospital (8.0%). A smaller number of concerns were raised from other Trust locations, including Queen Mary's Sidcup, Renal Satellite Units, Havens and Beckenham Beacon.

Comparison with 2024–2025 shows a reduction in the number of concerns raised at both Denmark Hill and PRUH, whilst reporting activity increased at Orpington Hospital. Monthly reporting patterns varied across sites, with Denmark Hill consistently accounting for the highest volume of concerns, reflecting its relative workforce size and operational scale. An increase in concerns raised at Orpington was observed during the year, particularly in June 2025, prompting further review of local themes and staff experience.

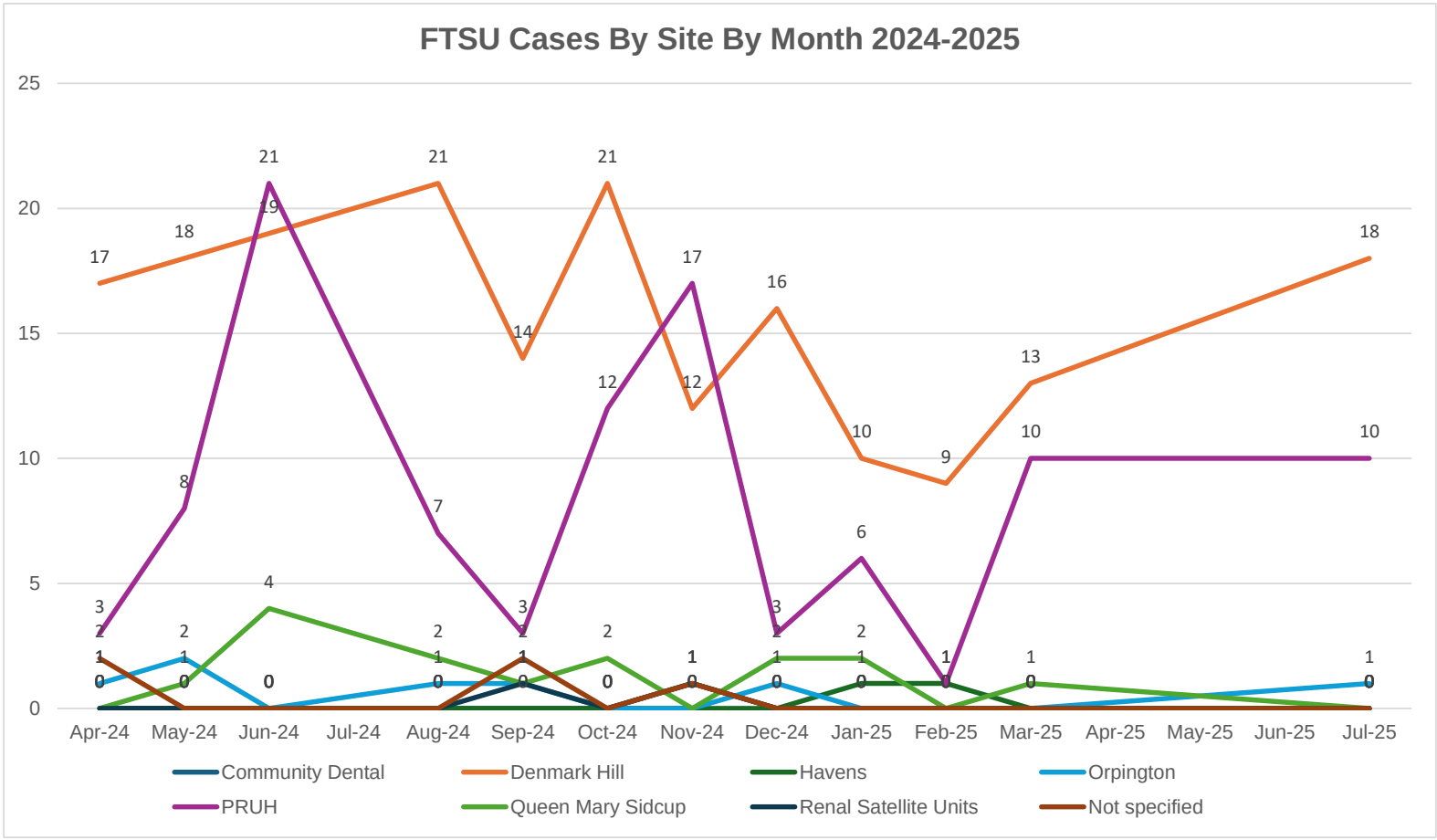
Concerns raised through the FTSU service informed targeted improvement activity within the Ophthalmology Department, Orpington, to support workplace culture and team working, demonstrating the Trust's commitment to organisational learning and continuous improvement.

Variations in reporting activity should be interpreted alongside workforce size, service configuration, organisational change, employee relations activity and wider culture indicators. Higher numbers of concerns do not necessarily indicate poorer organisational culture; they may also reflect increased awareness of the FTSU service and confidence amongst staff to speak up. Equally, lower reporting activity should not be assumed to indicate the absence of concerns and should be considered alongside broader workforce intelligence.


FTSU Cases By Site By Month 2025-2026
25
20
15
10
5
0
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Beckenham Beacon
Denmark Hill
Havens
Orpington
PRUH
Queen Mary Sidcup
Renal Satellite Units
Not specified

King's College Hospital NHS Foundation Trust

Freedom to Speak Up Annual Report 2025-2026



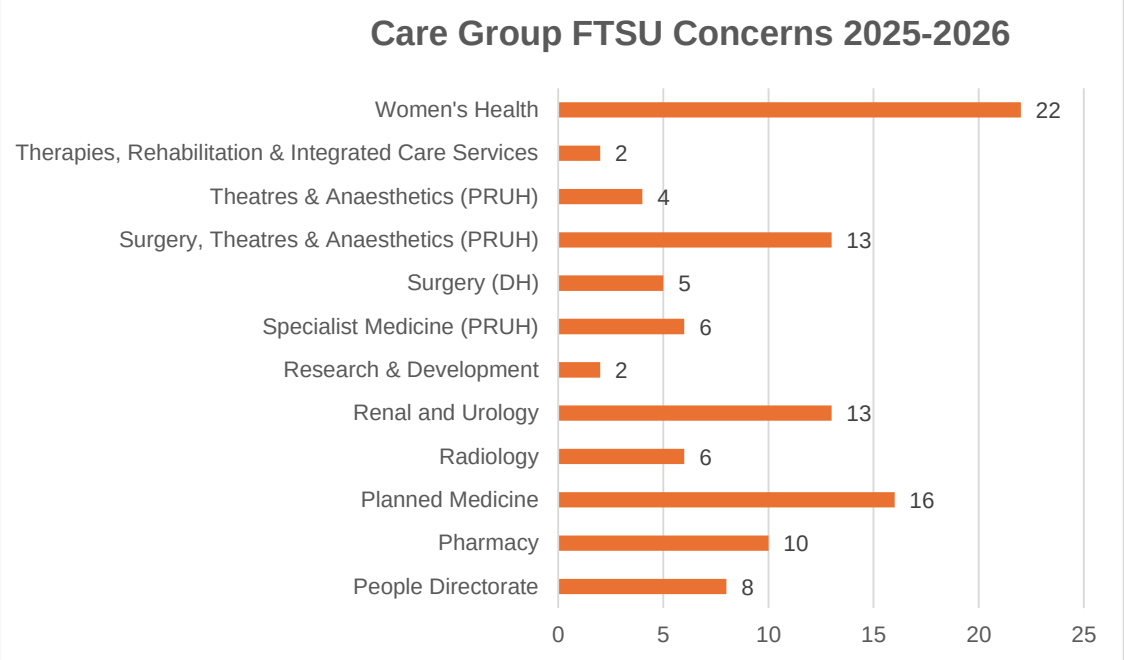
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Directorate and Care Group Analysis

FTSU concerns were recorded across a range of directorates and care groups during 2025-2026, demonstrating that the service remains accessible across diverse clinical and corporate areas of the Trust. Reporting activity varied between care groups, with Women's Health, Planned Medicine, Renal and Urology, and Surgery, Theatres and Anaesthetics (PRUH) recording the highest numbers of concerns during the reporting period. In some care groups this correlated with changes in services, and consultation with staff to change models of working and locations.

Variations in reporting levels should not be interpreted in isolation or used to compare organisational culture between services. Reporting activity may be influenced by workforce size, operational pressures, organisational change, awareness of the FTSU service and confidence amongst staff to speak up. Higher reporting rates may indicate a willingness to raise concerns, whilst lower reporting rates do not necessarily indicate an absence of issues.

Review of concerns raised across care groups identified that many issues related to workplace culture, team dynamics, leadership behaviours and employment processes, themes that are reflected elsewhere within this report. Recurrent themes are reviewed through appropriate governance arrangements and, where necessary, escalated to support organisational learning, targeted engagement and improvement activity.



Staff Group Analysis

Concerns were raised by staff from a broad range of professional groups during 2025–2026, demonstrating that the FTSU service continues to be accessed across the multidisciplinary workforce. Nursing and Midwifery staff accounted for the largest proportion of concerns, reflecting both the size of the workforce and the significant role these staff play in delivering frontline patient care.

Comparison with 2024–2025 shows that Nursing and Midwifery staff remained the most frequent users of the service, although overall reporting activity reduced compared with the previous year. Administrative and Clerical staff continued to account for a proportion of concerns, with reporting distributed consistently throughout the year. Medical and Dental staff also remained a reporting group, demonstrating continued engagement with the FTSU process.

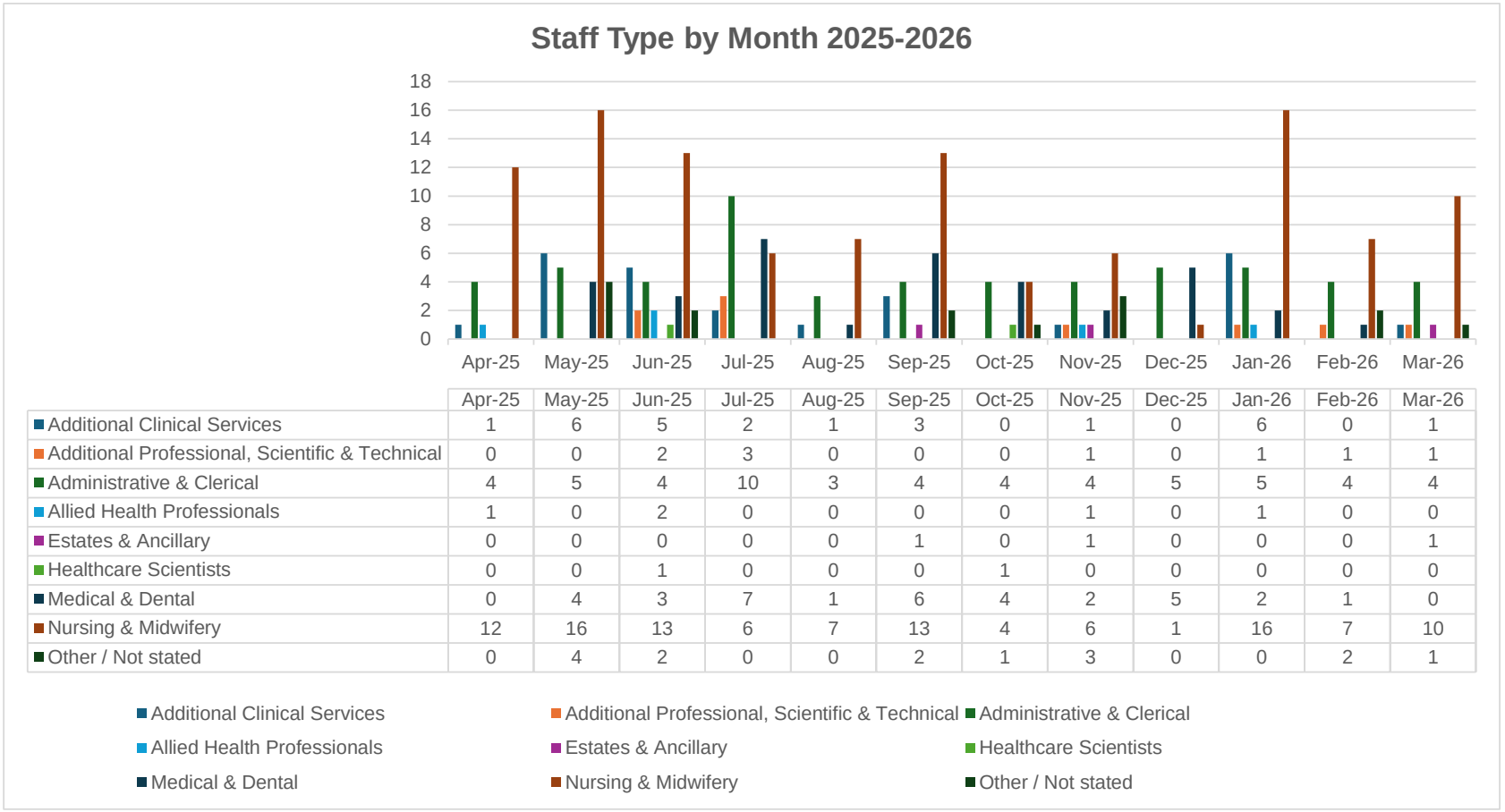
An increase in concerns raised by Additional Clinical Services staff was observed during 2025–2026, whilst reporting from smaller professional groups, including Healthcare Scientists, Allied Health Professionals, Estates and Ancillary staff, and Additional

Professional, Scientific and Technical staff, remained relatively low. These findings demonstrate engagement from a diverse range of staff groups across the Trust.

The distribution of concerns across multiple staff groups provides assurance that the FTSU service is accessible to a broad cross-section of the workforce. However, lower levels of reporting from some groups should be interpreted cautiously and may reflect differences in awareness, confidence, accessibility, workforce size, or opportunities to engage with the service rather than the absence of concerns.

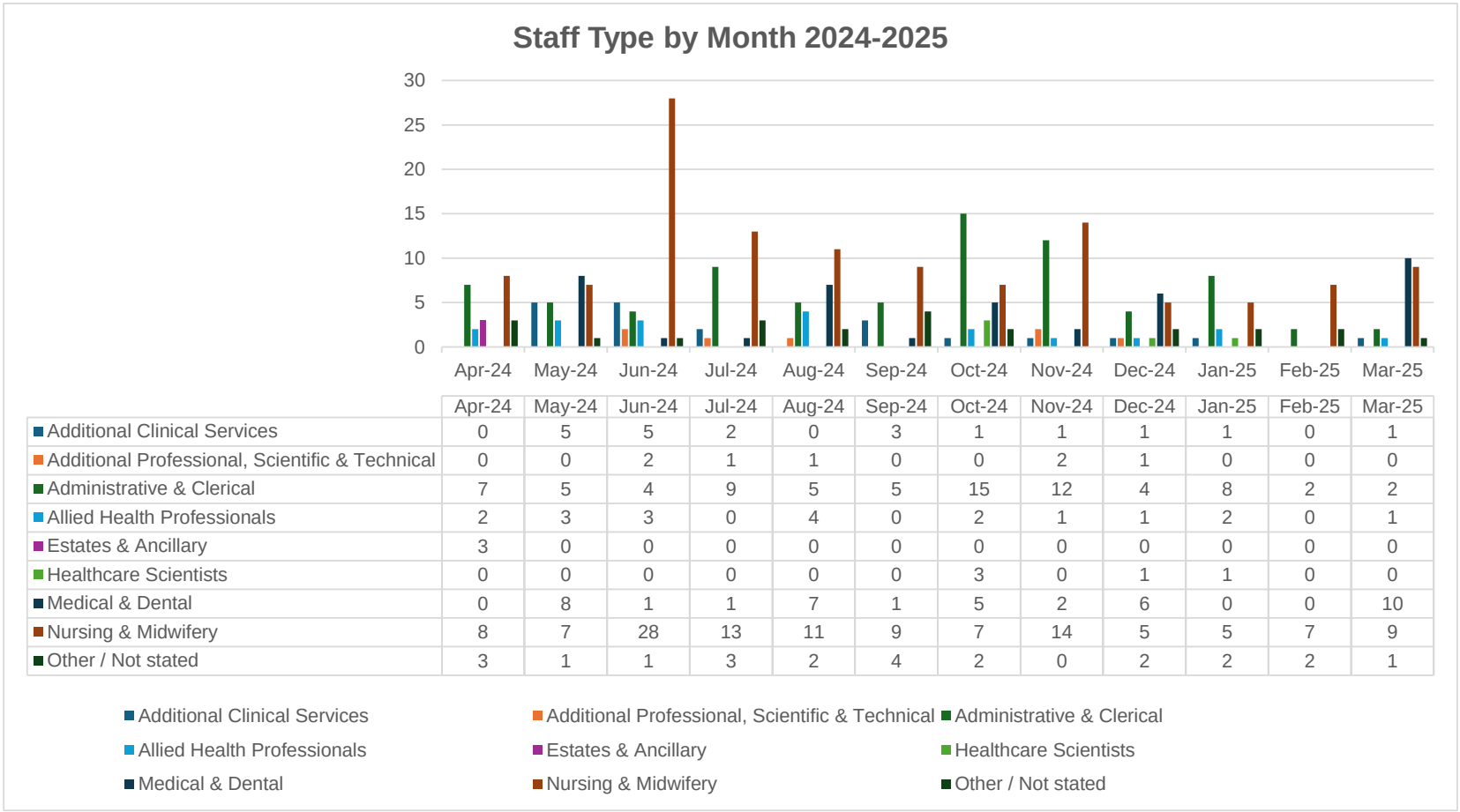
King's College Hospital NHS Foundation Trust

Freedom to Speak Up Annual Report 2025-2026



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Additional Clinical Services	1	6	5	2	1	3	0	1	0	6	0	1
Additional Professional, Scientific & Technical	0	0	2	3	0	0	0	1	0	1	1	1
Administrative & Clerical	4	5	4	10	3	4	4	4	5	5	4	4
Allied Health Professionals	1	0	2	0	0	0	0	1	0	1	0	0
Estates & Ancillary	0	0	0	0	0	1	0	1	0	0	0	1
Healthcare Scientists	0	0	1	0	0	0	1	0	0	0	0	0
Medical & Dental	0	4	3	7	1	6	4	2	5	2	1	0
Nursing & Midwifery	12	16	13	6	7	13	4	6	1	16	7	10
Other / Not stated	0	4	2	0	0	2	1	3	0	0	2	1

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	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Additional Clinical Services	0	5	5	2	0	3	1	1	1	1	0	1
Additional Professional, Scientific & Technical	0	0	2	1	1	0	0	2	1	0	0	0
Administrative & Clerical	7	5	4	9	5	5	15	12	4	8	2	2
Allied Health Professionals	2	3	3	0	4	0	2	1	1	2	0	1
Estates & Ancillary	3	0	0	0	0	0	0	0	0	0	0	0
Healthcare Scientists	0	0	0	0	0	0	3	0	1	1	0	0
Medical & Dental	0	8	1	1	7	1	5	2	6	0	0	10
Nursing & Midwifery	8	7	28	13	11	9	7	14	5	5	7	9
Other / Not stated	3	1	1	3	2	4	2	0	2	2	2	1

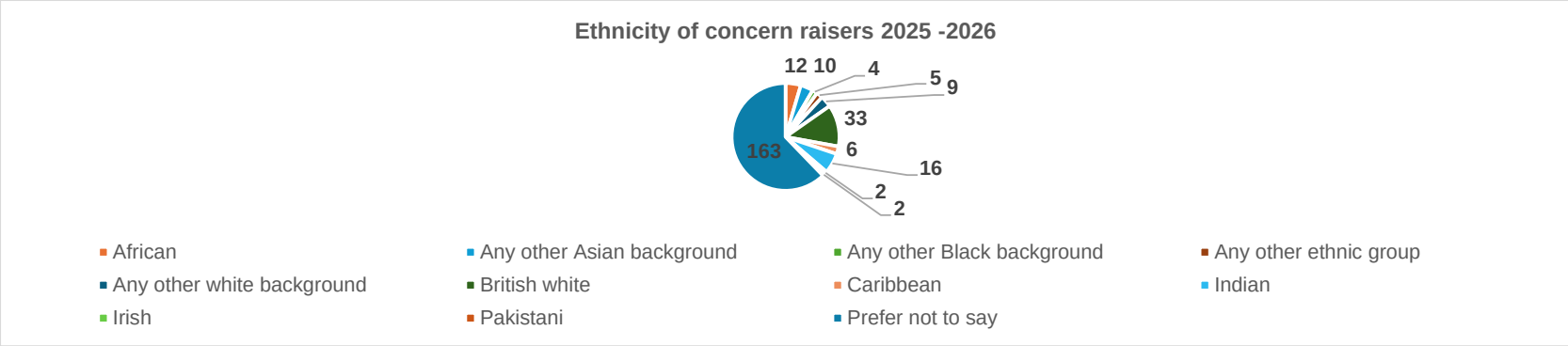
Profile of Concern Raisers

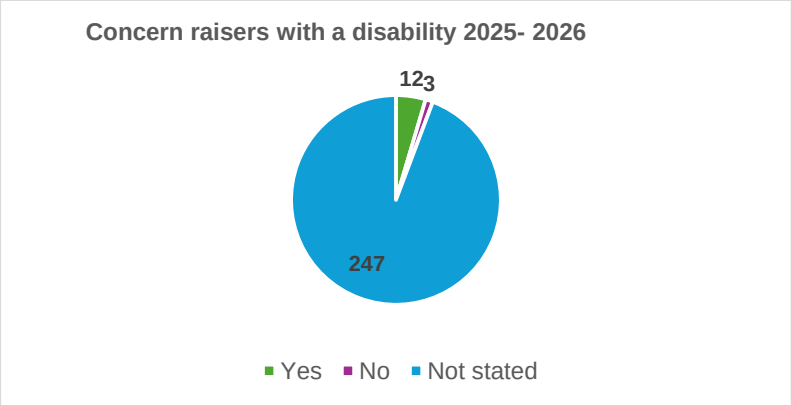
The FTSU service takes a person-centred approach, prioritising support for individuals who raise concerns. Demographic information is not routinely collected at the point a concern is raised. Available fields therefore contain a substantial proportion recorded as not stated or, where actively selected, prefer not to say. The data should not be used to draw conclusions about comparative access, experience or outcomes between groups.

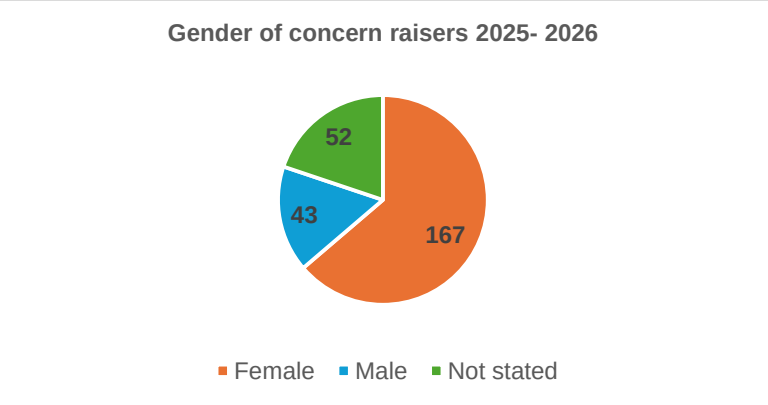
Following case closure, concern raisers are invited to provide feedback through a survey, which includes an opportunity to provide demographic information voluntarily. Many concern raisers provide feedback verbally or by email instead, meaning equivalent demographic information is not consistently available.

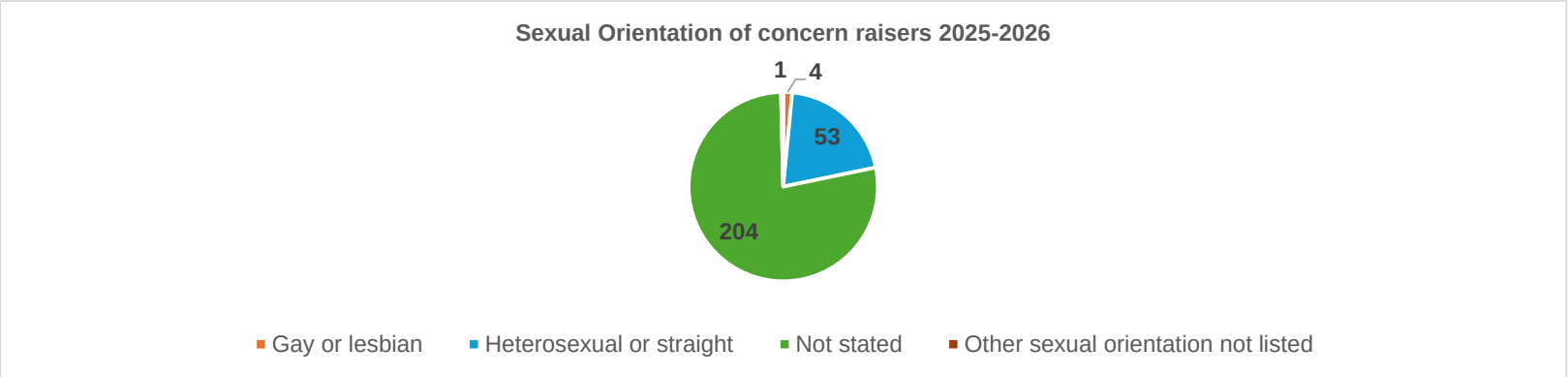
Whilst demographic profiling may provide additional insight into patterns of service utilisation, maintaining a safe, confidential and supportive environment that encourages staff to speak up remains the primary objective of the service. Where demographic information has been voluntarily provided, it has been included within this report.

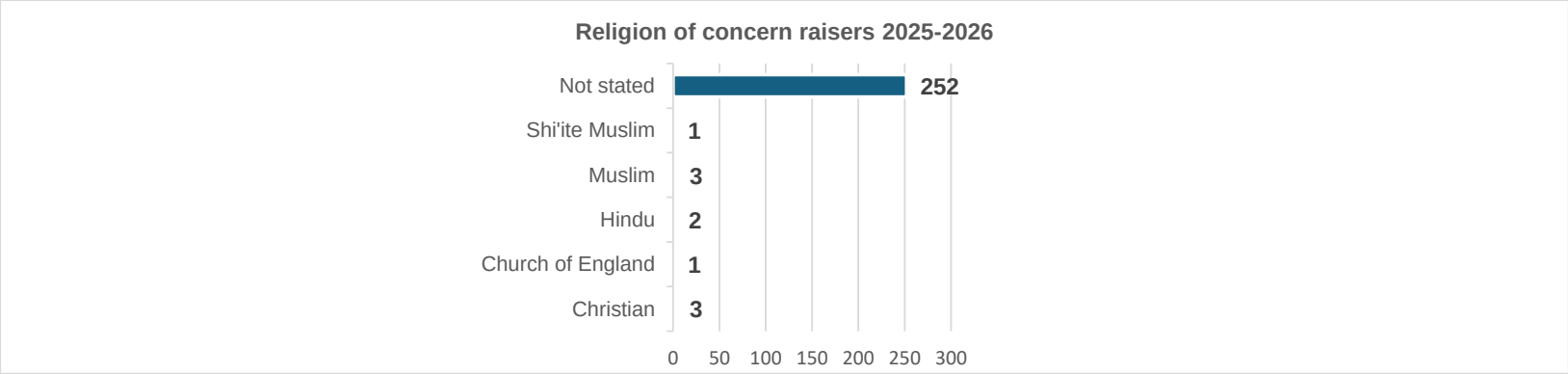
The Trust recognises the value of demographic intelligence in understanding the accessibility and inclusivity of the FTSU service. Work will continue during 2026-2027 to explore proportionate opportunities for improving demographic reporting, whilst maintaining the voluntary, confidential and person-centred nature of the service.


Ethnicity of concern raisers 2025 -2026
12
10
4
5
9
33
6
16
2
2
163
African
Any other Asian background
Any other Black background
Any other ethnic group
Any other white background
British white
Caribbean
Indian
Irish
Pakistani
Prefer not to say


Concern raisers with a disability 2025- 2026
12
3
247
Yes
No
Not stated


Gender of concern raisers 2025- 2026
52
43
167
Female
Male
Not stated

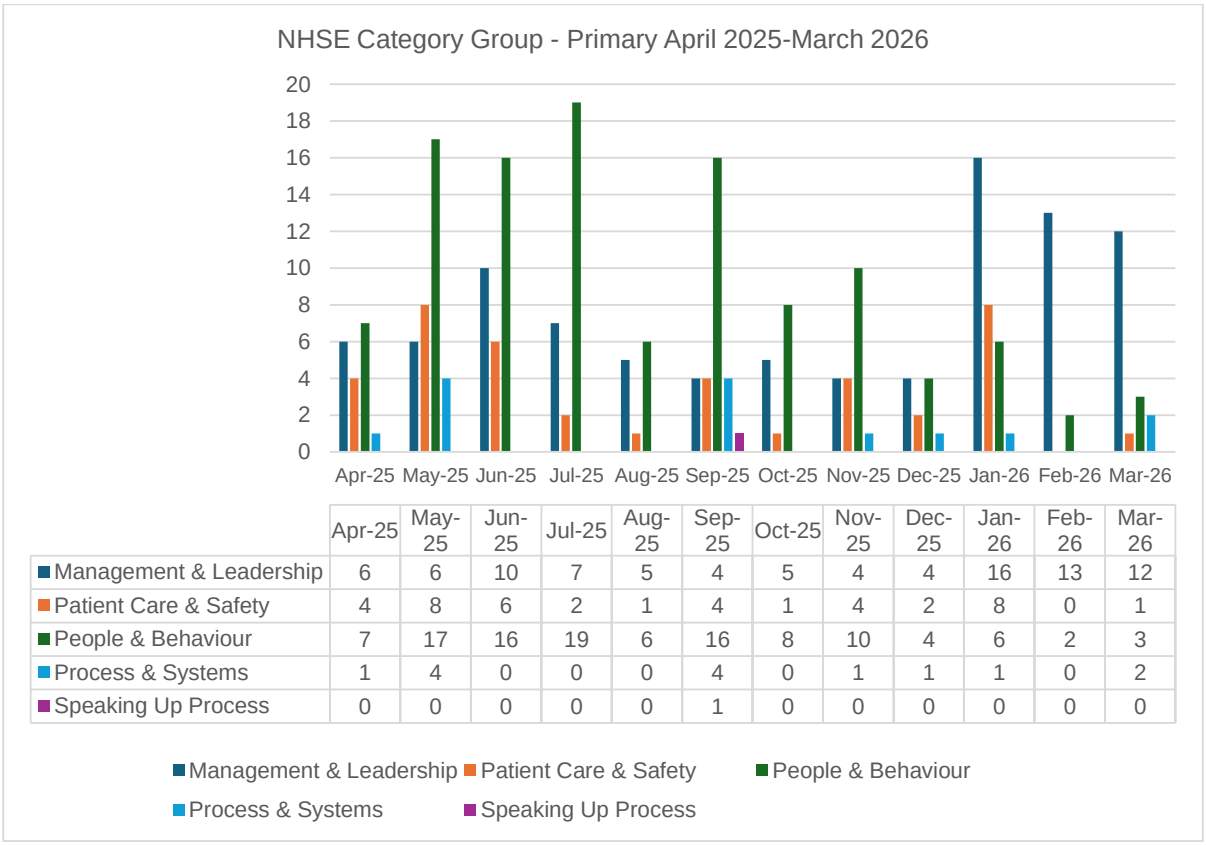

Sexual Orientation of concern raisers 2025-2026
1
4
53
204
Gay or lesbian
Heterosexual or straight
Not stated
Other sexual orientation not listed


Religion of concern raisers 2025-2026
Not stated
252
Shi'ite Muslim
1
Muslim
3
Hindu
2
Church of England
1
Christian
3
0
50
100
150
200
250
300

Categories of Concern

People and Behaviour remained the predominant category of concern, accounting for 114 cases (43.5% of activity). Management and Leadership represented 92 concerns (35.1%), while Patient Care and Safety accounted for 41 concerns (15.6%).

Although overall reporting activity decreased, the number of concerns relating to Management and Leadership increased during the reporting period. This suggests that leadership visibility, behaviours, communication, accountability and management practice continue to feature prominently in the issues that staff choose to raise through the FTSU service. As FTSU concerns represent matters raised by staff rather than substantiated findings, these themes should be considered as indicators of staff experience and organisational culture intelligence, highlighting areas that may warrant further exploration, triangulation or organisational support.



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Management & Leadership	6	6	10	7	5	4	5	4	4	16	13	12
Patient Care & Safety	4	8	6	2	1	4	1	4	2	8	0	1
People & Behaviour	7	17	16	19	6	16	8	10	4	6	2	3
Process & Systems	1	4	0	0	0	4	0	1	1	1	0	2
Speaking Up Process	0	0	0	0	0	1	0	0	0	0	0	0

Themes

The most frequently reported themes related to HR and Employment Processes, Workplace Culture and Team Dynamics, Inappropriate Behaviour, Leadership Concerns, and Bullying and Harassment. Together, these themes accounted for the majority of concerns raised during the reporting period.

These themes provide valuable insight into the issues staff felt were important to raise through the FTSU service. Many concerns involved multiple interconnected factors, including management decisions, workplace relationships and confidence in organisational processes.

As FTSU concerns represent matters raised by staff rather than substantiated findings, the themes should be viewed as organisational culture intelligence rather than evidence of wrongdoing. The recurring nature of these themes highlights areas that may benefit from further review, triangulation with other workforce information and continued organisational support. They reinforce the importance of ongoing investment in leadership development, psychological safety, staff engagement and compassionate management practice.

Patient Safety, Quality of Care and Safeguarding

41 concerns related to patient care and safety, including patient safety, quality of care and safeguarding issues. These concerns represent an important source of organisational intelligence and demonstrate staff willingness to raise issues that may affect patient outcomes.

The FTSU service provides an additional route through which workers can raise concerns about patient care, safety and safeguarding. Concerns are escalated through the appropriate governance processes to ensure they are reviewed, addressed and, where appropriate, inform organisational learning.

The Board can take reasonable assurance regarding the accessibility and utilisation of the service. However, recurring concerns relating to leadership, workplace behaviour, organisational responsiveness and detriment require continued attention. Although NHS

Staff Survey indicators improved, performance remained below national comparators, particularly in relation to confidence that concerns will be addressed.

Bullying, Harassment, Discrimination and Inappropriate Behaviour

Concerns relating to bullying, harassment, discrimination and inappropriate behaviour remained a significant feature of FTSU activity during 2025-2026. 26 cases were recorded under the detailed theme of Bullying and Harassment, 37 related to Inappropriate Behaviour or Attitude, 6 concerned Discrimination or Inequality, and 3 involved Sexual Harassment or Inappropriate Behaviour. Collectively, these themes represent a substantial proportion of concerns raised through the service and provide important insight into staff experience, workplace culture and interpersonal behaviours across the organisation.

Whilst concerns raised through the FTSU service should not be interpreted as substantiated findings, the volume and nature of these themes indicate that staff continue to use the service to raise concerns where they perceive behaviours, conduct or workplace interactions to be inconsistent with Trust values and expectations. These concerns can have a significant impact on staff wellbeing, psychological safety, team effectiveness and workforce retention and should therefore be considered as both workforce and organisational culture indicators.

The recurring nature of these themes aligns with wider organisational priorities relating to civility and respect, inclusion, equality, staff wellbeing and compassionate leadership. Analysis suggests that concerns relating to inappropriate behaviour, workplace culture and leadership are often interconnected and may reflect broader team or organisational dynamics rather than isolated incidents. As such, these themes should be triangulated with workforce, equality, employee relations, staff survey, violence prevention and staff experience intelligence to identify emerging risks, trends and opportunities for improvement.

The FTSU service continues to provide a safe and independent route for staff to raise concerns about behaviours and workplace culture, enabling issues to be identified, escalated and addressed through appropriate organisational processes. However, the prevalence of these concerns demonstrates the continued need to strengthen psychological safety, promote inclusive and respectful behaviours, and support leaders and managers to create positive working environments where concerns can be raised and resolved early.

Detriment Following Speaking Up

10 concerns involved allegations, experiences or fears of detriment following speaking up, representing 3.8% of all concerns raised during 2025-2026. These cases reflect concerns reported to the FTSU service and should not be interpreted as confirmed findings of detriment. Whilst relatively low in number, concerns relating to actual or perceived detriment remain important, as fear of negative consequences may reduce confidence in speaking up and discourage others from raising concerns.

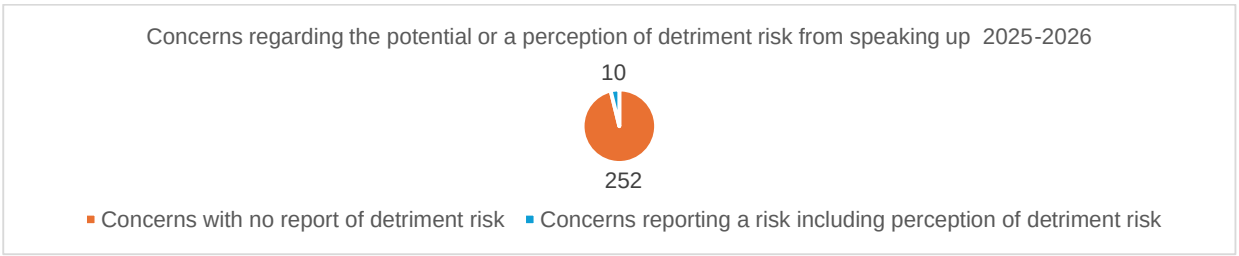
The Trust continues to monitor and respond to concerns of this nature as part of its commitment to fostering a culture in which staff feel safe to speak up.

Monitoring of Detriment Concerns

The Trust continues to monitor allegations, experiences and fears of detriment raised through the FTSU service. A detriment risk assessment has been developed to support a consistent and proportionate approach to identifying and managing potential risks to concern raisers.

These concerns are subject to ongoing review to ensure appropriate support arrangements are in place, risks are managed and any emerging themes are identified.

Whilst concerns raised through the FTSU service do not necessarily indicate confirmed detriment, monitoring actual and perceived detriment remains important in maintaining staff confidence that concerns can be raised safely, confidentially and without adverse consequences.

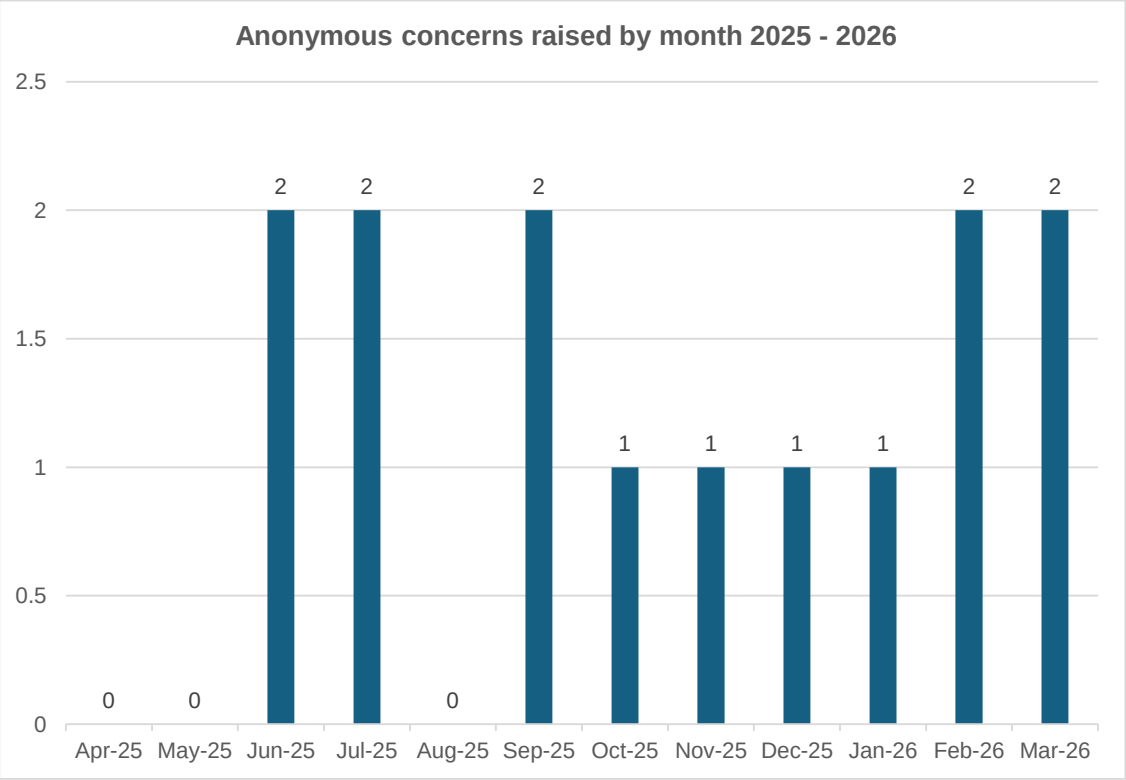


Anonymous Reporting

During 2025-2026, 14 concerns were raised anonymously, representing 5.3% of all cases. The relatively low level of anonymous reporting may indicate that most concern raisers felt able to identify themselves when accessing the FTSU service, although this should not be interpreted in isolation as evidence of psychological safety.

Workers may also disclose their identity to the FTSU Guardians while requesting confidentiality. This enables the Guardians to maintain contact, clarify the concern, provide support and offer feedback, while protecting the concern raiser's identity wherever possible. Anonymous reporting remains available for workers who do not feel able to disclose their identity, although it may limit further enquiry and individual feedback.

Anonymous reporting will continue to be monitored alongside wider staff experience and speaking-up indicators.



Staff Voice, Culture and Benchmarking

The 2025 NHS Staff Survey demonstrated continued improvement across all speaking up indicators. The overall "We Each Have a Voice That Counts" score increased from 6.41 to 6.49, whilst both Autonomy and Control and Raising Concerns scores also improved.

Indicator	King's 2024	King's 2025	Change	National 2025
We Each Have a Voice That Counts	6.41	**6.49**	+0.08	6.63
Autonomy and Control	6.75	**6.81**	+0.06	6.89
Raising Concerns	6.07	**6.17**	+0.10	6.37

Despite this positive trajectory, the Trust remains below national averages across all principal speaking up measures. The gap between staff feeling able to raise concerns and feeling confident those concerns will be addressed remains a key area for improvement. The findings suggest that future efforts should focus on demonstrating visible action, providing feedback and evidencing learning resulting from concerns raised.

Speaking Up Measure	King's 2024	King's 2025	National 2025
Feel secure raising concerns about unsafe clinical practice	66.8%	**68.4%**	71.1%
Confident concerns about unsafe clinical practice would be addressed	49.8%	**52.3%**	55.5%
Feel safe to speak up about anything that concerns them	53.5%	**54.3%**	60.3%
Confident the organisation would address concerns raised	40.5%	**43.0%**	47.6%

Visibility and accessibility of the FTSU service remain strong. During the reporting period, the FTSU intranet page received 1,191 unique visitors and 3,107 page views and was regularly amongst the most visited pages within the Working Here section of KingsWeb. This provides additional assurance regarding awareness of the service across the organisation.

Red-Flag Thematic Analysis and Triangulation

Trust-wide analysis

To strengthen the use of FTSUp intelligence, concerns raised during 2025-2026 were retrospectively mapped against a red-flag framework. The framework provides an additional lens through which recurring concerns may be considered in relation to caring, compliance, learning and teamwork culture.

A best-fit approach was used to align the primary theme recorded for each concern with the most relevant red-flag domain. The analysis reflects the nature of concerns reported to the FTSU service. It should not be interpreted as confirmation that harm occurred, that an allegation was substantiated, or that a particular service has a poor culture. Rather, the results provide thematic risk intelligence to support triangulation, further enquiry and proportionate organisational response.

Trust-wide distribution of red-flag themes

Red-flag domain	Number of concerns	Percentage of all concerns
Teamwork culture	61	23.3%
Teamwork culture: bullying and intimidation	44	16.8%
Teamwork culture: poor liaison and co-ordination	6	2.3%
Caring culture	41	15.6%
Learning culture	5	1.9%
Compliance culture	3	1.1%
No applicable red-flag category	102	38.9%
Total	**262**	**100.0%**

2025/6 FTSU Cases - Red Flag Themes

- The FTSU themes were used to assign red flags to the FTSU cases
- Teamwork culture was the most common red flag assigned, accounting for >40% of cases
- Bullying and Intimidation accounted for nearly 40% of the cases under the Teamwork culture red flag

NHSE Category Group	Primary Theme	Red Flag for Harm	Count of 2025/6 FTSU Cases
Patient Care & Safety	Patient Safety Concern	Caring Culture	41
Patient Care & Safety	Quality of Care Concern		
Patient Care & Safety	Safeguarding Concern		
Process & Systems	Confidentiality or Information Governance Concern	Compliance Culture	3
Process & Systems	Fraud or Misuse of Resources		
Process & Systems	Competency or Performance Concern	Learning Culture	5
Process & Systems	Training or Development Concern		
Management & Leadership	HR / Employment Process	N/A	102
Management & Leadership	Management or Leadership		
Process & Systems	Policy or Process Concern		
People & Behaviour	Staff Wellbeing / Psychological Safety		
People & Behaviour	(no theme)		
Process & Systems	Workload or Staffing Levels		
Process & Systems	Financial or Resource Concern		
People & Behaviour	Inappropriate Behaviour or Attitude	Teamwork Culture	61
People & Behaviour	Workplace Culture / Team Dynamics		
People & Behaviour	Bullying or Harassment	Teamwork Culture - Bullying and Intimidation	44
People & Behaviour	Discrimination or Inequality		
People & Behaviour	Workplace Culture / Team Dynamics - Intimidating Culture		
People & Behaviour	Inappropriate Behaviour or Attitude- Intimidating Tone		
People & Behaviour	Sexual Harassment or Inappropriate Behaviour		
Speaking Up Process	Detriment after Speaking Up		
People & Behaviour	Workplace Culture / Team Dynamics - Poor Communication	Teamwork Culture - Poor Liaison and Co-ordination	6

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The source mapping identifies 61 concerns under teamwork culture, 44 under teamwork culture involving bullying and intimidation, 6 involving poor liaison and co-ordination, 41 under caring culture, 5 under learning culture and three under compliance culture. The remaining 101 concerns were not assigned to one of the specified red-flag categories.

Analysis and interpretation

Teamwork-related culture issues formed the most prominent red-flag domain. When general teamwork culture, bullying and intimidation, and poor liaison and co-ordination are combined, 111 concerns, equivalent to 42.4% of all FTSU cases, fell within the wider teamwork-related domain. Of these, 44 concerns**,** or 39.6% of teamwork-related concerns**,** related specifically to bullying and intimidation.

This finding supports the wider analysis within this report, which identifies workplace culture, team dynamics, inappropriate behaviour, leadership concerns, bullying and harassment as prominent themes within speaking-up activity. It indicates that relationships, behaviours, communication and team functioning remain important components of the intelligence received through the FTSU service.

Caring culture was identified in 44 concerns, representing 15.6% of all activity. These cases related to concerns about patient safety, quality of care or safeguarding. The analysis reinforces the importance of maintaining effective links between FTSU, patient safety, quality governance and safeguarding arrangements so that concerns are escalated through the appropriate route and considered alongside other available safety intelligence.

A smaller number of concerns were aligned with learning culture and compliance culture. Although these categories accounted for a limited proportion of overall activity, the concerns remain relevant to organisational assurance because they included issues associated with competency, training and development, confidentiality, information governance and the use of resources.

For 102 concerns, representing 38.9% of all cases, no red-flag category was assigned. This group included concerns relating to employment processes, management and leadership, policy or process, staff wellbeing, workload, staffing and resources. The absence of an applicable red-flag category does not mean that these concerns were insignificant. They remain an important source of workforce and organisational culture intelligence and should continue to inform thematic review and improvement activity.

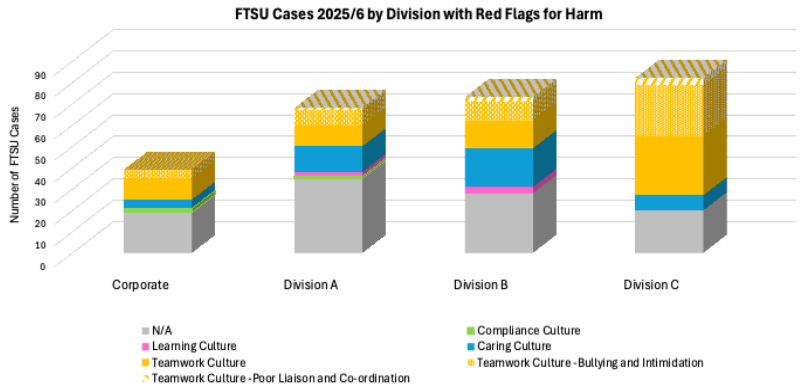
Divisional analysis, triangulation and assurance

Distribution of red-flag themes by division

Analysis by division found that teamwork-related culture was the most frequently identified red-flag domain across the organisation. The distribution, however, varied between divisions and should be interpreted alongside workforce size, service composition, local circumstances, staff confidence in speaking up and the availability of alternative reporting routes.

2025/6 FTSU Cases by Division with Red Flag Themes

- For all divisions, Teamwork culture was the most common red flag for harm identified in FTSU cases
- For division C, issues with Teamwork culture flagged in 2/3rds of FTSU cases – nearly half of these cases were 'Bullying and Intimidation'



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The divisional analysis records thirty-nine concerns in corporate services, 68 in Division A, 73 in Division B and eighty-two in Division C**.** These figures represent volumes of concerns raised through the FTSU service and are not rates adjusted for workforce size. They must therefore not be used in isolation to compare divisional culture or performance.

Division C recorded the highest number of concerns overall and the greatest concentration of teamwork-related themes. Of the 82 concerns recorded within Division C, 55**,** or 67.1%**,** were mapped to general teamwork culture, bullying and intimidation, or poor liaison and co-ordination. Within these fifty-five teamwork-related concerns, 24**,** equivalent to 43.6%**,** related to bullying and intimidation.

This concentration represents a signal for further triangulation and assurance rather than evidence of confirmed harm or a definitive assessment of divisional culture. Differences in reporting may be affected by the size and composition of the workforce, operational pressures, organisational change, awareness of the FTSU service and staff confidence in using available speaking-up routes.

The findings should therefore be considered alongside divisional Staff Survey results, employee relations information, workforce turnover, sickness absence, patient safety

intelligence and local culture or improvement activity. Where several sources identify a consistent or recurring pattern, further review may be required to understand the underlying factors and determine whether targeted intervention, support or additional assurance is needed.

Wider triangulation

The wider triangulation exercise considered FTSU activity alongside the NHS Staff Survey measure “We have a voice that counts”, changes in the number of leavers and HR early resolution cases.

2025/6 Staff Survey (‘We have a voice that counts’) and Comparison to 2024/5

- Staffing Groups are ranked by their average response to the 4 staff survey questions for ‘We have a voice that counts’ in 2025/6
- Ranked from highest to lowest average score
- The 2025/6 scores are compared with 2024/5

Legend- Compared to Organisation's Average
>20% higher
>10% higher
>5% higher
Within 5 %
>5% lower
>10% lower
>20% lower

Staff/Care Group	Average 2025/6	Change in Average 2025/6 Vs. 2024/5
R&D Renal		
Corporate Services		
PRUH Site Management		
Critical Care		
Major Trauma Network		
Pharmacy		
Integrated Medicine		
Medical Engineering and Physics		
Surgery		
Therapies Rehab & Integrated Care		
Divisional Management		
KHP		
Child Health		
Emergency Care		
Acute Specialty Medicine		
Renal and Urology		
Speciality Medicine		
Ophthalmology		
R&D Department		
Nurse Education		
Haematology		
Organisation Average		
Theatres and Anaesthetics		
Orthopaedics		
Medical Director		

Neurosciences and Stroke		
Radiology		
Site Management		
Cardiovascular Services		
STAE		
KCH Transformation		
People Directorate		
Womens Health		
Finance		
Planned Medicine		
Liver Gastro Upper GI and Endoscopy		
Dental		
R&D Neurosciences		
Cancer		
Private Patients		
Pathology		
Executive Nursing		
Estates and Facilities		
Patient Experience and Engagement		
ICT		
R&D Ambulatory Services		
Integrated Governance		
R&D Clinical Haematology		
R&D Liver		
Acute Provider Collaboration		
R&D Cardiac		

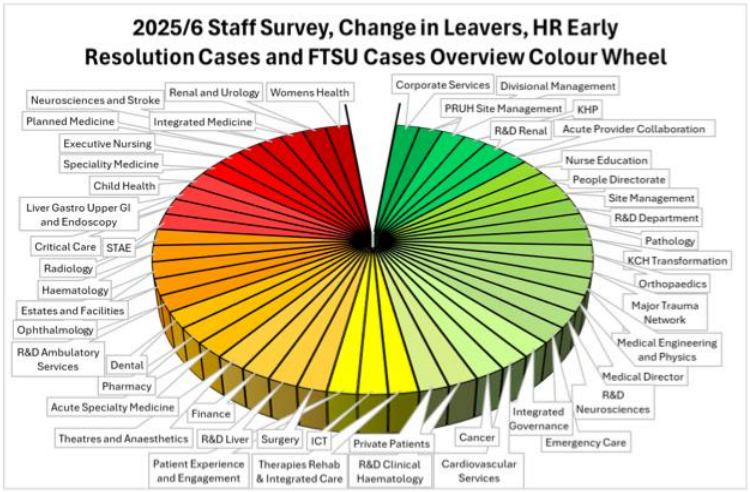
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King's College Hospital NHS Foundation Trust

Freedom to Speak Up Annual Report 2025-2026

2025/6 Staff Survey, Change in Number of Leavers, HR Early Resolution Cases and FTSU Cases Overview

- Care groups were scored by their percentiles in the 2025/26 staff survey results for 'We have a voice that counts questions' (higher, better)
- Amalgamated with their % increase in number of leavers compared to 2024/5 (lower, better)
- And the Number of early resolution HR cases and FTSU cases from the care group (lower, better)
- Care groups were then ranked by their overall score – from best performing to worst



4

2025/6 Leavers and Comparison to 2024/5

- Staff Groups are ranked by the % increase in number of leavers in 2025/6 compared to 2024/5
- Ranked from largest reduction to largest increase compared to the previous financial year

Legend- Compared to Organisation's Average
>20% higher
>10% higher
>5% higher
Within 5 %
>5% lower
>10% lower
>20% lower

Number of Leavers per Staff Group	2024/5	2025/6	Change in 2025/6 Vs. 2024/5
KHP	2	0	
ICT	65	13	
Nurse Education	4	1	
People Directorate	53	15	
PRUH Site Management	9	3	
R&D Cardiac	3	1	
R&D Clinical Haematology	9	4	
Patient Experience and Engagement	8	4	
Site Management	7	4	
Executive Nursing	15	9	
Pathology	48	31	
Orthopaedics	63	41	
Integrated Governance	6	4	
Liver Gastro Upper GI and Endoscopy	81	54	
Ophthalmology	48	33	
Therapies Rehab & Integrated Care	123	85	
Pharmacy	102	71	
Finance	17	12	
Medical Engineering and Physics	26	19	
Renal and Urology	58	44	
Planned Medicine	89	68	
Theatres and Anaesthetics	95	74	
Critical Care	161	130	
Cancer	16	13	
Dental	91	74	
STAE	112	93	
Neurosciences and Stroke	123	103	
Surgery	68	57	
Medical Director	13	11	
Acute Specialty Medicine	142	121	
Corporate Services	9	8	
Womens Health	115	104	
Emergency Care	74	67	
Cardiovascular Services	72	66	
Organisation average change			
Haematology	59	57	
Radiology	81	79	
Child Health	199	198	
Private Patients	1	1	
R&D Department	6	6	
R&D Neurosciences	16	17	
Speciality Medicine	47	50	
R&D Ambulatory Services	5	6	
Estates and Facilities	7	9	
R&D Liver	8	11	
Acute Provider Collaboration	2	4	
R&D Renal	0	1	
KCH Transformation	1	3	
Major Trauma Network	1	5	
Divisional Management	N/A	1	
Integrated Medicine	N/A	154	

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King's College Hospital NHS Foundation Trust

Freedom to Speak Up Annual Report 2025-2026

2025/6 HR Early Resolution Cases and Comparison to 2024/5

- Care groups were ranked by the number of HR Early Resolution cases in financial year 2025/6- from fewest cases to most
- Care groups were also ranked by change in number of cases compared to the previous financial year- from largest reduction in cases to largest increase

Care Group	HR Early Resolution Cases 2025/6	Change in 2025/6 Vs. 2024/5
General Medicine		
Pathology		
Site Management		
Cancer		
R&D Department		
Corporate Services		
Orthopaedics		
PRUH Site Management		
Strategy		
Child Health		
Acute Specialty Medicine		
Adult Medicine		
STAE		
Medical Engineering and Physics		
Estates and Facilities		
Executive Nursing		
Integrated Governance		
Medical Director		
Opthalmology		
Private Patients		

Surgery		
Trust Wide Programmes		
Planned Medicine		
Haematology		
Radiology		
Dental		
Theatres and Anaesthetics		
Therapies Rehab & Integrated Care		
Cardiovascular Services		
Finance		
Integrated Medicine		
ICT		
Liver Gastro Upper GI and Endoscopy		
Speciality Medicine		
Neurosciences and Stroke		
Patient Experience and Engagement		
Critical Care		
Renal & Urology		
Womens Health		
Pharmacy		

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2025/6 FTSU Speaking Up Cases and Comparison to 2024/5

- Care groups were ranked by the number of FTSU cases in financial year 2025/6- from fewest cases to most
- Care groups were also ranked by change in number of cases compared to the previous financial year- from largest reduction in cases to largest increase
- Care groups scoring more than 10% lower than the Organisation's average for 'I feel safe to speak up about anything that concerns me in this organisation' in the staff survey are highlighted

Legend
Worst 10%
Worst 20%
Worst 33%
Above Average
Below Average
Best 33%
Best 20%
Best 10%

Care Group	FTSU Cases 2025/6	Change in 2025/6 Vs. 2024/5
Denmark Hill Site Management		
International and Private Patients		
Orthopaedics		
Therapies Rehab & Integrated Care		
Major Trauma Network		
Estates and Facilities		
Finance		
R&D Department		
Chief Executives Office		
Executive Medical		
Theatres and Anaesthetics		
Cancer		
Emergency Care		
Deputy Chief Executive		
Surgery		
Dental		

Speciality Medicine		
Haematology		
Radiology		
Acute Specialty Medicine		
Liver Gastro Upper GI and Endoscopy		
People Directorate		
Pharmacy		
Executive Nursing		
STAE		
Child Health		
Renal and Urology		
Planned Medicine		
Critical Care		
Neurosciences and Stroke		
Integrated Medicine		
Womens Health		
Ophthalmology		

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Within the indicators included in that exercise:

- Women's Health and Renal and Urology had the least favourable combined indicator profiles;
- Pharmacy, Women's Health and Renal and Urology recorded the highest number of HR early resolution cases;
- Ophthalmology, Women's Health and Integrated Medicine recorded the highest number of FTSU cases; and
- teamwork culture was the most frequently identified red-flag domain across the divisions.

These findings should not be interpreted as a performance ranking. The indicators use different measures and are not all adjusted for workforce size. The analysis is therefore most appropriately used to identify areas where multiple intelligence sources may point towards a need for further enquiry, rather than to reach conclusions about the relative quality or culture of individual services.

Assurance and next steps

The red-flag framework provides the Trust with an additional mechanism for organising speaking-up intelligence and identifying recurring cultural or organisational risk signals. It also strengthens the connection between individual concerns and wider workforce, culture, quality and safety governance.

The Board can take assurance that FTSU information is being used not only to describe the number and nature of concerns raised, but also to inform a more systematic assessment of emerging themes. However, the analysis provides partial rather than full assurance because:

- the mapping was undertaken retrospectively using a best-fit methodology;
- red-flag classifications reflect reported concerns and not confirmed findings;

- some indicators are based on raw case volumes rather than workforce-adjusted rates;
- 102 concerns did not map to one of the specified red-flag domains; and
- further triangulation is required before conclusions can be drawn about the significance or persistence of local patterns.

Future reporting should demonstrate how identified themes have been considered through the relevant governance arrangements. Where triangulation indicates a consistent pattern, assurance should include the responsible service or executive owner, the action or review undertaken, the intended outcome and evidence of subsequent impact.

Shelford Group Benchmarking

Benchmarking against the Shelford Group, Model Health System provider median and national FTSU metrics provides additional context to help understand the Trust's reporting profile and the relative use of the FTSU service. It is important to note that higher reporting rates should not automatically be interpreted as evidence of poorer organisational culture. Within FTSU, higher reporting rates may indicate greater awareness of the service, increased confidence to raise concerns and stronger psychological safety, whilst lower reporting rates may indicate either fewer concerns or barriers to speaking up. Benchmarking should therefore be interpreted alongside staff survey findings, workforce indicators and qualitative intelligence from concerns raised.

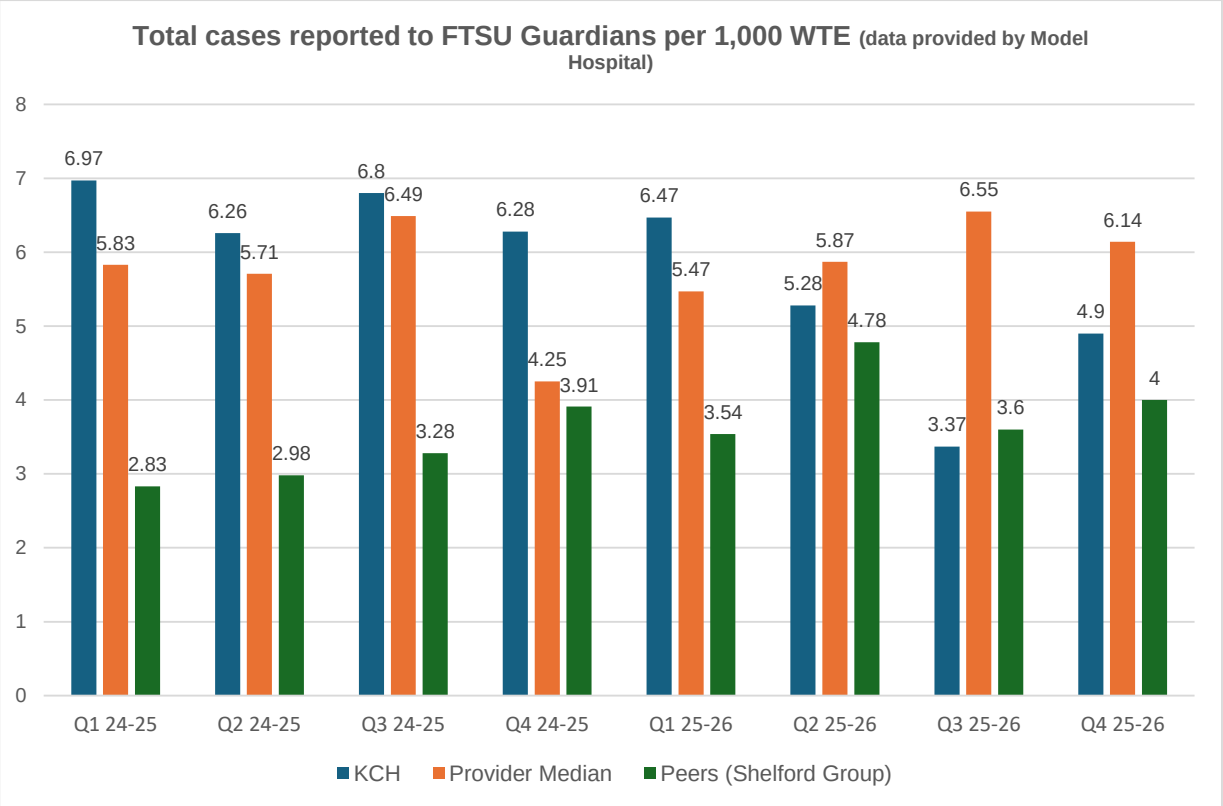
Overall Speaking Up Activity

King's has consistently reported a higher rate of concerns per 1,000 WTE than the Shelford Group comparator throughout most of the reporting period. In many quarters, reporting levels were also comparable to or above the Model Health System provider median.

The data demonstrates continued utilisation of the FTSU service by workers seeking support and raising concerns. Whilst some variation is evident between quarters, the overall trend suggests that awareness, visibility and accessibility of the service have been maintained. Throughout the reporting period, King's reporting activity remained above the Shelford Group benchmark and broadly aligned with the provider median.

The comparatively high utilisation of the FTSU service provides assurance that workers are aware of available speaking up routes and continue to access them when concerns arise. When considered alongside improving NHS Staff Survey speaking up indicators, the findings suggest sustained staff engagement with the service and continued organisational willingness to encourage concerns to be raised.

The utilisation profile provides assurance that workers remain aware of and continue to access the service. King's reporting activity was above the Shelford Group comparator in most quarters shown. Activity was above the Model Health System provider median in five of the eight quarters presented, although it fell below the provider median during Q2 to Q4 2025-2026. These trends should be interpreted with staff-survey, workforce and qualitative intelligence.

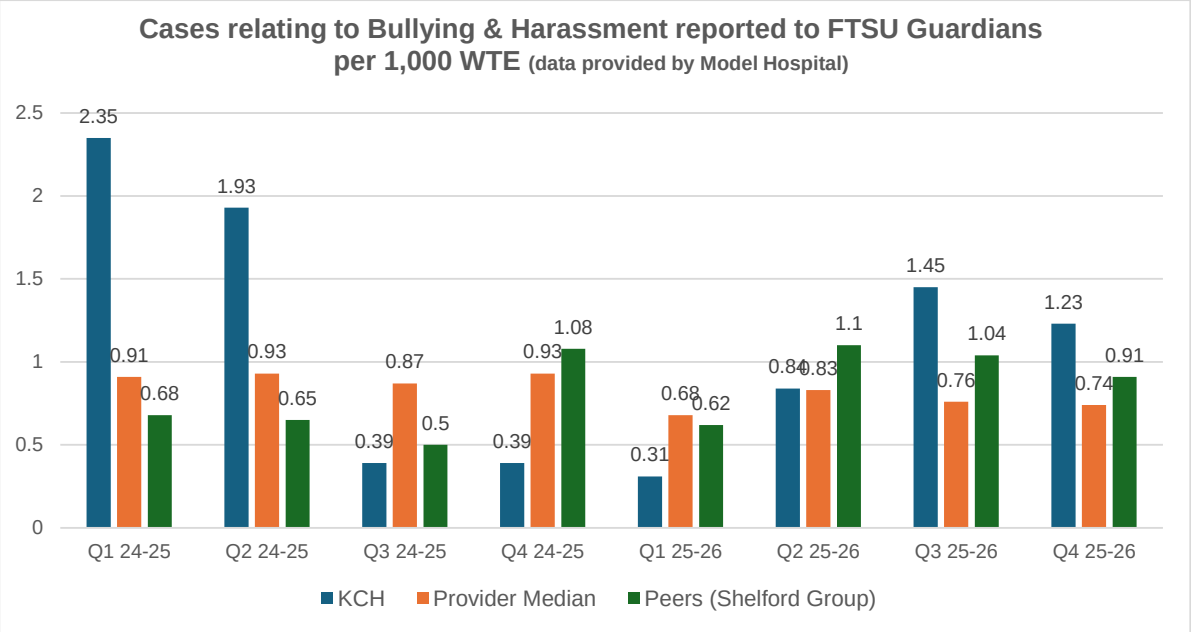


Bullying and Harassment

Benchmarking for Bullying and Harassment concerns demonstrates that King's has historically reported rates above both the provider median and Shelford peer average. Whilst quarterly variation is evident, reporting activity has reduced considerably from earlier peaks and has become more closely aligned with peer benchmarks during the most recent reporting periods.

The higher reporting rate may reflect increased staff willingness to report concerns relating to workplace culture, behaviours and interpersonal relationships. Given that many concerns are raised through FTSU before formal processes are initiated, the data provides valuable intelligence regarding staff experience and areas where improvements in culture, leadership and team dynamics may be required.

The reporting profile should not be viewed solely as an indicator of workplace conflict. Rather, it demonstrates that staff continue to utilise the FTSU service to raise concerns about behaviours and culture. The reduction in reporting rates compared to historical peaks may indicate improving organisational conditions, although continued monitoring remains necessary given the prominence of behavioural concerns within local FTSU data.

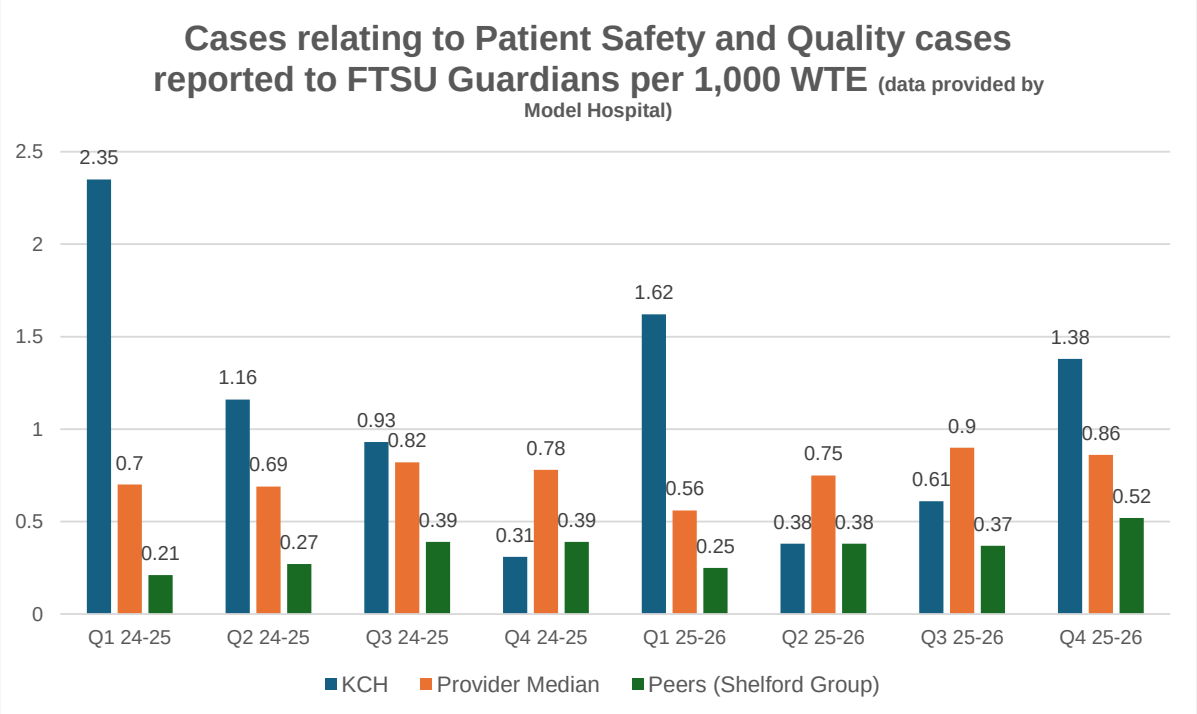


Patient Safety and Quality of Care

King's has consistently reported higher rates of patient safety and quality concerns than both the Shelford Group average and the provider median. This pattern has been sustained across several years and demonstrates that staff continue to raise patient safety concerns through the FTSU route.

The higher reporting rate is positive from a safety culture perspective. Freedom to Speak Up provides an additional mechanism through which risks can be identified, escalated and addressed before adverse outcomes occur. Evidence from high-performing safety cultures suggests that organisations with strong reporting cultures are more likely to identify emerging risks and opportunities for improvement.

The Trust's reporting profile provides assurance that staff continue to raise concerns relating to patient care and service quality. The data demonstrates the importance of ensuring effective links between FTSU, Patient Safety, Quality Governance and Risk Management processes to maximise organisational learning and improvement.

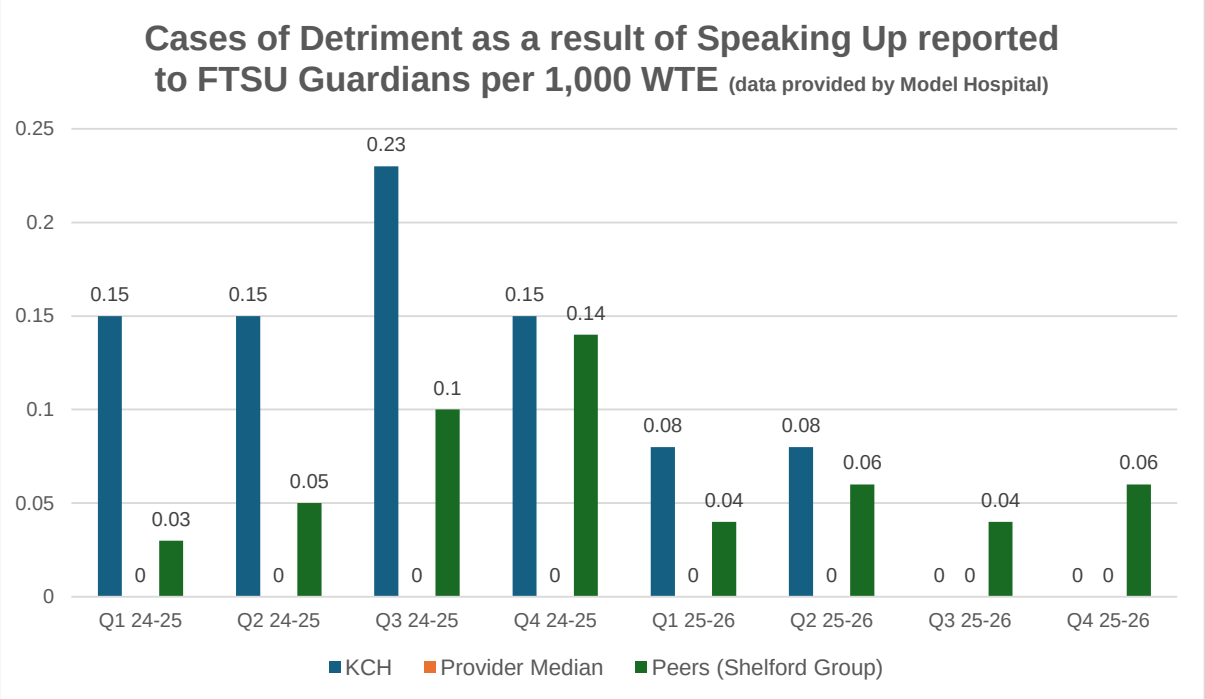


Following Speaking Up

Benchmarking data indicates that reports of actual, potential or perceived detriment following speaking up remain low across the NHS. Although King's reported higher rates than some comparators during parts of the reporting period, levels reduced during 2025-2026 and remained low overall.

Despite their low volume, concerns relating to detriment are significant because fear of negative consequences may discourage staff from speaking up. All reports of actual or potential detriment are subject to a detriment risk assessment and are escalated to the Freedom to Speak Up Executive Lead, Chief People Officer and Freedom to Speak Up Non-Executive Director for oversight and review.

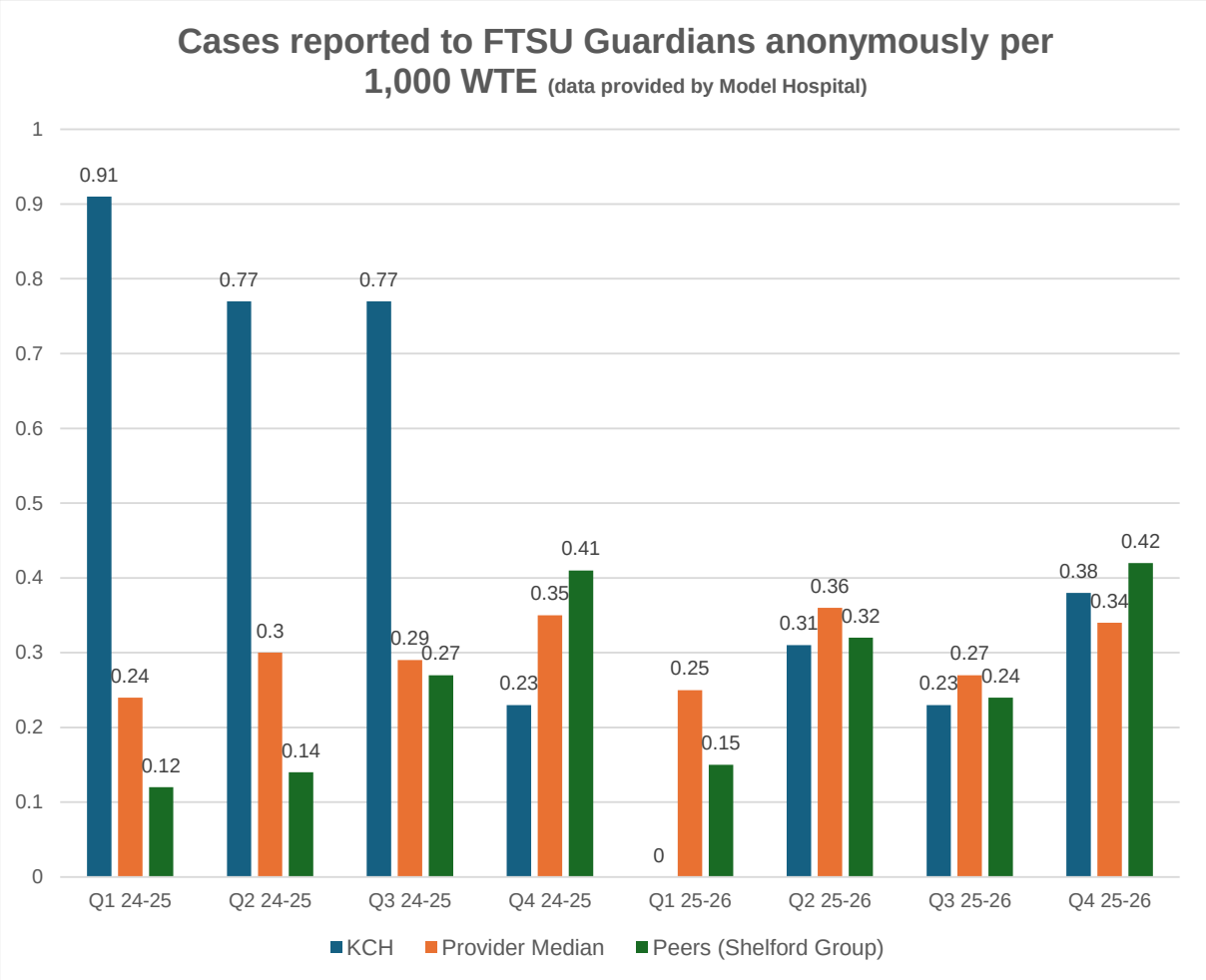
Concerns raised through the Freedom to Speak Up service do not necessarily represent confirmed findings of detriment; however, ongoing scrutiny of actual, potential and perceived detriment remains important in supporting psychological safety and maintaining confidence in the Trust's speaking up arrangements.



Anonymous Reporting

King's has historically reported higher levels of anonymous speaking up than both the provider median and Shelford peers. During 2025-2026, anonymous reporting reduced and moved closer to comparator levels. This may reflect increased willingness among some to identify themselves to the FTSU service but should not be treated as evidence of improved psychological safety with consideration of staff-survey findings, service-user feedback and wider culture indicators.

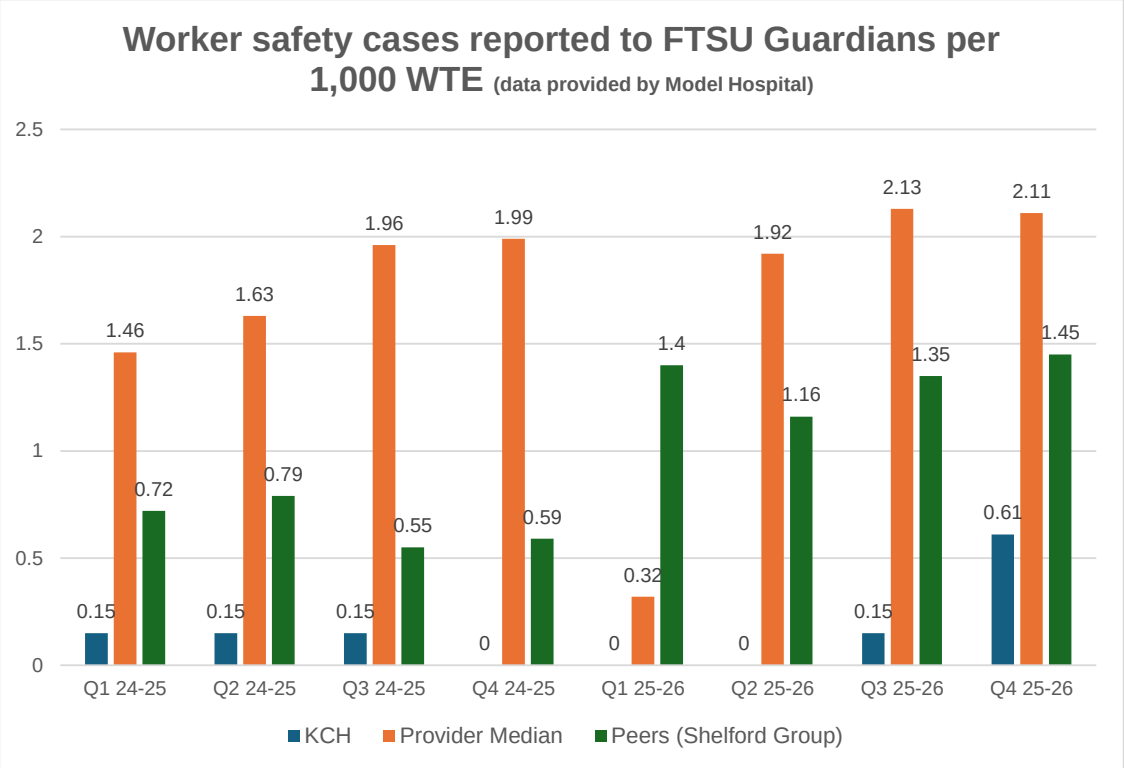
The Board can take assurance that staff have access to multiple routes for raising concerns, including anonymously where appropriate.



Worker Safety

Worker safety concerns reported through FTSU remain significantly lower at King's than both the provider median and the Shelford Group benchmark. Whilst a modest increase is evident in the most recent period, reporting remains substantially below comparator organisations.

This finding requires careful interpretation. Lower reporting may reflect fewer worker safety concerns being raised through the FTSU route; however, it may also indicate that concerns are being reported through alternative mechanisms such as incident reporting systems, health and safety processes, risk reporting arrangements or line management routes.

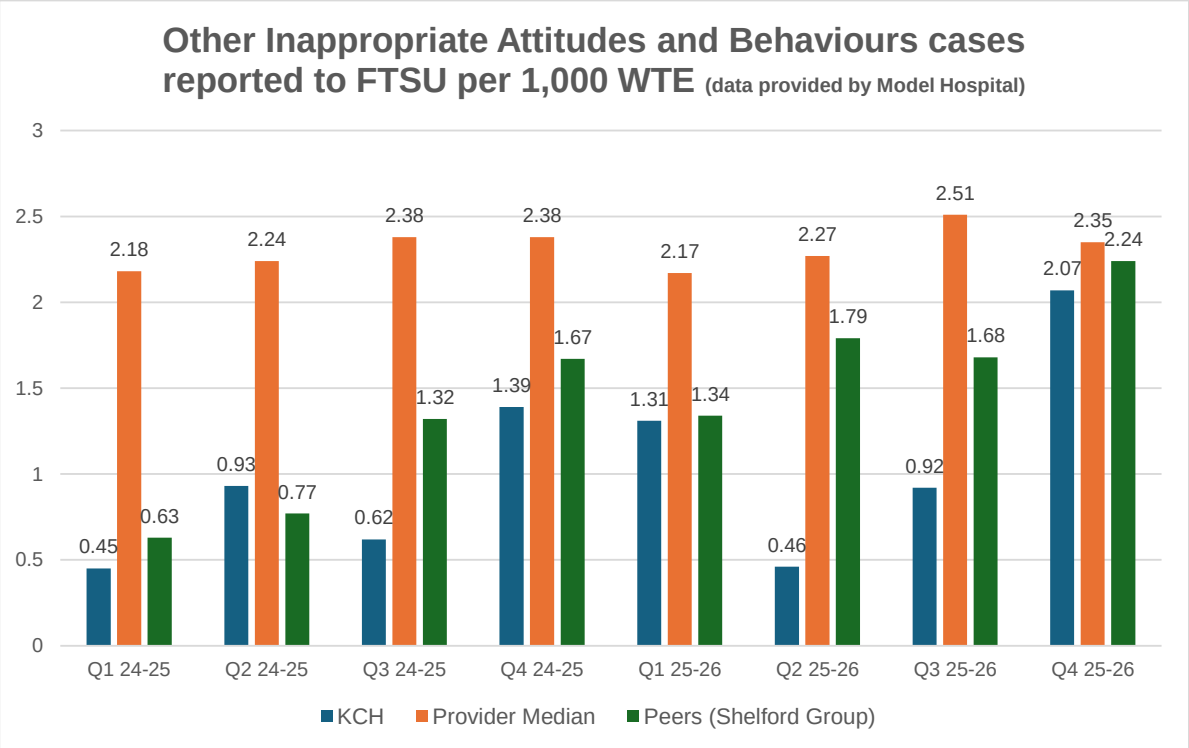


Other Inappropriate Attitudes and Behaviours

King's has reported consistently lower rates of concerns relating to inappropriate attitudes and behaviours than both the provider median and Shelford peers since 2023/24. Reporting has remained relatively stable and below benchmark comparators throughout the period.

Whilst at face value this could indicate a lower prevalence of these concerns, it should be interpreted alongside the Trust's local FTSU themes, which show workplace culture, inappropriate behaviour and leadership concerns remain prominent categories. Therefore, it is likely that some of these concerns are being captured under alternative FTSU classifications such as Bullying and Harassment, Workplace Culture or Management and Leadership.

The Trust should continue to review categorisation consistency and triangulate findings with employee relations, staff survey and workforce intelligence to ensure a comprehensive understanding of workplace culture issues.



Overall Benchmarking Assurance

Overall, benchmarking demonstrates an active FTSU reporting profile, with King's rates above Shelford Group averages in most quarters and varying above and below the national provider median. The data supports reasonable assurance that workers are aware of and continue to use the service. It does not, on its own, demonstrate a mature culture or confirm that the service is trusted across all staff groups.

When considered alongside improving NHS Staff Survey indicators, the benchmarking evidence supports reasonable assurance regarding visibility, accessibility and utilisation. Assurance regarding organisational response and impact remains partial because confidence that concerns will be addressed remains below the national comparator and measurable evidence of action, feedback and sustained improvement requires further development.

Board Self-Reflection Review 2025

The Freedom to Speak Up (FTSU) Board Self-Reflection Review was undertaken in July 2025 and involved Executive Directors and Non-Executive Directors assessing the Trust's speaking up culture against the NHS England Board Self-Reflection Tool, which is structured around eight principles of effective speaking up cultures. The review was informed by triangulated evidence including FTSU case data, feedback from FTSU service users, NHS Staff Survey results, workforce intelligence and organisational culture data. The purpose of the exercise was to support reflection, identify areas of strength, and inform the Trust's FTSU Strategy and improvement priorities.

The Board identified strengths in its commitment to Freedom to Speak Up, the support provided to FTSU Guardians, governance arrangements, and the continued visibility of speaking up within Board discussions. Responses generally reflected confidence that FTSU principles are embedded within governance structures and that Guardians receive regular engagement and support from Executive and Non-Executive leads.

The review also highlighted opportunities for further development. In particular, Board discussion recognised the importance of strengthening organisational understanding of

barriers to speaking up, improving how learning and improvement resulting from concerns are communicated, increasing assurance regarding the management of detriment, and enhancing the use of triangulated workforce and culture intelligence to identify emerging risks. Board members also recognised the need for greater visibility of actions taken following concerns raised and clearer evidence of the impact of speaking up on organisational learning and cultural improvement.

The findings were considered alongside feedback from FTSU service users, which highlighted positive experiences of support from FTSU Guardians but also identified concerns regarding organisational responsiveness, fear of repercussions, transparency of actions taken, and confidence that issues raised would lead to meaningful change. This triangulated approach provided valuable insight into both Board and staff perspectives and informed the development of high-level actions and priorities for the Trust's FTSU Strategy 2025–2028.

Speaking Up in Action: Learning, Improvement and Culture Change

The Freedom to Speak Up (FTSU) service continues to play an important role in creating a culture where colleagues feel safe to raise concerns, contribute ideas and support improvement. The examples below demonstrate how speaking up leads not only to the resolution of specific concerns but also to wider organisational learning, stronger partnerships and improvements in culture, safety and staff experience.

Pharmacy: Building Confidence Through Speaking Up

In July, a colleague raised concerns through the FTSU service regarding pharmacy processes that they believed could potentially affect patient safety. Initially wishing to remain anonymous, they were supported throughout the speaking up process and, over time, gained the confidence to engage directly with senior operational leaders.

An independent review of aseptic services was commissioned, examining each stage of the process and involving colleagues from across the service. While no patient safety risks were identified, the review highlighted opportunities to strengthen role clarity, collaboration and team working.

This case demonstrates how concerns can be heard, objectively reviewed and translated into service improvement and organisational learning. It also highlights the role of FTSU in fostering psychological safety and empowering colleagues to engage openly with leaders.

Sexual Safety: Acting Quickly to Protect Staff

An individual working for an organisation providing services to the Trust raised a concern through the FTSU service regarding sexual harassment by a contractor following a Trust-organised event.

The FTSU Guardian provided a safe and confidential space for the individual to speak up and, with their consent, escalated the concern through safeguarding processes. Working collaboratively with operational teams, timely action was taken, including preventing the contractor from undertaking further work on Trust sites. The individual was supported and kept informed throughout.

This case demonstrates the importance of accessible speaking up routes, prompt action and effective partnership working. It also reinforces the Trust's commitment to maintaining a safe, respectful and inclusive environment for everyone who works in or with the organisation.

Child Health: Ensuring the Family Voice Is Heard

A colleague raised a confidential concern through the FTSU service regarding their exclusion from an After-Action Review following the death of a child and sought assurance that the family's questions and concerns would be fully represented.

Engagement through the FTSU process provided assurance that the family's perspective had been appropriately shared and considered. It also identified opportunities to strengthen communication, clarify roles and improve collaboration between services involved in the review process.

Although the original decision remained unchanged, the concern prompted reflection, greater transparency and valuable learning. The case demonstrates how speaking up can strengthen trust, improve communication and provide assurance that the voices of patients and families remain central to learning and improvement.

Impact

These cases illustrate the breadth of issues raised through the FTSU service and the positive impact that speaking up can have across the Trust. Whether improving processes, strengthening safety, addressing inappropriate behaviour or enhancing learning following adverse events, the service continues to support a culture of openness, transparency and continuous improvement. Most importantly, they demonstrate that colleagues who speak up are listened to, supported and recognised for their contribution to making King's a safer and better place to work and receive care.

Feedback from FTSU service users

Feedback received from workers provides qualitative insight into their experience of the FTSU service. The examples below indicate that workers valued being listened to, supported and given an opportunity to articulate their concerns. However, positive feedback about Guardian support should be distinguished from assurance regarding the subsequent organisational response or resolution of the underlying concern.



Governance and Board oversight

The FTSU service continues to provide the Trust with a significant source of intelligence regarding organisational culture, leadership, workforce experience and patient safety. Effective governance arrangements ensure that concerns are escalated appropriately, risks are managed and learning informs improvement activity.

Board oversight remains essential in ensuring that emerging themes are acted upon, data quality is maintained and organisational learning is translated into measurable improvement. This requirement has become increasingly important under revised national reporting arrangements.

Conclusion

The Trust's Freedom to Speak Up arrangements remained visible, accessible and actively used during 2025-2026, providing workers with an important route to raise concerns and contributing valuable intelligence on culture, leadership, workforce experience and patient safety.

The Board can take assurance that staff continue to use the service and that concerns raised provide valuable intelligence relating to culture, leadership, workforce experience and patient safety. Survey results and reporting trends indicate continued progress in creating an environment where staff feel able to speak up.

The evidence therefore provides partial assurance regarding organisational response and impact. Priorities for 2026/27 should include stronger triangulation, clear ownership of improvement actions, continued monitoring of detriment, visible feedback to workers and more systematic evidence of the changes and learning resulting from concerns raised.

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 17

BOARD REPORT COVER PAPER

Report to:	Board of Directors
Date of meeting:	17 November 2026
Subject:	**Thirlwall Inquiry – Implications for King's College Hospital NHS Trust**
Author(s):	Samantha Machen, Assistant Director of Quality Governance
Sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery Dr Mamta ShettyVaidya, Chief Medical Officer
History:	King's Management Committee
Status:	

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

Purpose

The Thirlwall Inquiry was published September 2026. The Thirlwall Inquiry examined events at the Countess of Chester Hospital between 2015 and 2018, including the hospital's response to the increased number of neonatal deaths and serious concerns raised about Lucy Letby. This paper updates the board on the progress to the recommendations that relate to Kings College NHS Trust.

Recommendations:

KMC is asked to note the report for submission to the board of directors as per the letter of the 21 September 2026 from NHSE.

Strategy alignment

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

King's College Hospital NHS Foundation Trust

Main Report

1. Overview of the Thirlwall Inquiry

The Thirlwall Inquiry examined events at the Countess of Chester Hospital between 2015 and 2018, including the hospital's response to the increased number of neonatal deaths and serious concerns raised about Lucy Letby. The Inquiry's focus was not on reconsidering Letby's criminal convictions, but on understanding what happened within the hospital, how concerns were handled, how families were treated and what changes are required to protect patients in the future.

At a high level, the Thirlwall Inquiry recommendations focus on strengthening patient safety, early detection of concerns, and organisational accountability across the NHS. Key themes include improving monitoring and surveillance in neonatal services, enhancing the collection and use of clinical data, introducing clearer escalation and safeguarding processes when deliberate harm is suspected, improving investigation of unexpected deaths, and increasing support for bereaved families.

The full recommendations from the Inquiry are below as an appendix on Page 4 onwards (with those relevant for Kings College NHS Trust highlighted in yellow). The 17 recommendations can be grouped into 5 major themes:

1. **Strengthening patient safety surveillance and early detection**
2. **Creating a robust response to concerns about harm**
3. **Improving governance, leadership, and accountability**
4. **Strengthening independent scrutiny and speaking up channels**
5. **Investing in specialist support for patients, families, and clinical services**

Some of these themes relate to wider stakeholders, for example NHS England providing guidance and direction for organisations or pathways and training materials to be employed in NHS organisations. The overarching learning theme from this Inquiry is that unusual patterns (e.g., mortality rates) must have appropriate and rigorous oversight at all levels of an organisation. Another key learning is an organisation must have pathways where concerns are listened to and escalated through the right channels. As per NHS England's letter of the 21st of September, all NHS Trusts and ICB boards must reflect on the report and consider the findings. This paper sets out the Trust's planned response to the Thirwell Inquiry.

2. The Trust's initial response

Being alert to changes in data across quality, outcome, and effective portfolios is something that already is part of the monthly governance at the Trust. However, the Thirlwall Inquiry offers an opportunity for all NHS Trusts to reflect on progress and areas for improvement in

this area. As such, a Thirlwall Inquiry project group has been convened, led by the Assistant Director of Quality Governance, to monitor and track the recommendations from the Inquiry ahead of the required deadlines. Much of the focus of the recommendations, for example strengthening data availability to Board and monitoring trends, are already a key focus of the Trust's Quality Governance strategy and will continue beyond the response to the Thirwell Inquiry. We can provide initial assurance to the Board that the recommendations relating to NHS Trusts are underway, with good assurance currently for the recommendations ahead of various 2027 deadlines. The Child Health Division are engaging with this project group, with local involvement with the Local Maternity and Neonatal System (LMNS) and other system partners.

Whilst the Thirlwall Inquiry offers incredibly valuable learning from a neonatal perspective, we as a Trust must be proactive in assuring ourselves that we are looking wider than neonatal quality governance. Therefore, a review of how the learning from deaths portfolio and patient safety processes links in with quality governance and escalation to the board will be undertaken as part of this work programme.

The proposed next steps are:

- Trust wide gap analysis of all recommendations from the Thirlwall Inquiry to identify if the organisation already shows compliance with the recommendation and if not, the actions in place to ensure compliance
- Presentation of Thirlwall Inquiry to each Division, with an opportunity for divisional senior leaders to reflect on local reporting processes to enable staff are able to speak up and raise concerns
- Bespoke board development session on safeguarding organised as part of recommendations. Also, as part of board development to discuss what good problem sensing looks like. Freedom to Speak Up (FTSU) as part of a problem-sensing framework. Alongside complaints, incidents, mortality reviews, staff survey data, patient feedback and whistleblowing disclosures, FTSU intelligence provides valuable insight into risks that may not yet be visible through traditional governance mechanisms.
- Once the gap analysis has been completed, a designated executive lead will be assigned to outstanding actions, with milestones and deadlines attached to all outstanding actions
- To establish a reporting cycle so progress against actions are monitored regularly – this will routinely be reviewed and discussed at Outstanding Care Board with oversight at Kings Management Committee with reporting to the quality & research committee for review and consideration of relevant indicators and measures, risk, experience of care and intelligence.

Assurance for Board:

- We will provide an update of the actions and progress to King's Management Committee (KMC) in February 2027.
- Currently all actions relevant for the Trust are either partially complete or complete.

- Those partially complete have workstreams set up to monitor actions and will have Executive lead oversight for completion ahead of 31 March 2027 deadline.
- The Trust-wide gap analysis will be presented to Outstanding Care Board (OCB) in January 2027 and to King's Management Committee in February 2027.

NHS
King's College Hospital
NHS Foundation Trust

Recommendation	Theme	Recommendation detail	Responsible organisation(s)
1	CCTV and monitoring	All cots and incubators in all neonatal units should be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. The funding for this should be centrally managed and ring-fenced, to ensure consistency and implementation across all neonatal units at speed. By 31 March 2027, NHS England should set out a roadmap for how this will be implemented.	NHS England; all neonatal units
2	Insulin	i. Digital devices should be used to restrict access of insulin to authorised people and record access to insulin storage units. By 31 March 2027, all neonatal units must meet the expected requirements for access control and storage of insulin set out in the NHS England GIRFT Neonatology: Guide to safe insulin use. ii. Until access to insulin requires biometric data, each Trust should install CCTV cameras focused on storage fridges, cupboards or units. Cameras should store recordings for at least 28 days. iii. The GIRFT Laboratory Handling of Insulin Requests in the Investigation of Hypoglycaemia guidance for testing and reporting insulin and C-peptide results, issued October 2025, must be mandatory and nationally applied.	NHS England; all Trusts; all neonatal units

3	Bereavement care	The National Bereavement Care Pathway for neonatal death should be implemented nationally and in all Trusts by 31 August 2027.	All Trusts / national implementation
4	Safeguarding and contracts of employment	i. All Trusts must provide safeguarding training to all staff, appropriate to role and expertise, and Board members including Non-Executive Directors. Training should include how to deal with concerns and suspicions about deliberate harm caused by staff. ii. By March 2027, every existing contract of employment for work in an NHS hospital must include an obligation to follow all relevant safeguarding guidance, including the Suspicion of Deliberate Harm Protocol at Recommendation 9. Agency, bank and all new contracts must include the same obligation.	All Trusts / NHS hospitals
5	Operating systems (interoperability)	NHS England must provide, by 31 March 2027, a clear and timed route to ensuring that computer systems are harmonised across the NHS by December 2028. A mandatory information standard with interoperability requirements should be developed and implemented as soon as possible, enabling data relating to babies and neonates to be entered once, reviewed in a timely manner and used for continuous monitoring.	NHS England

6	Monitoring deaths in hospitals	i. By 31 March 2027, all hospital Trusts must have effective mechanisms for Board-level monitoring of all deaths of children and babies. ii. By 31 March 2027, all hospital Trusts must have a clear and predetermined route to senior management for escalation of concerning data trends or patterns.	All hospital Trusts
7	Data reporting	i. All hospitals with a neonatal unit should name a lead reporter responsible for inputting data regularly, at least weekly, and reviewing real-time data viewers on neonatal and maternity units in the MBRRACE system. The lead reporter must be trained to interpret the data and discuss it with clinicians. ii. Except where data requires immediate action and immediate reporting to the Medical Director and Board, the lead reporter should report to Trust Boards at least every six months on alerts or need for investigation and the investigation/action plan in place.	Hospitals with neonatal units; Trust Boards
8	Sudden Unexpected Death in Infancy and Childhood (SUDIC)	i. NHS England must immediately inform all Trusts with a neonatal unit that the SUDIC process applies to sudden and unexpected deaths of babies who have never left hospital; Trusts must draw this to the attention of relevant staff and the Board within seven days. ii. DHSC must complete review and revision of SUDIC guidelines and distribute revised guidelines to all Trusts by no later than 31 March 2027, explicitly stating the above application.	NHS England; DHSC; Trusts with neonatal units

		iii. SUDIC forms must be redesigned and shortened to minimise bureaucracy and focus on essential information.	
9	Suspicion of Deliberate Harm Protocol and guidance	Protocol: By 31 March 2027, NHS England must produce and distribute a one-page protocol for managers when concerns or suspicions arise that a healthcare professional may have deliberately harmed a patient. It must require immediate action on good-faith concerns, make clear belief/certainty is not required, permit no action only for concerns assessed and recorded as obviously irrational or malicious, prioritise patient protection pending investigation, state that moving/investigating a staff member is neutral, and require safeguarding steps leading to police involvement. Guidance: No more than two pages, covering assessment factors, guard against bias/loyalty/prejudice, communications with patients, parents and staff, patient safety first and requirement to investigate, and explaining contractual/professional consequences of failure to follow the protocol. Implementation: Trusts must embed the protocol and guidance within their hospital.	NHS England; all Trusts

10	Panel of experts	DHSC should give serious consideration to establishing a panel of independent experts from all specialties for emerging concerns about an individual and patient harm. Small independent teams, always including clinicians from the relevant specialty/specialties, would conduct swift technical investigations, include safeguarding considerations including contacting police, report findings to the Trust and DHSC, and be available as witnesses in subsequent proceedings.	DHSC
11	Medical examiners	i. By 31 March 2027, the National Medical Examiner should prepare and distribute a one-page document setting out all steps for a medical examiner dealing with the death of a neonate. ii. Revised SUDIC guidelines should be included within good practice guidelines for medical examiners, not merely signposted. iii. Medical examiners should ask attending practitioners directly about concerns that a child has been harmed or other safeguarding concerns, and where relevant ensure a same-day record of contact details of every doctor or nurse who attended the baby during life. iv. A pool of neonatologists should support medical examiners until sufficient regional neonatologist medical examiners can be appointed, with ring-fenced funding. v. DHSC should review the medical examiner system again in 2027, including adequacy and ring-fencing of funding; later reviews as directed by DHSC and NHS England.	National Medical Examiner; medical examiners; DHSC; NHS England

12	Paediatric and perinatal pathologists	DHSC and NHS England must ensure that, by June 2033, there are 37 doctors in training posts as paediatric and perinatal pathologists, in line with the Royal College of Pathologists workforce requirement. The incentive scheme should remain in place and funded until at least 37 doctors are in training posts.	DHSC; NHS England
13	Accountability and regulation of managers	i. DHSC and NHS England must develop and implement a barring system for all managers, clinical and non-clinical, by September 2027; review it in 2030 with a view to full statutory regulation by September 2032. ii. NHS England must require Trusts seeking approval to move a senior manager to another Trust to demonstrate the move is not because of lack of capability/misconduct and that the manager meets the fit and proper person test. Approval must not be sought or granted unless these are demonstrated. iii. All managers must have an individual duty of candour to patients and colleagues, included in the code of conduct and employment contracts. iv. The NHS Leadership and Management Framework Code should urgently be amended to put the duty to put patients first at its beginning. v. In the Leadership and Management Framework Standards, the competency delivering across healthcare	DHSC; NHS England; all Trusts / NHS managers

		should be first, with putting patients first and reporting safety concerns/incidents fundamental.	
14	Care Quality Commission (CQC)	i. CQC should conduct without-notice inspections of hospital departments, with at least two current practising experts in the relevant field on inspection teams. ii. Inspectors should investigate what is happening and not accept statements at face value; questions should test the effectiveness of processes. iii. Training should make explicit that CQC is responsible for ensuring hospital patient safety, not merely checking that processes exist. Neonatal inspections should determine whether babies are safe rather than operate as a box-ticking exercise.	Care Quality Commission (CQC)
15	Assessment of the performance of CQC	There must be rigorous and consistent review and assessment of CQC performance by the Health and Social Care Committee, initially annually and, once the committee is satisfied, once every three years or at another frequency determined by the select committee.	Health and Social Care Committee

16	Parliamentary and Health Service Ombudsman	The functions of the National Guardian's Office should be taken over by the Parliamentary and Health Service Ombudsman in England. The Ombudsman's powers must be increased to include investigating complaints that NHS whistleblowing has not been dealt with adequately, and assisting whistleblowers by referring concerns to relevant NHS bodies and overseeing the response.	Parliamentary and Health Service Ombudsman; National Guardian's Office
17	Implementation of recommendations	A new responsibility for auditing implementation of recommendations of statutory inquiries into NHS bodies should be given to the National Audit Office. Funding for appropriate additional staffing should be available so it may begin work by September 2027.	National Audit Office

To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

21 September 2026

Thirlwall Inquiry report and recommendations

Dear colleagues,

Lady Justice Thirlwall's report is a sobering moment for all of us working in the NHS. From the devasting failure, both of individuals and the system, to act quickly enough to safeguard babies, to the questions it poses about the NHS culture that prevented this – the need for change goes beyond the walls of a single hospital ward. We must address these together now.

Our thoughts remain very much with the families affected who have experienced unimaginable loss and pain, and the NHS repeatedly failed them. The care, safety, and safeguarding of all patients is the principal duty of all of us, and this is why we must all act with the urgency, curiosity, and openness to ensure that the learning from this Inquiry is translated into clear action.

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This is not just a matter for Trusts with neonatal services. It is a matter for every single Trust and ICB Board to consider, and for every member of staff across the NHS.

Recommendations

On Tuesday, the Secretary of State delivered a statement in Parliament that committed to commencing a series of actions recommended in the final report, while the Government considers the Inquiry's recommendations in full.

Specifically:

- Urgently work to develop plans for all cots and incubators in all neonatal units to be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. Taking learning from places where this is already used, we will develop a national approach to support neonatal units to implement this;
- Go further on new guidance on the safe use and storage of insulin and strengthened guidance for medical examiners reviewing neonatal death;
- Undertake a review of the 'Working Together to Safeguard Children' (April 2026) and safeguarding training nationally;
- Work through plans to regulate NHS managers through a barring scheme for senior leaders who fail in their responsibilities;
- Continue rollout of the National Bereavement Care Pathway for families experiencing neonatal loss.

Actions needed now

Trusts should immediately progress the following actions in response to the Inquiry's findings:

- **Every Trust and ICB Board to review the Thirlwall report and to consider its findings at the next available public Board meeting:** Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.
- **Sudden and Unexpected Death In Children** (SUDIC): The Inquiry rightly made clear that no member of staff should ever assert that they did not know what to do in response to a sudden and unexplained death. The SUDIC protocol is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably

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expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death**.** This includes sudden and unexpected deaths within neonatal units. **All Trusts with a neonatal unit must urgently communicate to all relevant staff and the Board that the SUDIC process applies as set out above. This must be completed by no later than Monday 28 September 2026.** It is important to note that SUDIC reporting runs alongside your own internal reporting processes.

- **National Bereavement Care Pathway for stillbirth and neonatal death:** ICBs and providers should take immediate action to improve care of the bereaved as has already been set out in the NHS Medium Term Planning Framework (October 2025).

- **Insulin**: By 31st March 2027, all neonatal units must meet requirements for access control and storage of insulin as set out in the GIRFT neonatology Guide to safe insulin use. Until access to insulin requires the provision of biometric data, each Trust should urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units by 30 November 2026 at the latest. The cameras should store recordings for at least 28 days.

- **Safeguarding:** Trusts and ICBs should ensure that all staff and Board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required.

In addition, Trusts are reminded that the Insightful Provider Board guide is intended to help Boards identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively.

Health and wellbeing

We are mindful that the findings of this Inquiry may impact the confidence of parents and families whose babies are currently receiving neonatal care. We would urge you to consider what steps can be taken locally to provide parents with assurance of the care being given and support that is required during the care of their baby.

We also recognise that caring for very sick babies can be psychologically difficult for staff and this is an opportunity to review the support mechanisms in place for staff working in these services.

Next steps

The report firmly underlines why the urgent work we are doing through the Maternity and Neonatal Care 10-Point Plan must be a top priority for the NHS. As the Secretary of State has clearly set out, the safety, safeguarding and wellbeing of mothers and babies must never be treated as a side issue and must be a central priority for NHS boards.

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The findings of this crucial report will be a key focus of our next CEO leadership event tomorrow**.** It is important that we challenge each other when we meet on whether we are all doing enough to ensure that babies and children are protected, no staff member is ignored when they raise concerns, and that we are consistently acting to the highest standards of governance and leadership.

Yours sincerely,





Duncan Burton

Chief Nursing Officer for England

Sarah-Jane Marsh

NHS England Chief Operating Officer

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King's College Hospital NHS Foundation Trust

AGENDA ITEM: 18

BOARD REPORT COVER PAPER

Report to:	Board of Directors
Date of meeting:	17 November 2026
Subject:	**Maternity & Neonatal Quality & Safety Integrated Report (August-September 2026)**
Author(s):	Mitra Bakhtiari, Director of Midwifery/Gynaecology Nursing Dr Lisa Long, Clinical Director Women's Health Dr Ravindra Bhat, Consultant Neonatologist & Clinical Lead for Neonatal Services
Sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery Dr Mamta ShettyVaidya, Chief Medical Officer
History:	Divisional Quality and safety, Women's Care Group maternity governance
Status:	

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

Purpose

The purpose of this report is to provide the Board with assurance regarding the safety, quality, governance and performance of maternity and neonatal services. The report highlights key risks, outcomes, workforce considerations and progress against national and local improvement programmes, enabling the Board to discharge its responsibilities for oversight, challenge and assurance and to ensure the delivery of safe, high-quality care for women, babies and families. Through this report joint executive oversight and accountability for board assurance is undertaken by the Chief Nurse & Executive Director of Midwifery and the Chief Medical Officer.

Recommendations

The Board is asked to discuss the report for evidence and assurance of the MATNEO services, Maternity incentive Scheme MIS (year 8) compliance for the end of November 2026 and submission in March 2027. To discuss the trust 's progress with 10-point action plan for the 2nd national submission on 31st December 2026.
The Board is asked to consider a delegated authority to Kings Management Committee (KMC) to sign off the December submission with reporting to the next board of directors meeting in January 2027.

Strategy alignment

King's College Hospital NHS Foundation Trust

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

Strategic risk - Link to Board Assurance Framework	*BAF 2 7 8*
King's Improvement Impact (KIM):	The report reflects KIM by demonstrating learning from data, feedback, measuring progress through KPIs, to enhance maternity and neonatal care quality and safety
Quality Impact	Board Safety Champions oversight with CNO & CMO
Health Equity Impact	Perinatal culture leadership, improving culture in maternity and neonatal services, supporting the equality assessment, and creating inclusive environment.
Workforce Impact	Triangulation of workforce metrics that supports high quality and safer maternity and neonatal care as well as consistent standards of care through learning from incidents, training and best practice, and ongoing monitoring of implementation and outcomes.
Research/Innovation Impact	Women's health research studies support service improvement and innovation within maternity services and learning from national education and shared learning across the multidisciplinary team and for further research, innovation and improvement.
Digital Impact	digital transformation using digital platforms for evidence submission, data collection and monitoring
Financial Impact	Failure to achieve all 10 Safety Actions of the Maternity Incentive Scheme will result in the Trust not recouping the additional 10% contribution, amounting to circa £2.3 million.
Legal/ regulatory compliance	Care Quality Commission (CQC); Maternity & Newborn Safety Investigations (MNSI); Mothers, Babies: Reducing Risk through Audits & Confidential Enquiries (MBRRACE-UK); CNST Maternity Incentive Scheme (MIS)
Communications and Engagement	Maternity & Neonatal Voices Partnership (MNVP), Local Maternity & Neonatal System (LMNS)

Use of Artificial Intelligence tools	Minimal AI tools have been used in line with trust policy
Committee that will provide relevant oversight KMC, Quality & Research Committee	

1. Executive Summary

Maternity and neonatal services continue to demonstrate stable performance across clinical outcomes, patient safety, workforce and governance indicators. External assurance through the Perinatal Quality Oversight Model (PQOM), regional insight visits and the NHS England 10-Point Maternity and Neonatal Action Plan confirms that the Trust has maintained compliance with key safety requirements. Joint accountability at board level is undertaken by the Chief Nurse & Executive Director of Midwifery and the Chief Medical Officer.

Key areas of assurance include:

- Stable clinical outcomes with no significant deterioration in key safety indicators.
- Lowest major obstetric haemorrhage rate across Southeast London.
- Partial compliance with the NHS England 10-Point Action Plan.
- Martha's Rule implementation on track for March 2027.
- Robust Homebirth governance arrangements recognised as an area of good practice.
- KCH has completed the senior leadership perinatal anti-racism program.
- Maternity Incentive scheme year 8 is on track for compliance
- There has been no Coroner, Regulation 28 and external concerns
- Completion of remaining 10-Point Action Plan evidence requirements by December 2026.
- First MOSS alert 28th October 2026
- The trust's BFI assessment for stage 2 is taking place in March 2027 jointly with the neonatal units
- The trust has achieved marked improvement for the last 12 months in compliance with Optimal cord clamping at DH site that is an outlier, now 69.4%, compared to a national average rate of 77.6%.
- ODN (Operational Delivery Network): Regional benchmarking of neonatal outcomes and quality indicators, providing assurance that performance is aligned with network and national standards.

2. Perinatal Quality Oversight Model

Since August 2025, the Trust has reported against the requirements of the Perinatal Quality Oversight Model (PQOM), previously known as the Perinatal Quality Surveillance Model. The model, originally implemented by NHS England in 2020, was revised and renamed in August 2025. Under the PQOM, local maternity units are required to report against an agreed set of quality and safety measures. The Trust provides information to the London Perinatal Quality Safety Improvement Group (LPQSG**)**, as part of regional oversight and assurance for maternity and neonatal services. Given the Trust's current maternity CQC rating, the service continues to receive regular insight visits from the London Regional Perinatal Team, undertaken on a six-monthly basis. The next review is on 27th November following July 2026 when the trust

demonstrated sustained compliance with the exit criteria from the Maternity Support Programme, from which the Trust successfully exited in December 2024**.** The Trust is awaiting implementation of a standardised Board assurance template to support consistent maternity and neonatal reporting, aligned to PQOM requirements and national assurance frameworks. This will strengthen triangulation of quality, safety and workforce metrics, providing clearer evidence of how improvement programmes, governance processes and clinical outcomes translate into measurable improvements in patient safety, experience and compliance.

2.1 Maternity Clinical Outcomes Dashboard (August-September 2026)

The maternity clinical outcomes demonstrate stable performance across key safety and quality indicators, with no significant deterioration (Appendices 1a and 1b). Activity levels across both DH and PRUH is reflecting the complexity of the population served. Routine surveillance through site-level PSIRF reviews has identified no concerns requiring escalation. The most notable trend remains the continued increase in caesarean section rates, affecting both elective and emergency births and reflecting patterns seen across SEL. Maternal request remains a contributing factor. A dedicated caesarean section audit is ongoing to better understand opportunities to reduce unwarranted variation. Areas of Focus remain:

- Continued monitoring of elective and emergency caesarean section rates.
- Delivery of the Preterm Optimisation Programme, including interventions aimed at reducing preterm and extreme preterm birth. Continued focus on avoidable term admissions to the neonatal unit (ATAIN), which remains the most reported incident type. Trust performance remains within the national target of <6%.

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2.2 **LMNS (Local Maternity and Neonatal System) Benchmarking:** KCH continues to perform favourably across maternity outcome measures**.** As the largest maternity provider within the LMNS, KCH manages the highest number of bookings and births, highest vaginal birth (52.6%). The lowest rate of major obstetric haemorrhage (2.1%).



Provider	Number of Deliveries	Number of Major Obstetric Haemorrhage occurring at Delivery	% Major Obstetric Haemorrhage occuring at Delivery
GSTT	2,695	124	4.6%
LGT	2,613	85	3.3%
KCH	2,722	56	2.1%
Total	**8,030**	**265**	**3.3%**

Provider	Number of Deliveries	Number of Vaginal Deliveries	% Vaginal Deliveries	Tear Count	% Tear in Vaginal Deliveries
LGT	2,613	1,346	51.5%	38	2.8%
KCH	2,722	1,432	52.6%	34	2.4%
GSTT	2,695	1,363	50.6%	27	2.0%
Total	**8,030**	**4,141**	**51.6%**	**99**	**2.4%**

2.3 Patient Safety incident Framework

	PMRT Compliance	MNSI Cases (new)	Still Births			HIE Cases	Neonatal Deaths	Maternal Mortality
			All	Term	Intrapartum			
Apr		0	9	0	0	0	1	0
May		2	1	0	0	0	2	0
June		0	5	0	0	0	3	0
July		0	1	0	0	0	2	0
Aug		0	3	0	0	0	1	0
Sep		1	2	1	0	0	4	0

Learning from Incidents						
2026	**InPhase**				**PSIIs**	**Never Events**
	New Incidents	**No. Closed**	**Remaining Open Month**	**Moderate Harm or Above**		
June	232	196	35	5	0	0
July	204	136	65	8	0	0

Aug	249	140	35	0	0	0
Sep	217	102	40	1	1 MNSI	0

MNSI referrals: September: term stillbirth, born via c-section. Vasa praevia diagnosed at C-section

Final MNSI Reports Received: Three final MNSI reports were received during the reporting period (Appendices 2,3,4). Key themes relate to strengthening telephone triage risk assessment processes, supporting safe decision-making and consent discussions during assisted vaginal birth, and improving communication between maternity and ambulance services during emergency transfers. Actions have been incorporated into existing maternity governance and quality improvement programmes, with progress monitored through established oversight arrangements.

- **MI-053800:** Recommendation to implement a structured risk assessment tool to support telephone triage, including guidance for the assessment and management of women reporting blood-stained liquor and reduced fetal movements (RFM).
- **MI-053801:** Recommendation to strengthen support and training for clinicians undertaking assisted vaginal births, ensuring women are offered and counselled regarding all appropriate birth options, including caesarean section where clinically indicated.
- **MI-059698:** Recommendation for the Trust to review and strengthen information-sharing processes between maternity and ambulance services to ensure relevant clinical information is communicated effectively during emergencies, supporting accurate risk assessment, timely clinical decision-making, and safe transfer of care.

Maternity Outcome Signal System (MOSS)

Since implementation of MOSS in November 2025, the Trust had not received any MOSS alerts. As part of compliance with Maternity Incentive Scheme (MIS) Year 8, the Trust completed a multidisciplinary (MDT) MOSS exercise, testing maternity and neonatal escalation processes, MDT coordination, communication and organisational response. Evidence of completion was submitted to the London regional team as required, with learning incorporated into existing governance and quality improvement programmes (Appendix 5). Following the reporting period, on 28 October 2026, the Trust received a MOSS alert. Although this falls outside the period covered by this report, the alert has been reviewed, and the organisational response is being managed in line with national requirements. A summary of the alert, response and any associated learning will be reported through the November 2026 Trust Board. The Trust remains compliant with MIS Year 8 requirements relating to MOSS and has demonstrated preparedness through successful completion of an MDT exercise.

Delays in Planned Elective LSCS and IOL Pathways (August-September 2026)

During August and September 2026, delays across planned elective caesarean section (CS) and Induction of Labour (IOL) pathways remained largely attributable to periods of high

maternity acuity, capacity pressures and neonatal service constraints. PRUH reported one elective LSCS delay and one IOL delay in August, with no delays recorded in September. At DH, no CS delays occurred in August; however, four delayed CS cases were recorded in September, primarily due to Neonatal Intensive Care Unit (NICU) capacity pressures. IOL admissions at DH were delayed on three days in August and 11 days in September, reflecting sustained operational pressures and neonatal capacity challenges. An ongoing quality improvement programme is focused on reducing delays within the IOL pathway through regular review of performance, identification of contributory factors, and implementation of improvements to support timely admission, induction and patient flow. Delays were predominantly related to system capacity and acuity pressures rather than process failures. Oversight continues through routine operational, twice daily huddles and governance processes, with targeted improvement work/audits to reduce delays and maintain safe, timely access to care.

2.4 Perinatal Mortality Review Tool (PMRT) (August-September 2026)

Sixteen deaths were notified to MBRRACE-UK, of which 11 met criteria for PMRT review (1 late miscarriage, 5 stillbirths, 5 neonatal deaths); seven reviews were completed during the reporting period. No recurring themes, avoidable factors, safety concerns, or emerging inequalities were identified. Outcomes remain consistent with previous reporting periods and reflective of the Trust's complex tertiary population, with prematurity remaining the main contributor to mortality. PMRT reviews provide assurance that the Saving Babies' Lives Care Bundle (SBLCB v3) remains embedded in practice. The Trust has achieved all requirements of the Maternity Incentive Scheme (MIS) Year 8, with ongoing oversight through the monthly MIS Panel chaired by the Executive Safety Champion and supported by the LMNS (Appendix 6). Additional external assurance is provided through MBRRACE-UK national surveillance and benchmarking. The table below summarises outcomes by ethnicity and alignment with SBLCB v3 elements.

Outcome	Gestation	Ethnicity	Associated SBLCB Element(s)	Review Findings
Late Miscarriage	23 weeks	White	Preterm Birth	No care concerns identified; extreme prematurity. Prematurity remains the principal contributor to mortality.
Stillbirth	31 weeks	Mixed	Preterm Birth	No SGA or growth-related concerns identified.
Neonatal Death	24 weeks	Mixed	Preterm Birth	Extreme prematurity; care bundle appropriately applied.
Neonatal Death	27 weeks	White	Preterm Birth	Extreme prematurity; no themes identified.
Neonatal Death	38 weeks	Asian	Smoking/Diabetes Fetal Monitoring reviewed	Mother declined smoking cessation support Gestational diabetes appropriately managed No contributory concerns identified through PMRT review.
Neonatal Death	37 weeks	Black	Fetal Monitoring reviewed	No concerns relating to intrapartum monitoring identified.
Neonatal Death (Twins)	23 weeks	Black	Preterm Birth	Extreme prematurity; care bundle appropriately applied.

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Outcome	Gestation	Ethnicity	Associated SBLCB Element(s)	Review Findings
Stillbirth	31 weeks	Asian	Fetal Growth Surveillance	No contributory concerns identified.
Stillbirth	35 weeks	Black	Fetal Growth Surveillance	No contributory concerns identified.
Stillbirth	36 weeks	White	Fetal Growth Surveillance	No contributory concerns identified.
Stillbirth	37 weeks	White	Fetal Monitoring	No contributory concerns identified.

2.4.1 Explanation of grading following PMRT review

For cases of late miscarriage or stillbirth, the grading is assigned respectively to the following questions:

Grading of care

Grading of care of the mother and baby up to the point that the baby was confirmed as having died:

- ○ A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care of the mother following confirmation of the death of her baby:

- ○ A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

For cases of neonatal death, the grading is assigned respectively to the following questions:

Grading of care

Grading of care of the mother and baby up to the point of birth of the baby:

- ○ A - The review group concluded that there were no issues with care identified up the point that the baby was born
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care of the baby from birth up to the death of the baby:

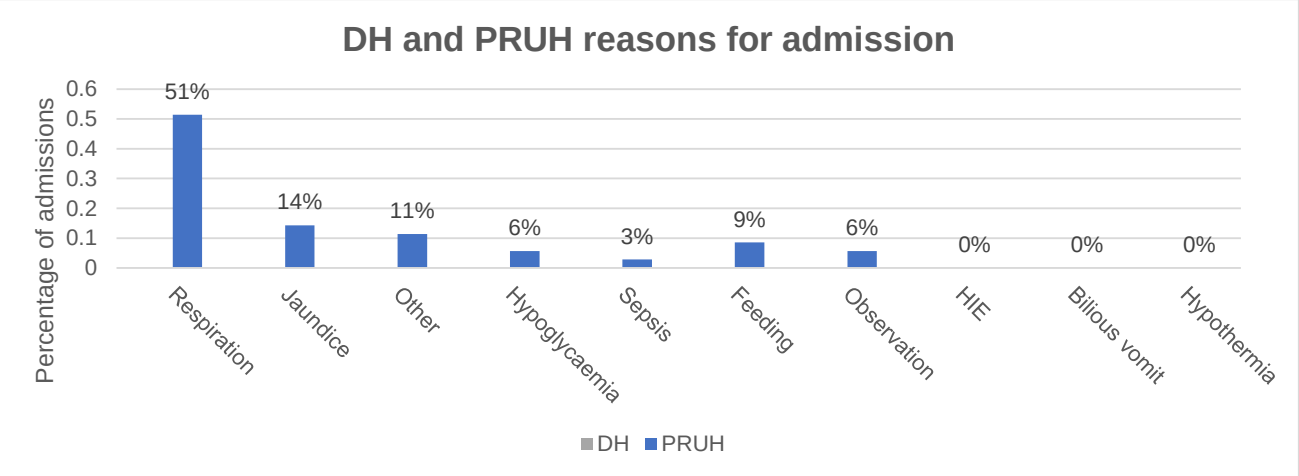
- ○ A - The review group concluded that there were no issues with care identified from birth up the point that the baby died
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

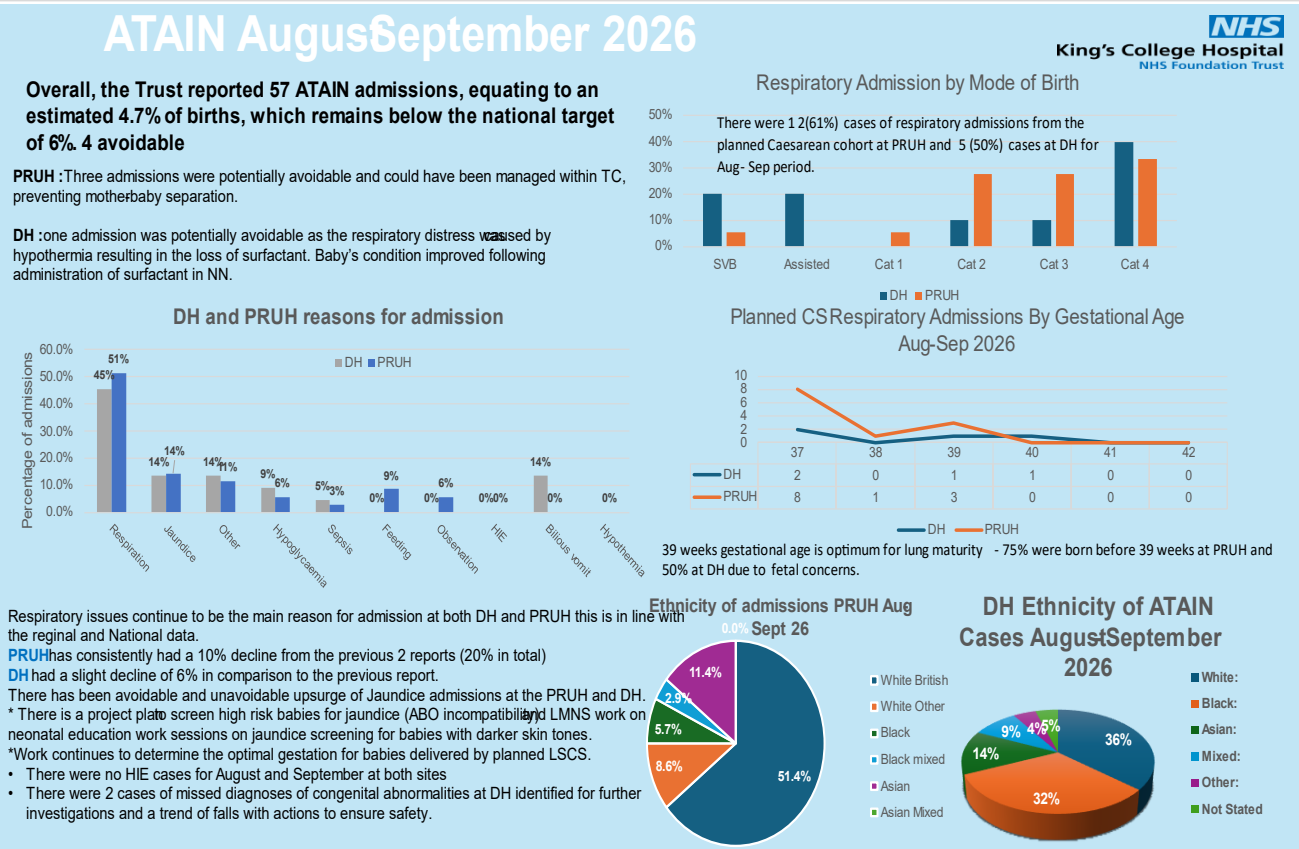
Grading of care of the mother following the death of her baby:

- ○ A - The review group concluded that there were no issues with care identified for the mother following the death of her baby
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

2.5 Avoidable Term Admissions to the Neonatal Unit (ATAIN)

The Trust reported 57 ATAIN admissions (4 avoidable), equating to an estimated 4.7% of births, remaining below the national target of 6%. Respiratory morbidity continued to be the leading reason for admission at both sites, consistent with regional and national trends. Of respiratory admissions, 61% at PRUH and 50% at DH were associated with planned caesarean births, highlighting an ongoing focus on optimising the timing of planned caesarean delivery where clinically appropriate. No Hypoxic-Ischaemic Encephalopathy (HIE). Ongoing work is focused on improving jaundice screening and parental education and optimising respiratory outcomes for babies born by planned CS births.





2.6 Perinatal Care and Neonatal Outcomes (ODN Benchmarking)

The ODN dashboard (Appendix 7) demonstrates that neonatal outcomes at both DH and PRUH remain stable and compare favourably across key quality indicators associated with high-quality neonatal care, particularly infection prevention, magnesium sulphate administration and early breastmilk provision. The data reflects the complexity of the population served, particularly at DH as a tertiary neonatal intensive care unit caring for a high volume of extremely preterm infants. The data demonstrates that KCH performs well in several indicators. No emerging safety concerns identified through ODN benchmarking. Ongoing quality improvement work is focused on optimisation measures known to improve preterm outcomes, including antenatal steroids, thermoregulation, and breastfeeding support.

2.6.1 Key areas Performance

- Magnesium sulphate administration continues to achieve or exceed the national standard at both sites, reaching 90.5% at DH and 100% at PRUH, supporting prevention of neurological injury in preterm infants.
- Early breastmilk provision remains strong, with both units exceeding the ODN standard for breastmilk within the first two days of life.
- Bloodstream infection rates remain low, with zero infections reported at PRUH and continued reductions at DH.
- ROP (Retinopathy of Prematurity) screening performance continues to improve, particularly at PRUH.
- Mortality rates and major neonatal outcomes remain stable despite the complexity of babies cared for across the service.

- Antenatal steroid administration remains below expected levels across both sites, mainly due to timing of admission.
- Admission temperature compliance remains below the 90% standard.
- Breastfeeding at discharge remains below the ODN benchmark and has reduced over recent months.
- Parental consultation and long-term follow-up attendance remain below aspirational targets.
- DH has seen a small increase in intraventricular haemorrhage (IVH) rates which continues to be monitored through neonatal governance processes.

2.7 Health Equity, Ethnicity and Deprivation

Analysis of outcomes by ethnicity and deprivation for month of August 2026 (Appendix 8) demonstrates that disparities are seen in early access to care and caesarean birth rates. This is among Black women and those with greater deprivation. No significant inequalities have been identified in maternal outcomes. These findings continue to inform the Trust's Health Equity and Anti-Racism Plan, Perinatal Anti-Discrimination program (PEADP), with progress monitored through maternity governance structures.

Area	Finding	Action
Early Access to Care	Lower early booking rates among Black women and those living in the most deprived areas.	Targeted community engagement and access initiatives.
Late Booking	Higher rates of booking after 20 weeks among Black women.	Actions monitored through the Equity and Anti-Racism Action Plan.
Category 1 & 2 Caesarean Births	Higher rates among Black women, Asian women and more deprived groups.	Ongoing review through the Caesarean Section Audit and pathway improvement work.
Severe PPH & Third-Degree Tears	No significant variation identified.	Continue routine monitoring.
Overall Maternal Outcomes	No significant disparities in major clinical outcomes.	Maintain surveillance through governance processes.

2.8 Workforce Metrics Summary (September 2026)

Overall, workforce indicators remain stable, with strong performance in appraisal compliance and continued focus on reducing sickness absence and vacancy levels. Recruitment and retention activity continue, whilst targeted action is being taken to address areas of ongoing challenge.

Metric	Sep-25	Sep-26	Position
Voluntary Turnover Rate	8.20%	7.23%	▼ Improved
Sickness Absence	7.31%	7.60%	▲ Slight increase
Appraisal Compliance	87.55%	91.49%	▲ Improved
Core Skills Compliance	88.52%	85.51%	▼ Deterioration

2.8.1 Key highlights

- Appraisal compliance has improved significantly, increasing to 91.49%, exceeding the Trust target and demonstrating strengthened management oversight and staff engagement.
- Voluntary turnover has reduced from 8.20% to 7.23%, suggesting improved workforce stability and retention.
- Sickness absence remains above the trust desired level. Continued focus on wellbeing, attendance management and staff support is ongoing.
- Core skills compliance remains below target at 85.5% and has shown a gradual decline throughout the year, requiring focused recovery plans to ensure compliance with mandatory training requirements.

2.8.2 Midwifery and Maternity Support worker (MSW)

Midwifery vacancies remain within the Trust target at 13.67 WTE (4.3%), and the service continues to demonstrate compliance with Birthrate Plus recommendations. Recruitment activity continues, including successful student midwife recruitment and initiatives to convert preceptors and fixed-term staff into substantive posts. The most significant workforce challenge remains within the MSW workforce with circa 30% vacancy (27wte), where targeted recruitment, workforce

redesign, Band 2 uplift arrangements and internal career development pathways are in progress. Recruitment is in progress.

2.8.3 Medical Workforce

Medical staffing remains fully established, with no consultant or trainee vacancies, providing stability across the multidisciplinary workforce and supporting the delivery of safe maternity care. GMC survey indicates positive assurance around training and junior doctor supervision and out of hours access.

2.8.4 Neonatal Workforce Establishment (BAPM Compliance)

Midyear establishment review of the neonatal workforce review has identified that the service remains below full compliance with BAPM workforce standards, primarily due to a shortfall in Qualified in Specialty (QIS) neonatal nurses and the overall establishment required to support activity within a tertiary neonatal intensive care service. A business case has been developed and is in progress to address this gap. Currently, 116.9 WTE staff are in post against a funded establishment of 131.8 WTE, with vacancies reducing from 17.4 WTE to 14.9 WTE. Recruitment activity continues, supported by a focus on workforce development through the QIS training programme. Temporary staffing requirements are predominantly met through the staff bank, with minimal agency use, in line with BAPM principles. The service has a strong leadership, education and governance infrastructure, including dedicated nursing leadership, practice development, governance, bereavement and discharge coordination roles. Robust workforce oversight is provided through the Neonatal Staffing and Bed Capacity Group, supported by monthly monitoring through the Neonatal Nursing Workforce Tool, establishment reviews, daily operational huddles and a neonatal escalation framework. Recognising the wider national and regional workforce challenges, neonatal workforce compliance remains a risk on the LMNS risk register, with ongoing monitoring through Trust, ODN and LMNS governance structures. The business case and associated workforce improvement plan provide a clear trajectory towards achieving BAPM compliance and strengthening the resilience of the neonatal service.

2.8.5 Bank and Agency Fill Rates (August-September 2026): The Trust continues to rely predominantly on the internal Bank workforce, which accounted for 71.9% of all requested shifts, while agency utilisation remained very low at 0.7%. Although 27.4% of shifts remained unfilled, workforce risks were mitigated through established escalation processes, twice daily huddles and 4 hourly reviews of Birth rate plus acuity to arrange redeployment to level up acuity dependency.

Workforce Fill Position	Aug-26	Aug %	Sep-26	Sep %
Bank Filled	1,120	72.2%	958	71.5%
Agency Filled	13	0.8%	7	0.5%
Total Filled	**1,133**	**73.0%**	**965**	**72.1%**
Unfilled	418	27.0%	374	27.9%
Total Requests	**1,551**	**100%**	**1,339**	**100%**

2.8.6 Training: remains compliant in line with core competency framework v2 and MIS year 8 safety action B.

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Reporting Period: September 2026	Can you demonstrate 90% attendance for the following staff groups?								
Fetal Monitoring									
Target 90%	DH			PRUH			Cross-site		
	No. Eligible	No. Compliant	%	No. Eligible	No. Compliant	%	No. Eligible	No. Compliant	%
Obstetric Consultants	16	16	100%	12	11	91.7%	28	27	96.4%
Obstetric Doctors	38	38	100%	22	21	95%	60	59	98.3%
Midwives	253	249	98.4%	218	199	91.3%	471	448	95.1%
Maternity Emergencies/ MDT (PROMPT)									
Target 90%	DH			PRUH			Cross-site		
	No. Eligible	No. Compliant	%	No. Eligible	No. Compliant	%	No. Eligible	No. Compliant	%
Obstetric Consultants	18	17	94.4%	12	12	100%	30	29	96.7%
Obstetric Doctors	37	36	97.3%	19	18	94.7%	57	55	96.5%
Midwives	253	238	94.1%	216	199	92.1%	469	437	93.2%
Maternity support workers & health care assistants	47	45	95.7%	41	38	92.7%	88	83	94.3%
Obstetric Anaesthetic Consultants	11	10	90.9%	19	18	94.7%	30	28	93.3%
Obstetric Anaesthetic Doctors	18	17	94.4%	23	22	95.7%	41	39	95.1%
Can you demonstrate that **at least one** MDT emergency scenario is conducted in a clinical area or at point of care during the MIS reporting period?								Yes	
Neonatal Basic Life Support									
Target 90%	DH			PRUH			Cross-site		
	No. Eligible	No. Compliant	%	No. Eligible	No. Compliant	%	No. Eligible	No. Compliant	%
Neonatal Consultants or Paediatric Consultants covering neonatal units			100%			100%			100%
Neonatal Junior Doctors			100%			100%			100%
Neonatal Nurses	106	106	100%	43	40	90%	149	144	96.6%
Advanced Neonatal Nurse Practitioner (ANNP)	3	3	100%	n/a	n/a	n/a	3	3	100%
Midwives	253	238	94.1%	216	199	92.1%	469	437	93.2%
Is a formal plan in place demonstrating how you will ensure a minimum of 90% of **neonatal and paediatric medical staff** who attend neonatal resuscitations have a **valid resuscitation council NLS certification** by year 7 of MIS and ongoing?								Yes	

2.9 Perinatal Executive and Frontline Leaders' Safety Champion Walkabouts

Two Maternity Safety Champion Walkabouts were undertaken during the reporting period, focusing on frontline staff engagement, patient experience, operational pressures and service resilience. Visits were undertaken within the Denmark Hill Maternity Triage Service and the PRUH maternity wards, with participation from the Executive Safety Champion, Clinical Safety Champion and Maternity and Neonatal Voices Partnership (MNVP).

2.9.1 Maternity Triage (DH)

The walkabout focused on patient flow, capacity, staffing and patient experience within the maternity triage service. This included review of the maternity triage benchmarking assessment and findings from the recent three-month BSOTS compliance audit. Key themes identified included the management of women attending outside planned pathways, particularly women being reviewed through the Maternity Assessment Unit (MAU) and Home Birth Service (HBR), which can contribute to increased activity and capacity pressures within triage. Opportunities were also identified to improve wayfinding and patient navigation to ensure women access the most appropriate service first time. The Trust is currently progressing a costed improvement plan as part of the national maternity triage review and benchmarking programme, with submission due in

December 2026. A multidisciplinary working group has been established to oversee delivery and implementation.

2.9.2 Maternity Wards (PRUH)

The walkabout reviewed postnatal ward capacity, patient experience and the operational impact of rising caesarean section rates on bed occupancy, staffing requirements and patient flow. Discussions also focused on service resilience and business continuity arrangements during periods of operational disruption, including incidents such as utility outages. Key learning identified the need to strengthen staff awareness of business continuity procedures and escalation arrangements. In response, work is progressing to review capacity, demand management and theatre utilisation, including development of a business case to improve elective caesarean section scheduling, enhance resilience and maintain capacity for emergency activity.

2.9.3 Action Plan

Theme	Action	Lead	Governance Oversight
National Triage Standards	Complete benchmarking action plan and submit national return by December 2026. Improve patient wayfinding and information regarding access to maternity services	MDT Triage Working Group	Safety Champion Group
Business Continuity	Increase staff awareness and testing of business continuity and escalation procedures Review attendance pathways through MAU and HBR to reduce avoidable demand within triage	Matrons	Risk and Governance Committee
Elective Theatre Capacity	Progress business case to optimise elective activity and maintain resilience for emergency demand	Clinical Director	Divisional Governance

2.10 Patient Experience and Engagement

2.10.1 CQC Maternity Survey

The Trust has reviewed the 2026 CQC Maternity Survey findings and developed a targeted improvement programme to address identified opportunities. Performance was broadly stable, with 58 of 60 questions showing no statistically significant change from 2025 and one area demonstrating significant improvement, with more women reporting that their infant feeding decisions were respected.

Areas of Strength	Areas for Improvement
Performance stable across most measures	Out-of-hours infant feeding support
Improved respect for women's infant feeding decisions	Staff awareness of women's medical history
Partner experience above comparator organisations	Antenatal infant feeding information
Majority of measures in line with national benchmarks	Pain management during labour
	Mental health support during pregnancy

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2.10.2 Patient feedback

While September 2026 saw a reduction in FFT satisfaction alongside increases in PALS contacts and formal complaints, feedback continues to highlight compassionate, respectful and supportive care from maternity staff. Communication, appointment management and access to care remain the most consistent themes across all patient experience measures and are the primary focus of improvement activity. An improvement programme is in place, including co-production with women and families, enhanced staff education, implementation of the NHS England Maternal Care Bundle, Baby Friendly Initiative accreditation work, and the introduction of the MyChart Pregnancy Care Companion. Patient experience metrics are reviewed monthly through LMNS and MNVP partnership meetings, supported by the 15 Steps for Maternity Services methodology to understand women's experiences in real time. To strengthen oversight, a new High-Quality Care Dashboard has been introduced (Appendix 9). This supports monitoring against key priorities: communication with women and families, appointment booking and waiting times, and consistency of information and personalised care planning. Patient Experience Metrics and Emerging Themes can be seen in table below:

Indicator	Aug-26	Sep-26	Change	Key Positive Findings	Key Improvement Themes
FFT	93.8%	90.0%	▼ 3.8%	Caring staff (609), approachable staff (564), dignity and respect (172)	Communication with patients (44)
PALS	26	30	▲ 4%	Feedback reflects ongoing engagement with the service	Communication with patients (79), appointment times (39), appointment booking (22)
Complaints	14	16	▲ 2%	Complaint backlog reducing, with closures exceeding new complaints in September	Communication, information sharing and understanding of care plans

2.10.3 Positive patient feedback: The image below highlights a selection of positive feedback received from women and families during the reporting period.



2.10.4 Listening Service

Consultant midwives; run twice weekly clinics that provides an important mechanism for referring women who need to discuss their care.175 consultations between June and September 2026 across DH and PRUH were completed. Referrals included birth trauma, tokophobia, neurodivergence, complex medical and social needs, Vaginal Birth After Caesarean (VBAC) counselling, homebirth planning and requests for care outside standard guidance. The service continues to support shared decision-making, personalised care planning and learning from women's experiences, with themes routinely reviewed through maternity governance processes.

2.10.5 Complaints Performance

Between October 2025 and September 2026, the service received 165 complaints and closed 154 complaints. Complaint management performance has improved, with complaint closures exceeding new complaints in seven months during the reporting period. The most common themes relate to communication, information sharing, staff attitudes and understanding of care plans. The data across LMNS is comparable with similar themes being reported across SEL.

3.0 External Assurance and Regulatory Compliance

3.1 NHS England Maternity and Neonatal 10-Point Action Plan:

The Trust submitted its baseline assessment against the NHS England Maternity and Neonatal 10-Point Action Plan on 25th September 2026 (Appendix 10). Following regional and national review, feedback was received on 23rd October 2026, recognising the progress made across maternity and neonatal services and confirming circa 85% compliance. Of the 26 deliverables reviewed, 18 were aligned with the Trust's self-assessment, reflecting strong governance, patient safety systems, workforce oversight and Board assurance arrangements. The review identified eight areas requiring further evidence or strengthened assurance, although the majority relate to demonstrating existing arrangements rather than implementing new programmes of work. In several areas, the Trust already holds supporting evidence and will strengthen the presentation of assurance. Importantly, similar themes and evidence gaps have been identified across London providers. During November 2026, the findings will be reviewed collaboratively through the Southeast London (SEL) and Southwest London (SWL) maternity systems to agree a shared London-wide approach where appropriate. The Trust will incorporate this learning into a targeted improvement plan and submit its final response and supporting evidence by 31st December 2026. Overall, the review provides assurance that maternity and neonatal services are progressing well against the 10-Point Action Plan, with focused work underway to strengthen evidence, demonstrate impact, and achieve full compliance. with progress monitored through existing governance structures and reported to the Quality Committee and Trust Board ahead of the December 2026 submission deadline. Overall Position:

Outcome	Number
Deliverables Reviewed	26
Ratings Aligned with Trust Self-Assessment	18
Areas Requiring Further Evidence / Assurance	8

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3.1.1 Improvement Plan for December 2026 Submission

The actions below reflect the key recommendations identified through national review and will be overseen through existing governance arrangements.

Action	Requirement	Key Actions	RAG
2.3 Outcomes, Experience and Clinical Audit 5.2 Equity and Tackling Inequalities	Board reporting of variation by ethnicity and deprivation	Six-monthly Board review of the national EDI dashboard. Development of a local EDI dashboard	
3.1 Executive Leadership and Accountability	Joint accountability between CNO and CMO	Joint maternity and neonatal oversight arrangements; ensure joint sign-off of performance reports, executive accountability	
6.3 Neonatal Workforce Establishment	Workforce review	Complete neonatal workforce review, to align to BAPM recommendations.	
6.5 Anaesthetic Cover	24/7 anaesthetic cover assurance	Document compliance with 24/7 obstetric anaesthetic cover requirements	
6.6 Workforce Pressures and Escalation	Strengthen workforce reporting	Strengthen Board oversight of workforce	
8.3 Learning and Improvement	Open learning and thematic review tracker	Thematic review tracker incorporating PMRT, MNSI, incidents, complaints and claims; evidence triangulated learning, actions and impact at Board level.	

3.1.2 Martha's Rule: Implementation of Martha's Rule remains on track to achieve the national compliance deadline of 31st March 2027. Governance arrangements are established, with both Trust-wide and maternity leadership in place. Delivery plans are progressing in line with NHS England requirements and are being integrated with existing maternity safety and escalation processes. Based on current progress, the service remains on track to meet national requirements. The next phase of work will focus on pathway testing, Epic development, confirmation of 24-hour review arrangements and implementation of monitoring measures. Progress to date includes:

- Established governance and programme leadership.
- Commencement of maternity implementation planning.
- Development of patient, family and staff escalation pathways.
- Integration with existing clinical escalation and deterioration pathways.
- Planning of digital solutions, assurance metrics and staff training.

3.1.3 Homebirth Service Review

The Homebirth Service continues to provide safe, personalised care supported by robust multidisciplinary governance arrangements and aligns with national policy supporting informed choice and personalised maternity care. Monthly Homebirth Forums provide structured oversight of risk assessment, complex care planning, transfers, care outside guidelines and organisational

learning. A small number of occasions where homebirth team capacity was unavailable have been identified for further review and learning. Suspension of home birth services in the reporting period affected one woman, although she had requested a transfer for pain relief. Ongoing monitoring will continue to focus on service capacity, transfers, outcomes and equity of access. During August and September 2026, cases were reviewed through formal multidisciplinary processes. Review findings demonstrated:

- Consistent risk assessment and personalised care planning.
- Appropriate multidisciplinary review of women choosing care outside guideline recommendations.
- Ongoing reassessment of care plans in response to changing clinical circumstances.
- Effective governance oversight of transfers and outcomes.
- No significant safety concerns identified.

3.1.4 Perinatal Equity and Anti-Discrimination Programme (PEADP)

The Trust continues to participate in the PEADP in partnership with the NHS Race and Health Observatory, supporting delivery of the national maternity equity agenda and NHS England's 10-Point Action Plan. This work focuses on reducing inequalities in maternity outcomes and experiences, strengthening anti-racist practice, and ensuring women's voices inform service improvement. To date, 35 senior maternity, neonatal and corporate leaders have completed PEADP development sessions to strengthen leadership accountability and capability to identify and address inequity, discrimination and bias. A Maternity Health Equity and Anti-Racism Action Plan has been developed (Appendix 11), aligned to the Being Heard Four-Point Action Plan, and is being progressed in partnership with the LMNS and MNVP. The accompanying appendix sets out the Trust's detailed action plan and monitoring framework. Progress will be reviewed through maternity governance arrangements and the Being Heard Four-Point Action Plan, ensuring that women and families are heard and actively involved in shaping services, inequalities in outcomes addressed, staff are supported to challenge racism, bias and discrimination, learning is translated into measurable and sustainable improvement. Delivery will be monitored through routine reporting to the Maternity Governance Committee, with oversight of actions, milestones and impact measures. Outcome, experience and safety data will continue to be reviewed by ethnicity and deprivation to provide assurance that actions are contributing to reduced inequalities and improved maternity outcomes. This will be finalised in Nov as part of PEADP's action learning set. Key achievements include:

- Leadership development completed for 35 senior leaders.
- Equity embedded within maternity governance, quality and safety review processes.
- Review of incidents, complaints, patient feedback, birth reflections and mortality reviews through an equity lens.
- Development of a sustainable anti-racism education programme from 2027.
- Creation of a six-priority action plan focused on equitable clinical pathways, risk assessment, pain management, personalised care and informed consent.

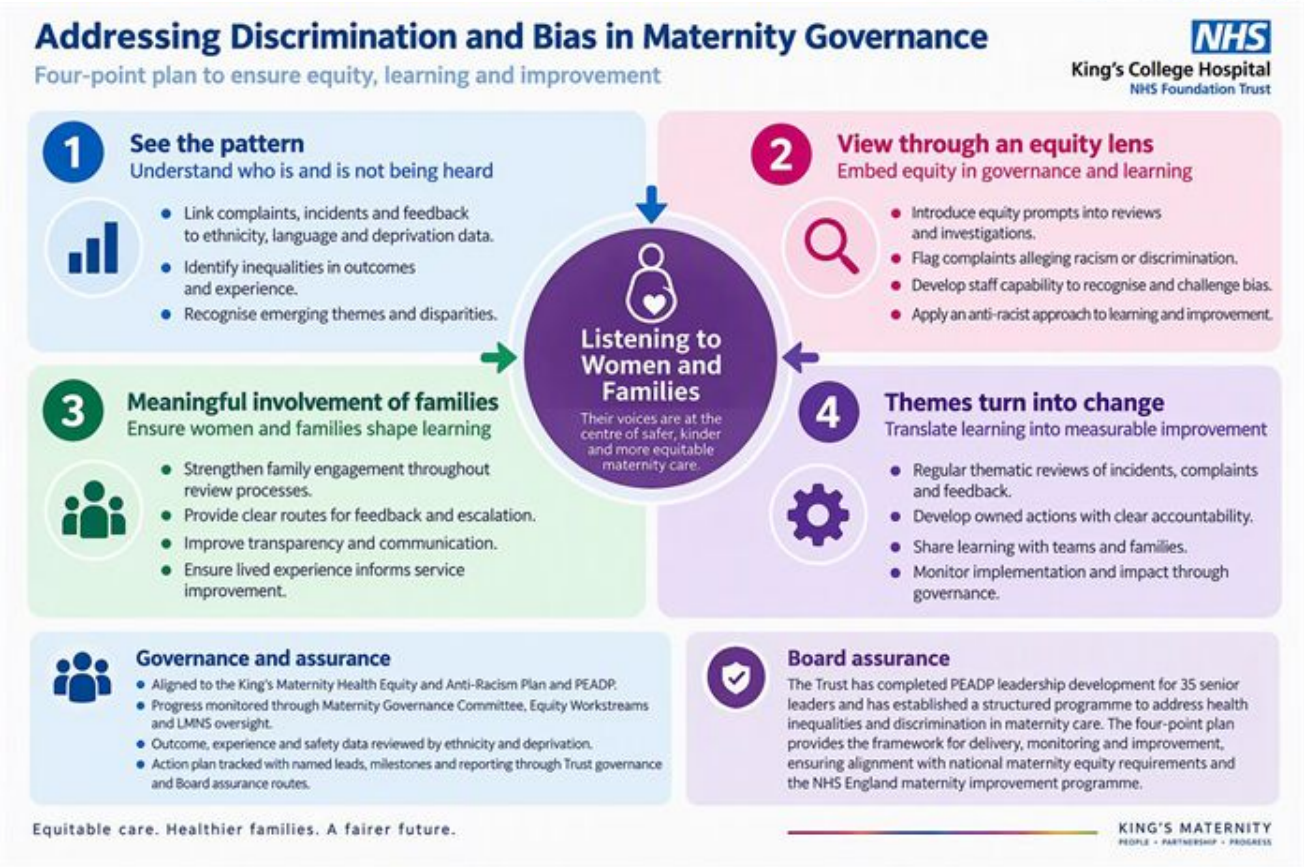
3.2 CQC Maternity Improvement Plan Update (October 2026)

Significant progress has been made against the CQC Maternity Improvement Plan, with 40 of 45 actions (89%) completed, one action in progress and four actions requiring an agreed OCB extension to demonstrate sustained compliance and embed improvements. Actions relating to patient safety, governance and workforce have largely been completed and incorporated into routine operational and governance processes. Within the Safe domain, improvements have been evidenced across triage, fetal monitoring, VTE compliance, safeguarding, medicines management, equipment assurance and guideline compliance. Clinical standards continue to improve, supported by strong fetal monitoring audit results, enhanced risk assessment compliance and sustained VTE performance. Appraisal compliance has also achieved the Trust target. Telephone Assessment Line (TAL) assurance remains the principal area requiring further evidence. While the Trust remains compliant with the RCOG requirement for 24/7 access to maternity triage services, there is currently no nationally mandated standard for TAL provision. The Trust is working closely with the LMNS to support development of a SEL wide Triage assessment model and implementation of a digital telephony solution. In parallel, maternity triage is being reviewed as part of the national maternity 10-Point Action Plan, with a national standard anticipated within the next 12 months. The Trust has completed the required benchmarking exercise, with national submission due by December 2026. Within the Well-Led domain, governance arrangements continue to strengthen through CNST assurance, leadership visibility, safety champion programmes, Freedom to Speak Up engagement, Professional Midwifery Advocate support and structured governance reviews. Workforce metrics continue to improve, although the focus now shifts towards demonstrating sustainability and evidencing that improvements remain embedded over time. The service continues to meet regularly with the Care Quality Commission (CQC) to review progress, provide evidence of improvement and receive external oversight and challenge regarding delivery of the improvement programme. This ongoing engagement provides additional assurance that actions are being sustained and that improvements remain embedded within everyday practice. The four actions requiring OCB extension relate to:

- Telephone Assessment Line assurance and implementation of the Netcall solution.
- BSOTS assurance and evidence of sustained triage compliance.
- Equipment monitoring and audit compliance.
- Documentation and risk assessment assurance.

3.3 Maternity Incentive Scheme (MIS) Year 8

The Trust remains on track to achieve full compliance requirements by the end of Nov 2026. Progress against all safety actions is detailed in Appendix 12, which demonstrates delivery of the required evidence and ongoing monitoring arrangements. Subject to completion of final assurance processes, the Trust intends to submit its declaration of compliance by March 2027. Under the MIS Year 8 requirements, organisations are required to provide assurance that all safety actions have been met and sustained. The final submission requires review and sign-off through Trust governance processes, with assurance provided by the Integrated Care Board (ICB) as part of the regional and national validation process.



4.0 Women's Health Research

The maternity and gynaecology research portfolio continues to expand, with active participation in national multicentre studies and successful recruitment across several research programmes. Progress demonstrates a strong research culture across both Denmark Hill and PRUH, supporting innovation, evidence-based practice and opportunities for women and families to participate in research. Ongoing Maternity Research Studies include:

Study	Focus	Key Update
AURORA	Evaluation of AI-enabled handheld ultrasound devices to assess fetal growth in pregnancy compared with standard ultrasound.	First participant successfully recruited.
PANDA	Maternity research study (network programme).	DH recognised as Site of the Month for improved data quality and recruitment of over 80 participants.

Study	Focus	Key Update
GILD	National recruitment study.	PRUH received recognition for randomising the 489th participant and achieving 30% of recruitment target.
ICP Study	Maternal and cord blood research study.	Ongoing recruitment supported by maternity clinical teams.

5.0 Appendices List

The following appendices support this report:

- Appendix 1a: Maternity Clinical Outcomes Dashboard - Denmark Hill
- Appendix 1b: Maternity Clinical Outcomes Dashboard - PRUH
- Appendix 2: MNSI Final Report MI-053800 - Telephone Triage and Risk Assessment
- Appendix 3: MNSI Final Report MI-053801 - Assisted Vaginal Birth and Informed Consent
- Appendix 4: MNSI Final Report MI-059698 - Ambulance Service Communication and Transfer of Care
- Appendix 5: Maternity Outcome Signal System (MOSS) MDT Exercise Report and Learning
- Appendix 6: Perinatal Mortality Review Tool (PMRT) Assurance Report and SBLCBv3 Review
- Appendix 7: Neonatal Operational Delivery Network (ODN) Benchmarking Dashboard
- Appendix 8: Health Equity, Ethnicity and Deprivation Dashboard
- Appendix 9: High-Quality Care Dashboard (Patient Experience, FFT, PALS and Complaints)
- Appendix 10: NHS England Maternity and Neonatal 10-Point Action Plan Self-Assessment and Improvement Plan
- Appendix 11: Maternity Health Equity and Anti-Racism Action Plan (PEADP)
- Appendix 12: Maternity Incentive Scheme (MIS) Year 8 Compliance and Evidence

Annex 1: Critical safety check

The **critical safety check** is a rapid, structured review of intrapartum care operations led by the perinatal leadership team, co-produced with staff working in these areas and approved by an accountable executive member of the Trust Board (see responsibilities below). It is not designed to replace comprehensive audits, investigations or case reviews.

Objective: To conclude whether an intrapartum service has a safety issue that needs to be addressed.

Areas of focus: Improvement timelines from known safety themes, leadership and culture, time-limited safety care pathways, risk assessment and escalation processes and safe staffing.

Responsibilities: Completed by the perinatal leadership team and approved by an accountable Trust Board executive (i.e. Chief Nurse, Chief Medical Officer or executive Trust Board Safety Champion) within 8 working days from a signal (including external peer review in level 2 signals). If a signal is received over the weekend, the timeline starts from the next working day. The check should be agreed/approved face to face or virtually where possible.

After completion and approval: Share with ICBs and regions for oversight and support where a safety issue is identified. ICBs/regions can stand down if a check does not conclude there is a safety issue.

Assumed knowledge/processes in place: The perinatal leadership team should have the below information available prior to the critical safety check:

Publication reference: PRN02098_ii

<table>
<tr><th>Knowledge/process</th><th>Include summary or refer to relevant documents for the attention of accountable Trust Board executives</th></tr>
<tr><td>Have an early understanding of the causes of death for events over the past 3 months</td><td>
<table>
<tr><th>Date</th><th>Type of loss</th><th>MRN</th><th>Additional info</th></tr>
<tr><td>15/7/2026</td><td>NND 37/40</td><td>40505111</td><td>CDH – Had FETO at HBR @ 24/40. No care issues identified</td></tr>
<tr><td>08/9/2026</td><td>NND 38/40</td><td>40559059</td><td>CDH, Day 1 – Had FETO at HBR @ 24/40. No care issues identified</td></tr>
<tr><td>20/9/2026</td><td>NND 37/40</td><td>35498349</td><td>Day 11, cardiac abnormalities and fetal hydrops. Suspicion of syndrome at nuchal scan. Nuchal fold 6mm Declined antenatal genetic testing. Genetic testing has subsequently found the baby to have Noonan syndrome</td></tr>
</table>
</td></tr>
<tr><td>Commissioned formal investigations where appropriate</td><td>All cases reported to MBRRACE, via SPEN
For PMRT review, starting from November
No cases of neonatal deaths met criteria for MNSI or PSII</td></tr>
<tr><td>Involved families in the investigation process where appropriate and listened to their insights and feedback</td><td>All families are contacted by the bereavement team and maternity patient safety to collect any questions and feedback before the PMRT and CDR reviews.
Almost all families have contributed to the PMRT reviews this year</td></tr>
<tr><td>Emerging and known safety themes with any timelines of action plans to address</td><td>PMRT – No identified themes. Most deaths have occurred due to extreme prematurity or congenital abnormality</td></tr>
</table>

Advice for completing the check:

- Do not share patient identifiable information on this form with anyone who does not have a lawful basis to see it – redact first.
- Section 2 does not need to be completed if the service has completed this in relation to a previous signal in the past 3 months.

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- The completed and approved check needs to be shared with ICBs and regions within 8 working days even if not all questions can be completed.
- Italicised text should be deleted before completing.

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Section 1 – MOSS pre-completion check

This section provides accountable Trust Board executives with additional context that may explain the signal, whether the pre-requisites for implementing MOSS are in place and if there was a recent signal which allows perinatal leadership teams to skip section 2.

MOSS pre-completion check		
Questions	**Answer**	
	Yes/No	**Description**
Have you identified an issue with the data displayed by MOSS (for example, the event was not at term or care/delivery did not take place at the site displayed)?	Yes	False MOSS in October 2026 which was rectified. This report is treated as a MOSS drill in line with the Maternity Incentive Scheme year 8, considering that the trust has not received any validated MOSS alert to date.
Is the trust site that signalled a NICU plus cardiac surgery centre?	No	
Were any of the events in MOSS that occurred over the last 3 months unavoidable? Please state why.	No	A rapid review of the three cases was undertaken. No care issues were identified. All three babies had congenital abnormalities with poor prognosis. Cases will be presented for PMRT in November.
Are the pre-requisites for implementing MOSS in place (page 5-6 of Standard Operating Procedures)?	Yes	
Have you completed a critical safety check previously for a signal that has occurred within the last 3 months?	No	*If 'yes', go to section 3 and do not complete section 2 as this is likely to repeat a similar response.*

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Section 2 – Are key safety elements of your intrapartum service in place?

Please complete this section focussing on the activity of your intrapartum service **over the last 3 months**. This section does not need to be completed if you have completed it previously for a signal that occurred within the last 3 months.

Safety culture - conversations with staff and service users		
Questions	**Answer**	
	Yes/No	**Brief description with any action taken** (bulleted only)
1. Are the perinatal leadership team, accountable Trust Board executives and staff (on labour ward, triage and birth centre) working well together?	Yes, this is working well	• Fetal monitoring reviews weekly, includes risk assessment and partogram • Perinatal meeting weekly • ATAIN review weekly • Rapid reviews for ad hoc cases • Maternity and Neonatal safety walkaround (Obstetric, Neonatal, MNVP • Implementation of PSIRF, with weekly panels
2. How do you measure your leadership culture and how frequently is this done? What actions have you taken?		NHS Staff Survey (annually), Freedom to Speak Up data and workforce indicators (monthly), staff pulse surveys (quarterly), staff engagement events (monthly), and Executive and Non-Executive Maternity Safety Champion walkarounds (monthly). Culture, workforce and safety metrics are reviewed monthly through the Women's Health Care Group governance structure and reported quarterly to the Board through the Maternity and Neonatal Assurance Report, aligned to the Perinatal Quality Surveillance Model.
3. What have service users/MNVP Leads fed back that they feel could be improved?		positive experiences of care and staff support. Opportunities for improvement included better communication during delays, earlier information on birth and postnatal planning, improved education on the longer-term implications of hypertension, and clearer signage and wayfinding. Actions have been incorporated into local service improvement plans.

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4. From your walkarounds and conversations with staff:		
a) What do staff feel is working well in providing safe care in labour and birth?		Staff identified strong teamwork, compassionate patient-centred care, feeling trusted in their roles, and a shared commitment to safety as key strengths in supporting safe care during labour and birth. Staff remain highly motivated and report that patient care is the organisation's top priority.
b) What do staff feel could be improved to achieve better outcomes?		Caesarean section capacity
Are you achieving safety timelines for these care pathways?		
5. Is the maternity service achieving a triage of new cases within 15 minutes of presentation?	Yes - plans are already in place to maintain/improve this	Compliance and improvement actions are monitored through the CQC improvement plan, with executive oversight and monthly performance review. The national maternity triage benchmarking assessment has been completed, and the service is developing a costed improvement plan aligned to the national triage specifications (deadline dec 2026). There is no evidence of associated adverse clinical outcomes, and ongoing monitoring has not identified any patient safety concerns arising from current triage performance.
6. Is the maternity service achieving commencement of induction of labour (IOL) within 6 hours from point of admission for induction (from home or ward)	Yes - plans are already in place to maintain/improve this	Inductions of labour are discussed at twice daily huddles and antenatal ward rounds. All delays are reported and reviewed as part of red flag.
7. Is the maternity service achieving **category 1** caesarean sections as soon as possible and usually within 30 minutes	Yes - plans are already in place	category 1 caesarean section performance is routinely monitored, with 90% of cases achieving the recommended decision-to-delivery interval of 30 minutes.

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of the decision to deliver?	to maintain/improve this	

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8. Is the maternity service achieving **category 2** caesarean sections as soon as possible and usually within 75 minutes of the decision to deliver?	Yes - plans are already in place to maintain/improve this	Category 2 caesarean section performance is achieved within the recommended 75-minute decision-to-delivery interval. Timely delivery is supported through continuous labour ward oversight, multidisciplinary team working, consultant presence, theatre prioritisation processes and twice-daily safety huddles.
Are you achieving regular multi-disciplinary team (MDT) communication of known and/or emerging risk factors on the labour ward?		
9. Are you achieving at least one MDT huddle every day on the labour ward based on NHSI guidance?	Yes - this is already in place	
10. Do your huddles always include a consultant obstetrician, anaesthetist, midwifery co-ordinator and member of the neonatal team?	Yes - this is already in place	
11. Is the maternity service achieving a structured handover process in the labour ward, such as SBAR or an equivalent, that can manage known or emerging risks and involves the MDT?	Yes - this is already in place	
Are your teams carrying out appropriate risk assessment and escalation?		
12. Is the service achieving compliance with element 4 of the current version	Yes - this is	

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of the Saving Babies' Lives Care Bundle?	already in place	
13. Is the service achieving 90% of attendance in each relevant staff group (as per Maternity Incentive Scheme guidance) at: • Fetal monitoring training • Multi-professional maternity emergencies training • Neonatal resuscitation training	Yes - this is already in place	
Is there a stable workforce offering safe and effective care during labour and birth?		
14. Have staff been redeployed or non-clinical midwifery staff (e.g. managers / specialist midwives) utilised to meet minimum **midwifery safe staffing levels** as per your Trust safe staffing policy?	Yes	Staff are safely redeployed in line with the Trust Safe Staffing Policy, ensuring the right staff, with the right skills, are in the right place at the right time. Staffing, activity and acuity are monitored through safety huddles and the Birthrate Plus acuity and dependency tool, reviewed at least every four hours, with escalation and redeployment of appropriately skilled staff undertaken where required to maintain safe care.
15. Have there been **obstetric staffing shortfalls** impacting on safe care delivery?	No	
16. Have there been any **anaesthetic staffing shortfalls** as per RCoA guidance impacting on safe care delivery?	No	

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Section 3 – Is there any additional information that accountable Trust Board executives should pay attention to?

Board attention remains focused on workforce culture and wellbeing, delivery of the CQC improvement plan, maternity triage performance, induction pathway flow and workforce sustainability. Clinical outcomes remain reassuring, with no recurring themes or evidence of systemic safety concerns identified. Ongoing oversight is maintained through maternity governance, learning from reviews and PSIRF investigations, and the Women's Health Care Group strategic improvement programme, which aligns quality, safety, workforce, operational and financial priorities with clear accountability for delivery, whilst ensuring continued focus on health inequalities and national maternity improvement requirements. Ongoing oversight is maintained through maternity governance, learning from reviews and PSIRF investigations, and the Women's Health Care Group strategic review process, which is developing a three-year improvement plan aligned to Trust priorities. This programme focuses on sustaining quality and safety, supporting staff, improving operational performance and delivering financial sustainability, with clear accountability and governance arrangements for delivery.

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Section 4 – Conclusion from this critical safety check

This section is used to summarise the outcome of the critical safety check for accountable Trust Board executives. If more than one safety issue has been identified and these are being dealt with differently, then overall the perinatal leadership team should select the RAG rating which best describes the safety issue(s) with the highest risk.

Question	Answer
How would you summarise the outcome of this critical safety check?	GREEN - No safety issues in our intrapartum service have been identified.

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Section 5 – Recommendation from this critical safety check

It is recommended that the below actions are taken following the relevant conclusion of this check from section 4.

Conclusion	Action(s)	Please select
***GREEN** – No safety issues in our intrapartum service have been identified.*	• No action is required other than sharing the completed check with ICB (executive with responsibility for maternity and neonatal services and Director of Quality) and regional colleagues (Regional Chief Nurse, Midwife, Obstetrician and Medical Director) for awareness. **The critical safety check provides assurance that maternity services are operating safely, with no systemic safety concerns or recurring themes identified. Improvement actions are in place where required and are subject to ongoing governance and executive oversight.**	☒
***GREEN/AMBER** - There is at least one known safety issue in our intrapartum service, with a plan of action already in place and progressing as planned.*	• The completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note on page 6 of Standard Operating Procedures). • The perinatal leadership team should continue to report to the Trust Board on plans as required. • The Trust Board should continue to provide oversight and active engagement to ensure plans progress and are completed at the required speed.	☐
***AMBER** - There is at least one known safety issue in our intrapartum service, with a plan of action already in place but it is not progressing as planned.*	• The completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note on page 6 of Standard Operating Procedures). • An urgent discussion between the perinatal leadership team and the Trust Board is required within 4 weeks with an agreement get plans back on track within 12 weeks. • The Trust Board should continue to provide oversight and active engagement to ensure plans progress and are completed at the required speed.	☐
***AMBER/RED** - There is at least one known safety issue in our intrapartum service, but a plan of action is not in place.*	• The completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note on page 6 of Standard Operating Procedures). • An urgent discussion between the perinatal leadership team and the Trust Board is required within 4 weeks with an agreement on a plan within 8 weeks. • The Trust Board should continue to provide oversight and active engagement to ensure plans are made and make progress at the required speed.	☐

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***RED** – At least one new safety issue in our intrapartum service has been identified which requires a plan of action.*	• The completed check should be shared with ICB colleagues for oversight and regions for awareness, or regional colleagues only if oversight responsibilities have been transferred (see important note on page 6 of Standard Operating Procedures). • An urgent discussion between the perinatal leadership team and the Trust Board is required within 4 weeks with an agreement on a plan within 8 weeks. • The Trust Board should continue to provide oversight and active engagement to ensure plans are made and make progress at the required speed.	☐

DATE: 13th October 2026

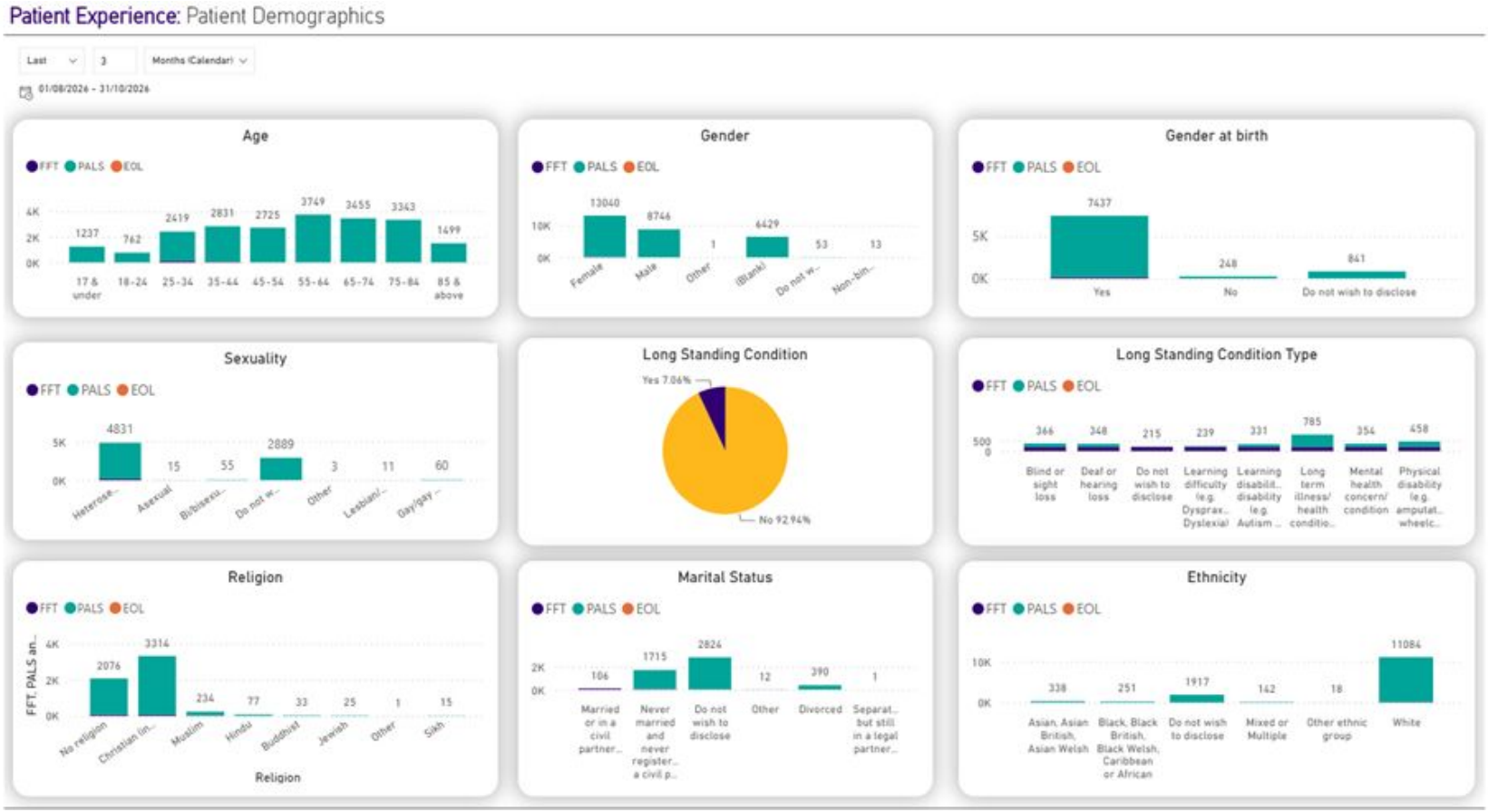
AGREED BY MEMBERS OF THE PERINATAL LEADERSHIP TEAM AND TRUST BOARD EXECUTIVE(S) AS FOLLOWS:

NAME(S)	ROLE(S)
Mitra Bakhtiari	Director of Midwifery
Lisa Long	Clinical Director
Ravi Bhat	Clinical neonatal lead
Sian Williams	General Manager

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Appendix 12: Maternity patient experience Dashboard Aug-Oct 2026



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Appendix 12: Maternity patient experience Dashboard Aug-Oct 2026

Patient Experience: Complaints and Patient Advice and Liaison Service

Last 3 Months (Calendar) 01/08/2026 - 31/10/2026 | Specialty: All | Site: All

Complaints

	Aug-2026	Sep-2026	Oct-2026
Complaints Opened	14	16	
Complaints Closed	15	25	

	Aug-2026	Sep-2026	Oct-2026
Informals Opened		1	
Informals Closed			

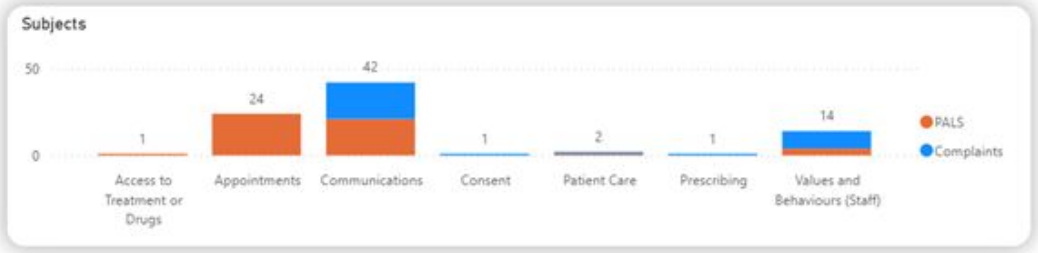
Patient Advice and Liaison Service

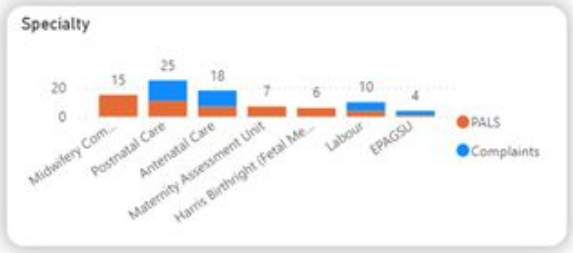
	Aug-2026	Sep-2026	Oct-2026
No. PALS contacts	26	30	
Concerns	8	13	
MyChart contacts	0	0	
Compliments recieved	1	4	











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Appendix 12: Maternity patient experience Dashboard Aug-Oct 2026

Patient Experience: Community Postnatal



Friends and Family Test

Site	Aug-2026	Sep-2026	Oct-2026
Denmark Hill		50.0	
Total		50.0	

Site	Aug-2026	Sep-2026	Oct-2026
Denmark Hill		2	
Total		2	





Additional survey questions -Average score out of 5 for selected period

Involved in making decisions	Information and explanations	Respect and dignity
3.00	2.50	3.00

qrCode	
FFT Source %	100%
FFT Source	2

Patient Advice and Liaison Service

	Aug-2026	Sep-2026	Oct-2026
No. PALS contacts	8	4	
Concerns raised	1	2	
Compliments recieved	1	0	

King's College Hospital NHS
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Appendix 12: Maternity patient experience Dashboard Aug-Oct 2026

Patient Experience: Labour and Postnatal Ward

Last 3 Months (Calendar)
01/08/2026 - 31/10/2026

Site: All

Department: All

86 Responses

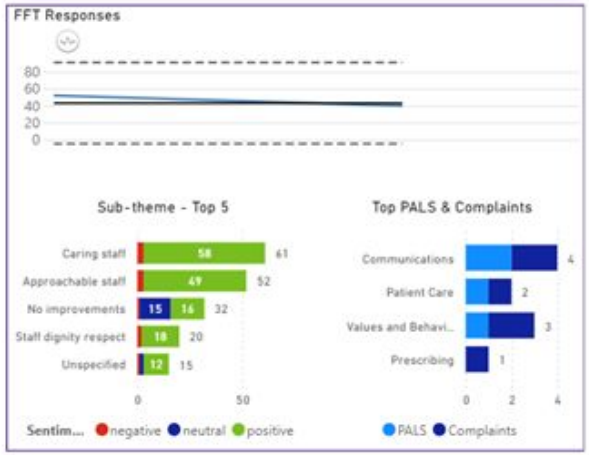
95.3 FFT Score

Friends and Family Test

Site	Aug-2026	Sep-2026	Oct-2026
Denmark Hill	95.7	88.2	
Princess Royal University Hospital	100.0	100.0	
Total	96.2	94.1	



Site	Aug-2026	Sep-2026	Oct-2026
Denmark Hill	46	17	
Princess Royal University Hospital	6	17	
Total	52	34	



Additional survey questions -Average score out of 5 for selected period

Involved in making decisions	Information and explanations	Pain relief - support in choice	Respect and dignity
4.81	4.78	4.69	4.84

	kiosk	qrCode	website
FFT Source %	73%	1%	26%
FFT Source	63	1	22

Patient Advice and Liaison Service

	Aug-2026	Sep-2026	Oct-2026
No. PALS contacts	1	6	
Concerns raised	1	3	
Compliments recieved	0	3	

4

King's College Hospital NHS
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Appendix 12: Maternity patient experience Dashboard Aug-Oct 2026

Patient Experience: Antenatal

Last 3 Months (Calendar)
01/08/2026 - 31/10/2026

Site: Multiple selections

Department: All

109 Responses

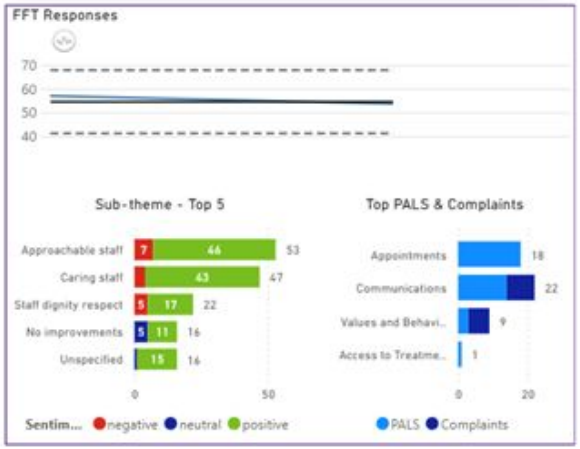
89.9 FFT Score

Friends and Family Test

Site	Aug-2026	Sep-2026	Oct-2026
Denmark Hill	91.1	88.1	
Orpington Hospital	100.0	100.0	
Princess Royal University Hospital		50.0	
Total	91.2	88.5	



Site	Aug-2026	Sep-2026	Oct-2026
Denmark Hill	56	42	
Orpington Hospital	1	8	
Princess Royal University Hospital		2	
Total	57	52	



Additional survey questions -Average score out of 5 for selected period

Involved in making decisions	Information and explanations	Respect and dignity
4.45	4.50	4.69

	kiosk	qrCode	website
FFT Source %	41%	15%	44%
FFT Source	45	16	48

Patient Advice and Liaison Service

	Aug-2026	Sep-2026	Oct-2026
No. PALS contacts	17	20	
Concerns raised	6	8	
Compliments recieved	0	1	

King's College Hospital NHS
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Appendix 12: Maternity patient experience Dashboard Aug-Oct 2026



King's Maternity Health Equity and Anti-Racism Plan

October 2026

Purpose and scope

This plan covers what King's maternity itself must do to reduce inequity in access, experience and outcomes. It leaves the Trust and the LMNS everything they already own.

In scope: the care women, birthing people and babies receive at Denmark Hill, the PRUH and in the community. That means clinical processes, experience of care, outcomes, service user voice and maternity governance.

Out of scope by design:

- Workforce race equity (recruitment, progression, disciplinary processes, staff experience). The Trust Culture and People Strategy leads; maternity delivers it locally and supplies data.
- System-wide work (community engagement, pre-pregnancy health, cross-trust data definitions). The South East London LMNS leads; maternity contributes and adopts.

What to call it. A delivery plan is the best fit. The aims already exist at national, LMNS and Trust level, so this document's job is local delivery, not a new direction.

Option	What it signals	Fit
Delivery plan	How maternity delivers commitments made elsewhere, plus its own gaps	Best fit; avoids a fourth strategy on the same subject
Action plan	A list of tasks with owners and dates	Accurate, but undersells the aims and governance
Strategy	A new vision and multi-year direction	Risks duplicating the Trust and LMNS documents

A 2026 to 2028 timeframe would end alongside the LMNS action plan, with a review once the National Action Plan is published in December 2026.

What already exists

Five levels above the service have already made commitments on maternity equity. King's maternity should adopt or contribute to these, not rewrite them.

Level	Source	What it already commits to	What King's maternity does with it
National	Amos final report, recommendation 5 (June 2026)	Racism, discrimination and inequality treated as critical safety issues by trusts within 12 months; better recording of inequalities data; evaluation of anti-racism training	Show how King's meets it by June 2027
National	NHS England 10-point plan (July 2026)	PEADP rolled out by end of 2026; regular review and action on inequalities dashboards; Maternal Care Bundle by March 2027; monthly outcomes and experience data at public board; triage audit; Martha's Rule	Adopt as written; no local equivalents
National	National Action Plan (due December 2026)	Not yet published	Review this plan when it lands
London	CapitalMidwife Anti-Racism Framework	Nine workforce initiatives with bronze to gold awards	Workforce side; routes through the Trust strategy
Borough	Southwark Maternity Commission (2024)	Five-year plan with recommendations to trusts on leadership against racism, fairness of services and listening to families	Cross-reference actions; report once, not twice
System	SEL LMNS strategy and action plan 2023 to 2028	Six workstreams, set out below	Contribute and adopt

Level	Source	What it already commits to	What King's maternity does with it
Trust	Culture and People Strategy	Fair recruitment and people processes; career development and senior representation; leadership accountability; bullying, harassment and psychological safety; data and staff voice; divisional ownership	Deliver as a division; no separate workforce actions here

The LMNS action plan, workstream by workstream

The LMNS leads most of the system-wide enabling work. What is left to King's is how care is delivered and experienced inside its own service.

LMNS workstream	LMNS already leads	Left to King's maternity
Engaging with communities	Five commissioned community organisations; faith and voluntary sector engagement; MNVP training, support and remuneration	Acting on what King's own MNVP and listening routes report
Information and access	Care plans translated into the 10 most spoken languages; BRAINS decision tool; Birth Choice Guides; interpreter best practice resources	Checking these are used at King's, and by whom
Data	LMNS dashboard at trust and borough level; ethnicity recording quality; yearly thematic analysis of engagement; staff resource on talking about race and difference	Service-level outcome, incident and experience data by ethnicity and deprivation, and acting on it

LMNS workstream	LMNS already leads	Left to King's maternity
Choice and personalisation	Standardised care and support plan; Friends and Family Test question on care plans; disability passport (2025 to 2026)	Equity in who is offered and supported in which choices at King's
Care pathways	Maternal Medicine Network measures by ethnicity and deprivation; trauma-informed care training; pre-conception plan; compassionate charging policy	Equity inside King's own clinical processes: triage, escalation, risk assessment, pain relief, consent
Staff	Workforce Race Equality Standard and staff survey monitoring; Anti-Racism Framework adoption; standardised culturally sensitive training	Nothing in this plan; reported through the Trust strategy

The LMNS plan was due for review in January 2025, so the status of each item needs checking with the LMNS before this map is relied on.

Already under way in King's maternity

- PEADP sessions, delivered with the NHS Race and Health Observatory and Aqua
- Patient experience data suite: complaints thematic analysis, birth debrief data, Friends and Family Test and PALS representation analysis, journey mapping
- Out-of-guidance birth planning governance forum
- Anti-racism benchmarking in nursing and midwifery education and practice

Where King's maternity adds value

Five gaps sit with the service alone. No national, LMNS or Trust document will close them for King's.

1. **Equity inside clinical processes.** Nobody above the service checks whether triage, escalation, risk assessment, pain relief, consent and choice are applied consistently across groups at King's.
2. **Service-level data that leads to action.** The LMNS dashboard works at trust and borough level. King's needs its own outcome, incident and experience data by ethnicity and deprivation, discussed where decisions are made.
3. **Racism and discrimination as a safety issue.** The LMNS strategy frames the problem as equity and access. Amos now asks trusts to treat racism and discrimination as safety issues, which means building them into incident, complaint and learning processes.

4. **Being listened to.** The LMNS leads community engagement. Only King's can change whether a woman who raises a concern on its wards is heard and acted on.
5. **Ownership across the whole team.** PEADP builds understanding among leaders. The service has to turn that into objectives held by every area, not by one role or programme.

Aims

Six aims mirror the structure of the Trust workforce aims, applied to care instead of employment. The plan uses outcomes data, patient experience measures and lived experience evidence to tackle inequity in access, experience and outcomes for women, birthing people and babies.

1. **Fair clinical processes.** Strengthen fairness and consistency in core clinical processes, including risk assessment, triage, escalation, pain relief and informed consent.
2. **Access and personalised care.** Improve access, early booking and personalised care for the communities experiencing the poorest outcomes.
3. **Leadership and accountability.** Strengthen leadership expectations, behaviours and accountability for equitable care, treating equity as a safety and quality issue within maternity governance.
4. **Discrimination and being heard.** Address discrimination, bias and the experience of not being listened to, so that families feel safe to raise concerns and staff feel safe to challenge inequitable care.
5. **Data and service user voice.** Use outcome, incident and experience data by ethnicity and deprivation, alongside service user voice, to identify hotspots and target improvement.
6. **Shared ownership.** Strengthen ownership across all maternity and neonatal teams, so that health equity is not the responsibility of one lead or programme.

Workforce race equity within maternity is guided by the Trust Culture and People Strategy. This plan focuses on health inequalities, recognising that equitable staff experience and equitable care are closely linked.

Action plan

Fifteen proposed actions, each tied to an aim and to the external commitment it delivers. Dates are proposals to test; owners are still to be assigned.

Aim	Action	Measure	Proposed by	Delivers
1	Audit triage waits, escalation response and time to pain relief by ethnicity, deprivation and	Baseline and size of any gap between groups	Mar 2027	Amos rec 5; NHS England triage audit

Aim	Action	Measure	Proposed by	Delivers
	interpreter need, at both sites			
1	Review a sample of notes for consistency of risk assessment and consent discussions across groups	Share of notes meeting the standard, by group	Jun 2027	Amos rec 5
1	Run one improvement project on the largest gap found, using the Observatory's anti-racism improvement method	Change in the gap against baseline	Dec 2027	PEADP
2	Report booking by 10 weeks by ethnicity, deprivation and language; target outreach with LMNS community partners where it is lowest	Gap in share booked by 10 weeks	Mar 2027	LMNS strategy
2	Audit who is offered and takes up place of birth options, personalised care plans and translated materials	Offer and uptake rates by group	Jun 2027	LMNS choice and personalisation
2	Audit professional interpreter use at booking, consent,	Share of women needing an interpreter who	Mar 2027	LMNS information and access

Aim	Action	Measure	Proposed by	Delivers
	labour and discharge	had one at each point		
3	Make equity a standing item in maternity governance and in the perinatal report to board, with data by ethnicity and deprivation	Item present at every meeting from start date	Jan 2027	NHS England 10-point plan; Amos rec 5
3	Name midwifery, obstetric and neonatal leads jointly accountable for this plan	Leads named and in post	Dec 2026	Amos rec 5
4	Add prompts on ethnicity, language and possible discrimination to incident review, complaint handling and learning responses	Share of reviews with the prompts completed	Mar 2027	Amos rec 5; NHS England 10-point plan
4	Monitor who uses Martha's Rule and other routes for raising concerns, by ethnicity and language	Use by group against birth population	From roll-out	NHS England 10-point plan
5	Agree a core equity dataset for outcomes and experience, with definitions aligned	Dataset agreed and first report produced	Feb 2027	NHS England 10-point plan; LMNS data

Aim	Action	Measure	Proposed by	Delivers
	to the LMNS dashboard			
5	Raise completeness of ethnicity recording at booking	Share of bookings with a valid ethnicity code	Mar 2027	Amos rec 5; LMNS data
5	Compare who gives feedback through the Friends and Family Test, PALS and complaints with who gives birth at King's; reach under-heard groups with the MNVP	Representation gap by group	Apr 2027	Southwark Maternity Commission; LMNS engagement
6	Give each clinical area one equity objective drawn from its own data	Areas with an objective and a named lead	Apr 2027	Amos rec 5
6	Build equity content into existing mandatory training using LMNS culturally sensitive training, not a new course	Share of staff trained	2027/28 training plan	LMNS staff workstream; PEADP

Three things are deliberately absent: workforce actions (Trust strategy), community engagement programmes (LMNS) and new translated materials or decision tools (LMNS).

Leadership and responsibility

Accountability sits with the maternity leadership team, and delivery sits with existing senior roles. The consultant midwife leads the programme but does not own every action.

Role	Holds	In practice
Chief Nurse and Medical Director	Board accountability	Receive the monthly equity data; resolve resourcing; joint accountability as set out in the NHS England 10-point plan
Director of Midwifery, Clinical Director and neonatal lead	Joint accountability for this plan	Sign it off; hold aim leads to account through maternity governance
Programme lead (consultant midwife)	Expert leadership and coordination	Sets the method; interprets the data; leads PEADP; coaches aim leads; links to the Trust, LMNS and boroughs
Six aim leads	Delivery of one aim each	Own that aim's actions, measures and reporting
Matron and clinical lead for each area	One equity objective per area	Chosen from the area's own data; reviewed at governance
MNVP chair	Co-production and challenge	Shapes priorities; tests whether changes are felt by families
Trust Culture and People team	Workforce race equity	Leads the workforce side; maternity reports in

Suggested aim leads

Each aim goes to roles that already control the relevant process, so the work sits where decisions are made.

Aim	Suggested lead
1. Fair clinical processes	Labour ward lead obstetrician with the intrapartum matron
2. Access and personalised care	Community matron with the Choice and Personalisation lead
3. Leadership and accountability	Director of Midwifery with the Clinical Director
4. Discrimination and being heard	Maternity governance lead with the patient experience lead
5. Data and service user voice	Digital midwife with the MNVP chair

Aim	Suggested lead
6. Shared ownership	Matrons, with the practice development lead

What changes

Today one consultant midwife holds programme leadership, delivery and reporting, alongside clinical work and other portfolios. Under this model that post keeps programme leadership and hands delivery and reporting to the aim leads.

Programme leadership still needs protected time that the current post cannot give. A separate business case will set out the options, including a consultant midwife post with half its time protected to lead this plan.

Governance and measurement

The plan reports once, through maternity governance, and shares the same data upwards to the Trust and the LMNS.

Audience	What it receives	How often
Maternity governance	Progress against all actions and the core equity dataset	Monthly
Trust board	Equity section of the perinatal report	Monthly, in line with the NHS England 10-point plan
Trust Culture and People governance	Maternity's delivery of the workforce aims	To the Trust's cycle
LMNS quality surveillance group	The same equity data, in LMNS definitions	Six-weekly
MNVP	Summary of what was heard and what changed	Twice a year

Headline measures. Six measures, each reported by ethnicity and deprivation: booking by 10 weeks, postpartum haemorrhage, severe perineal tears, stillbirth and neonatal death, professional interpreter use, and experience of being listened to.

Review points. January 2027, after the National Action Plan; June 2027, the 12-month mark for Amos recommendation 5; then yearly to 2028.

To confirm before circulation

This draft rests on public documents and the Trust aims shared so far. These points need King's own knowledge.

- ☐ What the Culture and People Strategy commits maternity to, its timeline, and how the division reports into it
- ☐ Which LMNS action plan items are complete, in progress or dropped since the January 2025 review
- ☐ King's current Anti-Racism Framework award status and where it is governed
- ☐ Current status of the four pieces of work listed as under way
- ☐ What the maternity record can already report by ethnicity and deprivation, and what needs building
- ☐ Trust obligations under the Southwark Maternity Commission, and any equivalents for Lambeth and Bromley
- ☐ An owner for each action, and the three jointly accountable leads
- ☐ Exact committee names and reporting dates
- ☐ How the MNVP will co-produce the plan before sign-off
- ☐ Final name and timeframe

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 20

BOARD/COMMITTEE REPORT COVER PAPER

Report to:	Trust Board
Date of meeting:	17 November 2026
Subject:	Infection Prevention & Control Annual Report 2025-2026 & IPC BAF June 2026
Author(s):	Ashley Flores, DIPC
Sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery
History:	KE
Status:	Final report

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

Purpose
This Infection Prevention, Control & Antibiotic Stewardship Annual Report is submitted to King's Exec by the Infection Prevention and Control (IPC) Team. This report summarises the annual achievements, developments, performance and standards by the Trust and its staff in key areas and against key objectives, relating to infection prevention and control and prudent antibiotic prescribing.

Recommendations:
The Trust Board is asked to note this report for evidence of assurance to meet the Code of Practice on the Prevention and Control of Infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Strategy alignment

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

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

Strategic risk - Link to Board Assurance Framework	Infection Prevention and Control links to patient safety and the IPC BAF. The IPC strategy and annual work programme informs the Trust overall strategy for patient safety in relation to IPC.
King's Improvement Impact (KIM):	The Infection Prevention & Control team uses quality improvement methodology to coordinate and oversee improvement work related to specific infection control priorities.
Quality Impact	Good Infection Prevention and Control practices are key to providing safe, high-quality care to patients at King's.
Health Equity Impact	The content of this report has no implications for equality and diversity, although staff and patient immunisation uptake vary across groups.
Workforce Impact	Consultant microbiologist PA time was reduced during 2025-2026 due to internal promotion and other workforce changes. Recruitment is underway to replace these posts. The Trust IPC and AMS strategy will be reviewed in April 2027 considering the HIS workforce report workforce-report-final.pdf, with a plan to prioritise and strengthen the infection-specialist workforce in line with Trust and NHS long-term priorities.
Research/Innovation Impact	Product trials are complete for innovative products for urinary catheter care and prevention of UTI. A business case will be submitted this financial year.
Digital Impact	The IPC surveillance team remain committed to the production of automated data for healthcare-associated infection reports. Further support from Cogito, Cogstack and BIU is required to achieve this.
Financial Impact	An increase in HCAI has a direct financial impact because of additional antibiotic and screening costs, increased length of stay, increased cleaning costs, and there are operational pressures resulting from outbreaks of infection.
Legal/ regulatory compliance	The Department of Health and Social Care's revised Code of Practice on the Prevention and Control of Infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 remains the basis for the development of the Trust's IPC programme and activity for the Trust, with additional guidance and advice drawn from NICE Guidance, the UK Antimicrobial Resistance Strategy, and other key national publications.
Communications and Engagement	Once approved, the report will be shared at the IPC Committee.
Use of Artificial Intelligence Tools	No AI was used to produce this report.
Committee that will provide relevant oversight Quality & Research Committee	

King's College Hospital NHS
NHS Foundation Trust

King's College Hospital NHS Foundation Trust

Infection Prevention and Control and Antimicrobial Stewardship Annual Report

2025/2026







King's

Infection Prevention and Control & AMS Annual Report 2025-2026 DRAFT v2 Ashley Flores DIPC

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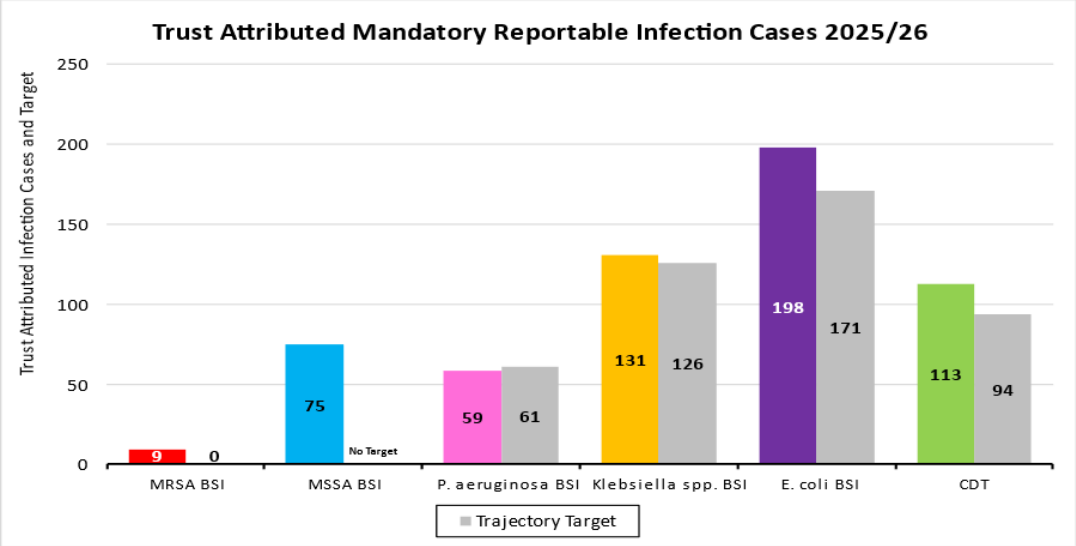
1.0 Executive Summary

This Infection Prevention, Control & Antibiotic Stewardship annual report has been prepared for, and is submitted to, the Kings Trust Board by the Infection Prevention and Control (IPC) Team. This report summarises the annual achievements, developments, performance and standards by the Trust and its staff in key areas and against key objectives, relating to infection prevention and control and prudent antibiotic prescribing.

The Department of Health's (DH) revised Code of Practice for Infection Prevention & Control (Health & Social Care Act, 2008) remains the basis for the development of the Trust's IPC programme and activity for the Trust, with additional guidance from NICE, the UK Antimicrobial Resistance Strategy, and other key national publications.

For 2025-2026, the Trust exceeded the UKHSA healthcare-associated infection (HCAI) targets for Trust attributed *E. coli*, *Klebsiella* spp. and MRSA blood stream infections (BSI), as well as *Clostridioides difficile* infection (CDI). The Trust achieved the target for attributed *P. aeruginosa* BSIs. Compared with the previous financial year, 2025/26 saw a modest reduction in MSSA BSI cases and a pronounced reduction of 22% in *Pseudomonas aeruginosa* BSI cases. In contrast, there was a marginal increase in *Klebsiella spp*. BSI cases whilst *E. coli* and MRSA BSIs rose by over 10%. Kings had the third lowest attributed CDI rate in the Shelford group in financial year 2025/26, was in line with the overall average for MRSA BSI, and the third lowest attributed MSSA BSI rate within the Shelford group.

Figure 1



All healthcare systems are under increasing pressure from rising patient complexity and multi-morbidity, more routine use of immunosuppressants, an ageing population, and the impact of antimicrobial resistance (AMR) and emerging pathogens (HIS, 2026). In November 2025, NHS England published a 'Call to Action' letter to all Trusts and Integrated Care Boards to act urgently to meet antimicrobial resistance (AMR) targets as set out in the National Action Plan.

Trusts were asked to identify three priority areas for AMR improvement and were presented to the Trust Board at the end of the financial year. The priority areas identified for King's are:

- Continue to improve IV to oral switch (IVOS) of antimicrobials
  - Reduce proportion of antibiotics administered IV by 2% per year, with a target reduction of 6% by Q4 2028/29.
  - Reduce the proportion of patients on IV antibiotics who are overdue PO switch by 5% per year, with a target of <15% by Q4 2028/29.
  - Achieve >90% compliance with KPI3 (has an IV to PO switch review taken place) via monthly MEG audits, by Q4 2028/29.

- Increase prescribing of antimicrobials from the 'Access' category (narrow spectrum)
  - Increase the proportion of prescribing from the 'Access' category by 4% per year with a target of 61% or more by Q4 2028/29.

- Reduce proportion of antibiotic courses greater than 5 days
  - Achieve 90% compliance with 5 days duration for community-acquired pneumonia (CAP) and hospital-acquired-pneumonia.

The Healthcare Infection Society (HIS) published an infection-specialist workforce report in May 2026, which outlines the recommendations for the infection-specialist workforce to be empowered to prevent and treat infections more effectively, whether in hospitals, clinics, care homes, or the community. Strengthening this workforce is an investment in safer patient care, better pandemic preparedness, and the nation's health security. The report details the roles of infection specialists across key domains – from antimicrobial stewardship and diagnostics to research and emergency response – and the specific actions required to support the strategic shifts, which includes education and training for all healthcare professionals and expanding the infection-specialist workforce. At King's, consultant microbiologist PA time was reduced during 2025-2026 due to internal promotion and other workforce changes. Recruitment is underway to replace these posts. The Trust IPC and AMS strategy will be reviewed in April 2027 considering the workforce report, with a plan to prioritise and strengthen the infection-specialist workforce in line with Trust and NHS long-term priorities.

Each year the IPC team prepares an annual programme of work which is monitored by the IPC Committee. The purpose of this programme of work is to ensure that a culture of continual improvement is maintained and to reduce avoidable harm to patients and staff from infections. The focus of our activities for the coming year is:

- Peer review of aseptic non-touch technique (ANTT) and implementation of recommendations.
- Priority areas for antimicrobial stewardship improvement.
- Reduction in device-related blood stream infections with urinary catheters and intravenous lines as the source.
- Using the King's Improvement Method for QI projects for a reduction in *Clostridioides difficile* infections, equipment and environmental cleaning, sustainability and non-sterile glove use, and MRSA.

Future challenges

The IPC Team continues to emphasise the fundamental requirement for individual members of staff to take responsibility to embed and maintain, through the guidance and leadership of their designated senior clinical leads, the principles, and practices of IPC as part of their duty of care.

Production of automated IPC data and reports, specifically in relation to healthcare-associated infection mandatory reporting requirements and surgical site infection surveillance. A Task & Finish group is in progress to provide support from BIU, Caboodle, Cogito and Cogstack analysts.

As in previous years, the age and condition of the older parts of the hospital buildings at Denmark Hill, the fabric of the estate, and the associated management of water systems and ventilation, is recognised on the Trust's corporate risk register. Progress has been made this year in the refurbishment programme and planned programme for maintenance of the water system, although there was no decant wad to facilitate the works in 25/26.

2.0 Infection Prevention and Control Arrangements

King's College Hospital NHS Foundation Trust is one of London's largest and busiest teaching trusts with a unique profile of local services and focused tertiary specialties. We have an international reputation for our work in liver disease and transplantation, neurosciences, foetal medicine, cardiac and blood cell cancer, attracting patients from the UK and overseas. The Trust provides a wide range of specialist acute and elective inpatient and outpatient services across several hospital and community sites throughout the Southeast, including Princess Royal University Hospital, Orpington Hospital, Beckenham Beacon, and Queen Mary's Hospital, Sidcup.

The Infection Prevention and Control (IPC) team provides an infection prevention and control service across all King's sites, including the dialysis units and community dental sites. The Team reports to the Board via the Quality, People and Performance Committees.

2.1 The IPC Team comprises of the following:

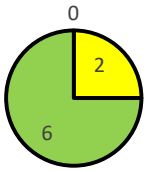
Chief Nurse & Exec DIPC	Tracey Carter
Director Infection Prevention and Control	Ashley Flores
Infection Control Doctors/ Consultant Microbiologists/AMS Leads	Dr Carmel Curtis Dr Martin Brown Dr Mustafa Atta Dr Sumati Srivastava Dr Caoimhe NicFhogartaigh

	Dr Jorge Abarca
Head of Nursing IPC	Rachael Ben Salem
Infection Prevention and Control Matrons	Kayna Zapala Catherine Ganda
IPC Nursing/Practitioner Team	Rashmi Thannikkal Carmelo Giuseppi Del Castillo Sherin Joseph Victoria Adesina Shyrell Downie Urooj Bhatti Kim Ramos (0.5WTE)
Surgical Site Surveillance/IPC Nurses	Genelyn Ildefonzo Querwin Dolores (neuro)
Antimicrobial pharmacists	James Hinton Yetunde Ogunade Elisha Zafar
IPC Surveillance Team	Godfrey James (Lead) Mehmet Pilot Katrina Brooks
Office Manager	Stephanie Sutton
IPC Administrator	Jessica Evers

2.2 Assurance Framework

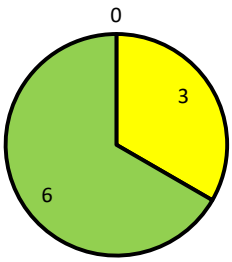
The national Infection Prevention & Control Board Assurance Framework (NHSE 2025) helps providers self-assess compliance with measures set out in the National Infection Prevention and Control Manual (NHSE 2025), the Health and Social Care Act 2008: code of practice on the prevention and control of infections (2022), and other related disease-specific infection prevention and control guidance issued by UKHSA. For King's, overall compliance with each element of the code of practice is summarised below.

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users



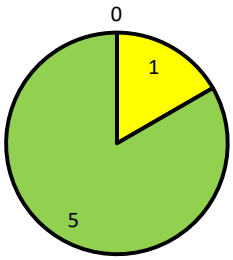
1. Non-compliant 2. Partially compliant 3. Compliant

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections



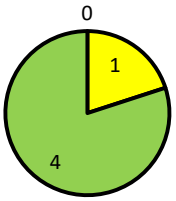
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3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance



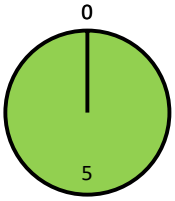
1. Non-compliant 2. Partially compliant 3. Compliant

4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment in a timely fashion.



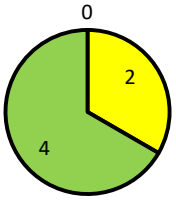
1. Non-compliant 2. Partially compliant 3. Compliant

5. Ensure early identification of individuals 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 others.

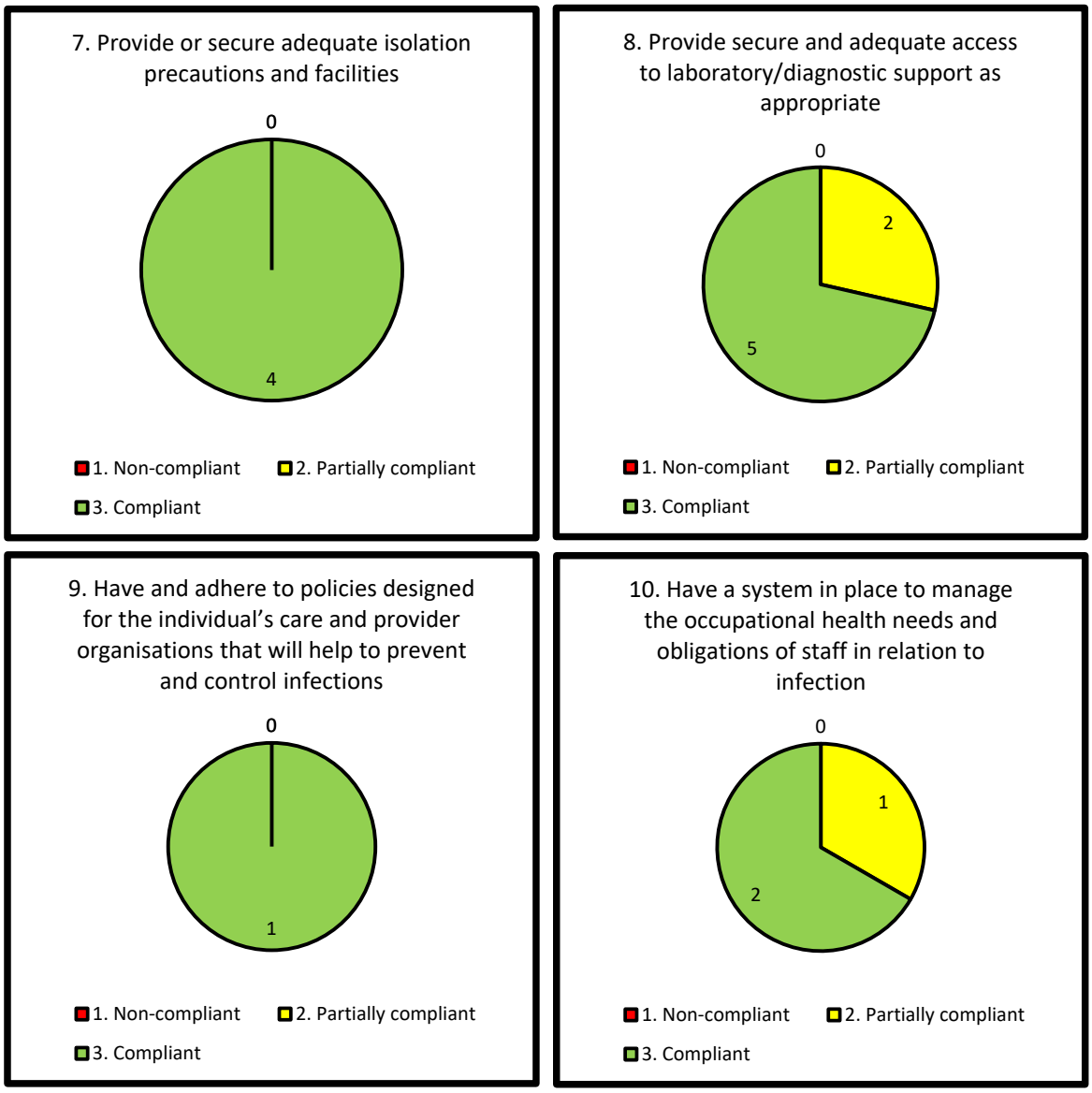


1. Non-compliant 2. Partially compliant 3. Compliant

6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection



1. Non-compliant 2. Partially compliant 3. Compliant



2.2.1 Board of Directors

The Board of Directors are responsible for ensuring the Trust has appropriate Infection Prevention and Control (IPC) systems in place to enable the organisation to deliver its objectives and statutory requirements. The Board seeks assurance of this in the following ways:

- Receiving the IPC Annual Report and Board Assurance Framework.
- Inclusion of IPC KPIs in the Performance Report to the Board.
- Through governance reporting pathways which include the Patient Safety Committee, Integrated Quality Report and the Quality Committee.

2.2.2 Quality Committee

This Committee monitors and reviews the effectiveness of IPC structures and systems to ensure their compliance with the Trust's overarching governance framework and with the requirements of external regulatory bodies.

2.2.3 Infection Prevention and Control Committee

The Infection Prevention and Control Committee is chaired by the DIPC, and reports into the Patient Safety Committee. The main functions include:

- Preventing and reducing the incidence of HCAIs in King's College Hospital NHS Foundation Trust.
- To determine and oversee the implementation of the Infection Prevention and Control Strategy 2024-2027 and Annual Programme of Work.
- Promote best practice and embed a learning culture through the Trust's Infection Prevention and Control management structures.
- To ensure that national, local and Trust targets relating to reduction in rates of specific infections are met and to ensure that KCH stays ahead of the field in identifying and implementing new initiatives to prevent and control infection.

To do this, the committee:

- Monitors compliance with the criteria of the Code of Practice for IPC in the Health and Social Care act.
- Receive reports from Care Groups and relevant Sub Committees.
- Monitors incidence of alert organisms including MRSA blood stream infection, *Clostridioides difficile* infection (CDI), MSSA and gram-negative blood stream infection.
- Acts as an Improvement Group for PSIRF.

2.2.4 Environmental Action Group

The Environmental Action group reviews audit data and environmental reports at PRUH and South Sites and Denmark Hill and ensures that actions are taken to address areas that do not meet with the required standards. The Group includes representation from the IPC team, Capital Estates and Facilities Department, PFI partners as well as senior nursing representation at Head of Nursing and Matron Level. The remit of the Group includes environmental cleaning, equipment cleaning and other environmental issues as required.

2.2.5 Decontamination Committee

The Decontamination Committee is chaired by the DIPC. The Decontamination Committee is a sub-group of the Infection Prevention and Control Committee. The main purpose and function is to ensure that the decontamination of clinical instruments and patient nearside equipment is of a high quality, complies with national and local guidelines and ensures that appropriate actions are taken to address issues where gaps in practice are identified, in collaboration with KFM, Estates and the AE for Decontamination.

2.2.6 Ventilation Committee

The Ventilation Committee is a multidisciplinary group formed to oversee the commissioning, development, maintenance, and validation of ventilation systems. The aim of the VSG is to ensure the safety of all ventilation systems by patients, staff, and visitors, to minimise the risk of infection associated with airborne pathogens or other contaminants. The group is chaired by the Associate Director of Estates.

2.2.7 Antibiotic Steering Group (ASG)

The King's ASG aims to promote rational, safe, effective, and judicious use of antimicrobials within the Trust. This group is chaired by the Antimicrobial Pharmacist and reports to the Infection Prevention and Control Committee. The group fulfils the following functions:

- Oversee the use of antimicrobial agents within the trust.
- Promote high quality, rational and cost-effective prescribing, and use of antimicrobial agents.
- Monitor prescribing patterns, by clinical audit or other means, and expenditure of new and expensive antibiotics across the trust.
- Prioritise areas of prescribing concern and take appropriate action to improve antimicrobial use in these areas as necessary.
- Develop, implement, and maintain evidence-based Trust guidelines and policies relating to antimicrobial use as written guides or on the intranet accessible to all relevant health care professionals.

2.2.8 Water Safety Group (WSG)

The WSG is a multidisciplinary group formed to oversee the commissioning, development, implementation, and review of the Water Safety Plan. The aim of the WSG is to ensure the safety of all water used by patients, staff and visitors, to minimise the risk of infection associated with waterborne pathogens. It provides a forum in which people with a range of competencies can be brought together to share responsibility and take collective ownership for ensuring the identification of water-related hazards, assessment of risks, identification and monitoring of control measures and development of incident protocols.

2.2.9 Infection Control Clinical Leads (ICCL) Group

This group is chaired by the Trust Infection Control Doctor and is composed of consultant representatives from each Clinical Care Group at the DH site and by a single consultant at the PRUH site (there isn't clinical representation from all areas due to lack of funding for ICCL at the PRUH). The main purpose of the group is to inform and feedback any infection control and AMS related issues to the consultant body and wider Care Groups. The group also reviews both surveillance and audit data cross-site, there is also a DIPC report which links nursing and medical messaging and there is feedback from the leads to the IPC team.

3.0 UKHSA Mandatory Alert Organism Surveillance and Reporting

Compared with the previous financial year, 2025/26 saw a modest reduction in C.diff cases and MSSA BSI, and a pronounced reduction of over 10% in P. aeruginosa BSI cases. In contrast, there was a marginal increase in Klebsiella spp. BSI cases whilst E. coli and MRSA

BSIs rose by over 10%. There were no MRSA BSI cases at the PRUH and Orpington, and 9 cases at Denmark Hill.

Figure 2

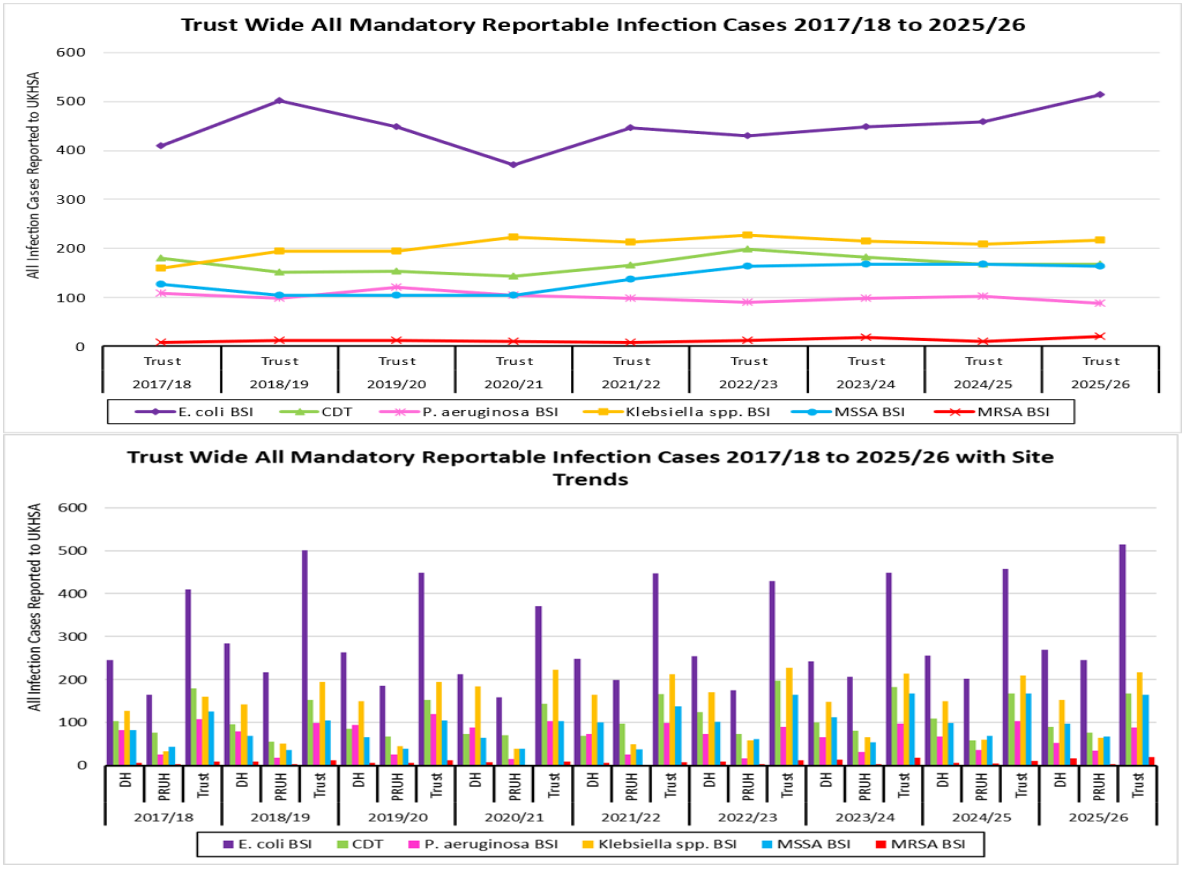
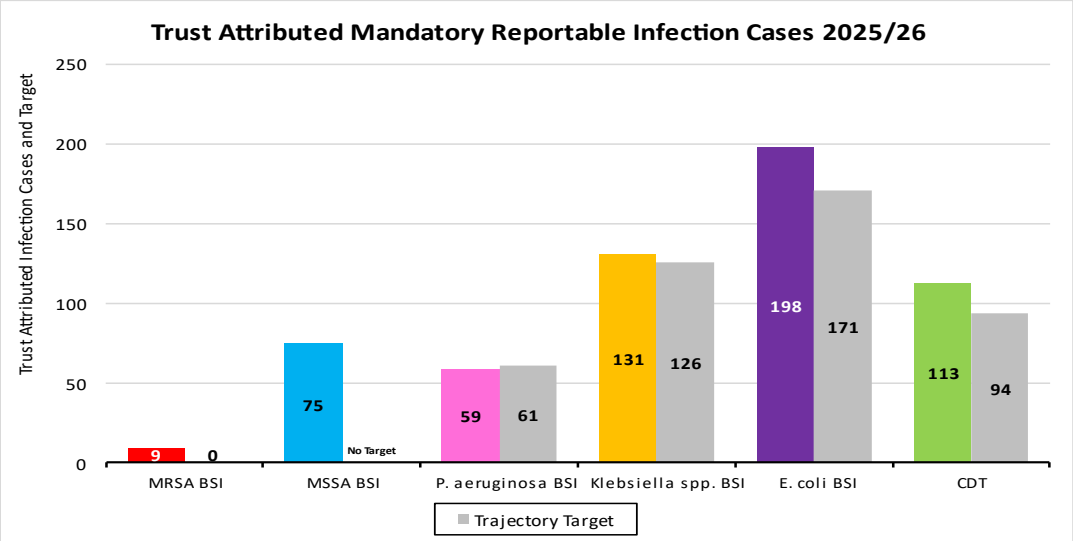


Figure 3



The Trust exceeded UKHSA HCAI targets for Trust attributed *E. coli*, *Klebsiella* spp. and MRSA BSIs, as well as CDTs. The Trust achieved the target for attributed *P. aeruginosa* BSIs.

3.1 MRSA and MSSA Bacteraemia

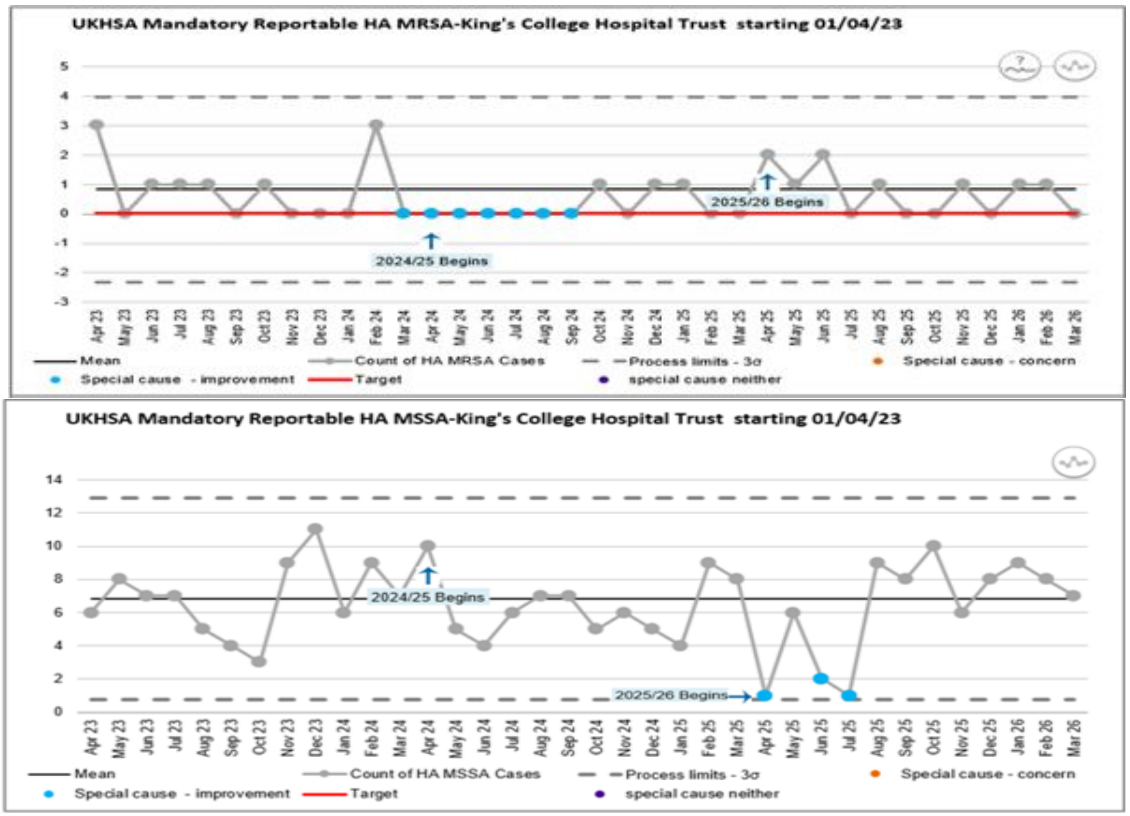
There were 9 Trust-apportioned MRSA cases in 2025-2026, which was an increase from the last financial year. Sources as follows:

Table 1

Trust apportioned MRSA BSI by ward 2025-2026

Ward	Probable source
NICU	Intravenous line
Annie Zunz	Urinary catheter
Critical Care C	Chest infection
Critical Care D	Traumatic surgical wound
Coptcoat	Surgical wound
Lonsdale	Skin & soft tissue infection (eczema)
Byron	Wound infection
Mary Ray	No clear source
Cotton	Diabetic foot ulcer

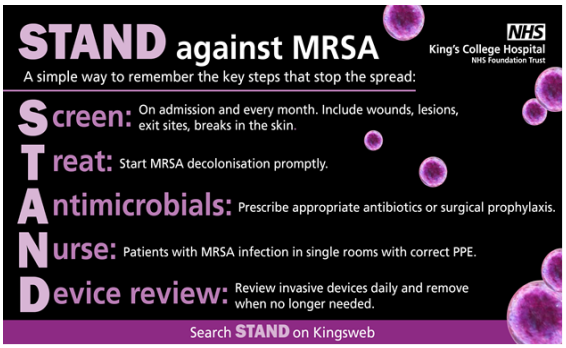
Figure 4 *SPC charts MRSA and MSSA 2023-2026*



Issues identified include inconsistency of MRSA screening practice, and delays to prescribing MRSA decolonisation protocol. Actions as follows:

- Re-established MRSA screening compliance reports, which are shared with the Divisions monthly.
- 'Our Practice Advisory' on Epic to remind doctors to prescribe MRSA protocol.
- Trust-wide MRSA campaign, which was launched during IPC week in October 2025. This incorporated ward-based teaching regarding MRSA screening and protocol.
- MRSA Task & Finish Group.

The Trust-wide MRSA campaign was launched during Infection Prevention & Control week 20th-24th October 2025. The campaign website includes mini-guides for the prevention & control of MRSA Launching STAND against MRSA - Kingsweb

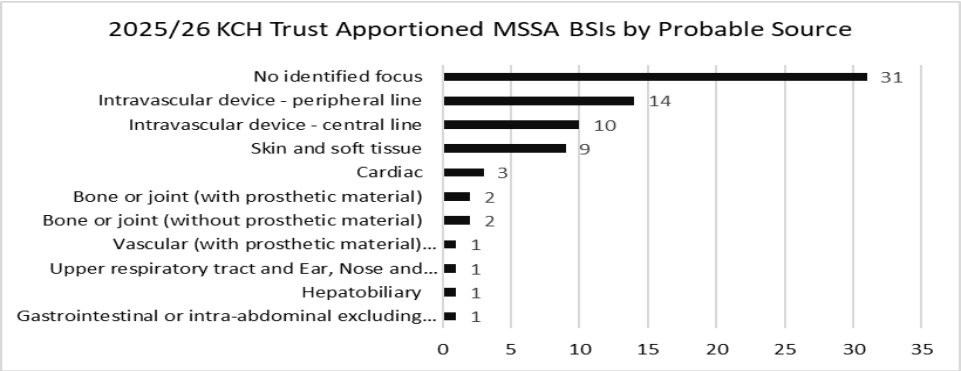




There is no UKHSA-set target for apportioned MSSA (Methicillin-sensitive *Staphylococcus aureus*) BSI cases; healthcare-associated cases remained within the common cause variation limits throughout the year without notable trends. There was 75 Trust attributed MSSA BSI cases in 2025/26. Cases at Denmark Hill rose 13% whilst PRUH and South Sites achieved a 23% reduction compared with the previous financial year. This pattern represents a reversal of the trend observed in the preceding financial year, during which Denmark Hill saw a 20% reduction, whereas PRUH and South sites experienced a 19% increase in cases.

3.2 MSSA BSIs Probable Sources 2025/26

Figure 5

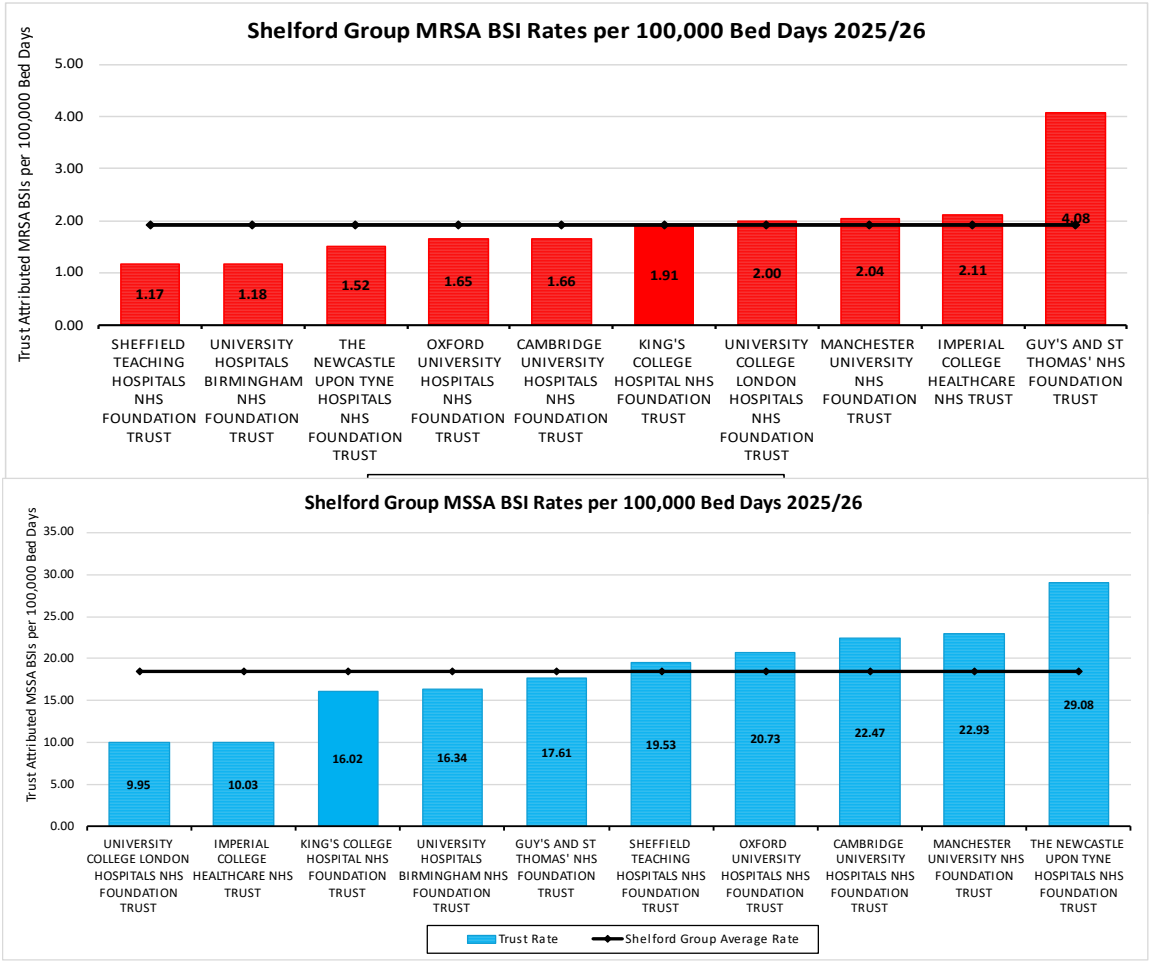


Over 70% of cases either have no identified focus or are linked to intravascular lines. Skin and soft tissue remain the most common non-device source.

For the 2025/26 financial year, King's MRSA BSI rate was in line with the overall average observed across the Shelford group NHS Trusts. In the same period, King's reported the third lowest attributed MSSA BSI rate within the Shelford group.

Figure 6

Shelford Group MRSA & MSSA BSI Rates 2025/26



3.3 Gram negative blood stream infections *(Escherichia coli* (E. coli), *Klebsiella* spp and *Pseudomonas aeruginosa*)

Trust wide, King's had a 10% increase in attributed E coli BSI cases; PRUH and South Sites were largely responsible for the increase, with a 21% rise in apportioned cases, compared to a 6% increase at Denmark Hill.

For Klebsiella spp., the Trust total declined slightly; Denmark Hill recorded a 2% increase, whilst PRUH and South Sites experienced a 18% reduction in apportioned cases.

There was also a 22% decrease in apportioned *P. aeruginosa* bacteraemia in 2025/26; PRUH and South Sites reported a 17% reduction, whilst Denmark Hill saw a 25% reduction.

Figure 7

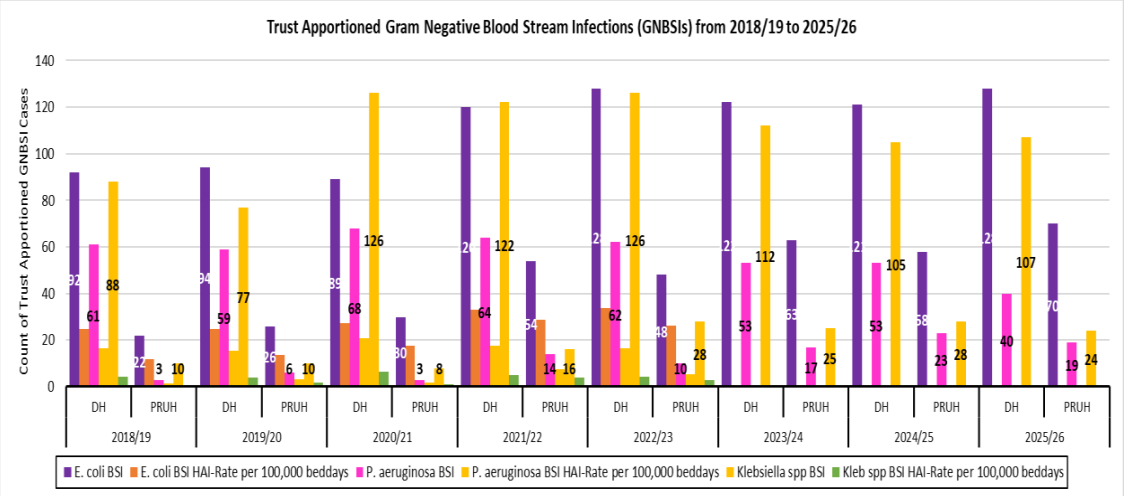
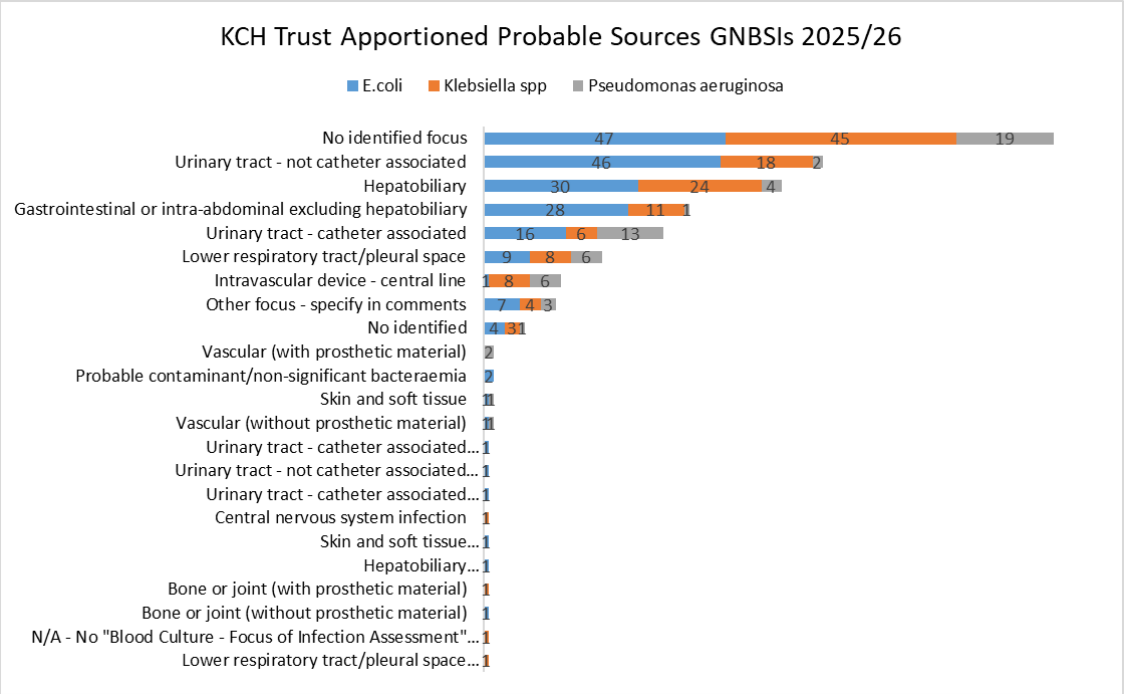


Figure 8



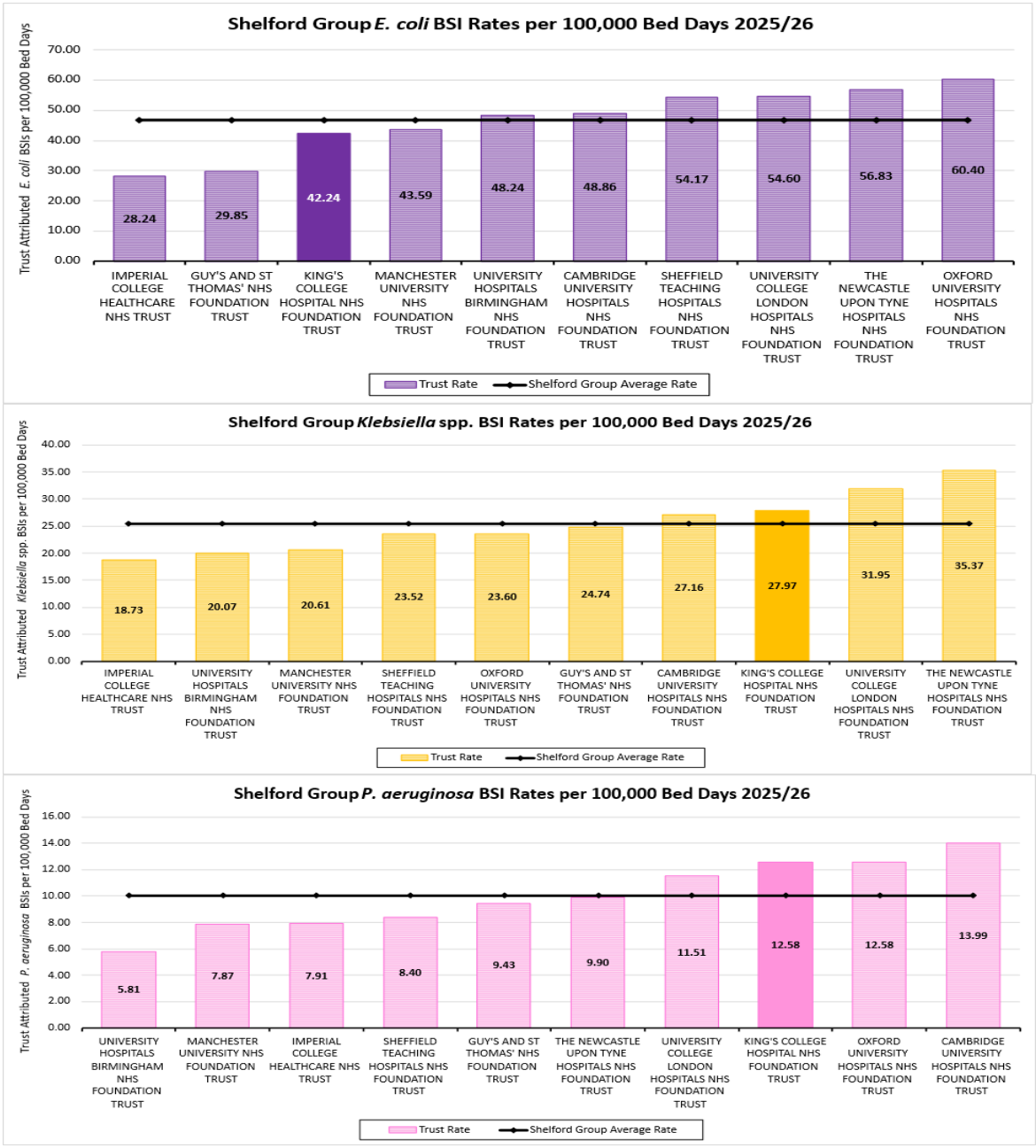
Among those with an identified source, the urinary tract, hepatobiliary and gastrointestinal tract dominate, collectively accounting for over half of all cases (51%). Central line-associated infections were responsible for 4% of cases (n=15) and urinary catheters were the source of 9.5% of all cases (n=37).

King's *E. coli* BSI rate was the third lowest within the Shelford group for the 2025/26 financial year. In contrast, the Trust's *Klebsiella spp*. BSI rate was the third highest in the group, and we tied with Oxford University Trust for second highest *P. aeruginosa* BSI rate within the Shelford group in 2025/26. This is likely because King's is both a solid organ and haematology

transplant centre with highly immune suppressed patients who are particularly vulnerable to Pseudomonas infection.

Figure 9

Shelford Group GNBSI Rates 2025/26



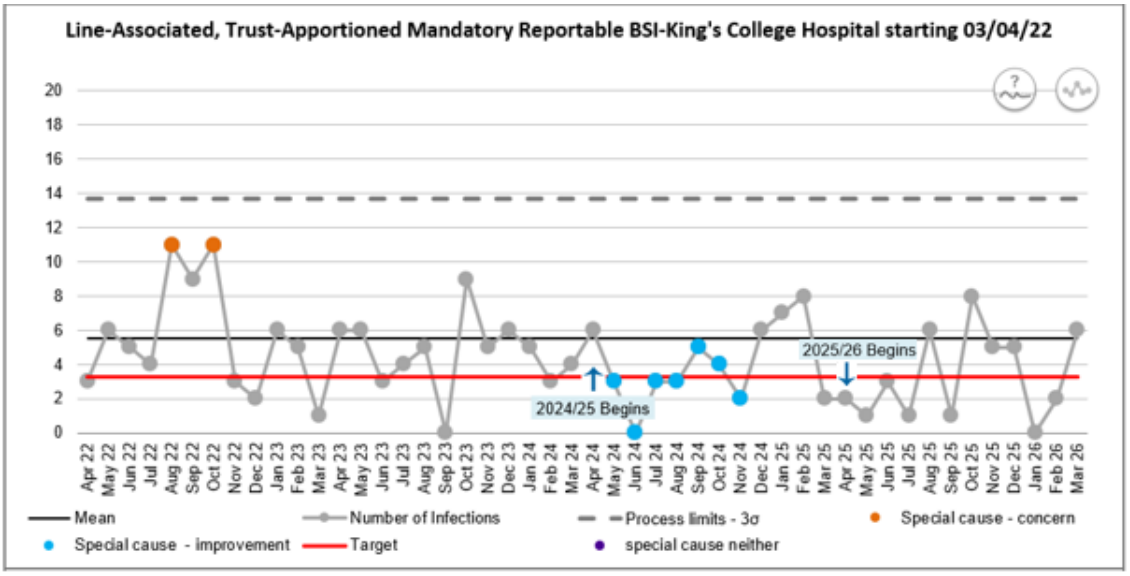
3.4 Intravenous line and urinary catheter-related blood stream infections

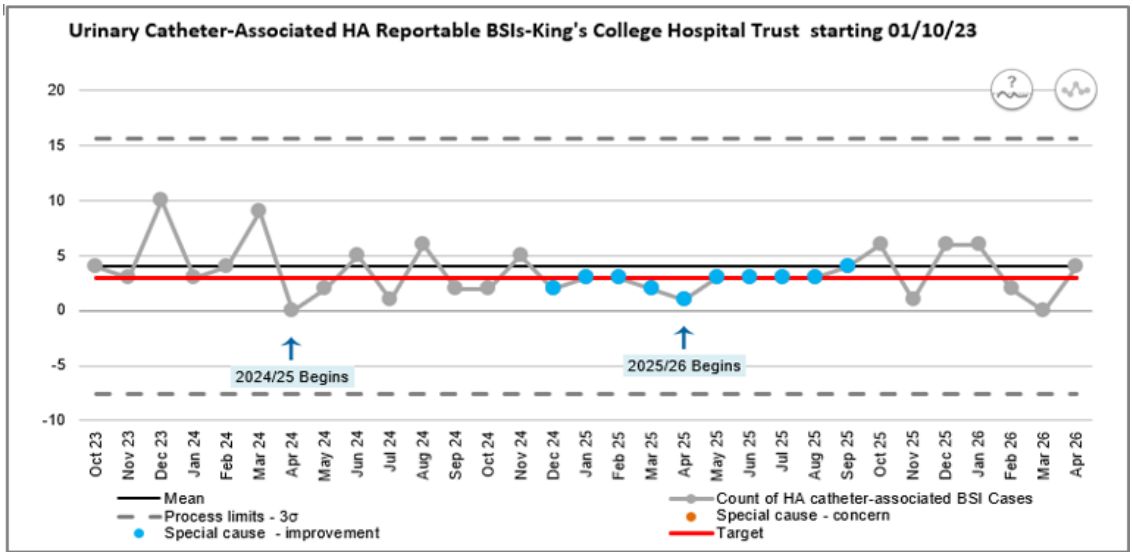
The SPC chart for Trust attributed IV line-associated BSI cases demonstrates variation remaining within the bounds of common cause. Trust attributed urinary catheter-associated urosepsis cases show a period of sustained improvement from the end of the previous

financial year to mid- 2025/26. On the Denmark Hill site, intravenous line-related BSI reduced from 49 in 2024/25 to 40 in 2025/2026, an 18% reduction.

Figure 10

Trust Attributed Device-Associated BSIs 2022/23 to 2025/26 – SPCs





Work during the year included audit of IV-line care, and implementation of daily wash with chlorhexidine (Hibiwash) for all patients with central lines, as there is evidence that chlorhexidine bathing has been associated with a reduction in healthcare-associated bloodstream infection.

Interventions to reduce urinary catheter-related BSI included:

- A Trust-apportioned catheter-associated UTI (CAUTI) report has been built in Epic, and the IPC team commenced validating this report in April 2026.
- An electronic prompt has been added to the Epic ward round note, as a visual reminder to prompt doctor review of urinary catheters post-op.
- We extended the 'Tic Twoc' study to 4 additional wards, which involves placement of stickers on urinary catheter bags to prompt review and earlier removal.
- Participation in the SEL Lambeth and Southwark urinary catheter meeting.
- Close liaison with the Bladder & Bowel service on evaluation of alternatives to urinary catheterisation and trial of the Purewick device.

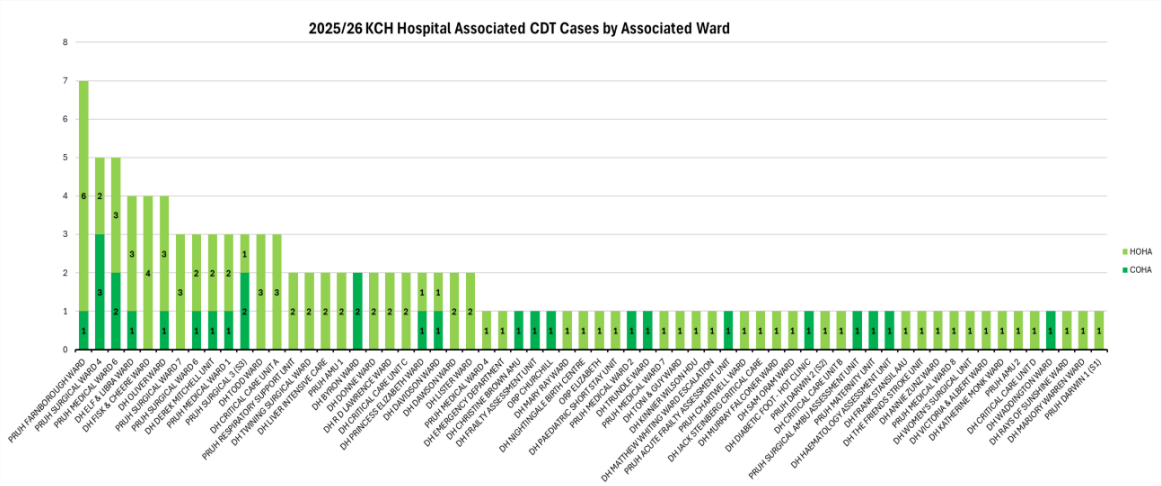
3.5 *Clostridioides difficile* infection (CDI)

During 2025-2026, there were 113 Trust-apportioned CDT cases (85 hospital-onset and 28 community-onset healthcare-associated). Trends differed by site; Denmark Hill had a 21% decrease in cases from 85 in 2024/25 to 67 in 2025/26, whereas cases attributed to PRUH & Orpington increased 77% from 26 to 46 (44 at PRUH and 2 at Orpington).

Most wards had low numbers, with 51 wards reporting only one or two cases each. The highest-number ward was PRUH Farnborough Ward with 7 cases (6 HOHA, 1 COHA), followed by PRUH Surgical Ward 4 and PRUH Medical Ward 6 with 5 apiece, and three DH wards Elf & Libra, Fisk & Cheere, and Oliver each recording 4 cases. Together these six wards accounted for 29 cases, or 26% of the total.

Overall, King's had the 3rd lowest hospital acquired CDT rate in the Shelford group for both financial years with 23 cases per 100,000 bed days in 2024/25 and 24 cases per 100,000 bed days in 2025/26.

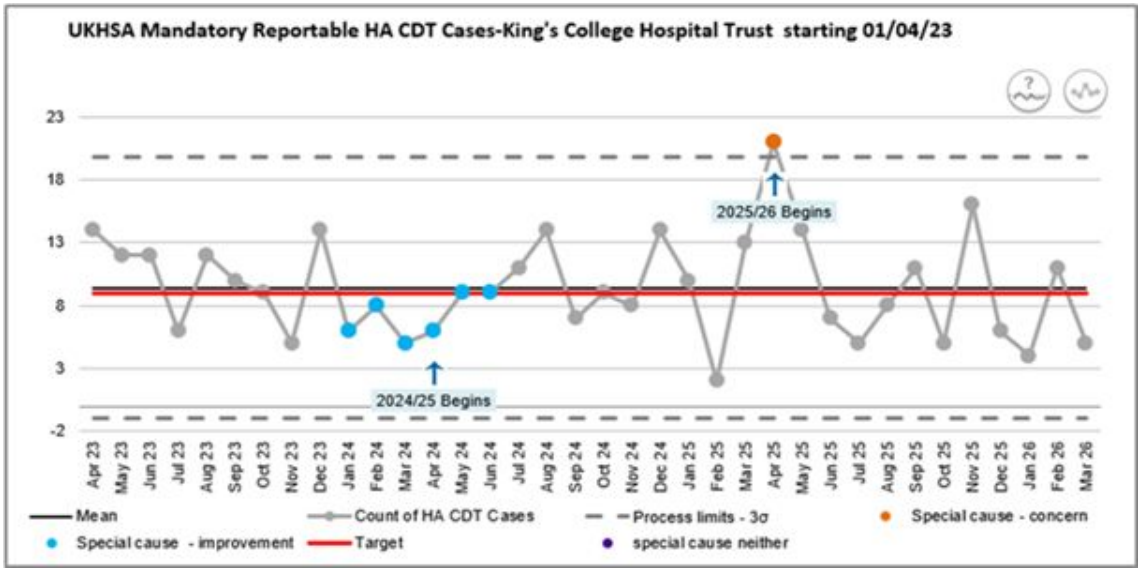
Figure 11 *CDI by ward 2025-2026*



The SPC chart for Trust attributed CDT cases shows a short period of concern in the first month of the financial year; however, activity subsequently stabilised, with case numbers remaining within the limits of common cause variation for the rest of the year.

Figure 12

SPC chart Toxin Positive Clostridioides difficile Cases (Aged 2 and over)

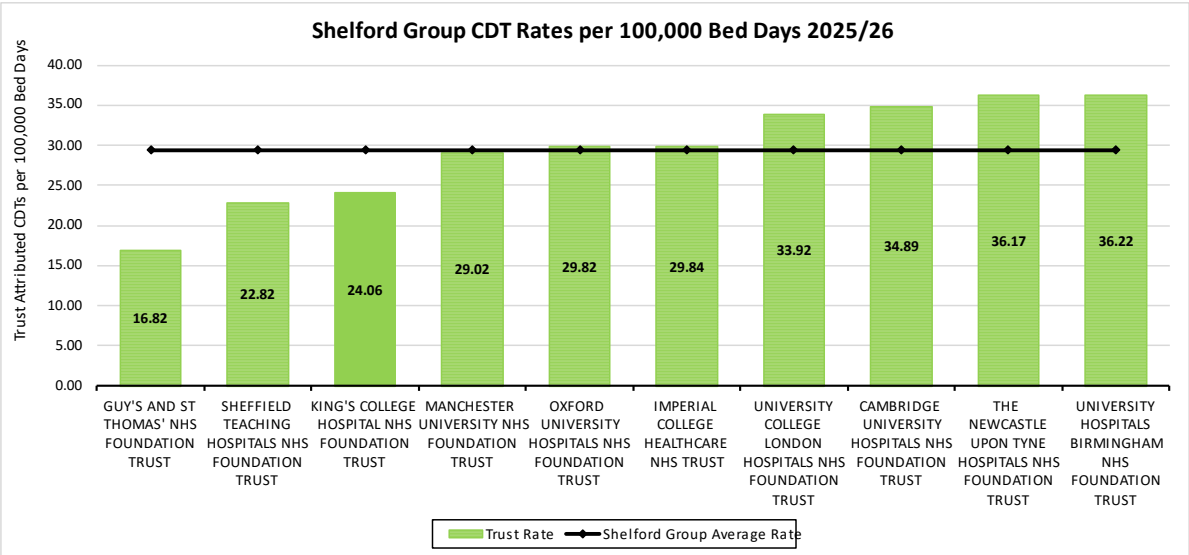


Shelford Group data

Kings had the third lowest attributed CDT rate in the Shelford group in financial year 2025/26.

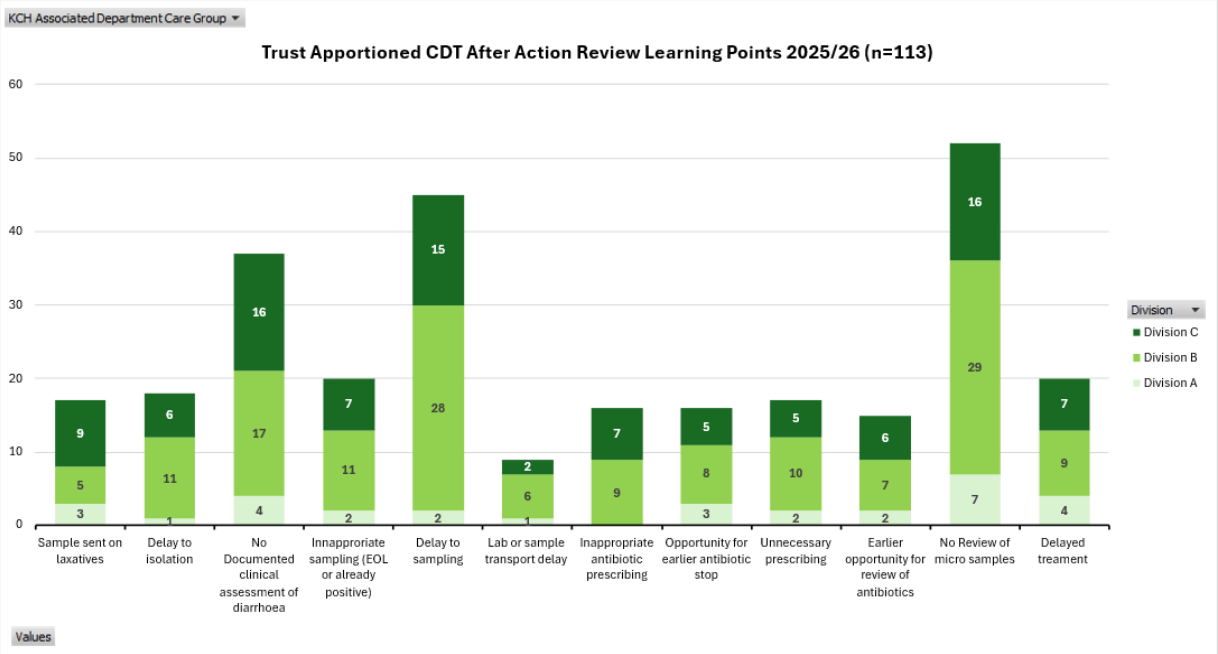
Figure 13

Healthcare-associated C. difficile rates Shelford Group



3.5.1 C. difficile After-Action Review (AAR) theme analysis

Figure 14

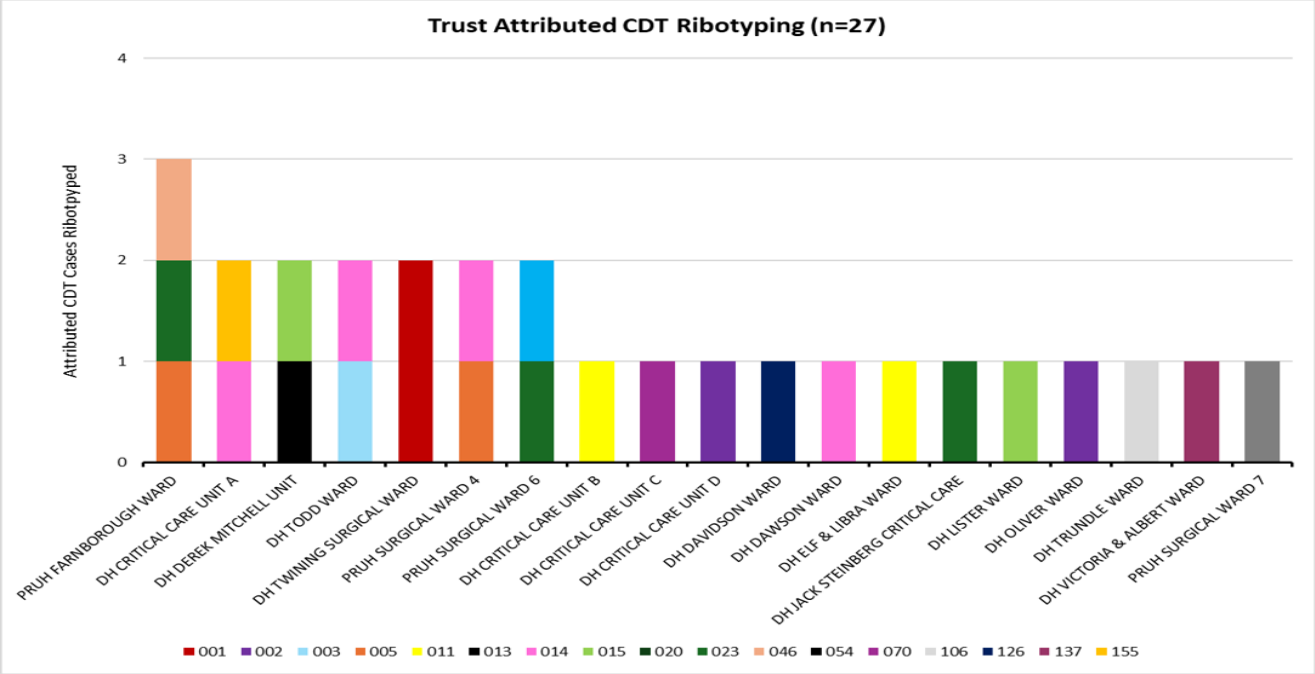


Samples were delayed in 40% of Trust attributed CDI cases, and no documentation of clinical assessment of diarrhoea was noted in a third of cases. The IPC nurses have continued to share the 'clinical assessment of diarrhoea' guide with the wards and carry out daily review all samples with the clinical areas. Please see section 4.2 re the QI group for *C.diff*. A large proportion of learning was from antimicrobial prescribing issues. In many cases, there was no documented evidence that prescribers had reviewed relevant microbiology results when reviewing antibiotics.

3.5.2 CDI ribotyping results

In the event we identify a cluster of cases, all Trust apportioned *Clostridioides difficile* (toxin positive) cases are referred to the UK Health Security Agency (UKHSA) for ribotyping identification which allows the identification of linked cases.

Figure 15



The IPC team declared Periods of Increased Incidence (PII) in the following wards:

- Farnborough Ward (PRUH)
- CCU A (DH)
- Derek Mitchell (DH)
- Todd (DH)
- Surgical 4 (PRUH)
- Surgical 6 (PRUH)
- Twining (DH)

However, ribotyping was the same on only one ward, which was the 2 cases on Twining ward, implying no evidence of cross infection on any of the other PII wards.

3.6 Incidents/Outbreaks

Delays in microbiology turnaround times, particularly for CPE and *C.auris* screening results, were a concern due to the associated outbreak risks. A plan is in place with the pathology provider focussing on improving performance in this area.

3.6.1 Carbapenemase-producing Enterobacterales (CPE)

Carbapenemase-producing Enterobacterales (CPE) bacteria spread rapidly in healthcare settings and can lead to poor clinical outcomes because of limited therapeutic options. These bacteria are of clinical significance in patients with serious medical conditions or undergoing complex surgical procedures as they are resistant to commonly used antibiotics. The increased incidence of CPE across the world has significant cost and operational implications for healthcare providers.

Table 2

CPE outbreaks during 2025-2026

Date	Ward (all DH site)	CPE gene identified
June 2025	Charles Polkey	3 IMP and 2 NDM.
July 2025	Howard	5 cases NDM and 3 OXA-48
July 2025	Oliver ward	2 cases Klebsiella pneumoniae KPC, 1 NDM and 1 OXA-48.
September 2025	David Marsden	2 cases Klebsiella pneumoniae OXA-48
October 2025	Kinnier Wilson ward and HDU	4 cases Klebsiella pneumoniae KPC and 1 OXA-48
November 2025	David Marsden	2 cases Klebsiella pneumoniae KPC
March 2026	Cotton	3 cases *Klebsiella pneumoniae* - IMP

Interventions to control the outbreaks included sink cleaning and etiquette poster, bay closure, enhanced cleaning, daily surveillance, increased patient screening, ward-based audit and education. Clinell bed bath wipes and chlorhexidine wash cloths were introduced to replace the use of disposable wash bowls, soap and water on any ward with a CPE outbreak. It is hypothesised that this intervention interrupts the chain of transmission associated with the use of sinks, wash bowls and associated equipment. Use of CHG washcloths may have reduced any potential reservoir of microorganisms on patients' skin. Peracetic acid wipes for environmental cleaning were recommended for all ward cleaning during CPE outbreaks.

3.6.2 Candidozyma auris

Candidozyma auris (*C. auris*) is a rapidly emerging fungal pathogen with a global distribution. First identified in 2009 in Japan, it was designated a critical priority fungal pathogen by the World Health Organization in 2022. Severe invasive infections may occur, associated with high mortality, seen mostly within healthcare settings. *C. auris* can cause a wide variety of infections in both adult, paediatric and neonatal populations, including bloodstream, intra-abdominal, bone and cerebrospinal fluid (CSF) infections through to superficial skin infections. *C. auris* has developed resistance to many available classes of antifungals, with emergence of pan-resistant strains (UKHSA 2025). Several prolonged *C. auris* outbreaks have occurred in UK hospitals since 2015, requiring interventions to control and prevent further spread. The highest national incidence is in South London.

Table 3

C. auris outbreaks during 2025-2026

Date	Ward (all DH site)	Number of cases
June 2025	PICU	2 (1 of the cases was imported from Egypt)
September 2025	LITU	3
October 2025	Jack Steinberg	2
January 2026	Oliver	4 cases (1 was community acquired)

The outbreaks were managed in close liaison with the Consultant Microbiologists and the UKHSA. Robust IPC measures were implemented, including twice weekly screening of all patients on the ward, enhanced PPE with long-sleeved gowns and gloves for all patients, disinfection of equipment with hydrogen peroxide vapour (HPV) and enhanced environmental screening. IPC interventions continued until which time the positive patients and contacts had been discharged.

3.6.3 Summary of viral outbreaks

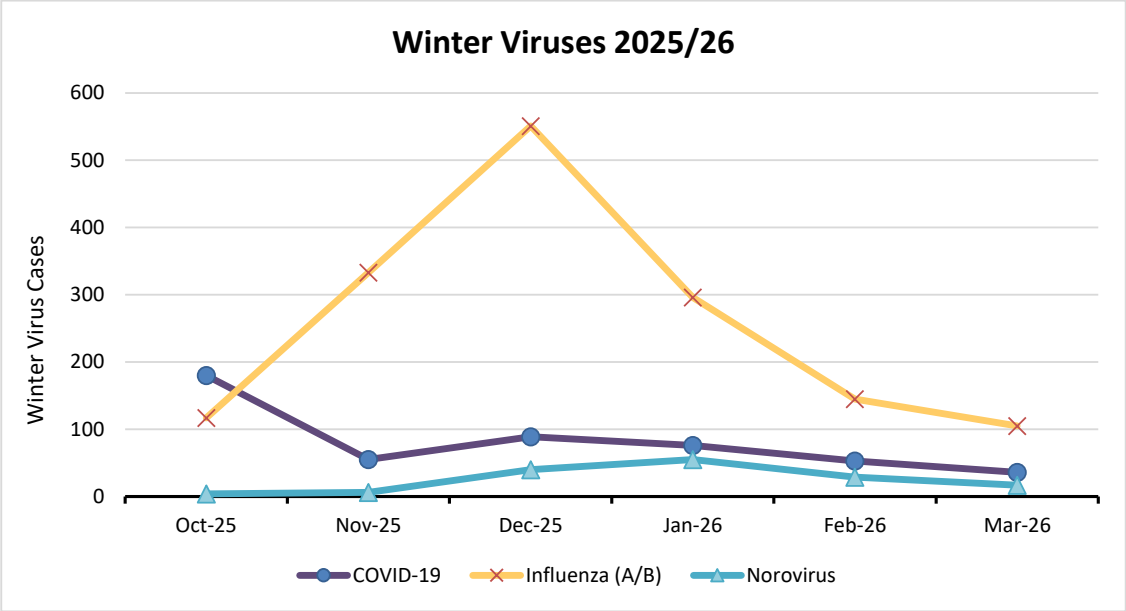
For the financial year 2025-2026, Influenza predominated the winter virus cases in 2025/26, peaking sharply in December 2025. COVID-19 cases outnumbered Influenza cases in October 2025, then declined steadily throughout the season. Norovirus cases peaked in January 2026.

Table 4

Winter Viruses October 2025-March 2026 (Community and Trust)

Month	COVID-19	Influenza (A/B)	Norovirus
Oct-25	180	117	4
Nov-25	55	333	6
Dec-25	89	551	40
Jan-26	76	296	55
Feb-26	53	145	29
Mar-26	36	105	17

Figure 16



Bed spacing, lack of mechanical ventilation and high bed occupancy are likely to be contributory factors in numbers of Trust-apportioned cases and outbreaks. High ED attendance and 'corridor care' in the winter may have also contributed to the spread of infection. A risk assessment was undertaken for the infection control risks associated with placement of additional patients over and above ward template, 'one-up'. One of the main lessons identified in managing outbreaks successfully was early identification of patients with respiratory symptoms to prompt early testing and isolation. The Trust continued to employ the combined Flu and COVID lateral flow test to ensure prompt testing on symptom onset, in addition to the respiratory viral panel based in the laboratory. IPC validation audits were undertaken during the outbreaks, which helped identify IPC practice issues such as cleaning, hand hygiene and glove use, with the ward managers overseeing practice. Efficacy audits led by facilities, IPC and ISS validated cleaning scores in the clinical areas which provided assurance on how effective cleaning is being undertaken on the affected wards. None of the outbreaks resulted in a major disruption of service as regards full ward closures.

3.7 Contact Tracing

3.7.1 Invasive group A streptococcus (iGAS)

Invasive GAS (iGAS) is an infection caused by *Group A streptococcus* and occurs when the organism is isolated from a normally sterile body site, such as the blood. iGAS is a notifiable disease; health professionals must inform local health protection teams (HPTs) of suspected cases. The IPC team contact trace all in-patient cases of iGAS. Close contacts receive written information and are advised to have a heightened awareness of the signs and symptoms of GAS for 30 days after the diagnosis in the index patient, and to seek urgent medical advice if they develop such symptoms. Any high-risk staff exposures are referred to Occupational Health, and a decision to treat is made on a case-by-case basis after discussion between a Microbiologist/Infectious Disease Consultant and an Occupational Health practitioner,

considering the type of exposure and length of time the patient has been on antibiotics and HCWs working without appropriate PPE. The local HPT ensure relevant information is given in written form to close personal contacts for community contacts. There were 30 episodes of contract tracing for iGAS across the Trust during 2025/2026, with no episodes of transmission.

3.7.2 TB contact tracing

There were seventeen occurrences of contact tracing for TB cases during the financial year, which has doubled since the year before. There was no onward transmission in the hospital setting from any of the cases. All forms of active TB are statutorily notifiable; the notification of cases prompts timely risk assessment for appropriate clinical and public health responses to cases and their contacts. IPC work closely with the TB team, Respiratory Consultants, Health Protection team and Occupational Health during contact tracing exercises. The tracing and screening of people who have had contact with an active case of TB is a critical component in the control of transmission and the early detection of infection. At-risk patient contacts were followed up by the TB team and staff by Occupational Health. 'Warn and inform' letters were sent to all contacts of people with smear-positive TB, where appropriate. Educational sessions for clinical teams were undertaken by a Consultant in Infectious Diseases and Microbiology. For suspected/confirmed infectious respiratory TB, patients should be nursed in a negative pressure isolation room, with respiratory precautions. Access to negative pressure single rooms remains a challenge at Kings on both sites.

3.7.3 Measles/Pertussis/Chicken pox/Mpox

Measles is the most infectious of all diseases transmitted through the respiratory route and symptoms can be severe, particularly in immunosuppressed individuals and young infants. In 2025, there were 959 laboratory confirmed measles cases reported in England. Over the last 10 years, there has been a decline in coverage of the measles, mumps and rubella (MMR) vaccine particularly in urban areas and deprived communities. An evaluation led by UKHSA showed that the national MMR catch up campaign and regional and local tailored interventions aimed at improving uptake have been successful at reaching key under vaccinated communities but more needs to be done to sustain progress and prevent further outbreaks from occurring (UKHSA 2025). During April 25 - March 2026 there were 11 measles contact tracing episodes.

There were 4 contact tracing episodes for pertussis, 26 for chicken pox and shingles, and 2 for Mpox, with no hospital outbreaks.

Out of hours access to urgent staff testing and prophylaxis remains an issue, as Occupational Health work office hours.

4.0 Quality Improvement in IPC

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety

incidents for the purpose of learning and improving patient safety (NHSE, 2023). The framework is designed not just for investigations, but as an integrated continuous learning and improvement system where insights from safety incidents feed directly into broader patient safety and QI initiatives.

4.1 Cleaning QI IPC group

The Enhanced Cleaning Quality Improvement (QI) Project (CLEEN, Browne et al, 2023) has continued over the past year across pilot wards, focusing on improving the standard, frequency, and reliability of cleaning of reusable medical equipment and the near-patient environment to reduce cross-infection and healthcare-associated infections (HCAIs).

Key Findings

Infection Prevention and Control (IPC) fluorescence audits demonstrate variation in cleaning compliance (59%–94%), with improvements often seen during outbreaks but not sustained long-term. Frequently missed areas include:

- Bedside lockers
- Patient call bells
- Bedside sanitiser dispensers
- Shared clinical equipment

These findings indicate both operational pressures and inconsistent role clarity regarding cleaning responsibilities.

Interventions Implemented

- Enhanced cleaning of high-touch surfaces
- Weekly fluorescence audits with real-time feedback
- Staff education and behavioural prompts
- Support from dedicated clinical housekeepers and domestic teams
- Ongoing IPC monitoring and reporting

Staff Engagement: Questionnaire Insights (n=90)

- 99% of staff recognise cleaning as essential for patient safety
- Cleaning is widely viewed as a shared responsibility
- Teamwork identified as a key strength

Challenges Identified

- Time constraints due to workload and patient acuity
- Staffing pressures
- Lack of clarity in roles/responsibilities
- Inconsistent use of cleaning checklists (49% not using them)
- Variable handover of cleaning tasks

Risks

- Inconsistent practice and accountability gaps
- Increased risk of cross-contamination

Improvement Priorities

- Standardised cleaning protocols and checklists
- Clear role definition across staff groups
- Improved access to cleaning equipment
- Ongoing IPC training and education
- Strengthened leadership and accountability

Outcomes and Impact

The project is beginning to demonstrate:

- Improved cleaning awareness and engagement
- Increased audit visibility and feedback loops
- Potential for reduced environmental contamination
- Faster control of outbreaks

Next Steps

The QI team is developing a standardised bedside cleaning checklist to:

- Improve consistency and compliance
- Clarify responsibilities
- Support audit and governance processes
- Enable wider roll-out across the Trust

Cleaning is recognised by staff as a critical patient safety intervention. However, to achieve sustained improvement, the Trust must embed structured processes, clear accountability, and consistent audit mechanisms. The CLEEN project provides a scalable model to standardise practice, reduce HCAIs, and improve patient outcomes and experience.

4.2 *C. diff* QI Group

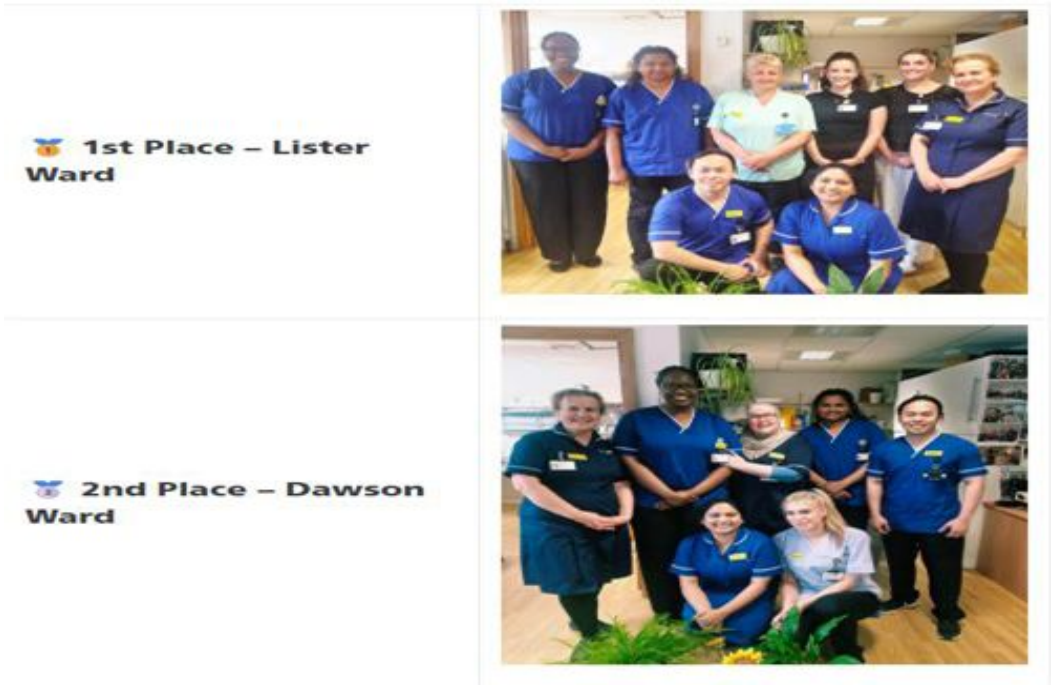
The *C. diff* QI group commenced in July 2024, with a view to examining the lessons learned from after-action reviews and to implement actions to address. Themes include stool sampling, antimicrobial prescribing, Epic documentation on stool charts and cleaning. The group is led by an IPC Matron and supported by clinical staff, microbiology, Estates and CEF.

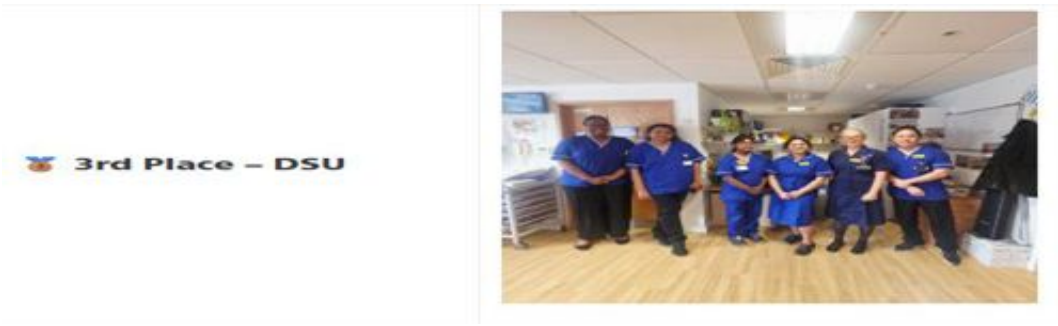
- 50% reduction was achieved in all Cohort 2 (2025/2026) focus areas: Katherine Monk, Marjory Warren, Dawson ward and Medical 2 except Medical 6 hence they have been invited to cohort 3 (2026/2027) focus group.

- Tristel jet product was successfully trialled in Cohort 2 focus areas and has been approved by the standardization committee to rolled out in cohort 3 focus areas: Oliver ward, Elf and Libra, Fisk and Cheere, Medical 6, Surgical 4 and Surgical 6 (with the exception of CCU C as product compatibility is still being checked).
- Using the sustainability model, all cohort 2 areas: Katherine Monk, Marjory Warren, Dawson and Medical 2 have been able to sustain improvement, which is evidenced in the April-May 2026/2027 *C. diff* mandatory data.
- The *C. diff* training is now replicated on other wards with high incidence of *C. diff.*
- The project continues to improve *C. diff* awareness among both medical and nursing staff group.

4.3 WHO World Hand Hygiene Day and Infection Prevention & Control Week 2025

The importance of hand hygiene and MRSA was the focus on WHO Hand Hygiene Day in May 2025, and national Infection Prevention and Control week in October 2025. Stands were displayed in the main entrances of the Golden Jubilee wing and the cafeteria at the PRUH. We had an amazing response to the Infection Prevention & Control (IPC) Board Competition for Global Hand Hygiene Day, which showcased the fantastic work in clinical areas across the Trust. The IPC boards were informative, engaging, and visually outstanding, all powerfully highlighting the importance of hand hygiene, patient safety, and infection prevention within our clinical areas. Congratulations to our winners!





4.4 IPC Link Practitioners Programme (IPCLPs) and IPC Symposium 2026

The IPC Link Practitioners' Study Days provide dedicated learning opportunities for IPC Link Nurses to remain up to date with infection prevention and control policies, emerging risks, and key organisational priorities. The sessions also facilitate the sharing of best practice and lessons learned across hospital sites, enabling link practitioners to support and promote IPC initiatives within their clinical areas.

The June IPC Link Practitioners' Study Day focused on several key policy updates, including the management of intravenous (IV) lines and the clinical assessment of patients with diarrhoea prior to submitting stool specimens. The Waste Manager delivered a session on the correct segregation of waste and highlighted the importance of complying with Trust policies and Environmental Agency regulations. Updates to the MRSA policy were also presented, including the introduction of Hibiscrub as a decolonisation product. Given the increase in MRSA cases across the organisation, link practitioners were encouraged to cascade this information within their respective clinical areas.

To support their role, IPC Link Practitioners were also granted access to the IPC shared drive, providing a central resource for policies, guidance documents, educational materials, and audit tools.

Environmental cleaning was another key focus area. The Cleaning Supervisor delivered a presentation on the importance of maintaining a safe and clean healthcare environment and outlined the processes used to monitor and validate cleaning standards. This session reinforced the critical role environmental cleanliness plays in reducing the risk of healthcare-associated infections.

The increasing challenge of antimicrobial resistance (AMR) highlighted the need for practitioners to strengthen their understanding of antimicrobial stewardship. The session explored the role and responsibilities of healthcare professionals in promoting appropriate antimicrobial use. Nurses were encouraged to support antimicrobial stewardship initiatives by ensuring antimicrobial prescriptions are reviewed regularly and that treatment durations are clearly documented within the electronic patient record system.

In response to increasing rates of catheter-associated urinary tract infections (CAUTIs), the Bowel and Bladder Specialist delivered a session on appropriate catheter management. This

included discussion around indications for catheter insertion, consideration of alternatives to catheterisation, and the importance of ongoing catheter review to minimise patient harm and infection risk.

The October Study Day focused on winter preparedness and the management of seasonal infectious diseases. Sessions covered the recognition, management, and prevention of influenza and gastrointestinal viral infections, with particular emphasis on the appropriate use of isolation precautions and risk assessments. Measles was also highlighted due to its continued public health significance. The importance of vaccination, early identification, prompt triage, and effective patient management were discussed as essential measures to prevent transmission and outbreaks within healthcare settings.

Overall, the IPC Link Practitioners feedback reported that the study days were informative, relevant, and beneficial to their clinical practice. Participants valued the opportunity to receive policy updates, develop their knowledge of current IPC issues, and share learning with colleagues. The sessions reinforced the important role of IPC Link Practitioners in promoting best practice, supporting patient safety, and acting as champions for infection prevention and control within their clinical areas.

4.5 King's Harm Free Care – Infection Control Training Summary (April 2025 – March 2026)

Between April 2025 and March 2026, a total of **203 preceptees** attended the *Harm Free Care Infection Control* sessions, delivered across **12 classes**.

Key Learning Themes Identified from Feedback:

- Hand hygiene practices and the **HANDS campaign**
- Correct **selection and use of PPE**
- **Aseptic technique (ANTT)** and safe clinical practice
- Understanding **infection transmission** and how to break the chain of infection
- Appropriate **cleaning protocols** and disinfectant use
- Awareness of **infection-specific precautions**, including MRSA and *Clostridioides difficile*
- Promoting **patient and staff safety**

Feedback Highlights:

- Strongly **positive feedback** regarding presentation style and engagement
- Sessions provided a valuable **refresher of existing IPC knowledge**
- Requests for **more practical, skills-based learning opportunities** and supporting resources

5.0 Antimicrobial Stewardship Group (ASG) 2025/2026

The King's ASG aims to promote rational, safe, effective, and economic use of antimicrobials within the Trust. This group is chaired by the Antimicrobial Stewardship Lead and Consultant in Microbiology and Infectious Diseases and reports to the Infection Prevention and Control Committee. The group fulfils the following functions:

- Oversee the use of antimicrobial agents within the trust.
- Promote high quality, rational and cost-effective prescribing, and use of antimicrobial agents.
- Monitor prescribing patterns, by clinical audit or other means, and expenditure of new and expensive antibiotics across the trust.
- Prioritise areas of prescribing concern and take appropriate action to improve antimicrobial use in these areas as necessary.
- Develop, implement, and maintain evidence-based Trust guidelines and policies relating to antimicrobial use as written guides or on the intranet and Eolas app, accessible to all relevant health care professionals.

Activities during 2025/2026 included:

- In November 2025, the antimicrobials Key Performance Indicators (KPIs) were relaunched on the MEG platform, requesting a review of 5 random patients in each ward area. Using the MEG platform enables clinicians to easily input data and also to review their own performance. Promotion of the KPI audits on the MEG platform continues.
- The ASG continued to promote intravenous (IV) to oral (PO) switch of antimicrobials, following two years of participating in the national CQUIN. Posters were produced to demonstrate the impact of antimicrobial IV to PO switch, including not only financial savings, but reductions in length of stay, savings in nursing time, reduced risk of IV line-related bacteraemia, and reduction in the carbon footprint by switching to PO antimicrobials. Posters were distributed for display in all ward areas across the Trust as a visual reminder of the importance of IV to PO switch.
- IV to PO switch ward rounds continued during 2025/2026 involving a Consultant Microbiologist and an Infection Pharmacist, to promote opportunities to switch a patient's treatment from IV to PO when appropriate. A survey was also undertaken to understand the barriers to switching IV antimicrobials to PO. 86 responses were received (48% doctors, 27% pharmacists and 22% nurses)

- Almost half of respondents were either unsure or unaware of the Trust's IV to PO switch criteria
- When the 86 respondents were asked what the main barriers to IV to PO switch are:
  - 52 responded 'not wanting to switch to oral without confirming with a senior'
  - 40 responded about the 'culture/tradition of completing the IV course'
  - 38 answered 'lack of review of IV antibiotics / decision making on ward rounds'

This highlights the need to provide further education and awareness of where to access information to prescribers, but also to engage senior clinicians to review antimicrobials on every ward round and to promote IV to PO switch at the earliest opportunity.

- A group of 'Antibiotic Champions' was set up, led by Dr LJ Smith, to engage doctors, nurses and pharmacists to champion and promote IV to PO switch on the wards, and during ward/board rounds. The Group also promotes antimicrobial stewardship in general and collects data examining IV to PO switch on the wards. The group meets every two weeks and continues into 2026/27.
- In November 2025, NHS England published a 'Call to Action' letter to all Trusts and Integrated Care Boards to act urgently to meet antimicrobial resistance (AMR) targets as set out in the National Action Plan. Trusts were asked to identify three priority areas for AMR improvement and present these to the Trust Board by the end of the financial year. The priority areas identified for King's are:
  - Continue to improve IV to oral switch (IVOS) of antimicrobials
    - Reduce proportion of antibiotics administered IV by 2% per year, with a target reduction of 6% by Q4 2028/29
    - Reduce the proportion of patients on IV antibiotics who are overdue PO switch by 5% per year, with a target of <15% by Q4 2028/29
    - Achieve >90% compliance with KPI3 (has an IV to PO switch review taken place) via monthly MEG audits, by Q4 2028/29
  - Increase prescribing of antimicrobials from the 'Access' category (narrow spectrum)
    - Increase the proportion of prescribing from the 'Access' category by 4% per year with a target of 61% or more by Q4 2028/29

- Reduce proportion of antibiotic courses greater than 5 days
    - Achieve 90% compliance with 5 days duration for community-acquired pneumonia (CAP) and hospital-acquired-pneumonia

- Following the launch of EPIC in October 2023, we were unable to track our antimicrobial consumption for approximately 18 months. However antibiotic consumption (Defined Daily Doses (DDDs) per 1000 Admissions) data is now available to review, and is regularly presented and reviewed at ASG and Infection Control Clinical Leads meetings. Current performance against key AMS indicators highlights that KCH is performing well against national targets:
    - Total antibiotic prescribing

KCH is currently 17.5% below the target for total antibiotic consumption

The national target is to reduce total antibiotic consumption by 5% by 2029 from 2019/20 baseline (AMR National Action Plan 2024 – 2029).

- ‘Watch’ and ‘Reserve’ antibiotic (broad-spectrum) prescribing

KCH is currently 27.1% below the 2019/20 baseline.

There is no target for this metric, however the NHS Standard Contract 2026/27 states “Trusts must use all reasonable endeavours, consistent with good practice, to safely reduce overall antibiotic use and increase the proportion of antibiotic use from the “Access” Category (i.e. reduce broad-spectrum antibiotic consumption), in accordance with the requirements of the National Action Plan for Antimicrobial Resistance)”.

- Prescribing of antibiotics from the ‘Access’ category (narrow spectrum)

The proportion of antibiotics prescribed from the ‘Access’ category is 53% (Q3 2025/26).

The baseline is 49% (Q1 2025/26). The target is to achieve an annual 4% increase in prescribing from the “Access” category, to achieve a 12% increase by Q4 2028/29 (61% of antibiotic prescribing from the “Access” category by Q4 2028/29).

- IV to PO Switch

21% of all antibiotics were prescribed intravenously at KCH (Q3 2025/26). An increase of 1% from baseline (Q1 2025/26).

- The ASG continues to work towards reducing its use of all antimicrobials, ‘Watch’ and ‘Reserve’ (broad-spectrum) antibiotics, and to increase its consumption of ‘Access’ (narrow spectrum) antibiotics, in line with the NHS Standard Contract and the recently published National Action Plan ‘Confronting antimicrobial resistance 2024 to 2029’. This publication highlights the need to reduce total antimicrobial

consumption and to reduce consumption of broad-spectrum antibiotics, which the ASG will continue to lead upon.

- The ASG continues to work alongside colleagues at GSTT and RBH, and with EPIC sites nationally to understand available AMS functionality within EPIC, and to develop this further. Work has progressed, with input from prescribers, to identify aspects of EPIC that could be developed and introduced to support AMS, including:
    - Highlighting patients due or overdue review for IV to PO switch
    - Highlighting patients due for review 48 – 72 hours after initiation of treatment
    - Review of 'hard stops' to reduce the risk of antimicrobial prescriptions continuing inappropriately
- A dashboard to highlight antimicrobial prescribing by indication, ward, Care Group is in development for use by clinicians to understand their own antimicrobial prescribing practice. The dashboard gives information for indications, including:
    - Duration of treatment
    - Antimicrobials prescribed for each indication
    - Choice of IV or PO antimicrobial for each indication

The aim is that, once finished, the dashboard will be shared with all clinicians to be able to examine their own prescribing of antimicrobials and understand where improvements may be made.

- A joint pharmacy and microbiology led teaching session on antimicrobials was conducted on two occasions for Foundation year trainees Trust wide in September 2025. This received excellent feedback and will be a regular annual slot early in the programme for new junior doctors.
- The ASG oversaw applications to add a number of antimicrobials to the Trust formulary, including:
    - Cefepime (approved)
    - Meropenem/Vaborbactam (approved by ASG but not signed off financially. Non-Formulary request required)
    - Aztreonam/Avibactam (approved by ASG but not signed off financially. Non-Formulary request required)
    - Rezafungin (approved)

- The ASG led on managing antimicrobial drug shortages, including anti-tuberculosis treatments, anidulafungin, levofloxacin tablets and chloroquine tablets, to ensure that patients continued to receive appropriate and effective treatment.
- A limited penicillin allergy de-labelling service exists. Until recruitment into Microbiology vacancies, this is dependent on cases being identified opportunistically by the microbiology clinicians but will hopefully become a more proactive service when staffing is adequate to support a regular review of an EPIC report to identify potential candidates for delabelling and optimisation of their antimicrobials.
- Several guidelines were developed or updated:
    - Early Onset Neonatal Sepsis Guidelines
    - Management of Adult Neutropenic Sepsis Guidelines
    - Protocol for Islet Allograft Transplant
    - Neonatal Antibiotic Guidance
    - Transcatheter Aortic Valve Implantation (TAVI) Antibiotic Prophylaxis Guideline
    - Clinical Guidance for Continuous and Extended Infusions of Piperacillin/Tazobactam and Meropenem in Adult Critical Care
    - *Pneumocystis jirovecii* Guideline
    - Treatment of COVID-19 Infection in Adult Inpatients Guideline (Updated)
    - Axillary and Breast Treatment Guidelines
    - Antibiotic Use in Chimeric Antigen Receptor T-Cell (CAR-T) Recipients
    - General Critical Care Units: Antifungal Guideline for Use in Non-Haematology/ Oncology and Non-Liver Patients
    - Intraabdominal Infection Guidelines (Updated)
- Clinical trials involving antimicrobials were also reviewed:
    - Exacerbation and Symptom Control After Pseudomonas Eradication Treatment in Adult Bronchiectasis: a multicentre randomised controlled trial (ESCAPE)

6.0 Surgical Site Infection Surveillance (SSIS)

The Trust complies with the requirement to complete one module of orthopaedic Surgical Site Infection Surveillance (SSIS) through the United Kingdom Health Security Agency

(UKHSA). A continuous programme of SSIS for Total Hip Replacements (THR) and Total Knee replacements (TKR) at Orpington, PRUH and Denmark Hill has been in place since January 2014, led by the SSIS Nurse. Currently, the Trust have not participated in the voluntary coronary artery bypass graft procedures due to low capacity to validate. Figures 17 and 18 below provides the SISS data for hip and knee replacements between January 2025 to December 2025.

Figure 17

Trust wide Total Number of Mandatory Hip Total Hip Replacements

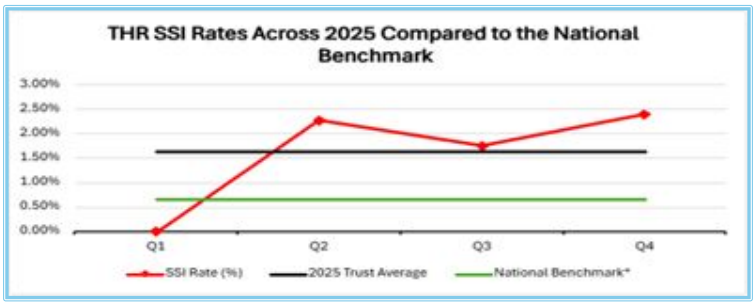
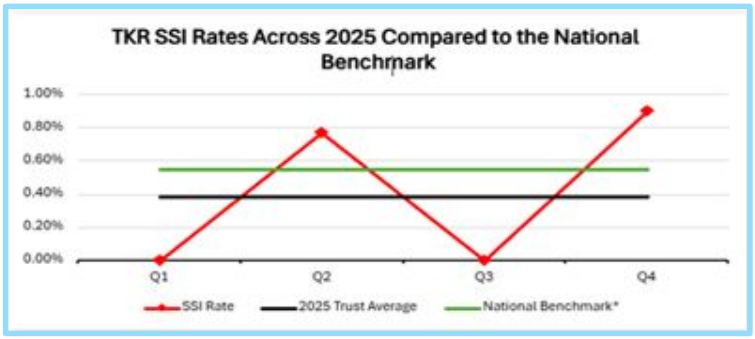


Figure 18

Trust wide Total Number of Mandatory Total/partial Knee Replacements



It can be gleaned from figures 17 and 18 that there has been an increased number of SSI on both procedures compared to last year's report where we only received 1 high outlier letter above the 90th percentile in the knee arthroplasties.

For the year 2025, a total of 3 outlier letters from Q2 through to Quarter 4 above the 90th percentile was received at Orpington hospital site.

The hip arthroplasties were continuously above the national benchmark (just over 0.50%) with a trust average just above 1.50%. It was from these procedures where we received 2-outlier letters. Quarter 2 inpatient and readmission SSI risk was 2.6% whilst Q3 was 1.0%.

Compared to the knee arthroplasties, we only received 1- high outlier letter above the 90th percentile for 2025. There was a rise of SSI in Q2 with a trust average of 0.40% and a national benchmark of below 0.60%, however, there was no high outlier received as we were not at all at the 90th percentile mark. Moreover, we recently received the knee arthroplasty high outlier letter in April 2026 as we were above the 90th percentile, national bench marking at 0.60% for Q4. The inpatient and readmission SSI risk on this period was 0.9%.

Contributing factors identified from investigations included:

- Missing MRSA screening result.
- Theatre ventilation with Air Handling Unit (AHU) outside building refurbishments (now improved).
- Laminar flow grill cleaning and electrical works refurbishments.
- Compliance to theatre discipline, preoperative skin preparation, hand hygiene in Boddington and McKenzie King wards emphasized.
- Improved discharge leaflet on monitoring surgical site infection was in place
- Review of medical history on preassessment e.g. Diabetes, patients on immunosuppression, smoking to avoid complications like SSI.
- Early swabbing of surgical site if deemed oozing for a while especially with wound dehiscence.

A surgical site infection surveillance nurse for the Neurosciences Care group was commissioned and started in post in February 2026, to monitor surgical site infections in cranial and spinal procedures, and work with Neurosciences to prevent surgical site infection.

7.0 Vascular Access Service (VAS)

The key achievements for the service during 2025-2026 were:

- We have been able to capture estimated Vascular Access Team Activity of 3,655 procedures which includes, PICC line insertion, Midline insertion, Femoral line insertion, Port accessing/deaccessing, DIVA service and other troubleshooting procedures.

- A permanent recruitment into a post for the role of Line practitioner PDN

- Transfer of Insertions of Apheresis line to the vascular access team from radiology.

- Introduction Tegaderm CHG dressing into all clinical areas as the preferred dressing of choice in the Trust including venepuncture in inpatient areas in accordance with internation standards

- Sustaining the Paediatric Line insertion service. We have 6 ANPs fully established; 4 more than last year.

- Presented 3 posters relating to Paediatric line insertions at the 9th World Congress on Vascular Access (WoCoVa) in Spain April this year.

7.1 Vascular Access Service Training and Education

IV training and education continues as an important strategy to standardise practice and ensure that clinical staff can prevent IV related complications on patients with IV devices.

a. ANTT

- A new ANTT e-learning module to provide interactive platform for the module
- We continue to engage with medical staff in ensuring all medical staff arriving at King's has input on "Line Care & Management and Device Section" Training

b. Venepuncture and Cannulation (V&C)

- The Cannulation and Venepuncture training is now back withing the domain of the Team, including bank staff.

c. IV Link Nurse Masterclass

- The Trust's Vascular Access team delivered the largest intravenous masterclass on Friday 24 April, titled 'Vascular Access 360: Connecting Care Across Different Specialities'. The conference was held in the Fetal Medicine Institute and was attended by nearly 100 delegates.

d. Professional development

As part of our development, we continue to enrol in the non-medical prescription course, another on the leadership development course and others are awaiting clearance and support to attend conferences, seminars and other development opportunities.

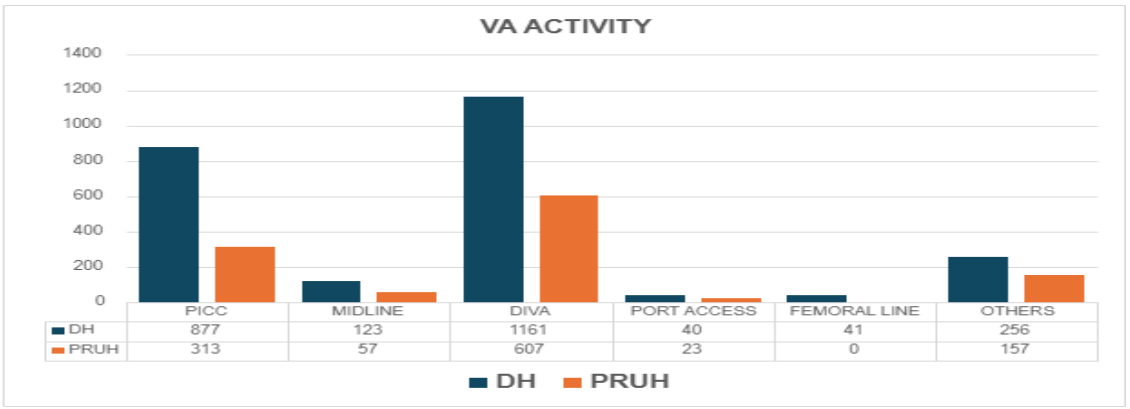
7.2 Clinical Workload

The Vascular Access team operate a daily list for PICC, Midline, ultrasound guided cannulation, ultrasound guided blood sampling, as well as femoral lines insertions from a dedicated procedure room at DH. We are also part of the service for removal of tunnel Vascath for renal patients. Aside from the insertions in the procedure rooms, we see patients in theatres, wards and CCUs for line insertions also. Paediatric patients are now regular on our lists continue to absorb the work from Radiology. We cover the PRUH and South Sites also.

Figure 19



Figure 20



8.0 Decontamination

The decontamination of medical devices is overseen by the Trust Decontamination Committee which reports and provides assurance to the Infection Prevention and Control Committee which links to the Patients Safety Committee and ultimately reports to the Trust Executive Board.

The provision of decontamination service is split across sites. All services are provided by third party providers IHSS Ltd supply the service at Denmark Hill site and Steris provide the service for the remainder of the sites and the dental school at Denmark Hill. The services have improved and issues have been managed through regular contract management meetings. The service provision has been through the tender process and the contact awarded. Contracts are managed by Kings Management services (KFM) a wholly owned subsidiary of Kings College Hospital Trust

The provision of Trust flexible endoscopy decontamination services, including staff, is provided by Kings Management services (KFM). This service is delivered to the Denmark Hill

site via an onsite endoscopy decontamination unit that was refurbished in 2023. This unit has been audited by JAG and met their requirements. The unit was certified to ISO 13485 Medical devices - Quality management systems: Requirements for regulatory purposes in May 2025. The certification provides assurance as to the standards within the unit and it is subjected to external audits annually by MHRA appointed notified bodies. This was significant achievement. The new endoscopy decontamination unit at PRUH opened in June2026 and the services will be certified once the service provision and quality system has been embedded.

The Trust appointed to the vacant Decontamination Lead post August 2025. This will provide a consistent and increased time resource to dedicate to providing assurance of decontamination standards across the Trust.

To ensure the consistency of decontamination of medical devices that require high level disinfection it was agreed that we would concentrate on the 3 different methods currently used in the Trust at this time. Audits have been undertaken in most of areas to look at compliance and areas for improvement, this included training and competency assessments to ensure the processes are safe. Potential alternative methods were agreed to be investigated and assessed for suitability and validation prior to being available for staff. This will involve working with Procurement.

Due to the limited time resources the planned audit schedule for 2025/6 was not completed, however the high-risk areas were all audited and where actions required these have been addressed. The audit schedule for 2026/7 is developed and with the higher level of resource will be achieved this will provide assurance that the Trust practices are in line with local and national guidance.

Audit reports are generated and, where appropriate, recommendations made for improvements. Any risks identified are recorded on the InPhase incident reporting system and discussed routinely at the bi-monthly Decontamination Committee. The Trust Annual Decontamination Strategy provides a focus for improving practices within the organisation and to identify work priorities.

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Appendices

Appendix 1: Glossary of Terms

ACCP	Advanced Critical Care Practitioner
ANTT	Aseptic Non-Touch Technique
AUSG	Antibiotic Usage Steering Group
BC	Blood culture
Bla IMP	Imipenemase metallo-betalactamase gene
BSI	Blood Stream Infection
CCU	Critical Care Unit
CDI	*Clostridioides difficile* Infection
COCA	Community Onset Community-Associated
COHA	Community Onset Healthcare-Associated
COIA	Community Onset Indeterminate-Association
CPE	Carbapenemase Producing Enterobacterales
DIPC	Director of Infection Prevention & Control
DH	Denmark Hill site
DH	Department of Health
ETT	Endotracheal tube
GAS	Group A streptococcus
HCAI	Healthcare-associated Infection
HCW	Healthcare worker

HOHA	Hospital onset healthcare-associated
iGAS	Invasive Group A streptococcus
IV	Intravenous
IPC	Infection Prevention & Control
JAG	Joint Advisory Group on GI Endoscopy
KCH	King's College Hospitals
KFM	King's Facilities Management
KPC	Klebsiella pneumoniae Carbapenemase gene
KPI	Key Performance Indicator
MRSA	Meticillin resistant *Staphylococcus aureus*
MSSA	Meticillin- sensitive *Staphylococcus aureus*
NEC	Necrotising enterocolitis
NDM	New Delhi metallo-β-lactamase-1 gene
NICE	National Institute for Clinical Excellence
NICU	Neonatal Intensive Care Unit
OPAT	Outpatient Parenteral Antibiotic Therapy
OXA-48	Oxa-48 gene
PDQ	Post-Discharge Questionnaire
PICC	Peripherally inserted Central Line
PPE	Personal Protective Equipment
PRUH	Princess Royal University Hospitals
PVC	Peripheral Venous Catheter
RCA	Root cause analysis
SSD	Sterile Services Department

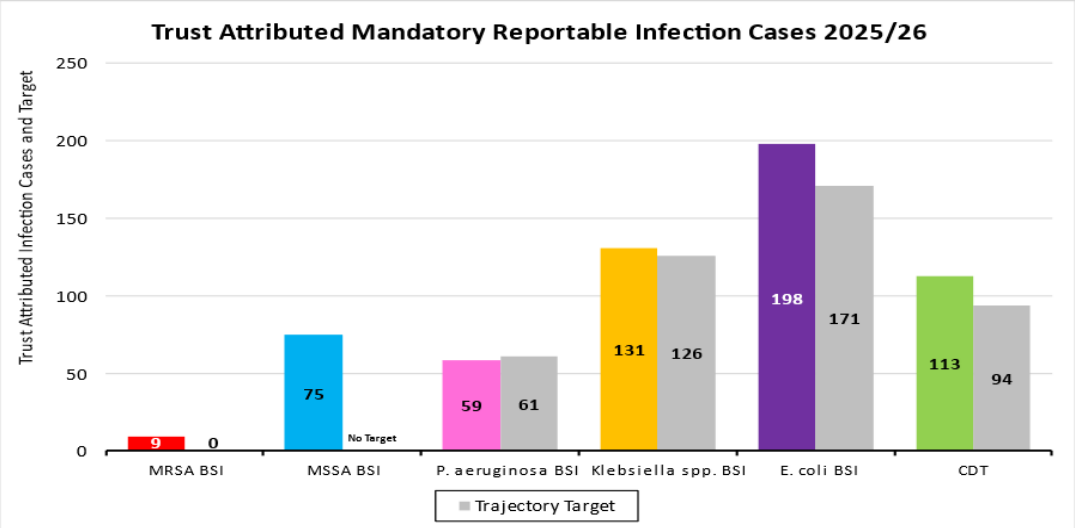
SSI	Surgical Site Infection
SSISS	Surgical Site Surveillance Scheme
THR	Total Hip Replacement
TKR	Total Knee Replacement
UKHSA	United Kingdom Health Security Agency
UTI	Urinary Tract Infection
VAS	Vascular Access Service
VRE	Vancomycin Resistant Enterococcus
VSG	Ventilation Safety Group
VLTI	Vascular Line tip infections

King's College Hospital NHS Foundation Trust

Infection Prevention & Control Annual Report 2025-2026 Summary

This Infection Prevention, Control Annual Report summarises the annual achievements, developments, performance and standards by the Trust and its staff in key areas and against key objectives, relating to infection prevention and control and prudent antibiotic prescribing.

For 2025-2026, the Trust exceeded the UKHSA healthcare-associated infection (HCAI) targets for Trust attributed *E. coli*, *Klebsiella* spp. and MRSA blood stream infections (BSI), as well as *Clostridioides difficile* infection (CDI). The Trust achieved the target for attributed *P. aeruginosa* BSIs. Compared with the previous financial year, 2025/26 saw a modest reduction in MSSA BSI cases and a pronounced reduction of 22% in *Pseudomonas aeruginosa* BSI cases. In contrast, there was a marginal increase in *Klebsiella spp*. BSI cases whilst *E. coli* and MRSA BSIs rose by over 10%. Kings had the third lowest attributed CDI rate in the Shelford group in financial year 2025/26, was in line with the overall average for MRSA BSI, and the third lowest attributed MSSA BSI rate within the Shelford group.



Key achievements

- Intravenous line-related BSI reduced from 49 in 2024/25 to 40 in 2025/2026, an 18% reduction.
- A reduction of 22% in p*seudomonas aeruginosa* BSI cases.
- A modest reduction in MSSA BSI cases compared to the previous year.
- Denmark Hill had a 21% decrease in C. diff cases from 85 in 2024/25 to 67 in 2025/26.
- We had the third lowest rate of *C.diff* of the Shelford Hospitals.

Key Risks

Epic - the production of automated data and reports, specifically in relation to healthcare-associated infection mandatory reporting requirements and Surgical Site Surveillance, remain a challenge. A Task & Finish group is in progress with support from Cogito, Cogstack and BIU.

Outbreaks of healthcare-associated infection – there is a continued risk of outbreak of healthcare associated infection which is multifactorial, including IPC practice, variation in cleaning, lack of ventilation in general wards, bed spacing, fabric of the Estate (which impacts on cleaning standards) and lack of decant ward. Placement of additional patients over and above ward template during times of operational pressures impacts the risk of cross infection. Delays in microbiology turnaround times, particularly for CPE and *C.auris* screening results, were a concern due to the associated outbreak risks. A plan is in place with the pathology provider focussing on improving performance in this area.

We do not meet our HCAI objectives - The focus for the coming year will continue to be a reduction in *C. difficile* infections, MRSA, and reducing the risk of patient harm associated with avoidable blood stream infections (where invasive devices are the source), and improvements in antimicrobial stewardship (antibiotic IV to oral switch).

Estates - The age and condition of the older parts of the hospital buildings, the fabric of the estate, and the associated management of water systems and ventilation, is recognised on the Trust's corporate risk register. For PRUH & SS, addressing the fabric of the Estate and management as part of contractual requirements.

Sustaining QI Improvement work – the capacity to spread Quality Improvement work to the entire Trust, and how to sustain improvement in the medium to long term.

Each year the IPC team prepares an annual programme of work which is monitored by the IPC Committee. The purpose of this programme of work is to ensure that a culture of continual improvement is maintained and to reduce avoidable harm to patients and staff from infections. The focus of our activities for the coming year is:

- Peer review of aseptic non-touch technique (ANTT) and implementation of recommendations.
- Priority areas for antimicrobial stewardship improvement.
- Reduction in device-related blood stream infections with urinary catheters and intravenous lines as the source.
- Using the King's Improvement Method for QI projects for a reduction in *Clostridioides difficile* infections, equipment and environmental cleaning, sustainability and non-sterile glove use, and MRSA.

King's College Hospital NHS Foundation Trust

AGENDA ITEM: 21

BOARD/COMMITTEE REPORT COVER PAPER

Report to:	Trust Board
Date of meeting:	17 November 2026
Subject:	**Safeguarding and Vulnerabilities Annual Report 2025-2026**
Author(s):	Wayne Hurst, Deputy Chief Nurse David Glover, Associate Director of Safeguarding and Social Work. Zoe Lane, ADoN Safeguarding Children and Maternity Kieran Quirke, ADoN Mental Health
Sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery
History:	Previously considered by the Vulnerabilities Assurance Committee Kings Management Committee
Status:	

Decision/ Approval		**Discussion**		**Assurance**	✔	**Information**	✔

Purpose

To provide an update on the Trust's Safeguarding and vulnerability service activities for 2025-2026 and to provide assurances of the Trust's adherence to statutory duties regarding safeguarding adults and children.

Recommendations

The Trust Board is asked to note this report for evidence of assurance to comply with the Children's act 1989 (2004), Working together to safeguard children (Statutory framework (2026), London child protection procedures (2026), and The Care Act (2014).

Strategy Alignment

High-Quality Patient Care	✔	**Strong Successful Partnerships**	✔

1 King's values ✔ Caring ✔ Collaborative ✔ Inclusive ✔ Innovative

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 7 and 8*
King's Improvement Impact (KIM):	KIM approach adopted in initiatives delivered.
Quality Impact	*Describe the actual or anticipated impact on patient safety, clinical effectiveness, patient experience and outcomes. Include any quality risks and mitigating actions.*
Health Equity Impact	*Explain how the proposal will affect health inequalities, access to services, patient experience or outcomes for different population groups. State whether an Equality Impact Assessment (EqIA) has been completed or is required.*
Workforce Impact	*Describe the implications for staffing, workforce capacity, skills, wellbeing, engagement, recruitment, retention, training or organisational culture.*
Research/Innovation Impact	*Explain whether the proposal supports research activity, innovation, education, digital transformation, service redesign or adoption of new technologies and practices.*
Digital Impact	*Describe any digital, information management, cyber security, data quality, AI or technology implications. Confirm whether digital and AI opportunities and risks have been considered.*
Financial Impact	*Summarise the financial implications, including revenue and capital requirements, recurrent and non-recurrent costs, savings, efficiencies, funding sources and affordability. Include the consequences of not proceeding where relevant.*
Legal/ regulatory compliance	To follow and be aware of national and local guidance including, but not exclusive to: Children's act 1989 (2004), Working together to safeguard children (Statutory framework (2023), London child protection procedures (2024). The Care Act (2014) The Mental Capacity Act (2005) The Prevent Duty Care Quality Commission
Communications and Engagement	Working with the local safeguarding authorities (LSA)

Use of Artificial Intelligence Tools	*State whether or not AI tools have been used in the work reported in this paper or the writing of the paper. Where AI has been used, confirm that its use is compliant with Trust policy; no sensitive, patient, or commercial data has been entered; content has been reviewed for accuracy and confidentiality.*
Committee that will provide relevant oversight Quality & Reserach Committee	

Report Overview

Safeguarding and Vulnerabilities Annual Report 2025–2026

Presented by: Tracey Carter, Chief Nurse and Executive Director of Midwifery.

1. Purpose

This report is to provide assurance that King's College Hospital NHS Foundation Trust safeguarding arrangements for adults, children and maternity (antenatal/postnatal) are effective and as such, the Trust is upholding its statutory responsibility.
The report provides evidence of key safeguarding activity for the 2025/2026 reporting period, highlighting the challenges, risks and priorities for 2026-2027.

This report presents an overview of activity, compliance and learning across the safeguarding and vulnerabilities agenda.

In addition to the core statutory functions held by the department, this report also includes key service updates from notable allied partners and departments in their work in supporting our most vulnerable patients.

Key updates, activity data, risk information and an outline of service developments in relation to the wider portfolio of vulnerabilities, including Mental Health, Alcohol and Addiction Support, Social Work Services, Clinical Vulnerabilities Team and Supporting Positive Behaviour.

Full report from page 9.

2. Background

Safeguarding is a fundamental component of all care provided at KCH. The Trust acknowledges that safeguarding children, adults and protecting those who are vulnerable is everyone's responsibility and that we all have a duty to protect our patient from abuse and harm.

The Safeguarding and Vulnerabilities service brings together the teams who support patients, families and staff where there are safeguarding concerns, complex social circumstances, mental health needs, learning disability or autism, homelessness, addiction,

violence and aggression, or other factors that may increase vulnerability. This integrated model includes safeguarding adults, safeguarding children and maternity, social work, the Homeless Health Team, the Learning Disability and Autism service, the Addiction Care Team, mental health colleagues, Supporting Positive Behaviour and the Vulnerabilities Clinical Team. By working as one connected service, teams are able to share expertise, identify risk earlier, reduce duplication and provide more coordinated support at the point of care.

The service has continued to develop from a statutory safeguarding function into a wider, relational model of care that supports complex decision-making, advocacy, risk management, training, policy development and multi-agency partnership working. This integrated approach has enabled practical service developments, including the expansion of the Vulnerabilities Clinical Team, the Helping Hands blood test clinic for children with learning disabilities and/or autism, increased emphasis on reasonable adjustments, improved de-escalation and trauma-informed training, strengthened links with domestic abuse and legal advocacy partners, and closer working with local authorities, police, mental health providers and voluntary sector organisations. It also supports the Trust to provide clearer assurance on activity, quality, compliance, risk, learning and improvement through a more consistent reporting structure into the Vulnerabilities Assurance Committee.

Co-location of the Safeguarding and Vulnerabilities service across both Denmark Hill and the Princess Royal University Hospital has strengthened the visibility, responsiveness and consistency of specialist support across the Trust. This cross-site presence also helps staff to access expertise more easily, supports shared learning between teams, and promotes a more equitable service offer for vulnerable patients regardless of where they receive care.

3. Discussion

Progress against Key Priorities and key achievements

During the 2025/26 reporting period, the Safeguarding and Vulnerabilities portfolio continued to strengthen as an integrated, cross-site service supporting patients, families and staff where safeguarding concerns, complex social circumstances, mental health needs, learning disability or autism, homelessness, addiction, violence and aggression, or other vulnerabilities are present. The year was marked by improved governance, clearer assurance routes, stronger partnership working and a sustained focus on trauma-informed, person-centred care. Key achievements included sustained statutory safeguarding delivery across adults, children and maternity; improved training compliance; expansion of vulnerability-focused clinical support; strengthened violence prevention and restrictive practice oversight; continued development of mental health improvement work; and practical service innovations that improved access, safety and patient experience.

Across the portfolio, teams delivered a broad programme of improvement. Safeguarding adults, children and maternity services maintained high levels of activity while strengthening supervision, policy review, multi-agency engagement and learning from statutory reviews, Section 42, Section 44 and Section 47 processes. The Learning Disability and Autism service was reconfigured within the wider vulnerabilities model, improving alignment with

patient need and supporting greater use of reasonable adjustments, including the Helping Hands blood test clinic for children with learning disabilities and/or autism. Adult and children's safeguarding training compliance improved, with Level 3 safeguarding compliance reaching above 90% and Oliver McGowan training implementation continuing across the Trust.

The wider vulnerabilities programme also delivered tangible improvements in patient care and staff support. The Vulnerabilities Clinical Team expanded its role as a liaison and advocacy service for highly complex patients, supporting clinical teams with positive behaviour support planning, complex discharge, mental capacity issues and trauma-informed approaches.

Mental health, addiction, homelessness and social work services continued to address some of the Trust's most complex operational and health inequality challenges. Mental health improvement work progressed through the Patient Safety Mental Health Improvement Group, development of the Denmark Hill Emergency Department Mental Health Area, work on detained patient pathways, refreshed enhanced therapeutic observation and care standards, and strengthened collaboration with SLaM, Oxleas and voluntary sector partners. The Addiction Care Team maintained specialist support across Denmark Hill and PRUH, contributed to the approved South East London business case to restore seven-day provision, and supported community referral pathways and medically assisted withdrawal. The Homeless Health Team continued step-down accommodation and legal advocacy work, including Southwark Law Centre support, while social work services strengthened EPIC reporting, hardship support, practice education, staff support and specialist roles including the Adolescent and Young Adult Liver Social Worker.

Overall, the 2025/26 reporting period demonstrates a maturing Safeguarding and Vulnerabilities portfolio with stronger cross-site visibility, clearer governance, more consistent reporting, and a growing focus on relational, preventative and trauma-informed care. The portfolio has delivered measurable progress while continuing to manage significant demand, complexity and system pressure. Priorities for 2026/27 will focus on consolidating these improvements, strengthening data-led assurance, sustaining workforce development and continuing to reduce health inequalities for the Trust's most vulnerable patients.

Overview of Activity and Achievements

Safeguarding and vulnerabilities services continue to operate as a fully integrated model encompassing children's and adult safeguarding, maternity, social work, mental health, homelessness, addiction care, learning disabilities, and the Clinical Vulnerabilities Team. This whole-system approach has strengthened communication between teams, enabled timely interventions at the point of care, and supported more coordinated multi-agency responses.

During 2025/26, services across the Safeguarding and Vulnerabilities portfolio continued to manage sustained demand and increasing complexity:

- **Adults:** 2856 referrals (up from 2,628 in 2024/25).
- **Children:** 3,859 referrals, remaining consistently high compared with 2024/25 and 137 lower than that total. Referral sources for children were as follows:
    - Emergency: 3,185 (82.6%)

- Safeguarding service: 166 (4.3%)
- All other specialties each contributed small proportions (≤1.7%)

Across safeguarding adults, safeguarding children and maternity, social work, homelessness, learning disability and autism, addiction care, mental health, supporting positive behaviour and the Vulnerabilities Clinical Team, activity during 2025/26 remained high and increasingly complex. The portfolio responded to a wide range of needs, including abuse and neglect, mental ill health, domestic abuse, exploitation, homelessness, substance use, neurodiversity, challenging behaviour and complex discharge. This sustained demand reflects improved staff awareness, earlier identification and escalation of risk, greater visibility of specialist services and the growing complexity of patients and families presenting across the Trust, rather than an increase in harm alone.

- **Positive external assurance**: The Lambeth children social care Ofsted inspection highlighted the positive collaboration between us highlighting strong partnership working. The London Borough of Bromley received its first full CQC inspection in January 2026, the report praised the quality of partnerships which was identified as an area of strength within the published document.
- **Service innovation**: New initiatives such as the Helping Hands blood test clinic for children with learning disabilities, the continued rollout of the Vulnerabilities Clinical Team, and the creation of a dedicated adolescent and young adult liver social worker role have improved patient experience and reduced health inequalities.
- **Workforce development**: Implementation of the Oliver McGowan Tier 2 Learning Disability and Autism training has progressed, with Tier 1 compliance at 92% and over 230 staff completing Tier 2 at the time of this report, despite some initial challenges that presented with the face-to-face training component and quality. The tier 2 training format continues to be evaluated and supported. Safeguarding Children and Maternity Level 3 reached over 90% compliance.
- **Policy updates**: The safeguarding children and safeguarding maternity policies were comprehensively revised during the reporting period to reflect national updates and to improve accessibility and understanding for clinical teams.

Partnership working

Strengthened collaboration with local authorities, police, Victim Support, Southwark Law Centre, and voluntary sector agencies has supported improved safeguarding outcomes, including increased MARAC referrals and enhanced legal advocacy for homeless patients.

The Safeguarding Children and Maternity teams has also expanded partnership engagement to include Lewisham and Croydon, reflecting a rise in cases involving these local authorities. The team continues to attend partnership meetings in Bromley, Southwark, Bexley, and Lambeth. *Risks and Challenges*

Despite these successes, the Trust continues to face several system pressures:

- **Rising complexity of referrals**: Mental health presentations, domestic abuse, child exploitation, and neglect remain the most common safeguarding concerns, placing sustained pressure on safeguarding teams. Large numbers of children continue to present to our emergency departments with dysregulated behaviour, increasing length

of stay in both EDs and requiring external escalation. This has also extended stays for non-medical admissions in child health areas

- **Workforce and service gaps**: Staff turnover, long-term absences, and funding pressures have created vulnerabilities across some services, including the Homeless Health Team at the Princess Royal University Hospital (PRUH) and weekend coverage within the Addiction Care Team.
- **Violence and aggression**: Reported incidents of violence, abuse, and challenging behaviour increased to 9013 (up 26% from 7152 in 2024/25, and an increase of over 47% since 2023/24). However, deeper analysis of incidents would suggest the vast majority relate to clinically related challenging behaviour, underscoring the need for better and more accurate coding but also a clear strategy for ensuring our staff teams have access to training around trauma-informed approaches, enhanced de-escalation, and better staff support.
- **External service loss**: The discontinuation of the British Red Cross Homeless Resettlement Service has left a gap in post-discharge follow-up for homeless patients, increasing the need for alternative support pathways.
- Domestic abuse provision: The current externally managed and inconsistently resourced domestic abuse service does not provide sufficient on-site provision, oversight, or responsiveness to meet Trust need, particularly during periods of increased demand. This resulted in delays to specialist support, gaps in safeguarding response, and increased reliance on safeguarding teams to manage high-risk cases, with associated risks to patient safety, staff wellbeing, service effectiveness, and organisational reputation, alongside potential scrutiny in safeguarding and domestic abuse-related reviews.

Priorities for the 2025–2026 Reporting Period

Overall, there has been delivery of substantial progress against the key priorities, embedding trauma-informed practice, enhancing violence prevention measures and expanding the capacity of the Vulnerabilities team. Several areas, such as de-escalation training delivery, detained patient pathway alignment and children's ED environmental improvements will remain active priorities for the forthcoming reporting period, to consolidate gains and address remaining challenges.

Strengthen Safeguarding Capacity and Compliance

Maintain statutory safeguarding arrangements across adults, children, and maternity in line with the Children Act (2004), Care Act (2014), and Mental Capacity Act (2005).

Ensure learning from all local 7minute briefings and rapid reviews are disseminated to staff and result in improved processes.

Workforce Development and Training

Sustain compliance with Level 3 safeguarding training and ensure consistent delivery across all sites.

Enhance bespoke MCA/DoLS training to strengthen application in practice.

Vulnerabilities Clinical Team
Continue to develop the reach of the Vulnerabilities Clinical Team with a focus on support for outpatients and improving clinical outcomes.

Establish a clear and structured service line with a coherent approach to support for patients presenting with challenging behaviour between the ETOC team as first line and the Vulnerabilities Clinical Team providing more complex admission to discharge support.

Develop a simulation training programme to support staff in effective, trauma-informed and compassionate relational care.

Learning Disabilities and Autism
Complete and evaluate Trust-wide rollout of the Reasonable Adjustment Digital Flag.

Embed the Epic referral pathway and introduce a quarterly activity and outcomes dashboard.

Increase capacity and embed the Oliver McGowan Learning Disability & Autism training, with a focus on consistent use of the Reasonable Adjustment FYI flag on EPIC.

Strengthen LeDeR communication, Structured Judgement Review completion and cross-site workforce resilience.

Develop a network of LD and Autism champions to embed best practice in ward areas.

Improve use of the Universal Care Plan through co-production and audit.

Expand and evaluate Helping Hands and deliver the VR preparation pilot.

M*ental Health*
Develop better intelligence through a dashboard capturing mental health flow and also outcome related data across a range of physical healthcare pathways.

Continue to develop and improve the mental health governance structure throughout the Trust.

Support colleagues in our partner Mental Health Trusts to get easier and more fluid access to King's systems to improve communications and documentation.

Explore more progressive and radical approaches to support the compassionate care of patients with mental health co-morbidities in our Emergency Departments including the EmPATH model.

Positive Behaviour Support
Reduce violence and aggression incidents through trauma-informed, public health approaches and the wider rollout of the Vulnerabilities Study Day and de-escalation training.
Review the use of mechanical restraint to ensure safe, proportionate, and compassionate practice.

Support the rollout of the Broset Violence Checklist and Dynamic Appraisal of Situational Aggression clinical tools across all inpatient areas.

Homelessness and Social Work Integration
Align the function of homeless discharge pathways with wider trust discharge functions
Strengthen governance across Social Work departments through the development of new standardised EPIC report functionality.

Strengthen partnerships with community housing providers to improve the efficiency of housing delays and discharge from hospital.

Addiction Care
Deliver the approved business case to restore a seven-day Addiction Care Team service across Southeast London, improving community detox pathways and reducing unnecessary admissions.

Mental Capacity and DoLS
Relaunch the MCA/DoLS improvement forum and deliver consistent support for the next 12 months.

Finalise the new MCA/DoLS standalone policy in light of recent changes in case law
Revise training curriculums to ensure content is aligned to current legal position in respect of deprivation of liberties.

Partnership and Multi-Agency Collaboration
Maintain active engagement with statutory safeguarding boards, MARAC, local authorities, and voluntary sector partners to ensure timely, coordinated responses to complex safeguarding cases.

Continue to strengthen collaboration with Southwark Law Centre and Victim Support to address legal, housing, and domestic abuse risks.

Continue to engage with our safeguarding children partnerships meetings for Bromley, Southwark and Lambeth.

Full Report

1. Introduction & Scope

Safeguarding is a fundamental component of all care provided at KCH. The Trust acknowledges that safeguarding children, adults and protecting those who are vulnerable is everyone's responsibility and that we all have a duty to protect our patients from abuse and harm.

The report presents an overview of activity, compliance and learning across the safeguarding and vulnerabilities portfolio at the Trust between 1st April 2025 – 31st March 2026. During this time period, the data presented within this report has been shared and reviewed within the Quarterly Trust Vulnerability Committee.

This report provides:

- An outline of the monitoring arrangements and training undertaken to ensure the safety of patients and staff under our care.
- An update on safeguarding activity within this time period including progress made in strengthening safeguarding structure, processes, service, practices, and outcomes.
- An overview of any significant issues or risks regarding safeguarding and the actions we are taken to mitigate these.
- An overview and update from each of the service areas from teams working under our overarching 'vulnerabilities team' including mental health, supporting positive behaviour, social work, homelessness team and drug and alcohol services.

2. Background

The Safeguarding and Vulnerabilities Team works across the Trust and with external partner agencies. Each service is led by the relevant Assistant or Associate Director, with support from the Deputy Chief Nurse (Appendix 1). The Safeguarding and Vulnerabilities Service provides an integrated, Trust-wide approach to protecting and supporting children, adults, families and patients whose circumstances may increase their risk of harm or poorer health outcomes. Bringing together safeguarding, maternity, social work, mental health, learning disability and autism, homelessness, addiction care and specialist vulnerabilities expertise enables earlier identification of risk, coordinated intervention and compassionate, person-centred care across hospital sites and in partnership with external agencies.

3. Leadership, Governance and Team Structure

During 2025/26, the Safeguarding and Vulnerabilities Service introduced a revised governance structure to strengthen oversight, accountability and assurance across the portfolio. Each service retains clear clinical and operational leadership, with Named Professionals and operational leads responsible for day-to-day delivery and escalation through the relevant Assistant or Associate Director. The quarterly Vulnerabilities Assurance Committee provides overarching strategic oversight and receives reports from four operational forums: the Supporting Positive Behaviour Group, Vulnerable People Operational Group, Mental Health Act and Medical Emergencies in Eating Disorders Forums and Safeguarding Operational Group. Supporting governance arrangements include monthly

Restraint Reviews and the Exclusion Panel, which report through the Supporting Positive Behaviour Group, and the monthly Mental Capacity Act and Deprivation of Liberty Safeguards Forum, which reports through the Safeguarding Operational Group. This structure supports consistent reporting, scrutiny of risk, shared learning and escalation to the Trust's senior governance forums. The full reporting structure is set out in Appendix 2.

4. Safeguarding Services

There is a requirement of KCH to safeguard and promote the welfare of patients as set out in legislation including Section 11 of the Children Act (2004), Mental Capacity Act (2005), Working Together (2026), The Care Act (2014), Modern Slavery Act (2015), Serious Crime Act (2015) and the Domestic Abuse Act (2021).

The Trust is registered with and monitored by the Care Quality Commission (CQC), NHS England and the ICB. Within the CQC framework, there are 2 regulations which need to be met by registered providers, that are relevant to safeguarding, section 12: Safe Care and Treatment and regulation 13: Safeguarding service users from abuse and improper treatment.

It is the responsibility of every NHS funded organisation, and each individual healthcare professional working in the NHS, to ensure that the principles and duties of safeguarding children and adults are holistically, consistently and conscientiously applied, the well-being of children and adults is at the centre of what we do.

The Safeguarding Accountability and Assurance Framework (NHSE, 2022) states that every NHS funded organisation needs to ensure that sufficient capacity is in place for them to fulfil their statutory duties; they should regularly review their arrangements to assure themselves that they are working effectively. Organisations need to co-operate and work together, within new demographic footprints, to seek common solutions to the changing context of safeguarding and developing the new processes, using resources and skill effectively, to be able deliver the NHS Long Term Plan (2019).

All health providers are required to have effective policies and procedures to safeguard vulnerable individuals and to assure themselves, regulators and their commissioners that these are compliant and fit for purpose. These arrangements include safe recruitment, effective training for all staff and effective supervision arrangements, working in partnership with other agencies and identification of a Named Doctor, a Named Nurse, a Named Midwife and a Named lead for mental capacity act (MCA).There have been a number of key legal and policy changes which have focused on enhancing protection measures, improving staff training and incorporating technology to better safeguard vulnerable adults and children.

4.1 Safeguarding Children and Maternity

Safeguarding children and maternity in acute hospital settings is a critical aspect of healthcare that ensures the safety and well-being of vulnerable individuals. The policies and guidelines

in place are designed to protect children, unborns and their families from harm and to provide the necessary support and intervention when needed.

In the context of safeguarding children, healthcare professionals are required to be familiar with their responsibilities under the safeguarding policies. This includes knowing how and when to contact the Safeguarding Children Team for advice and making referrals to Children's Social Care. The Children Act (2004) emphasises that the primary responsibility for the care and protection of dependent children rests with parents, but healthcare professionals play a crucial role in identifying and addressing any safeguarding concerns.

Overall, safeguarding in acute hospital settings involves a multi-disciplinary approach, with healthcare professionals working closely with agencies to ensure the safety and well-being of children and unborns are met. This collaborative effort is essential in identifying risks, providing appropriate interventions, and ensuring that safeguarding policies are effectively implemented. The Trust ensures that these responsibilities are met through providing frontline staff with safeguarding supervision, safeguarding training and a visible safeguarding team, which functions as part of the overarching vulnerabilities service.

There has been some long-term absence within the Safeguarding children and maternity teams and together with natural movement and progression of postholders into new positions, this resulted in a period of time where mitigations were required, to ensure gaps in service provision were met. This risk was acknowledged on the Trust Risk Register during the reporting year. The safeguarding risk register is a critical tool used to identify, assess, and manage risks related to safeguarding children and maternity within the hospital setting. There is a clear plan of mitigation in place and at the time of writing this report, full recruitment has taken place and new staff have started in the service.

Referrals to the team in this reporting period was 3859. This demonstrates stabilisation of referral numbers when compared to the previous year 24/25. The main categories of abuse related to mental health, physical abuse, child exploitation, domestic abuse and neglect.
Mental health presentations for children, expectant mothers, and parents/carers continue to be one of the highest categories of referrals received by the safeguarding team, like the previous years. There has also continued to be an increase in presentations of neglect to the Trust, which may be related to the cost of living. Additionally, the impact of adverse childhood experiences on perinatal and child mental health has been observed, along with increases in the length of stay in our maternity areas due to homelessness. We continue to collaborate with our multi agency colleagues to combat this issue and raise it within the SEL ICS.

Service Area	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26
Safeguarding Children	846	802	586	786
Safeguarding Maternity	133	116	156	142

Exploitation and serious youth violence remain key areas of concern. The Safeguarding team has collaborated with local agencies, Solace and Red Thread to ensure that children

presenting with these exploitation concerns are supported and followed up in the community. The safeguarding team also attends subgroups, including MACE (Multi-Agency Child Exploitation) meetings, and collaborates within these forums to ensure there is strategic oversight across the safeguarding Southeast London partnership. These partnerships have led to improved outcomes, such as better coordination of services, enhanced support for vulnerable children, and more effective interventions to address exploitation and violence.

Ofsted Inspection

The Lambeth children's services Ofsted inspection highlighted strong and improving partnership working as a central driver of improved outcomes for children and families. Multi-agency collaboration was particularly effective within early help and safeguarding, with locality-based children's centres and the integrated referral hub providing coordinated access to support. Partner agencies such as the Trust contributed timely, high-quality referrals, and professionals worked together effectively through multi-agency meetings, strategy discussions and safety planning to manage risk. This collaborative approach was especially evident in responses to complex issues such as domestic abuse, exploitation and extra-familial harm, where intelligence-led, joined-up interventions improved safety, resilience and engagement with education and communities.

Health and wellbeing were clearly prioritised across services, with strong integration between social care and health partners ensuring that children's physical, emotional and developmental needs were well understood and addressed. Children in care benefited from coordinated planning that supported access to specialist health services, with additional in-house provision mitigating delays and ensuring timely support. Multi-agency approaches also underpinned effective responses for vulnerable groups, including those affected by domestic abuse, neglect and mental health needs, as well as care leavers who received proactive support to access physical and mental health services. Overall, this joined-up focus on health contributed to improved stability, wellbeing and long-term outcomes for children and young people.

Key Priorities for 2026/27

- **Strengthen safeguarding leadership, governance and assurance** through the implementation of the new Safeguarding Operational Group and Vulnerabilities Assurance Committee arrangements, ensuring robust oversight of risk, quality improvement, learning and statutory compliance.
- **Enhance safeguarding practice across children's, maternity and neonatal services** by embedding learning from reviews, inspections and national guidance, promoting consistent, evidence-based safeguarding assessments, professional curiosity and effective risk management.
- **Develop and sustain a resilient safeguarding workforce** through recruitment to key specialist posts, strengthened supervision arrangements, leadership development and delivery of high-quality safeguarding education and training programmes.
- **Strengthen multi-agency partnership working and escalation pathways** to improve outcomes for vulnerable children, unborn babies and families, with particular focus on complex safeguarding cases, delayed discharges, domestic abuse, exploitation and contextual safeguarding concerns.

- **Improve the use of data, audit and quality improvement methodologies** to identify trends, demonstrate impact, monitor disproportionality, and drive measurable improvements in safeguarding outcomes across all services.
- **Embed the requirements of national safeguarding reforms and emerging legislation**, including *Working Together to Safeguard Children 2026* and mandatory child sexual abuse reporting arrangements, ensuring staff are equipped to respond effectively to contemporary safeguarding risks.

4.2 Adult Safeguarding

King's College Hospital has continued to strengthen and embed its safeguarding arrangements, demonstrating a clear organisational commitment to delivering high-quality, person-centred practice alongside effective partnership working across the wider system. Safeguarding adults remains a vital function of the trust and is there to protect a patient's right to live in safety, free from abuse and neglect.

The workforce has been relatively stable over the reporting period with no notable gaps in respect of coverage or an inability to provide timely responses across all of our estates. The department continues to be led by the Assistant Director of Social Work & Safeguarding Adults who reports to the Director of Nursing for Vulnerable Patients. The executive lead for all Safeguarding at King's is the Chief Nurse.

The trust continues to adhere to its statutory duties in respect of the safeguarding of adults, our safeguarding team remains committed in preventing the abuse of adults who might be unable to protect themselves because of their disabilities or care needs.

During the reporting period, 2856 referrals were made to safeguarding adult service. This is the third year of a consecutive increase in activity (2628 referrals in 2024-2025). The data reflects a continued trend of increased organisational knowledge and awareness and demonstrates improved visibility of the safeguarding service.

The safeguarding adult team continues to benefit from the increase in functionality available within the EPIC digital system, this is the third year that the team has been using the platform and there is greater awareness and understanding of some of the more nuanced and specialist functions available within the record system. All safeguarding referrals continue to be reviewed by a qualified social worker or registered nurse. These professionals undertake analysis, review & triage of referrals and ensure that the trust adheres to its statutory duties pursuant to The Care Act 2014.

We continue to receive a large volume of work where the patient may appear vulnerable but may not meet a statutory threshold requiring a safeguarding intervention. This pattern is noted within Safeguarding Boards where conversion rates between initial concerns and a S42 investigation remain low. The teams continue to utilize knowledge of wider community pathways and third sector services to ensure that patients in need who do not meet a statutory threshold are still considered for onward support.

The referral mechanisms within EPIC allow for the trust to be fully compliant with its statutory duties in relation to safeguarding. The team continues to proactively engage with ICT and System teams in ensuring good governance and risk mitigation regarding the King's College Hospital NHS Foundation Trust patient record system.

The Assistant Director of Safeguarding Adult's and the Director of Nursing for Vulnerable Patients continue to lead and support strong relations with our key partners across the system. This strategic leadership is supported through active engagement with the respective statutory safeguarding boards of Lambeth, Bromley and Southwark respectively.

During the reporting period the trust can confirm active engagement and contributions to the statutory boards and there has been consistent engagement and input into the specialty sub-groups & performance & quality forums that inform the strategic objectives of the overall board.

The trust continues to take a proactive approach to learning from safeguarding adult reviews, including those undertaken outside the local area. Learning is translated into practice through targeted training and engagement activity within clinical areas where it is felt there is best opportunity to influence future safeguarding responses.

In response to themes identified through safeguarding adult reviews, there has been a continued focus on improving practitioner understanding of self-neglect, recognising this as a complex area of practice that is often referenced within published reviews.
During the reporting period, there have been a total of 4 safeguarding adult reviews published where King's has been actively contributing to the analysis and review.

Our core statutory partners are those in which we are geographically based, Lambeth & Bromley respectfully. This is the third year we have not seen a commissioned statutory review in respect of Lambeth residents and as such is likely being underreported. This will be taken forward as a key service development across the new reporting window.

The complex case pathway (CCP) remains a tool available for us at King's to help co-ordinate and manage complexity in high-risk situations involving adults who are experiencing chronic self-neglect and there are concerns/disputes over the person's capacity. The team have benefited from some London Borough's commissioning dedicated pathway coordinators which supports timely management of the complex cases and manages all minutes/action trackers. The complex case pathway that has been created to allow improved management and responses to people with complex needs who may not sit under the traditional framework of safeguarding.

The Complex Case Pathway was developed in response to learning from Safeguarding Adults Review (SARs) and in collaboration with Bromley and Southwark Safeguarding Adults Boards. The team has requested 11 CCP's over the reporting period and it is noted that this is increasingly considered within team reviews and huddles as a method of managing complex risk associated with presentations involving fluctuations of capacity. safeguarding systems and processes remain well established, with effective referral pathways in place and the continued use of the complex case pathway to support multi agency risk management in high-risk situations.

Making safeguarding personal principles remain embedded within policy and practice, the safeguarding adult's policy was updated in the last reporting period and is up-to date. Policies

and practice aims to focus on the views, wishes and outcomes expressed by the individual. In the reporting period we have attempted to make improvements in this area, however it remains. Establishing the outcome of Section 42 enquiries has seen some improvements locally and the monthly forums with both Lambeth & Bromley continue with active input made by all partners.

The teams routinely undertake delegated enquiries on behalf of the local authority in the format of a King's implicated report. In the reporting period there have been a total of 18 investigations of abuse investigated by the trust. This can be summarised by the following:

- 5 allegations of physical assault
- 2 allegations of inappropriate deprivations of liberty relating to inappropriate methods of discharge
- 1 allegation of institutional abuse
- 4 allegations of neglect at the point of transfer of care
- 4 allegations of abuse attributed to neglect in providing basic standards of care
- 2 allegations of sexual abuse

The Care Act 2014 advocates a person-centered rather than process-driven approach. This is an area of continued development for the service and informs our objectives. The team continues to benefit from the additional capacity acquired in the previous reporting period. This has allowed the team to be divided across the new divisional structure within the trust and subsequently this allows the team to commence 1:1 discussions and case discussions with clinical areas.

The main categories of abuse assessed and reviewed by the team were self-neglect, neglect and Domestic abuse. Neglect and acts of omission remain the highest reported type of abuse at 31% (29% recorded in 24/25). Self-neglect has seen a steady increase which can be attributed to increased awareness and identification. This accounted for 19% of safeguarding enquiries which is comparable to previous years.
Monthly meetings take place with the leads for safeguarding, complaints, and PALS to enable triangulation of any issues that factor into the safeguarding remit, enabling more responsive feedback and agile response when needed.

Key Priorities for 2026/2027

1. Strengthen safeguarding operational reporting through engagement with the new safeguarding operational group, ensuring robust oversight and assurance is provided to the organisation

2. Enhance standards of practice and standardise the approach to review/triage/assessment across the safeguarding teams

3. Improve standards of audit and review through the completion of new audit methodologies with findings routinely shared and delivered to division colleagues

4. Embed the mental capacity act 2005 and continue to assess for change in respect of Deprivation of Liberties.

5. Support the delivery of a new Multi-Agency-Solutions-Panel (MASP) in conjunction with Safeguarding Adult Boards across London

6. Improve the way we engage with divisions and strengthen partnerships for learning from King's

4.3 Prevent

Prevent is part of the Governments strategy for counter terrorism (CONTEST) and seeks to reduce the risks and impact of terrorism on the UK. Health is a key partner in the Prevent Agenda and raising awareness of Prevent among front line staff providing health care is crucial. The trust currently requires staff to undertake mandatory training in respect of Prevent, as a minimum, all staff working in a healthcare setting must know what to do if they are concerned someone is at risk of becoming radicalised and the referral procedure for this concern. This includes knowing who to contact in their organisation to communicate their concerns or seek advice.

In line with the Royal College of Nursing and Royal College of Paediatrics and Child Health safeguarding documents and UK Core Skills Training Framework, the safeguarding teams oversee compliance against the core skills levels 1-3 Prevent Training on the Prevent Duty. This framework identifies 2 levels of competence and provides examples of groups that fall within each competency level. Level 3 builds upon the competencies, knowledge and skills of the proceeding combined level 1 and 2 basic awareness. In addition to the mandatory core skills training, the safeguarding adult teams deliver mandatory level 3 safeguarding adult's training across the organisation, this also refers to Prevent and the importance of safeguarding those at risk of radicalisation and exhibiting radical extreme views against marginalised groups and communities.

The trust has completed all required quarterly returns in respect of Prevent training compliance, this is a core reporting requirement for the service. The submissions are completed by the safeguarding leads however the overall executive lead for Prevent remains the Chief Nurse who is the executive lead for all safeguarding functions within the trust.
King's College Hospital NHS Foundation Trust made one Prevent referral in the reporting period, with 2 referrals completed in 2024-2025. The referral was initially accepted by Prevent however did not progress to involvement from subsequent support panels and the case was eventually closed. The case supported good information sharing with counter-terrorism teams within the Metropolitan Police.

The trust remains committed in its focus to supporting those at risk of exploitation and Prevent remains a vital safeguarding function, supporting both individual safeguarding responses and awareness raising for those at risk.

4.4 Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and Liberty Protection Safeguards (LPS) Activity

The Mental Capacity Act 2005 (MCA) remains one of the most widely applied legal frameworks within the Trust. The Act provides a framework for supporting adults who may lack the mental capacity to make particular decisions for themselves, while promoting their rights, autonomy and involvement in decision-making. It is intended to protect and empower individuals who

may have difficulties making decisions as a result of conditions including dementia, acquired brain injury, learning disabilities or mental illness.

While the department does not have direct responsibility for overseeing all aspects of MCA practice across the Trust, the team continues to provide oversight of arrangements relating to Deprivation of Liberty Safeguards (DoLS). This includes the submission and management of applications to the relevant local authority where it is considered that a patient's care and treatment arrangements amount to a deprivation of liberty and are in their best interests.

During the reporting period, the Trust oversaw 1,105 requests for authorisation of a deprivation of liberty, a reduction from 1,308 in the previous reporting period. Further reductions are anticipated considering recent legal changes and their implications for the management and authorisation of deprivation of liberty arrangements.

There remains no further update regarding the implementation of Liberty Protection Safeguards (LPS). The implementation of LPS, which was intended to replace the existing DoLS framework, has been subject to significant and ongoing delays. In the absence of a confirmed implementation date, the Trust has continued to maintain dialogue with clinical areas through focused discussions relating to the MCA, supporting ongoing awareness and application of the legislation in practice.

During the year, there were some initial challenges in establishing and mobilising the MCA working group. These have been recognised and addressed as part of the Trust's ongoing work to strengthen governance and oversight of MCA-related practice. The working group provides an important forum for identifying areas for improvement, sharing learning and supporting a consistent approach to MCA practice across clinical services.

Education and engagement have remained key areas of focus throughout the reporting period. In addition to ongoing awareness and support provided to clinical teams, bespoke MCA training sessions have been delivered within clinical areas where themes relating to mental capacity have been identified through incident reporting or hospital-implicated activity. This targeted approach has enabled learning to be directly linked to identified areas of concern and has supported teams to strengthen their understanding and application of the MCA in practice.

Work to revise the MCA Code of Practice also remains ongoing, recognising that the existing Code requires updating following its implementation in 2007. The Trust has continued to engage with national developments, including participation in NHS England workshops and contributing to the consultation process. The Trust will continue to monitor developments relating to both the MCA Code of Practice and LPS and will ensure that local arrangements are reviewed and updated as further national guidance becomes available.

4.5 Domestic Abuse (DA) and IDVA Services

The trust currently has a team of 4 independent domestic violence advocates (IDVA), one employed by Solace and the remaining individuals hold employment status with Victim Support.

Victim Support have been running the pan-London domestic abuse (DA) service since July 2015, in October 2025 the Mayor's Office for Policing and Crime (MOPAC) commissioned Victim Support to lead Safe Horizons a consortium of specialist domestic abuse services providing a support service for diverse London communities and residents who are affected by domestic abuse.

The hospital IDVA's are co-located within the safeguarding & vulnerabilities department and accept referrals in respect of patients and staff. The service is consent based and aims to provide rapid review of high-risk domestic abuse situations. The support from the team consists of safety planning, emotional and practice support, advocacy, engagement with criminal justice pathways and general advice provision in respect of personal safety and relationships.

Any referral that highlights domestic abuse concerns that is received by the trust safeguarding teams is initially reviewed/triaged by a registered nurse or qualified social worker who will then send through and further liaise with the IDVA's. The IDVA's accept activity via phone or email and aim to review patients within 48 hours. It is expected that for all individuals who are seen by an IDVA, the team will complete an assessment of risk and support the development of safety plans.

In the last reporting period, the Victim Support service went through a significant consultation which has had an impact on the responsiveness of our on-site provision. The department is now only deploying on-site IDVA's one day a week for each site, leading to significant gaps in service delivery that are mitigated through the deployment of safeguarding practitioners. The team recognizes the significant transition and change brought about the consultation and we have seen several members of Victim Support leave their role in the last year which again contributes to service disruption. In light of the disruption the service made the decision to declare the current service challenges as an organisational risk, the inability to have sustained delivery of domestic abuse services is a significant risk to both patient and staff safety.

During the reporting period, Victim Support have responded to a total of 380 referrals in response to requests involving victims of domestic abuse. This can be broken down further to site specific, with 250 of these requests coming from Denmark Hill site and the remaining 130 categorized as PRUH & South sites.
We also work closely with Solace on our under 25yrs patients on the Denmark hill site who have been on site throughout the reported timeframe for 80% of the working week. There referrals were noted to have received 85 referrals with engagement at 76%. Unfortunately, the current IDVA has provided notice which will impact the availability for the coming year.

The Domestic abuse provision is currently on the Trust Risk Register due to these concerns.

4.6 Partnership Working

Effective safeguarding relies upon strong multi-agency partnership working to ensure that children, young people and adults at risk receive timely, coordinated and proportionate

support. Throughout the reporting period, safeguarding teams have continued to strengthen collaborative relationships across health, social care and wider partner agencies, supporting a whole-system approach to safeguarding and promoting positive outcomes for those requiring protection and support.

The Trust works closely with children's and adults' social care services, maintaining effective information-sharing arrangements and contributing to the assessment, intervention and care planning processes led by statutory safeguarding partners. These partnerships support early identification of risk, informed decision-making and coordinated responses that place the individual at the centre of safeguarding activity.

To strengthen safeguarding assurance and promote continuous improvement, the Trust actively participates in multi-agency audit programmes through both Safeguarding Children Partnerships and Safeguarding Adults Boards. Audit findings are used to evaluate practice, identify areas of good performance, and inform service improvements. Learning arising from audits, safeguarding reviews and partnership activity is routinely disseminated through established governance structures, enabling themes, trends and emerging risks to be identified and addressed.

During the year, safeguarding professionals have continued to contribute to and deliver multi-agency training, supporting a shared understanding of safeguarding responsibilities, legislative requirements and best practice across the partnership. Established communication forums have provided opportunities for professional challenge, shared learning and collaborative problem-solving, strengthening safeguarding practice and providing assurance that lessons identified are translated into service development and improved outcomes for vulnerable individuals.

The Trust remains an active and committed partner within local safeguarding arrangements. Associate Directors continue to contribute strategically to local Safeguarding Children Partnerships and Safeguarding Adults Boards, supporting the development of safeguarding policy, strategic priorities and multi-agency learning. Through this involvement, the Trust contributes to the oversight of safeguarding performance across the system and supports the delivery of statutory reviews, ensuring that learning is identified, disseminated and embedded into practice.

Partnership working with housing services remains an important component of safeguarding activity, particularly for individuals experiencing homelessness, housing instability or domestic abuse. The KHP Homeless Service works closely with local housing providers to identify and mitigate risks associated with unsafe accommodation and social vulnerability. These collaborative arrangements support advocacy on behalf of patients, facilitate access to appropriate housing pathways and contribute to improved health, wellbeing and safeguarding outcomes for some of the Trust's most vulnerable populations.

Safeguarding teams maintain strong working relationships with police and criminal justice partners, reflecting the complex nature of many safeguarding concerns encountered across Trust services. The Hospital Liaison Police Officer continues to provide an important link between the Trust and the Metropolitan Police Service, supporting effective information

sharing, professional consultation and coordinated responses to safeguarding risks. This partnership enhances the Trust's ability to respond promptly to concerns, manage risk effectively and contribute to safeguarding investigations where required.

The Children's Safeguarding Team works closely with Child Health Social Work colleagues to ensure children and families receive timely support at the earliest opportunity. Through coordinated assessment, early help and family support interventions, the partnership promotes a preventative approach to safeguarding, helping to address emerging concerns before they escalate. This collaborative model supports continuity of care, strengthens engagement with families and contributes to improved outcomes for children throughout their journey within Trust services.

Partnerships with the voluntary and community sector continue to play a vital role in the delivery of safeguarding support. The Trust works closely with specialist organisations, including Victim Support and Solace, to provide expert advocacy and support for individuals affected by domestic abuse. Through the Independent Domestic Violence Advocate (IDVA) service, patients can access specialist advice, safety planning and onward support, helping to reduce risk, improve access to protective services and promote recovery. These partnerships provide additional assurance that patients experiencing abuse receive timely, person-centred support from appropriately skilled professionals.

Moving forward, the safeguarding and vulnerabilities department remain committed to fostering collaborative relationships across the system, recognising that safeguarding is everyone's responsibility and that partnership working is essential to creating safe, supportive, and resilient environments for all.

4.7 Employment Practice

The Trust procedure and allegations against staff policy was successfully implemented during the reporting period after a successful pilot that identified significant learning. The processes defined within the policy are helping to support a consistent and standardised interpretation of risk when allegations are made against the workforce.
Where allegations were raised in this reporting period, all cases are initially reviewed by the associate directors within the safeguarding team who oversee a central mailbox that allows for staff across the organisation to report concerns in respect of allegations against staff. The Associate Director of Nursing for Safeguarding Children would ordinarily oversee matters in respect of the Local Authority Designated Officer (LADO) and the equivalent role within adult safeguarding oversee matters pertaining to Persons in a Position of Trust (PIPOT).

Those cases which met criteria for LADO discussion were all referred accordingly and cases were managed under the allegation's framework with regular oversight and chairing of panel meetings by either the Director of Nursing or Deputy Chief Nurse. These meetings have expanded in the reporting period, with routine assessment and analysis of risk offered by the trust equality, diversity and inclusion lead in ensuring that decision making is culturally informed and sensitive to diversity considerations when deciding a level of risk.

During 2025–26, King's implemented the NHS England Sexual Safety in Healthcare Charter and associated Sexual Safety Charter Assurance Framework. These initiatives were introduced to address sexual harassment, abuse and misconduct within healthcare settings and reinforce a culture of safety, dignity and respect for both staff and patients. The framework is not owned by the safeguarding and vulnerabilities department however the team are routinely involved in the assessing of risk when allegations in respect of sexual misconduct are raised by members of the workforce.

The guidance recognises that sexual misconduct can occur between staff members, from patients towards staff, from staff towards patients, and from third parties. The allegations against staff policy is aimed to offer psychological safety for victims, it promotes a culture of open reporting and ensures that when concerns are raised these are addressed consistently and effectively.

During 2025–26, sexual safety remained a significant workforce safeguarding priority across the organisation.

4.8 Safeguarding Training

Within the Trust, both Safeguarding children and Maternity level 1 and level 2 training courses are available as e-learning packages. Level 3 training sessions are currently held monthly and are facilitated using a blended approach. The level 3 sessions are delivered in one day; both teams provide in-person and virtual learning sessions that are available for staff to complete throughout the year. We also provided bitesize training, care group webinars, presented at conferences and trained our social care colleagues in health-related safeguarding topics such as medical neglect and non-accidental injuries.

Safeguarding training is a fundamental part of the Trust's duty to safeguard and promote the welfare of those at risk. This training forms part of the mandatory training framework and compliance is monitored through the Trust LEAP training platform. Training compliance figures are reported to the Trust Vulnerability Assurance Group and to the ICB via the safeguarding dashboard system.

We continue to provide feedback via the Data Collection Framework on compliance rates for mandatory Prevent training and data has successfully been reported throughout the reporting period.

During the reporting period compliance for safeguarding children level 3 has improved to above 90% which is a huge improvement from last year's 81%. The compliance rate for the Safeguarding Adult training has improved from 79% to 91%.

Compliance training rates with Mental Capacity (MCA)/ Deprivation of Liberty Safeguards (DoLS) is monitored monthly by the safeguarding adult's team and presented at the quarterly Vulnerabilities Assurance Committee. In addition to mandatory training on MCA/DoLS, the teams support the delivery of bite sized learning throughout the reporting period, we have successfully delivered 8 bespoke sessions on MCA/DoLS to a range of hot spot areas and in response to incidents involving patients who have been subject to harm who were under a DoLS.

In addition to our training and education curriculums, our teams are often tasked in supporting the facilitation of supervision sessions for staff across the trust. This operationally sits as the responsibility of our named professional roles, a service priority for the subsequent reporting period is to ensure our support functions are aligned to the new organisational divisional structure.

5 Social Work Services

The King's Social Work department currently provides professional leadership and support to a workforce of 32 qualified social workers working across a range of specialist functions and clinical services. Whilst many practitioners are embedded within multi-disciplinary teams delivering psychosocial interventions and patient-facing support, others hold specialist roles in areas such as safeguarding, homelessness and professional Leadership. Collectively these roles support a more holistic approach to healthcare, ensuring that social, psychological, environmental and safeguarding perspectives are taking into consideration with clinical decision making and service delivery.

During 2025/2026, social workers continued to support patients and families experiencing a wide range of psychosocial needs. Alongside acute health concerns, many patients presented with issues relating to safeguarding, homelessness, self-neglect, mental ill health, domestic abuse, substance misuse, financial hardship, housing insecurity and social isolation. These challenges often intersect, creating significant barriers to recovery, discharge planning and longer-term wellbeing.

5.1 Digital development of EPIC

Over the past year, the Social Work Department and Safeguarding teams have continued to work in partnership with Digital Health Colleagues to strengthen the visibility of social work and safeguarding team activity within EPIC. A key milestone has been the implementation of a dedicated social work contact note, providing a standardised approach to documentation and enabling clearer identification of social work involvement within patient records. Whilst reporting functionality remains in development, this work represents an important step towards improving data quality, professional visibility and the ability to understand and demonstrate the contribution of social work across the Trust.

5.2 Social Work Practice Education

The Department continues to demonstrate a strong commitment to developing the future workforce through its Practice Education Programme. Over the past year the programme has continued to grow, strengthening both placement capacity and the departments' ability to support the development of future social workers. A key achievement during this period has been the successful training of an additional Practice Educator, further enhancing the departments capacity to provide high-quality learning experiences.

During 2025/2026, the department supported 5 social work students on placement, providing a total of 440 placement days and generating an income of approximately £6,800. In addition, the department supported its first social work apprentice to undertake a placement within a

local authority setting, helping to establish a positive partnership with local authority colleagues and strengthening opportunities for future collaboration.

5.3 World Social Work Day 2026

World Social Work Day (WSWD) 2026 represented the department's most ambitious celebration of the profession to date. Building on the success of previous years, the event brought together social workers, students, partner organisations and Trust leaders to celebrate the contribution of social work within healthcare whilst promoting learning, collaboration and professional development.

The programme included guest speakers, professional reflections, student contributions and opportunities for networking and shared learning. Emphasis was placed on strengthening relationships between health and social care partners, reflecting the international theme of unifying communities and recognising the important role social workers play in connecting people, services and systems.

5.4 Paediatric Oncology Grant

Through partnership working, the Paediatric Oncology Social Work Service successfully secured a pilot grant of £500 to provide practical support to families experiencing hardship during inpatient admissions. The funding has enabled the provision of supermarket vouchers to families experiencing financial strain, helping to alleviate immediate pressures associated with prolonged hospital stays. The pilot also established a framework for capturing feedback from beneficiaries, supporting the charity's future fundraising efforts. Subject to the success of the pilot, discussions are underway regarding the development of an ongoing quarterly grant programme, which would expand the departments' ability to provide targeted financial assistance and enhance support for families.

Samaritan Fund 2025/2026

The Adults and Children's Samaritan (SAM) Funds continue to provide an important source of practical support for patient and families experiencing hardship. Since June 2025, the Adult SAM fund has supported 73 patients through grants totalling over £2,800, Whilst the Children's SAM Fund has provided over £2200 of assistance to 44 families. The funds enable social workers and the wider safeguarding and vulnerabilities services to respond quickly to immediate practical needs, helping to reduce the impact on financial insecurity on health and wellbeing. In addition to providing essential assistance, these interventions can help to build trust and support engagement with healthcare services. Both funds are due for renewal in August 2026, ensuring their continued availability to support vulnerable patients and families across the trust.

5.5 Priorities for 2026/2027

1. **Developing the Social Work Strategy and Governance Framework**
   The development of a Social Work Strategy aligned to the Trust's new strategic vision will be a key priority during 2026/2027. Building on the introduction of the Social Work Senior Management Team and monthly Performance and Governance Meetings, the

strategy will provide a clear framework for service development, workforce planning, quality improvement and professional leadership.

2. **Advancing Digital Development through EPIC**
   The department will continue to work with the EPIC community team to develop a dedicated DH trust Social Work workflow within EPIC. Key priorities include embedding standardised workflows, improving data quality and strengthening reporting capabilities to support governance, risk management and service evaluation.

3. **Strengthen Practice Education and Workforce Development**
   Following continued growth within the Practice Education Programme, a key priority for 2026/2027 will be the implementation of a social work Practice Education Policy. The policy will establish a structured framework for practice educators and students, strengthen support and induction arrangements and formalise quality assurance processes. Alongside supporting the placement of apprentices and students, this work will contribute to work force sustainability, professional development and the continued generation of placement income for the Trust.

6 Homeless Health Services

King's Health Partnership (KHP) Homeless Team
The KHP Homeless Health Team provide support and quality discharge interventions for homeless clients attending or admitted to any of the KHP hospitals. The KHP Homeless Health Teams work in close collaboration with both hospital teams and with community services, in particular the GSTT Health Inclusion Team (HIT). The team currently operates within Guy's & St. Thomas' Trust, Kings College Hospital and South London and Maudsley (SLaM) services. The MDT at Kings consists of 1 X B8 Social Work Lead, 1x B7 Specialist Nurse, 1 x B7 Senior Social Work, 0.6 B6 Specialist OT and 2 x B5 Housing workers.

6.1 Denmark Hill

During 2025/2026, referral volumes to Denmark Hill showed moderate fluctuation but an overall upward trend, peaking in the winter months before experiencing a slight decline and subsequent stabilisation.

Over the past year, the Homeless Team has delivered training across the Emergency Department and inpatient services, engaging staff to raise awareness of homelessness, support the identification of homeless patients, facilitating referrals to the service, and address any challenges encountered. This has contributed to increased identification and referrals into the team.

6.2 Princess Royal University Hospital

Funding for the full-time Band 7 post at PRUH ended on 31 March 2025, after which there was no dedicated on-site Homeless Service. Despite this, the King's College Hospital (KCH) Homeless Team continued to provide guidance and support to PRUH staff when needed. Due to the absence of a dedicated service, referrals were not received through usual pathways,

and therefore no formal data is available to capture the volume of advice provided by KCH during this period.

In April 2026, a Band 6 Homeless Health Liaison Officer was successfully recruited to the role at PRUH, and since then 16 referrals have been received. Given that the post was vacant for a year, there is a significant need to rebuild awareness of homelessness across the hospital.

As part of this, plans are underway to introduce drop-in sessions for staff, offering advice and guidance on supporting patients experiencing homelessness at PRUH. The primary focus remains on improving patient flow and ensuring individuals experiencing homelessness receive appropriate and continuous care.

6.3 Step Down Pathway

The KHP Homeless Service continues to offer a vital step-down pathway for eligible patients experiencing homelessness, supporting effective discharge planning and patient flow. Over the past year, the service facilitated a total of 65 bookings, amounting to 152 nights of accommodation, with a total expenditure of £13,723.90

Hotel bed placements continue to focus on patients with exit plans, high-risk individuals, and rough sleepers. The step down is also used during Severe Weather Emergency Provision (SWEP).

In line with typical seasonal trends, demand for the service decreased during the summer months and rose again during the winter period.

Month-on-Month Hotel Summary (2025/2026)

Month	Total Spend	Nights	Bookings	Room Rate
Apr	£1,933.67	22	10	£83.54
May	£561.28	6	3	£93.55
Jun	£971.07	7	3	£138.72
Jul	£590.14	8	3	£73.77
Aug	£289.65	3	1	£96.55
Sep	£163.20	2	1	£81.60
Oct	£869.62	9	4	£95.74
Nov	£1,395.68	15	8	£93.05
Dec	£660.43	8	5	£78.40
Jan	£1,200.89	14	7	£85.78
Feb	£1,540.18	19	8	£81.06
Mar	£3,548.09	39	12	£90.15
Total	**£13,723.90**	**152**	**65**	**£89.18**

6.4 Legal Advocacy Service

Southwark Law Centre Homeless Patients Legal Advocacy Service:

Across the King's Health Partners (KHP), teams continue to benefit from access to second-tier housing and immigration legal advice, which plays a vital role in supporting complex discharge planning. Throughout 2025/2026, SLC worked on 30 complex KHP cases. 16 of these were new referrals made in 2025, and the remaining 14 were ongoing from previous years.

SLC completed 14 cases in 2025 and ended the year with 16 ongoing cases. This means that 14 slots were available for new referrals at the beginning of 2026. In total, Southwark Law Centre has provided 78 instances of second tier advice.

Outcomes in 2025 for the 14 concluded cases:

- 4 grants of refugee status
- 3 grants of limited leave to remain with recourse to public funds
- 1 successful change of conditions application, allowing access to benefits
- 1 grant of migrant accommodation
- 1 acceptance of local authority homelessness duty
- 2 patients deciding to voluntarily return to their countries of origin
- 2 patients deceased

Southwark Law Centre has delivered four targeted training sessions: Community Care for Migrants, an overview of Immigration Law, Accommodation for Migrants and Welfare Rights. These sessions were based on learning needs identified by KHP and attracted an average of 125 attendees from across the partnership. The training not only equipped staff with relevant and practical legal knowledge but also created a collaborative learning environment, enhancing legal literacy and awareness of current case law among professionals.

6.5 Volunteers and Student Partnership

The British Red Cross was previously funded by the Southeast London Integrated Care Board (ICB); however, this funding ceased in March 2025 and was not renewed. The impact of this has been significant, particularly within outpatient settings, where there has been reduced capacity to provide ongoing follow-up and holistic support for patients following discharge.
In response, we worked collaboratively with the Volunteer Service to relaunch the volunteer programme within the team and partnered with King's Legal Clinic to host our first cohort of ten housing law students. This initiative has proven effective, with volunteers and students supporting patients experiencing homelessness as they transition from hospital to the community, helping to address gaps in ongoing care and resettlement support. As a result of its success, the programme has now been extended to the SLaM and GSTT Homeless Teams.

6.6 Vulnerable Women's – Joint Working Partnership:

A Vulnerable Women's Meeting has been established over the past six months. The purpose of this forum is to identify and map women with complex needs and housing instability connected to Southwark, while promoting multi-agency collaboration between hospital and community services. The meeting facilitates the sharing of information, and resources to help prevent health deterioration and reduce further vulnerability.

The meeting is held monthly and is attended by a range of internal and external partners supporting vulnerable and homeless women across Southwark.

Following its initial six-month period, a review meeting has been scheduled next month to revisit the Terms of Reference and ensure the forum remains effective, responsive, and aligned with its intended objectives.

6.7 Borough Partnership and Joint Working Arrangements:
Across King's Health Partners (KHP), we work closely with several Councils, with Lambeth Councils being one of our primary borough partners, as such we have a joint working protocol in place, setting out agreed arrangements between Lambeth Council Housing Services and the KHP Pathway Homeless Team to support safe, timely, and coordinated discharge for patients who are homeless or at risk of homelessness. KHP is currently working in partnership with Lambeth Council to review this protocol, with the aim of strengthening joint responses and improving the timeliness of decision-making for patients.

Housing colleagues from both Lambeth and Southwark Councils have completed Licence to Occupy agreements and are now providing a regular on-site presence at King's College Hospital on a fortnightly basis. This initiative is expected to strengthen partnership working and improve the timeliness and effectiveness of responses to Duty to Refer (DTR) notifications and housing assessments.

6.8 Research Collaboration with Kings College London
The Kings Homeless Health Team contributed to a research project led by the Kings Legal Clinic and the Policy Institute at Kings College London. This research examined the impact of barriers to accessing homelessness services in London and the consequences for those experiencing homelessness. The findings highlight the complex challenges faced by this group and reinforced the value of specialist homelessness service in support access to health care, housing, patient flow and wider community support. We are proud to share that in January 2026, the research was nominated and won an award from the Kings Engage Research Award Network in the category for collaboration. The full report can be accessed here: kings-legal-clinic-closed-doors-report-final.pdf

6.9 Priorities for 2026/2027

1. **Addressing Housing-Related Discharge Delays:**
   Housing-related discharge delays continue to pose a significant challenge. A key priority is to strengthen collaboration with individual boroughs, improving partnership working, increasing transparency around housing provision, and addressing gatekeeping practices. Plans are in place to review the joint working protocol with Southwark Council, and to work with Lambeth and Bromley Councils to address delays associated with Temporary Accommodation (TA) panels. The overall aim is to reduce the number of medically fit for discharge (MFFD) patients who remain in hospital due to housing barriers.

2. **Strengthening Early Planning with Prison Services:**
   An increasing number of referrals have been received for individuals released from prison without a clear housing plan, often resulting in rough sleeping and subsequent hospital admission. Over the coming year, the focus will be on working collaboratively

with relevant prison services to promote earlier discharge planning and provide support to reduce the risk of homelessness upon release

3. **Enhancing Support for Vulnerable Women:**
   There is a recognised increase in the number of vulnerable women referred to the Homeless Team, highlighting the need for a coordinated, multidisciplinary response. The Vulnerable Women's Meeting provides a strong foundation; however, following a planned review of this forum, further work will be undertaken to strengthen the model. This will focus on improving early identification and ensuring robust, coordinated care plans are in place to support vulnerable women effectively.

7 Supporting Positive Behaviours & Violence Reduction

The NHS England Violence Prevention and Reduction (VPR) framework and teams work to protect NHS staff and patients from abuse, aggression, and violence. The approaches encourage organisations to distance themselves from the previous 'zero-tolerance' mindset and to consider a more holistic assessment as to why incidents occur and what support is required to reduce risks to staff/patients.

The Supporting Positive Behaviour Group (SPBG) did not meet as frequently during the reporting period however the group has been refreshed and relaunched in the department's new governance/report. The forum will be chaired by our Assistant Director of Adult Safeguarding and will aim to ensure consist of approaches to the management of violent incidents within the workplace. The group will ensure that the most vulnerable patients are distinguished within reporting data and embed a trust wide approach to the reviews of mechanical restraints.

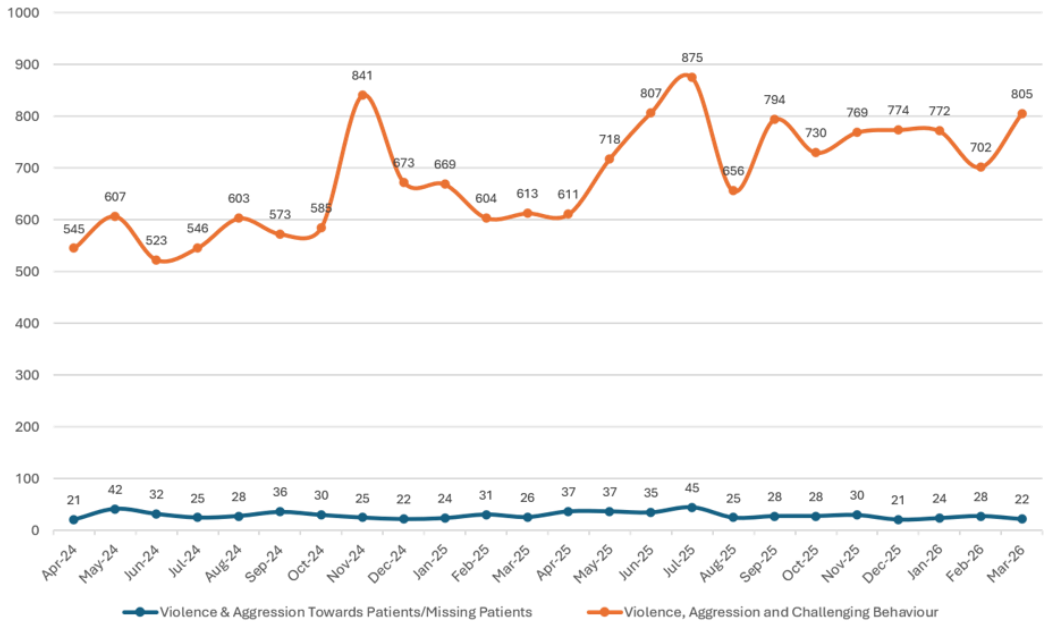
The group will continue to work under the direction of the Chief Nurse and Executive Director for Midwifery, who holds primary responsibility for overseeing the Trust's strategic direction and quality improvement work on violence and aggression in the workplace.

Mechanical restraint continues to be an area requiring improved governance, the existing arrangement supports reviews that occur within the Denmark Hill Emergency Department, with other departments considered on a bespoke/ad-hoc basis. The newly launched SPBG will commit to a trust wide mechanical restraint review process, we have identified cases requiring reviews and these are being actively worked through. In the reporting period the teams continue to meet regularly with ED and Security leads in the convening of restraint reviews. The work has supported improvement in restraint governance, documentation and training for staff – we continue to see application of trauma-informed care in the way the reviews are completed.

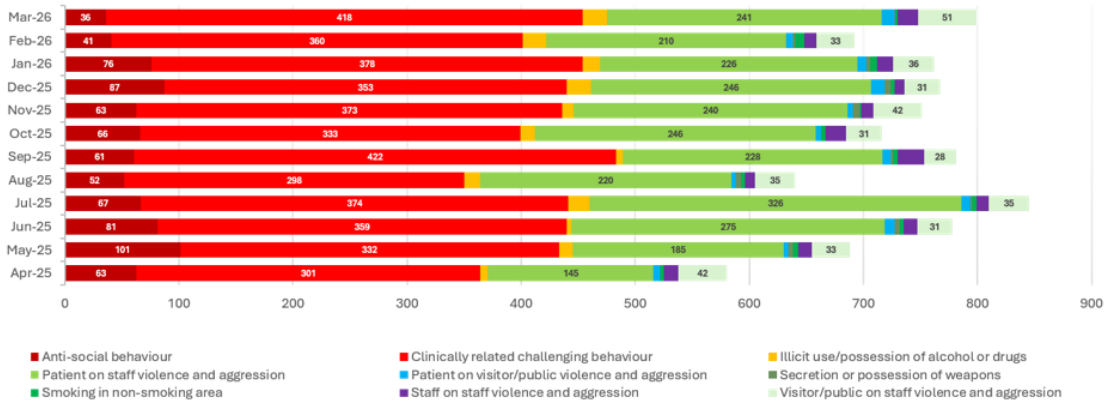
These improvements directly support the Trust's strategy—particularly its commitments to delivering high-quality care for patients and delivering strong, successful partnerships.

7.1 Incident analysis

The management of violence, abuse and challenging behaviour continue to be a significant issue for the Trust. There has been a stark increase in reported incidents over the past 2 years with 9.013 incidents reported in 2025/26 - this represents an increase of over 47%. Incidents have increased by 31% just from last year alone. The graph below shows the number of reported incidents across the 12-month period:



Incidents can be seen below broken down by sub-type:

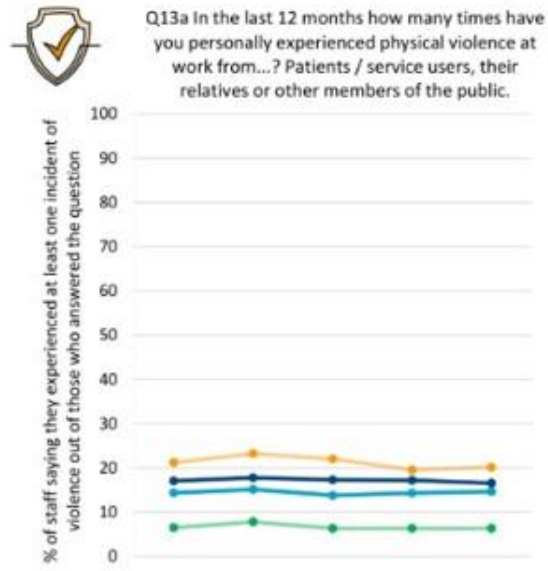


Care is needed when considering this data as some of the increase in incidents may well be due to increased reporting – considerable work has gone into encouraging staff to report incidents, and it is likely that as the InPhase system has become more embedded and familiar, that will have impacted staff use.

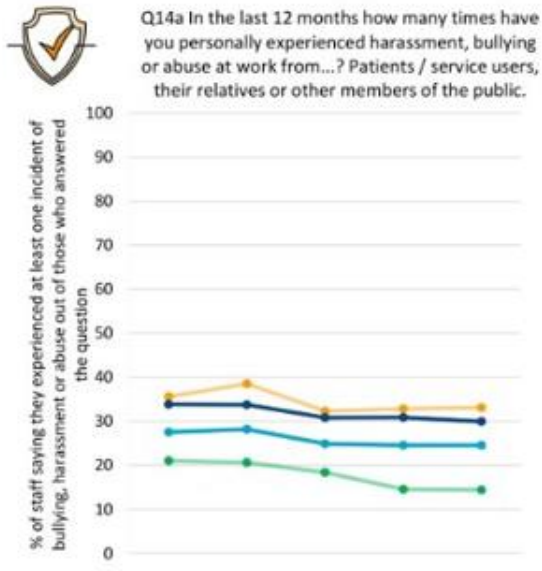
Additionally, despite changes to coding in 2024, in which a number of additional codes were introduced to try and better separate violence and aggression from clinically related challenging behaviour, the accuracy of data and how we interpret it remains a very significant issue.

Deeper analysis of just one month of data from 25/26 shows that nearly 75% of incidents recorded as 'patient on staff violence' actually concern clinically related challenging behaviour. There is also an issue that certain incidents – absconding and missing persons being one, along with self-harm – routinely get included as 'violence' due the way our reporting system is set up. This is an important distinction as while the 'violence' - in whatever form that takes – is very real and affecting to the staff involved regardless of its genesis – the approach we take as a Trust very much needs to take that into account if we are going to have an effective response. In a high proportion of these cases warning letters or banning will not be possible and certainly not ethical; therefore, we need our focus to be on how we can help staff better prevent and manage aggression in a clinical context.

Despite all of this we are seeing slight improvements in staff experience. NHS Staff Survey results have shown sustained but small reductions in the number of staff reporting both verbal (Q14a) and physical (Q13a) assault:



	2021	2022	2023	2024	2025
Your org	17.07%	17.79%	17.32%	17.19%	16.57%
Best result	6.50%	7.81%	6.35%	6.35%	6.35%
Average result	14.38%	15.15%	13.81%	14.31%	14.65%
Worst result	21.20%	23.21%	22.02%	19.54%	20.14%
Responses	4996	6149	6691	6755	6301



	2021	2022	2023	2024	2025
Your org	33.87%	33.79%	30.84%	30.90%	29.96%
Best result	21.03%	20.65%	18.41%	14.57%	14.44%
Average result	27.56%	28.20%	24.91%	24.59%	24.59%
Worst result	35.57%	38.56%	32.33%	32.84%	33.08%
Responses	4974	6135	6711	6756	6288

In addition, we have seen equally small but positive improvements in our WRES (workforce race equality standards) and WDES (workforce disability equality standards) figures related to verbal abuse, harassment or bullying – with experiences of abuse reported through WRES falling between 2021 and 2025 by 6% for black and ethnic minority staff (and by 16% for white

staff); and experiences for staff with an LTC reported through WDES falling by 11% in the same period.

During 2025/26, progress against several elements of the Supporting Positive Behaviour work programme was more limited than originally anticipated due to competing organisational priorities within the Vulnerabilities governance portfolio, particularly the significant focus required to support the Eliminating the Overuse of Temporary Care (ETOC) agenda, PSIRF implementation, and wider governance developments across safeguarding and vulnerabilities services. Despite this, key foundations have been established, and important areas of work have continued to progress.

A revised governance structure has now been implemented across the Trust, providing greater clarity of oversight, accountability, and reporting arrangements. This strengthened framework will enable the Supporting Positive Behaviour Group to be reinvigorated during 2026/27, ensuring delivery of its strategic objectives and providing renewed momentum to several initiatives that were necessarily delayed during the previous reporting period.

The Supporting Positive Behaviour Policy continues to outline the process that supports teams to consider formal action where there is evidence of deliberate violence or abuse towards members of staff.

7.2 Exclusion Panel

The exclusion process is delivered as a single function that offers Division Colleagues across the trust to obtain advice/guidance/authorisation regarding restrictions to a patient's ability to access trust services. During the reporting period all requests made to the exclusions panel were completed. Since the start of 2025 (Jan 2025 - Aug 2026) 12 total patients were discussed at the panel. Following these panels, a decision was made to exclude 7 of these patients; the remaining 5 patients were discussed and were not approved for Trust exclusion, and instead had actions agreed and put in place to support positive behaviour, including warning letters – these patients were not excluded due to either delay in escalation to the panel (and no attendance by the specific patient since initial incident), ongoing need for medical care, patient is known as vulnerable for a varied number of reasons, or planned support put in place including security attendance when planned appointments are taking place.

7.3 Training and Staff Support

The clinical vulnerabilities service has been instrumental in delivering training throughout the reporting period, talk down tips has been a major success with teams across the organisation having access to this specialist knowledge. The team compliment this through bespoke training throughout the year, and all content is aligned to trauma informed conflict resolution e-learning that is also available for staff. Whilst implementation of the new training framework progressed more slowly than anticipated due to competing organisational priorities, the training requirements have now been agreed, and a clear delivery plan is in place. Roll-out will continue during 2026/27 under the oversight of the refreshed governance arrangements.

The Supporting Positive Behaviour Group previously identified three strategic priorities aligned to the Patient Safety Incident Response Framework (PSIRF):

1. Staff Support
2. Early Risk Identification and Escalation
3. Incident Reporting and Data Quality

Although progress across these priorities was constrained during 2025/26, the work remains highly relevant and will form a key focus of the group's programme of activity during the coming year. The new governance structure provides an opportunity to re-establish improvement plans, identify executive and operational leads for each workstream, and strengthen monitoring arrangements to ensure delivery of agreed actions.
Enhancements to incident reporting dashboards have continued, improving local visibility of violence and aggression data.

The new Trust-wide violence reduction communications campaign has progressed significantly. Extensive engagement with staff, patients and carers informed the development of campaign materials, with final designs approved following executive review and staff consultation. The trust saw a positive increase in activity rates post completion of a successful communications campaign that aimed to raise the awareness of staff to report incidents.
The launch of the campaign, alongside a staff support toolkit being developed in partnership with the Wellbeing Team, will form an important part of the Trust's programme of work during 2026/27.

The establishment of a strengthened governance structure, coupled with greater organisational stability across vulnerabilities services, provides a strong platform for renewed progress over the coming year. The Supporting Positive Behaviour Group will be reinvigorated during 2026/27 with refreshed membership, clearer accountability, and a renewed focus on delivering practical improvements that support staff safety, patient experience, and the reduction of violence and abuse across the Trust.

8 Vulnerabilities Clinical Team

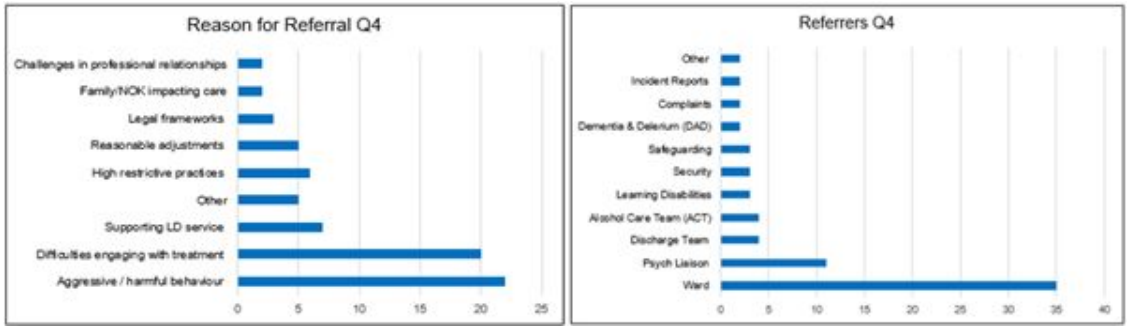
Established in 2023/24, the Vulnerabilities Clinical Team – a service that aims to act as a Liaison and Advocacy service supporting staff in caring for vulnerable patients who display an element of challenging behaviour over and above what is manageable by the MDT - continues to move from strength to strength. That the team is frequently sought out for advice and support by clinicians across all areas of the Trust is testament to their reach. Originally a group of senior staff working across the Safeguarding, Social Work and Mental Health portfolios, the team now has a clear service line and structure, with a Lead Nurse for Vulnerabilities reporting into the ADoN for Mental Health, and two Vulnerabilities Practitioners.

8.1 Activity

Data remains challenging for the team as it has not been possible to date to create a clear identity and referral process on EPIC. Work continues on improving this and it is now possible to collate some data from other sources – included in this report is the most recent data for Q4 2025/2026, during which time the team received 71 referrals, 58 of which were accepted. The majority of these came from Denmark Hill (51) with a smaller number from PRUH (20). Unsurprisingly perhaps – given the acuity within it – the majority of referrals came from Division

B – 38 in total - with 28 from Division A and 5 from Division C. 67 of the referrals were from inpatient areas, but 4 were from outpatients – an area in which the team hopes to expand their support and reach in 2026/2027.

The graphs below provide more information of referral source and reason. The vast majority of referrals have come directly from wards, but it is notable that the team have continued to develop strong relationships with other services around the hospital and a significant number of referrals now come from those teams – including Liaison Psychiatry, ACT and the discharge team.



Referral reasons can be broad, including legal frameworks, restrictive practice and supporting reasonable adjustments, but the majority still relate to either aggressive, agitated and potentially harmful behaviour or where patients have disengaged or a struggling to engage in treatment.

8.2 Training and Education

The Vulnerabilities Practitioners have continued to support education – with the Vulnerabilities Communication module offered once a month alternating between the DH and PRUH sites. This one-day course considers challenges in managing and caring for patients with a Vulnerability (including severe and enduing mental illness, learning disability, autism and other neurodiversity, dementia and delirium, and other cognitive impairments).

The team continues to support Talk Down Tips training – a simple intervention supporting a better understanding around de-escalation from the evidence-based Safewards suite of interventions. To date Vulnerabilities have provided this training to over 50 teams and across MDTs – and also to Teams outside of inpatient or ED areas. Bespoke versions have been created for CYP, and for teams working remotely in call centres. A new version aimed at supporting patients with dementia and delirium is in development.

Moving into 2026/27 the team will be looking at increasing their training role including to support the roll out of the Mental Health Capital Nurse Training passport in the latter part of the year; and the development and incorporation of simulation into the team's work.

8.3 Patient feedback

The impact of the team can be seen in the feedback they have received, such as the following, written by a patient with Schizophrenia who was admitted to King's for surgical amputations:

"You saved my life – you made me stronger. It was scary. You helped me the best you could. You upgraded my care. I am very happy. Don't stop helping people."

This feedback was received from the brother of a patient with a highly complex presentation including both physical and mental health co-morbidities:

"I so appreciate everything you have done for X and all the support and advice you have given me. Last year has been very stressful, uncomfortable and bewildering for her. But you made a giant difference to her quality of life. I am very regretful that I couldn't be there more in the last months, but I am very happy that you were able to go by and give her support. I know she didn't always show appreciation, but she really valued your visits - you definitely made it into the highly exclusive club of hospital personnel that she wanted to see".

9 Learning Disabilities and Autism

During 2025/26, the Learning Disability and Autism Nursing Service moved out of statutory safeguarding and became a distinct specialist nursing service. This reinforced that learning disability or autism is not, in itself, a safeguarding concern. Close working with adult and children's safeguarding continued through shared governance, escalation, case review and policy development.

9.1 Activity and demand

Children's referrals

Period	April	May	June	Quarter 2	Quarter 3
Referrals	-	-	-	**133**	**127**

Children's monthly referral data were available from June 2025 to March 2026. April and May were unavailable because there was no children's LD nurse cover during this time. Quarter 2 recorded 133 referrals and Quarter 3 recorded 127. Monthly referral rates were broadly stable, ranging from 34-53.

Adult referrals

Period	April	May	June	Quarter 2	Quarter 3
Referrals	49	45	39	**170**	**160**

Adult data was reported as monthly figures for April–June and quarterly totals for Quarters 2 and 3. These periods are not directly comparable and have therefore not been combined into a full-year total.

9.2 Quality Account priority and co-production

The Quality Account priority brought together co-production, hospital passports, Universal Care Plans, accessible information, safer environments, training and reasonable adjustments.

A December 2025 lived-experience group informed work on MyChart, passports and care plans. Widgit access supported development of governed Easy Read resources.

The Trust welcome booklet was also adapted into an Easy Read format. Lived-experience representatives contributed to the Quality Account work and presented alongside the service to executive and non-executive leaders. Project SEARCH interns provided further feedback on accessibility and usability.

9.3 Reasonable Adjustment Digital Flag

The Reasonable Adjustment Digital Flag was developed jointly with Guy's and St Thomas' to improve identification and visibility of individual adjustments in Epic.

A four-team soft launch started in December 2025. Testing led to agreed changes to FYI flag consistency, visibility and inpatient alerts. Trust-wide rollout, training and outcome monitoring remain the next steps.

9.4 Oliver McGowan Mandatory Training

During 2025/26, OMMT e-learning completion reached 66.94% (9,339 staff). A total of 244 staff completed Tier 1 and 674 completed Tier 2. Completion percentages should be read alongside headcounts because the identified eligible workforce changed during the year.

A quality review identified outdated content, limited King's-specific pathways and insufficient wellbeing support for experts by experience by the provider. These concerns were escalated, local quality assurance was strengthened and the ICB subsequently commissioned a new training provider which has commenced from the next finical year.

9.5 Targeted training

Alongside OMMT, the service delivered monthly Level 3 children's safeguarding training with LD/autism content, bespoke education for emergency and children's services, in-situ de-escalation simulation, trauma-informed care and sensory-support learning. A simulation was filmed to support wider delivery through study days and emergency-department induction.

Developing 2026/27 training programme	Recorded reach
Supporting children with LD/autism	Child Health Therapy Team — 10 attendees
Supporting children with LD/autism on adult wards	Murray Falconer — 18 attendees
Children's ward debrief	PRUH Children's Ward — 7 attendees
LD/autism huddle awareness	Emergency Department — four sessions; 6 attendees recorded per session

Trauma-informed care and de-escalation	Katherine Monk — 18 attendees
LD/autism virtual simulation	PRUH Children's Ward — 9 attendees

9.6 Helping Hands Blood Test Support Clinic at PRUH

The PRUH Helping Hands clinic provides planned, sensory-aware blood-test support for children with learning disabilities, autism with needle anxiety or previous trauma. Preparation, communication adjustments, play and coordinated phlebotomy support are tailored to each child.

82.7% successful blood-test completion rate
One-year outcome reported for the PRUH pathway

The result demonstrates that specialist preparation and reasonable adjustments can improve access and reduce repeated attempts and distress. The next phase is to evaluate experience, waiting time, repeat attendance and continue to avoid sedation or general anaesthetic, and to inform development at Denmark Hill.

9.7 Trust-wide improvement portfolio

Programme	Key progress
Digital and governance	Reasonable Adjustment Digital Flag; standalone Epic referral route and in-basket; Hospital Passport and Universal Care Plan work; completed LD&A Policy and SOP.
Clinical pathways	Helping Hands; development of a Denmark Hill blood-test pathway; adult blood-test work with GSTT; ED LD daily huddles; transition, cancer and dental pathway improvement. READY model for Paeds ED.
Accessible environments	Trust wide sensory space; outpatient sensory adjustments; neurodiversity-friendly gynaecology resources; Makaton and Easy Read materials.
Co-production and inclusion	Lived-experience input into the Quality Account; Project SEARCH feedback; LD Champions; support for parents with learning needs; transition and accessible health-education resources.
Innovation	VR preparation pilot; filmed TIC simulation for education resource.

9.8 Governance milestones

The Trust-wide Learning Disability and Autism Policy and accompanying SOP were completed. They establish responsibilities, referral criteria, escalation arrangements and RAG-rated response expectations for complex referrals.

9.9 NHS Learning Disability Improvement Standards benchmarking

The NHS Benchmarking Network framework assesses performance across rights, inclusion, workforce and specialist services. It provides an external reference point for VAC and Quality Account assurance.

National acute-trust benchmark	Finding
Staff able to identify required adjustments	**69%**
Staff confident adjustments are always delivered	**52%**
Trusts able to identify relevant patients on waiting lists	**63%**
Trusts routinely monitoring and Board-reporting waiting times	**33%**
Staff able to access additional specialist LD support	**44%**

10 Addictions Care Team

The Addiction Care Team is a clinically focused team comprising of Adult and Mental Health Nurses, a Consultant Hepatologist, Consultant Addiction Psychiatrist, and an team admin.

ACT is a KCH service, funded by KCH and the ICB's System Sustainability Funding, providing specialist care for patients with alcohol and/or drug-related issues across both Denmark Hill and PRUH sites. SLaM provides the team's senior addictions staff - the Service Lead and Addictions Consultant sessions, bringing dedicated addictions expertise, clinical supervision and teaching, and a direct link into national and South East London-wide addictions work. In practice, this means a consultant or senior addictions leader is always available to the team, the team gets a resident Dr at no additional cost, as well as wider opportunities and benefits to the service and the trust. ACT plays a critical role in improving clinical outcomes for patients, particularly through the safe and effective management of withdrawal, which helps prevent complications that can prolong hospital stays, supporting improved patient care, reduced readmissions and improving flow.

10.1 20205/26 Activity

3,798	2,687	1,958	537	563
Referrals received	**Assessments completed**	**Patients seen**	**Admissions prevented**	**Detoxes completed in hospital**

3,798 referrals were made to the team in 2025/26 (2,539 at Denmark Hill, 1,243 at the PRUH, and a further 16 at Orpington). The team only covering 5 days at reduced staffing levels meant a reduction on historic levels, and similar to last years performance. Meaning many patients were not assessed or missed due to lack of service cover.

Referrals received (consult orders)	25/26
Denmark Hill	2,539
PRUH	1,243
Total*	**3,798**

**Includes 16 referrals from Orpington, not shown separately above.*

Assessments completed	24/25	25/26	Change
Denmark Hill	1,782	1,727	▼55 (−3.1%)
PRUH	905	948	▲43 (+4.8%)
Total*	**2,687**	**2,687**	**—**

**Includes a small number of contacts (12 in 25/26) recorded under a third site code not mapped to Denmark Hill or PRUH.*

10.2 *Community referrals*

A central aspect of ACT's role is supporting patients into appropriate community services, either diverting them directly from A&E or arranging follow-up care after discharge. Well over half of patients referred (58.6% of those seen) were new to ACT, underlining the team's continued reach into people not previously engaged with community services

Community referrals	24/25	25/26	Change
Denmark Hill	818	746	▼72 (−8.8%)
PRUH	347	431	▲84 (+24.2%)
Total	**1,165**	**1,179**	**▲14 (+1.2%)**

10.3 *Medically Assisted Withdrawal*

Medically assisted withdrawal is supervised by the team for any patient admitted who needs medical support to withdraw from alcohol safely. The ACT does not electively admit patients,

but supports those that cannot be diverted to community services, are in severe alcohol withdrawal or have come in with other causes and require a detox. This year 724 patients required a supervised withdrawal. The reduction in 5 days meant that our outpatient detox clinic was unable to be utilised to reduce patients needing to stay in just for detox once otherwise medically fit. This is now operational again under the new investment.

Medically Assisted Withdrawal	24/25	25/26	Change
Detox required	Not reported 24/25	724	—
Completed in hospital	616	563	▼53 (−8.6%)

10.4 *Service Provision*

7-day ACT working	Alcohol Assertive Outreach (AAOT)
Live at both Denmark Hill and the PRUH from April 2026	To Cover the PRUH for the first time

During 2025/26 the team secured System Sustainability Funding from the South East London ICB to move ACT from five to seven days a week at both Denmark Hill and the PRUH Recruitment ran through the year, and both sites returned to full 7-day working from April 2026, restoring the weekend cover lost in 2024/25.

The same ICB funding extended the SLaM Alcohol Assertive Outreach service - previously concentrated in Southwark and Lambeth - to the PRUH which will launch in 26/27. Outreach and key working give patients with harmful or dependent alcohol use who frequently attend ED or are admitted assertive follow-up after discharge: joint visits with ACT, ward-based case-finding, and a 12-month holistic intervention to support patients.

10.5 *Quality Improvement*.

CABIN: Joshua Stapleton and Dr Nicky Kalk successfully secured funding to become a OHID pilot site for brief cocaine and alcohol interventions. The project works to screen and identify those using both powdered cocaine and alcohol - a population OHID has flagged as the fastest growing cause of deaths, having increased for twelve consecutive years. The pilot has shown measurable results in reducing cocaine and alcohol use and is expected to be rolled out at more sites using the model developed at KCH. Alongside its clinical role, CABIN's funding stream had an operational benefit this year this SLaM funding was used to secure a fixed-term Band 6 post at no cost to KCH. This let Denmark Hill return to 7-day working more quickly, ahead of the wider ICB-funded expansion.

CLEAR — the team's work on health inequalities in treatment access, focused on getting more people from under-served groups into care. The project looked at barriers and facilitators to why people do or don't engage with community addictions treatment and made several recommendations that we hope can be implemented both at King's and other ACT's to improve outcomes for patients and reduce inequalities.

King's College Hospital NHS Foundation Trust

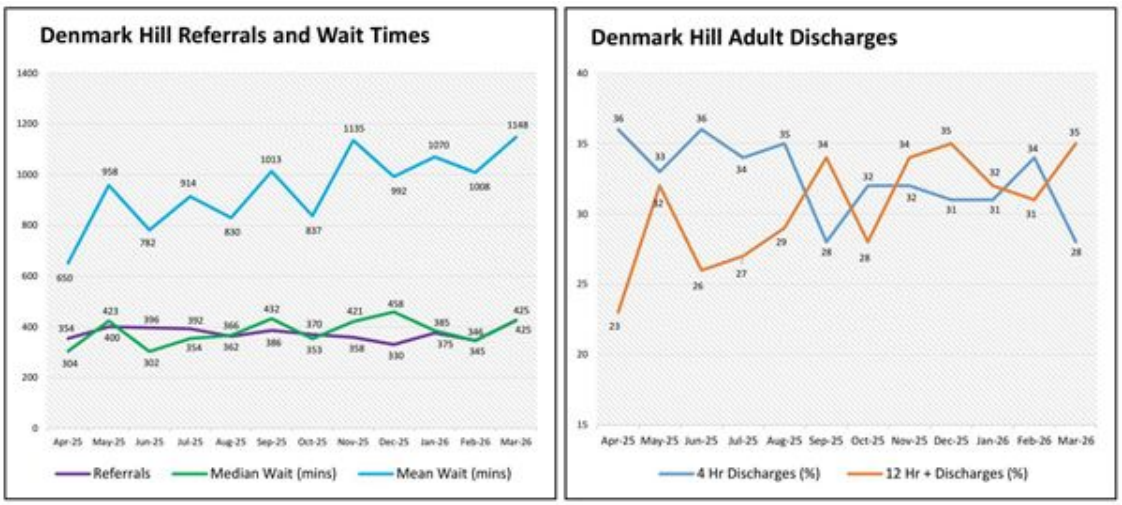
11 Mental Health

11.1 Data: Activity – Emergency Departments

Bed flow and mental health demand continues to be a primary challenge for our two Emergency Departments. Accurate data capturing this is improving but remains an issue; like most acute hospitals the variety of records systems used across Trusts means our Liaison Psychiatry teams are required to document across two. Our data for Denmark Hill is taken from SLaM's EPJS system and remains more accurate than our own, as the Liaison nurses are able to keep a much more exact series of timestamps along the patient's journey. Data from PRUH comes from EPIC and we have seen in the past a margin of error in what we might record against what Oxleas does – however with EPIC access now available to most of the Bromley team and better engagement with King's systems, this is improving. However, despite that the data still should be treated with a degree of caution.

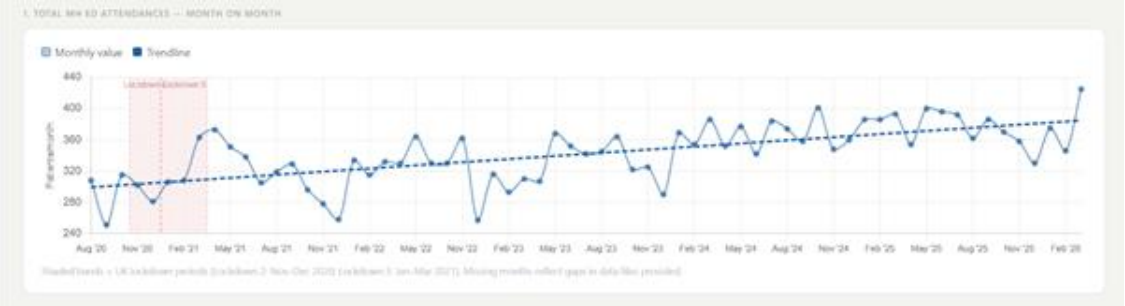
11.1.1 Denmark Hill ED - Adults

Adult referrals within Denmark Hill remained broadly similar on average – across 24/25 the team saw an average of 371 referrals per calendar month; in 25/26 this was 375. The mean length of stay for patients with acute Mental Health concerns at DH has risen from an average 14.4 hours to 15.7 hours, reaching a peak of over 19 hours in March. Median stay has also increased slightly from 5.5 to 6.4 hours.

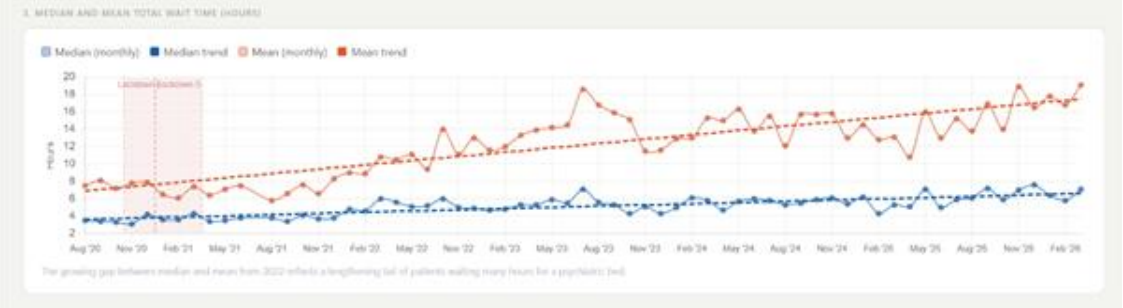


A longitudinal analysis of demand shows a much clearer picture of demand increase at Denmark Hill over the last 6-year period. There has been a very clear increase in referral numbers as can be seen in the graph below, with a linear increase throughout the period.

King's values Caring Collaborative Inclusive Innovative



During the same period, we have seen significant increases in length of stay.



Length of stay can also be seen here represented in a slightly different form – the number of total monthly hours, on average, patients have remained in the department:



However, despite this, outcomes for the team in relation to admission (both informal and formal) and community discharge have remained almost entirely stable despite this.



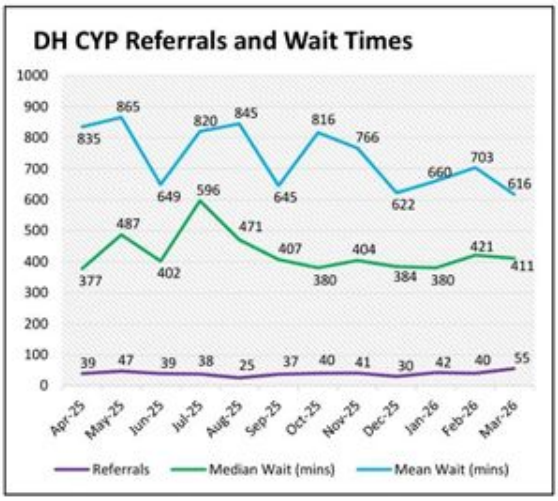
While all of this highlights things we mostly already well know – the impact of delays for patients waiting for mental health admissions – the data provides and additional insight.

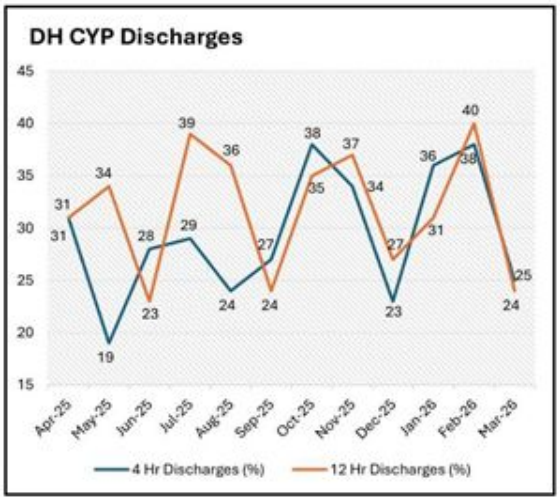
Notably while referrals have increased since 2020, the month-to-month numbers are still variable and often fall somewhere between 350-400; however, the number of patient hours in the department has increased dramatically during the same period, and as of last month are nearly four times what they were in 2020.

To put this increase in context, the Liaison Psychiatry team saw 373 patients at Denmark Hill in April 2021, who spent a combined total of 2387 hours in the ED. In January 2026, the team saw almost the same number of patients – 375 – but with nearly a 200% increase in hours, at a total of 6688. It's also worth noting again that – as with previous analyses we have done on the Liaison caseload at DH – outcomes and discharges have remained consistent (as % of caseload) for the entire 5-year period, despite those increases in hours. It explains why even if referral numbers are (very broadly) similar month to month – and outcome data would suggest overall acuity has not significantly changed – the pressures in ED relating to this patient group still feels so much higher.

11.1.2 Denmark Hill ED – Children and young people

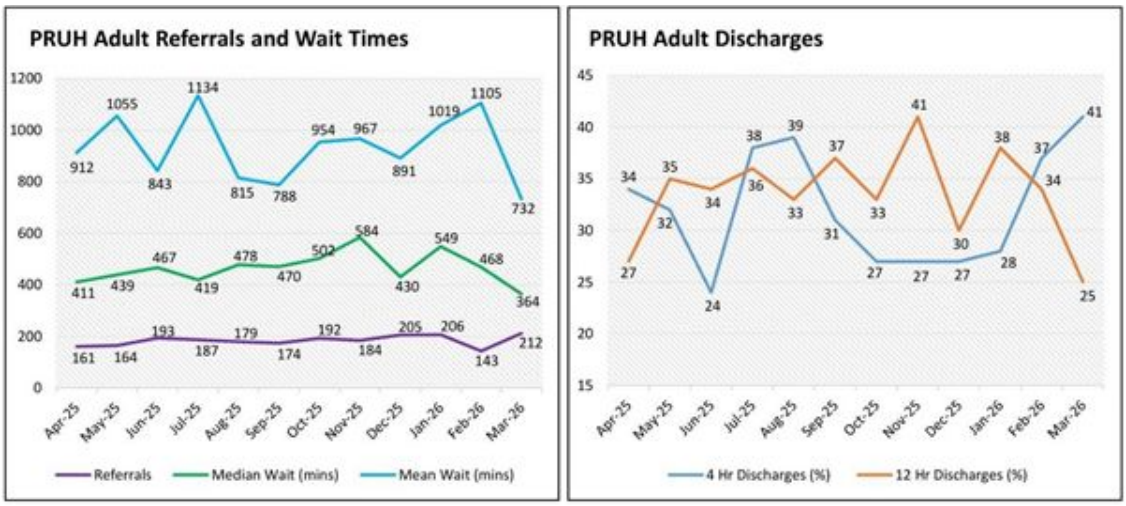
Referrals for CYP at Denmark Hill have showed a slight upward trend but there continues to be volatility both in relation to wait times and especially discharges. Long mean length of stay often correlates to a very small number of children with highly complex care needs, who often requiring multi-agency discharge planning.





11.1.3 PRUH ED – Adults

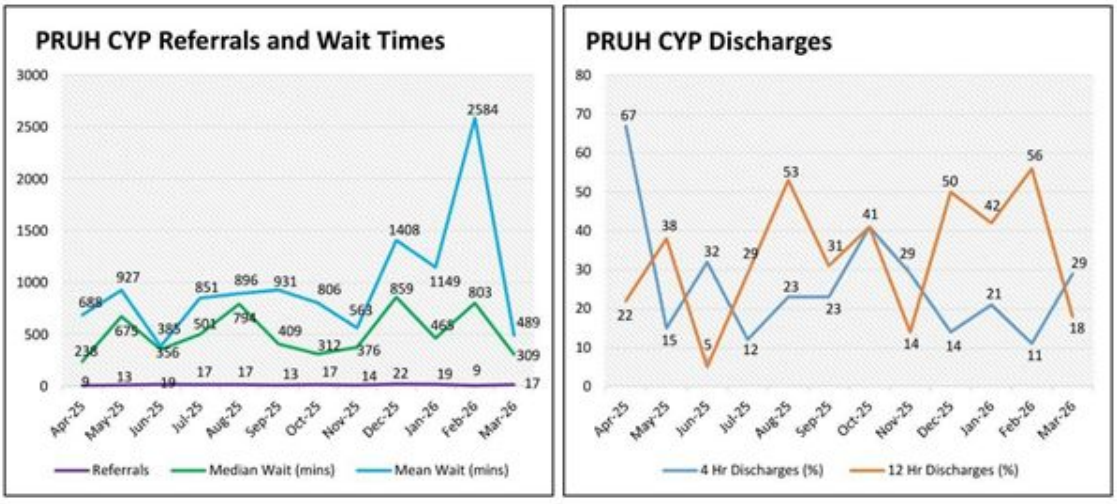
In 24/25 Data from PRUH ED showed a total of around 2100 recorded referrals across the year; 25/26 saw a slight increase with 2200 but rising to a peak of 212 in March – which was also the best month for performance with notable decreases in both median and mean length of stay.



It should be noted that demand is again not the only factor here; the fact that March showed both the highest number of referrals and the shortest waits indicates pressures are related to capacity and flow as much as the numbers of people arriving at the ED.

11.1.4 PRUH ED – Children and young people

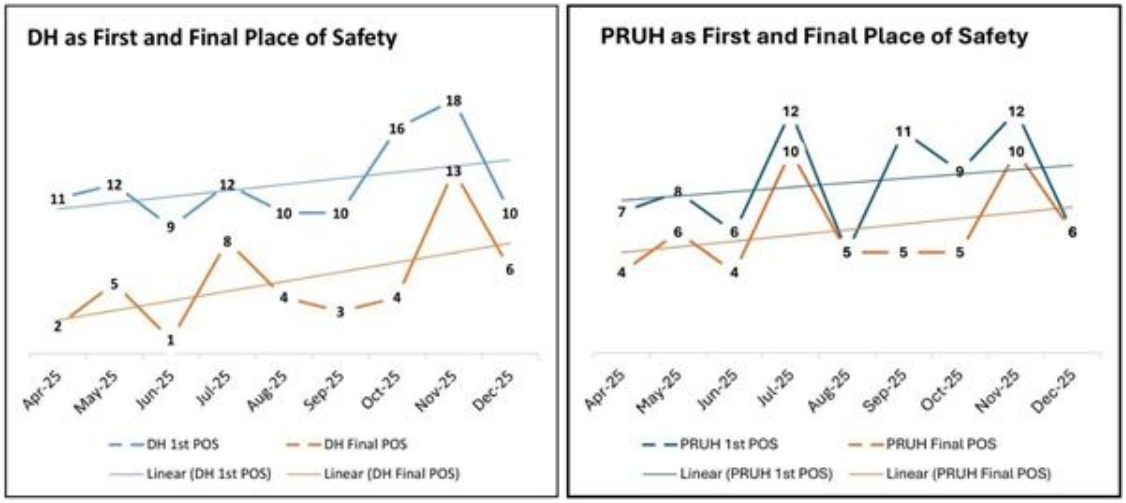
Recorded referrals to CAMHS Crisis Liaison at PRUH were much lower, but at times accompanied by dramatic increases in mean length of stay. This is particularly stark in February -as with Denmark Hill, these peaks typically correlate with a very small number of complex cases requiring a multi-agency response. Despite low numbers, 4-hour discharge rates have been notably poor, averaging out at just over 26%.



11.2 Section 136

Section 136 demand continues to impact both our EDs and the above graphs show linear increases across the year. It remains the case that the majority of Section 136 detentions in London continue to be taken to an Emergency Department, rather than a Health Based Place

of Safety in most cases. Thalamos data shows us that on average, 80% of go to the ED as the first Place of Safety, with 61% remaining there throughout their assessment.



We can see the impact of this in our EDs, with continued linear increases across 25/26. This pressure has increased after changes to prevent and Mental Health assessment from taking place within custody settings. While this change is welcome and right, it has meant an increased number of patients being placed on a S136 within Police stations and then moved to an ED.

Analysis of 136 spaces across London 18 months ago showed sufficient capacity for demand – however over that same period a number of providers have closed beds with little to no consultation. It is a priority for 26/27 that the 136-bed base in London is re-examined, and King's will join other London Trusts in working towards better oversight d capacity.

11.3 Inpatient data

We are again unable to include inpatient Liaison Psychiatry referrals in the report for either of our main sites; this is because there is no current manageable way to separate out consults to psychiatry from our EDs that have been placed for patients admitted to the ward from those strictly seen and discharged from the ED itself. This is complicated by the different structure of our two primary Liaison Psychiatry teams – the Oxleas service operates within a single team approach, and no separation between ED and wards, whereas the SLaM service has historically delineated the work between and ED PLN team and a medically led inpatient service.

It remains an urgent priority for our PSIRF MHIG to look at working with BIU to develop a mental health dashboard over the next 12 months, and also to find a way to record inpatient data – including information on extended length of stay for patients medically optimised for discharge – and additional data about specific conditions (such as an ability to record number of eating disorder patients admitted as an example).

11.4 Denmark Hill Emergency Department Mental Health Lower Intensity Area

25/26 saw the establishment of the Lower Intensity Area in DH ED – a quieter, more therapeutic environment offering 6 beds to patients typically awaiting transfer to an inpatient mental bed. The area has been a real success story with very positive feedback from patients and has at times helped relieve ED pressures where patients have been able to move from the main department. Unfortunately, the staff team have been recruited using government funding aimed at establishing a Mental Health Urgent Care Centre on the Maudsley site, so the area will gradually reduce capacity over late Summer and close in the Autumn.

Work is currently underway to in the development of the 6-bed Maudsley UTC which will allow for suitable patients to be diverted from ED. The unit will open in October 2026 but will serve all EDs in which SLaM provides Liaison Psychiatry services – and therefore it is unlikely it will significantly impact current demand at Denmark Hill.

11.5 Patient Safety Mental Health Improvement Group

Our Mental Health PSIRF Improvement Group was moved to a bi-monthly meeting in early 2026 as part of a review in order to allow for the development of Mental Health Incident Review Panels – these monthly meetings are intended to provide a space in which Mental Health InPhase reports from the previous month can be reviewed by a group including representatives from Liaison Psychiatry and SLaM and Oxleas governance.

Initial meetings have picked up a range of themes including:

- Communication (difficulty getting response from Liaison services at times)
- Documentation – particularly related to CAMHS at the PRUH site but also DH where notes might take hours to appear on EPIC and frustrate decision making
- Poor understanding or application of legal frameworks
- Difficulties with out of hours AMHP responses
- Bank/agency RMN response to incident

The PSIRF MHIG continues to focus on three main priority areas, which are listed below alongside some of the current work streams:

1. **Communication and relationships across organisational boundaries and internally within King's:**

- Set-up of 3 years eMHA licences for King's, which will significantly improve admin interface between SLaM, Oxleas and KCH
- Improvements to onboarding processes for SLaM and Oxleas teams to ensure faster and more consistent access to KCH systems

2. **Planning care, and enhanced care standards and quality:**

- ETOC team launched with service at DH moving to 24 hours at end Aug
- 5k charity funds allocated to the procurement of sensory and therapeutic engagement items for use with patients under the care of the ETOC team
- DASA, DASA:YV and BVC violence prevention tools set to launch in EPIC in late Sept
- KCH to be early adopter for the MH Training Passport
- KCH to be participatory site in a new refeeding in anorexia study – 'ANCORRA'

- New suicide prevention guidance in draft with expected launch early September

3. Effect of the environment on mental health patients and care:

- ICS-led working group being established to consider whether the American EmPATH model could be developed in SEL
- Work continuing to develop a 'Vulnerabilities Room' template to convert our safer rooms into positive de-escalation spaces. Several patient/carers focus groups have happened or are scheduled in August

11.6 Mental Health Act Forum

The MHA forum meets quarterly and aims to ensure oversight of MHA administration across the Trust, and to provide a space for clinicians to discuss challenges with the detention process,

This year the group has been able to successfully move forward a longstanding issue – the establishment of a service-level agreement on the PRUH site for MHA administration with Oxleas. This will ensure a much safer process at PRUH and provide much needed support for the Site Practitioners – which is vital, as increasing length of stay for patients detained to the Trust on Section 2 and awaiting inpatient mental health beds means a higher potential number of MHA tribunals on our sites.

In addition, the forum has developed MHA guidance this year and continues to work on opportunities to enhance knowledge of legislative frameworks throughout our staff teams.

Finally, the group will oversee the introduction of full eMHA licences for our ED staff and our site management teams in late 2026.

11.7 Children and Young People

The development of a dedicated monthly Mental Health governance panel for children and young people means a more consistent oversight of incidents which will provide better intelligence to our PSIRF meeting.

An ICS developed four module Children and Adolescent Mental Health course is now available on a regular basis for Trust staff. Spread over two half-days, the course covers behaviours that challenge, self-harm and suicide, psychosis and communication.

A vulnerable children's group, chaired by the ADoN for Safeguarding for Children and Maternity has also been working on initiatives which will directly impact our children who have mental health co-morbidities – most notably on the "No Second Night in ED" policy which recognises how harmful the ED environment can be when children are faced with long stays there, either due to prolonged assessment, delays in mental health bed allocation or complex social care scenarios – and aims to move children quickly to a paediatric inpatient bed when available and appropriate.

We have also – over the course of the year – re-developed our Talk Down Tips training to create a bespoke CYP version, supported by the Denmark Hill Paediatric Liaison Service.

11.8 Mental Health Training

During 2025/26 a range of Mental Health training courses have been provide throughout the organisation. These are delivered mostly in house and supported by the Associate Director of Nursing for Mental Health, the Vulnerabilities Team Practitioners and the Liaison Psychiatry teams.

Regular courses include:

- Band 3 Enhanced Therapeutic Observations and Care Training
- The Band 5 Preceptorship Mental Health Study Day
- Talk Down Tips de-escalation training
- Mental Health Legislation
- Suicide, Self-Harm and Ligature Awareness

The Liaison Psychiatry teams support quarterly sessions for ED teams on both sites, and the Paediatric Liaison Team support a 4-module course in Children and Young People's Mental Health which is available to book through LEAP. Additional bespoke courses are supported for teams where requested.

In early 2026 the Trust became one of three London pilot sites delivering a one-day Enhanced Therapeutic Observations and Care training course for qualified nursing staff. This was offered to 12 of our qualified ED nursing staff, and This course is intended to form pillar 5 of a new Capital Nurse Mental Health Training Passport which King's will also be an early adopter of in late 2026. The course was well received and addresses a vital gap in ensuring qualified staff – including seniors – have a clear and consistent approach to what 'good' ETOC looks like.

Work is currently underway to ensure we are prepared and ready to start delivering the additional courses making up the Mental Health passport from late 2026.
Limited available funding has meant we have not been able to offer any additional paid courses this year, but we continue to seek high-quality free learning and are working to make this available through a dedicated Mental Health Hub on the King's intranet.

11.9 MEED (Medical Emergencies in Eating Disorders)

Our quarterly MEED meeting continues to provide oversight for the care we provide to patients with Eating Disorders at King's and to ensure our localised guidance is fit for purpose. Good links with specialist eating disorders services from SLaM and the South London Partnership, and with the specialist MCCAED service for children and young people continue. Over the past year the group has also improved links with catering dietitians to ensure meal plans are up to date and reflect real time menus being offered across the hospital.

At time of writing the group has had contact with the University of Sheffield and Cambridge and Peterborough NHS Foundation Trust who have asked King's to participate in a new national research study called ANCORRA, looking at refeeding rates in adults. This is a major study to examine how effective our current approach to refeeding is, and important piece of work for King's to be a part of.

Our MEED priorities for the next 12 months are to strengthen our admission pathways at Denmark Hill and PRUH, and to work with Dietetics towards building dedicated eating resource within the team.

11.10 Enhanced Therapeutic Observations and Care

Our focus continues to centre on the improvement of both the efficiency of and the quality of Enhanced Therapeutic Observations and Care.

A business case for a new 30-person ETOC service at Denmark Hill was approved in January 2026 and a team has been recruited to most positions. The team will launch from August 2026 and will provide a single point of access model, with Band 7 staff providing triage assessments for all ETOC required for challenging behaviour. The team includes two Band 4 Activities Co-ordinators who will focus on ensuring every patient under the care of the team has a clear engagement and activities care plan.

We continue to be a major stakeholder in the national ETOC work and will be part of a collaborative in mid-late 2026 seeking to develop several quality improvement initiatives. We are also committed to supporting Capital Nurse in the development of a course aimed at supporting qualified ED nursing staff to recognise and support better enhanced care, as outlined in the Training section above.

11.11 Patient, Carer and Voluntary Service Involvement

The KCH Mental Health Advisory Group (MHAG) has relaunched and now has a regular meeting structure supported by Trevor Begg, patient/carer representative.
Recently the group supported a review of "We Can Talk" mental health e-learning and the views of the service users who took this will be collated and fed back to the CNO office.

The MHAG will also be supporting a full review of the internal training offered at KCH in MH and helping to redesign courses, with the intention that following this a MH Advisory Faculty will be created consisting of patient/carers who would like to co-facilitate training

Work is ongoing to provide Dementia Friends awareness sessions for staff, and the local Bromley Dementia Friendly Community will be delivering monthly sessions in the PRUH boardroom from October 2026.

In October 2025 we held our third annual Mental Health fair in the Hambleden Wing boardroom. This is now a yearly event which is well supported by a large number of community services working across the Lambeth and Southwark areas. It provides a way for staff and patients to learn about the work these services do in our local communities but also gives a welcome opportunity for those services to network with each other. We are looking forward to our fourth year of hosting the fair in October 2026.

12 Risk & Assurance

The safeguarding and vulnerabilities risk register is discussed at the Vulnerabilities Committee meetings and actions are monitored. Discussions in relation to mental health, violence and aggression risks also take place within mental health forum meetings and at the Trust wide supporting positive behaviour group. The below represents the risk register for the

reporting period. Ongoing reviews amend and change highlighted risks. It is expected that the current risk on inappropriate use of mechanical restrains will be reduced owing to extensive work in this area.

Risk ID	Risk	Controls	Rating
208	Inappropriate use of mechanical restraint including use of rigid cuffs.	• New restraint forum to be arranged and chaired by our service • The learning and feedback from restraint incidents will inform the new supporting positive behaviour group	16
567	Harm from violence, abuse and challenging behaviour	• TNA for de-escalation training completed. • Training package to introduce trauma informed care • Staff support, wellbeing and safety group • Clinical vulnerabilities team available to clinical areas	12
210	Inconsistent management of Mental Health Act across the Trust	• Live spreadsheet of detentions shared with site management team. • MHA forums in place	12
4137	Domestic Abuse Service Provision	• IDVA onsite cover only being 1 day per week	
55	Training to manage incidents of violence/abuse, challenging behaviour and restraint	• Security providing regular training. • AAR post incidents to identify learning and put in place appropriate actions. • TNA and business case in progress to present options and plan for trust wide comprehensive training provision.	12
3874	Discontinuation of trust third sector resources aimed to resettling vulnerable patients	• Discussions with community partners to improve transition of care. • Scoping volunteer service	8
226	Insufficient provision of Mental Health Enhanced Care	• NHSP bank through SLaM • Additional recruitment • MH CSW posts created	9
3280	Mental Health provision at Orpington	• Interim measure agreed with Oxleas for Bromley OA HTT to provide urgent in-reach assessment when required.	9
94	DOLS oversight	• DOLS trust wide working group • Mandated training compliance • EPIC electronic solution in progress.	8

The Trust continues to manage operational and clinical risks relating to mental health, safeguarding and patient safety. The risk associated with inappropriate mechanical restraint is under review and is expected to reduce, supported by robust governance, regular review panels and post-incident learning. Controls to mitigate violence, abuse and challenging behaviour remain in place, including trauma-informed care, de-escalation training and staff wellbeing initiatives.

Work continues to improve the consistent application of the Mental Health Act, strengthen staff training and enhance mental health care provision. Targeted recruitment and partnership working with community organisations, particularly in relation to homelessness support and mental health services at Orpington, are improving service delivery and reducing risk.

Trust-wide working groups and the planned electronic DoLS management system will strengthen oversight, support compliance and provide greater organisational assurance.

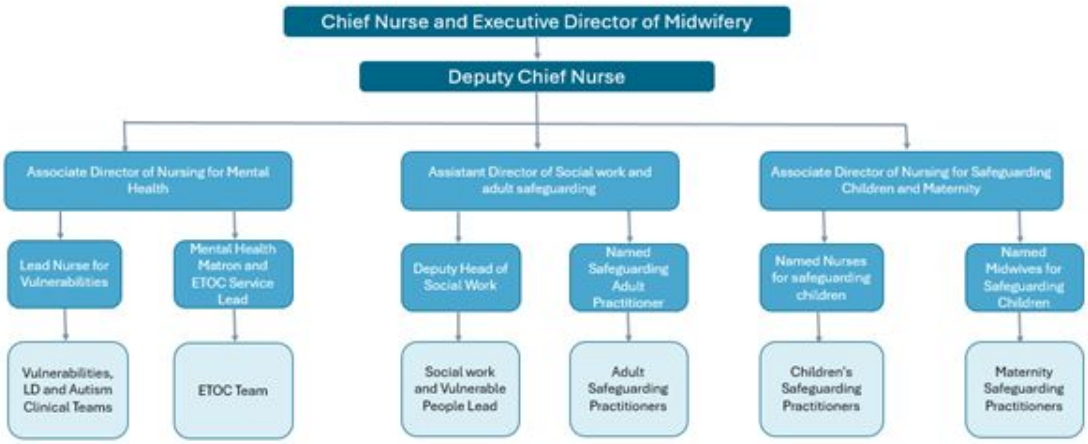
13 Conclusion and Assurance Statement

In summary, 2025-2026 has been a year of meaningful progress across the Safeguarding and Vulnerabilities portfolio, demonstrating the Trust's sustained commitment to safe, compassionate, and person-centred care. Strengthened governance, closer partnership working, and the continued embedding of trauma-informed practice have resulted in measurable improvements to patient safety, staff confidence, and service integration. Achievements such as the expansion of the Vulnerabilities Clinical Team, the introduction of specialist social work roles, improved training compliance, and the successful delivery of innovative initiatives, such as the Helping Hands clinic and enhanced staff support programmes, reflect a culture of continuous improvement and learning.

Looking forward, the Trust will continue to build on this strong foundation by further embedding trauma-informed approaches, developing workforce capability, and deepening collaboration across health, social care, and community partners. The key priorities for 2026–2027, summarised in this report, will focus on consolidating progress, strengthening data-driven assurance, and sustaining the culture of accountability and improvement that underpins this work. Through these ongoing efforts, safeguarding and vulnerability will remain central to the Trust's mission to deliver outstanding, equitable, and compassionate care for every patient.

King's College Hospital
NHS Foundation Trust

Appendix 1



Safeguarding and Vulnerabilities Team Structure.

King's College Hospital NHS Foundation Trust

Appendix 2

Safeguarding and Vulnerabilities Governance Structure

