King's College Hospital NHS
NHS Foundation Trust

Annual Report and Accounts 2009-10

King's

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LIST OF ABBREVIATIONS	
ACS	Acute Coronary Syndrome
A&E	Accident and Emergency
AHSC	Academic Health Sciences Centre
ALOS	Average Length of Stay
BCIS	British Cardiovascular Intervention Society
BME	Black and Minority Ethnic
CABG	Coronary Artery Bypass Graft
CAG	Clinical and Academic Group
CCAD	Central Cardiac Audit Database
C. diff	Clostridium Difficile
CMACE	Centre for Maternal and Child Enquiries
CMACH	Confidential Enquiry into Maternal and Child Health
CMPD	Case Mix Programme Database
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commission for Quality and Innovation
DDA	Disability Discrimination Act
DH	Department of Health
DNA	Did Not Attend
EBMT	European Group for Blood and Marrow Transplantation
ERP	Enhanced Recovery Programme
EPR	Electronic Patient Record
FCE	Finished Consultant Episode
GSTT	Guy's and St Thomas' NHS Foundation Trust
GUM	Genito-urinary Medicine
HASC	Hyper-Acute Stroke Centre
HES	Hospital Episode Statistics
HRWD	KCH's "How are we doing" inpatient survey
IHI	Institute for Healthcare Improvement
IOSH	Institute of Occupational Safety and Health
ISCT	International Society for Cellular Therapy
JACIE	Joint Accreditation Committee-ISCT & EBMT
JCC	Joint Consultative Committee
KCH	King's College Hospital NHS Foundation Trust
KCL	King's College London
KHP	King's Health Partners
LINks	Local Involvement Networks
LOS	Length of Stay
MAU	Medical Assessment Unit
MMC	Mortality Monitoring Committee

MRSA	Methicillin-resistant Staphylococcus Aureus
MTC	Major Trauma Centre
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NDA	National Diabetes Audit
NHFD	National Hip Fracture Database
NHS	National Health Service
NIAP	National Infarct Angioplasty Project
NIHR	National Institute for Health Research
NJR	National Joint Registry
NPSA	National Patient Safety Agency
nSTEMI	non-ST Segment Myocardial Infarction
OSC	Overview and Scrutiny Committee
PALS	Patient Advice and Liaison Service
PbR	Payment by Results
PCI	Percutaneous coronary intervention
PCT	Primary Care Trust
PEAT	Patient Environment Action Team
PFI	Private Finance Initiative
PICA Net	Paediatric Intensive Care Audit Network
PICU	Paediatric Intensive Care Unit
PMETB	Postgraduate Medical Education Training Board
POTTS	Physiological Observation Track and Trigger System
PROMS	Patient Reported Outcomes
PSSQ	Patient Safety & Service Quality Research Centre
QA	Quality Account
RCP	Royal College of Physicians
R&D	Research & Development
SLaM	South London and Maudsley NHS Foundation Trust
SpR	Specialist Registrar
STEMI	ST Segment Elevation Myocardial Infarction
SUIs	Serious Untoward Incidents
SUS	Secondary Users Service
TARN	Trauma and Audit Research Network
UHL	University Hospital Lewisham
VRE	Vancomycin-resistant Enterococcus
VSSGBI	Vascular Society of Great Britain and Ireland
VTE	Venous-thromboembolism
WHO	World Health Organisation

WHO WE ARE

King's College Hospital NHS Foundation Trust is one of London's largest and busiest teaching hospitals. We have a reputation for providing excellent local healthcare in the London Boroughs of Lambeth and Southwark, and a range of specialist services for patients across South East England and beyond.

King's is recognised nationally and internationally for its work in liver disease and transplantation, neurosciences, cardiac services, haemato-oncology and fetal medicine, and plays a key role in the training and education of medical, nursing and dental students.

King's is part of KHP's AHSC, a pioneering collaboration between KCL, and GSTT, KCH and SLaM.

KHP is one of only five accredited AHSCs in the UK and brings together an unrivalled range and depth of clinical and research expertise, spanning both physical and mental health. Our combined strengths will drive improvements in care for patients, allowing them to benefit from breakthroughs in medical science and receive leading edge treatment at the earliest possible opportunity.

King's works closely with other healthcare organisations, such as local PCTs and neighbouring hospitals, in delivering strong networks of healthcare locally.

For more information, visit www.kingshealthpartners.org

CHAIRMAN'S STATEMENT

Despite significant financial obstacles, we finished the year with a relatively small deficit and a record of high achievement in quality and operational performance.

This year has been a year of change for our Board of Directors. Medical Director John Moxham left our Board to become Director of Clinical Strategy for the KHP AHSC, and I am glad that he will continue to work for the benefit of our Hospital and our local population in his new role. He has been succeeded by Mr Michael Marrinan, a Consultant Thoracic Surgeon at King's who has been working as Deputy Medical Director for the last few years and who brings a wealth of experience and knowledge of King's to the role. Angela Huxham joined us as Director of Workforce Development and Roland Sinker rejoined us as Operations Director after a stint at KHP leading on Strategy. Dr Geraldine Walters, our new Director of Nursing and Midwifery, joins us from St George's Hospital where she was Director of Nursing and Patient Involvement & Director of Infection Prevention and Control. The last working address for our new Strategy Director, Jacob West, was No. 10 Downing Street, where he was Deputy Director of the Prime Minister's Strategy Unit and the Prime Minister's lead adviser on health policy. All this new blood has helped strengthen our executive team even more.

During the course of the last year we also said goodbye to non-executive directors Rita Donaghy and Sir Jonathan Michael. Rita had invested a large amount of time and commitment to King's and will be greatly missed. Jonathan was with us just a short time before leaving to take up the role of Chief Executive of Oxford Radcliffe Hospitals NHS Trust. I would like to thank them both for their invaluable contributions in the time that they sat on the Board.

We have continued to be active in our local community this past year with the support of our members and governors. Our campaign to make Denmark Hill station more widely accessible has now reached the stage where plans for new lifts and footbridge have been passed and building work will commence in November this year. We launched another rail campaign this year, to save the South London Line which runs between Victoria and London Bridge and is a vital transport link for patients and staff alike. Our governors and members were once again involved in lobbying the London Mayor and the Transport Secretary and talks and negotiations continue on this project.

Our plans for redeveloping our Emergency Department were consulted on early last year and the feedback led us to amend the proposals to include a separate area for mental health patients and increase the size of the other departments. The local community took a keen interest in our proposals and we are happy that the final amended plans have met with universal approval. We continue to work closely with our service users, the local PCTs and SLaM as the plans become reality.

Tim Smart has referred to the establishment of our values project that helps us along the path of value based decision making, which is a prerequisite for evidence based decision making in our Trust and our AHSC.

KHP continues to develop and we are now at the stage of appointing leaders for our CAGs, which will bring clinical services, research, and education activities together within a series of single managerial units across all four AHSC partners.

Finally, I would like to offer my thanks to our Board of Governors who continue to give up their time to help us engage with our members and local communities whilst giving us a valuable patient perspective.

Michael Parker
Chairman

CHIEF EXECUTIVE'S STATEMENT

Welcome to this year's annual report, which features some very significant achievements, and outlines some of the challenges we still face.

Patients have rated King's the best outpatient acute hospital in London and King's workforce has told us that we have made progress on some important workplace and employment issues. We consulted on and we have publicised the 'Kings Values', which describe what we believe in as an organisation. Commissioners have recognised the quality of our services by granting us MTC and HASC status, and regulators placed us among the best 10% of hospitals in the country by rating us 'Double Excellent'.

However, we have faced and we continue to face some difficult challenges. We are now much cleaner and much safer than we were a year ago, but we still need to strive to be the best. We enter the most difficult economic times for the NHS much leaner and more focused than we have ever been, but the challenges are great. The European Working Time Directive has caused our costs to rise, the income we receive is under pressure, and policy is increasingly directed at prevention and treatment closer to home, rather than referral to hospital. The work we are doing with patients, GPs and commissioners on implementing poly-systems and on creating innovative pathways for long term conditions such as diabetes and COPD will be essential for us to play a full part in the transformation of the NHS.

Our ambition is to be a beacon of modernity in healthcare. With our KHP partners and other partner organisations we intend to become leaders of a local healthcare economy which will meet the diverse needs of the many local communities we serve, and which we are proud to describe as 'the World on our doorstep'. Meeting the needs of these diverse communities, and reducing heath inequalities in south east London will require us to be both inclusive and innovative, and we are energised by the challenge.

The past year has not been easy, and the next few years will be even more testing; presenting us with many opportunities to improve. The lessons we have learned this year, by challenging ourselves to be better, will have put us in a strong position to achieve our vision and to better serve the populations of south east London and beyond.

Timothy Smart
Chief Executive

DIRECTORS' REPORT

Financial Review

2009/10 was a more difficult financial year for the Trust than recent years, due to reductions in central government funding, affordability issues for our local commissioners and high levels of activity meaning capacity was exceeded forcing high cost out of hours and off-site working.

For the year, the Trust made a surplus of £2.8m before exceptional items, compared to a planned surplus of £5.7m. After final discussions with the District Valuer, the interim revaluation of the Trust's land and buildings resulted in an impairment of £4.3m. This was primarily due to valuation on completion of capital projects and the incorporation of fair market value on the Trust's acquisition of the Coldharbour Lane Business Park. These impairments are considered exceptional items when calculating Monitor risk ratings. This left an overall position of a deficit of £1.4m.

Full year (£000)	
Income:	566,013
Expenditure:	(550,486)
Operating surplus:	15,527
Net Financing costs:	(9,364)
Public dividends:	(7,549)
Surplus/(Deficit):	(1,386)

Despite having an overall deficit, the overall liquidity position of the Trust was improved compared to the plan value. This was due to agreeing year end positions with PCTs in advance in exchange for prompt payment of outstanding amounts. The Trust has been able to maintain a position where there was only a minimal requirement to access its short-term working capital facility. (The Trust has in place a £25m working capital facility, to protect it from the effects of any short-term fluctuations in cash flow). The combined effect of the deficit and liquidity has resulted in the Trust achieving a year end financial risk rating of 3 using the Monitor system –a medium level rating.

Value for money and improved efficiency

In recent years, significant effort has been put into implementing service line management and a performance management framework across the Trust. The Trust has also invested in information technology to improve efficiency such as e-rostering and electronic patient status boards. Performance is peer reviewed as well as considered regularly by the Executive and the Board Performance Committee.

Trading environment and financial risks

As in most of the recent years, the main influence on the level of trading during the year has been the additional activity required to meet the national waiting time targets relating to a maximum treatment time from first referral of 18 weeks. In addition, the Trust has seen unprecedented levels of emergency attendances through the Emergency Department. The combination of these factors meant that for many periods of the year, the hospital was running at over capacity. In order to maintain waiting times, additional temporary staff were employed and activity was undertaken out of normal hours and at other facilities offsite. This had the effect of

substantially increasing costs. As a result, by Christmas, the Trust was running a small deficit. The bad weather over the December/January period led to a number of cancellations which, in turn, reduced income. The combined effect was to leave the Trust with a deficit of £3.6m at the end of Q3. The Trust instituted a savings programme to reduce costs for the remainder of the year, which successfully led to the outturn position.

Looking ahead, the economic downturn means that there is likely to be increased pressure on NHS income streams and therefore, an increased necessity to ensure that patients receive the most appropriate treatment in the most appropriate setting. It is likely that central funding streams will be squeezed, tariff increases will be zero and commissioners will seek to reduce activity.

In consultation with the governors, the Board of Directors has established a medium term financial strategy to increase efficiency, leverage the benefits of KHP and to diversify income. It is anticipated, however, that efficiency gains approaching 10% per annum will be required over the next three years in order to maintain financial viability.

Non-clinical activities
KCH Commercial Services Limited, the company established to oversee our commercial operations has now been in operation for 3 years. During that time, the first of the operating companies, Agnentis Limited, has continued to grow. It has expanded its product range to include a range of software solutions specially configured for use in the NHS. It is also anticipated that King's will expand into overseas markets in the coming year.

Changes to accounting policies
The Trust has completed the process of moving to adoption of International Financial Reporting Standards. The recent volatility in commercial land values means that it is difficult to assess the current relationship between the market value of land and its current holding value. The Board of Directors believes, however, that there is no significant difference between the balance sheet value and the long term market value of land.

External audit services
At its meeting on 6 May 2008, the Board of Governors resolved to appoint the Audit Commission as the Trust's external auditors for a further period of three years. The Trust incurred £81,000 in audit services fees in relation to the statutory audit for the year to 31 March 2010.

Non-audit services included an independent review of the Board of Directors and Board of Governors facilitated by the Audit Commission, reviewing issues such as roles and responsibilities, based on Monitor's Code of Governance (costing £6,000) and an audit review of the Trust's restated 2008/09 financial statements in accordance with IFRS (costing £12,000)**.**

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

After making enquiries, the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt the going concern basis in preparing the accounts.

Borrowing and capital plans
Monitor set a prudential borrowing limit for the Trust of £108m. Due to the adoption of International Financial Reporting Standards, the vast majority of this limit is consumed by past expenditure on the PFI schemes for the Golden Jubilee Wing and Ruskin Wing.

The Trust undertook further borrowing in the year to part finance the acquisition of the King's Business Park which not only produces revenue savings from rental income, but will allow the Trust to relocate non clinical services off the main acute hospital site providing room for the expansion of clinical services.

The Trust has a number of other developments planned over the next few years, many funded by capital grants or charitable donations, including:

- Improvements to the Emergency Department.
- Developments to support extended trauma services.
- Improvements to maternity facilities.
- Expanded critical care facilities.
- A clinical research facility.
- Improved fetal medicine facilities in conjunction with the Fetal Medicine Foundation.
- An academic neurosciences centre.

The aim of these schemes is to enhance the capacity of the Trust for research and academic activities related to our tertiary specialities and, also, to complement the facilities available in our partner organisations in the AHSC.

We will continue with our policy of maintaining our asset base by committing capital expenditure on existing assets at a level broadly consistent with their rate of depreciation.

Operating and Performance Review

2009/10 will be the second year of review by the newly formed CQC, replacing the Healthcare Commission. All NHS Trusts will be awarded a Quality of Care rating of Excellent, Good, Fair or Weak, based on performance against:

> **Core Standards and Existing Commitments**: is the trust getting the basics of healthcare right - in other words, is it meeting the Government's core standards and existing commitments for the NHS.
>
> **National Priorities**: as well as getting the basics right, is the trust making and sustaining ongoing improvements in its services. This is judged by performance against the Government's new national priorities for the NHS.

The Trust ratings for 2009/10 will be published in October 2010. We are confident that we will deliver an "Excellent" or "Good" rating. We have full compliance with all 23 national core standards, signed off by our Board of Directors. In addition to this, we are confident in our performance against the existing commitments and new national priorities set by the CQC.

Key Performance Highlights in 2009/10

Despite a continued increase in GP referrals and referrals from other hospitals throughout 2009/10 and an unprecedented demand on our emergency services in the winter months we were still successful in delivering against the key national and local targets for A&E, 18 week referral to treatment, infection control and cancer waits.

<u>Accident & Emergency '4 hour wait'</u>

Despite the unprecedented demands on our Type 1 A&E services (emergency department) through the winter months, the Trust achieved a full year performance above the 98% target. The Trust's overall performance against the '4 hour wait' target for all A&E type services was 98.39%.

<u>Achieving 18 weeks</u>

King's delivered the Department of Health's April – December 2009 targets in respect of 18 weeks from referral to treatment with a month on month achievement above the target of 90% of admitted patients and above the target of 95% of non-admitted patients receiving treatment within this timescale.

In the last quarter of the year the targets had to be achieved across all specialties and the Trust was successful in doing this. This achievement was the result of the Trust making changes to a number of patient pathways and undertaking a significant number of additional planned procedures. Many cases previously treated through day surgery are now treated in outpatients. More treatment is being delivered in the day surgery unit avoiding the need to admit patients overnight or longer. Finally, the length of time that patients stay in the hospital is also falling. These improvements reduce patients' risk of acquiring hospital infection and ensure that they return home to familiar surroundings more quickly.

In order to achieve these increases in patients treated, whilst reducing their length of stay, staff have worked on evenings and at weekends. A number of patients have also been treated at independent centres.

Infection Control

In 2009/10 the Trust reduced its level of MRSA bacteraemia cases by 33%, moving from 39 cases in 2008/09 down to 26, ahead of the national expected limit of 43 and the local target set by commissioners of 32.

In addition to this we delivered ahead of our requirements in reducing levels of C-Difficile cases. We reported 135 cases in 2009/10, a reduction of 32% from 2008/09 (199 cases) and well ahead of our national expected limit for 2009/10 of 202 cases and delivering a year ahead on our 2010/11 limit of 162.

Research and development

In 2009/10, the Trust Executive approved a £1.5 million investment in clinical and translational research. These funds were advertised widely, and 90 high quality applications were received, of which 22 were funded from 1 April 2009, the majority acquiring funding over a two year time frame. This investment has already resulted in eight abstracts / posters being presented at national and international meetings, with one editorial published, as well as further grant monies (£270,000 and £15,000) obtained by two groups, and one NIHR PhDship granted.

Research funding was also made available to Allied Health professionals from both the British Research Council and KCH funds, and this allowed funding of several individuals to undertake PhDs.

Research activity across the Trust is now well supported by an expanded R&D Office and by the appointment of R&D Research Facilitators during 2009/10. The Facilitators are working with clinical researchers to ensure research applications progress speedily through the R&D governance process, as well as supporting the Divisional R&D leads in their development of local R&D governance structures. Research was also promoted in the successful R&D open meeting held at the Weston Education Centre earlier this year when presentations were given by all Divisions. This is being followed up by regular "Breakfast Clubs" held in the Boardroom allowing research to be presented by each Division in turn.

The KCH/KCL NIHR PSSQ has facilitated closer working in respect of patient safety, quality and risk issues in the clinical arena between clinicians and research leaders. This work has also been facilitated by the secondment process of NHS staff to the Centre, which continues to grow. The PSSQ has been highly successful, for example, securing an EU grant of around £1 million.

Research output from this campus has been excellent with a number of high impact publications in both in general (e.g. New England Journal of Medicine) and specialist journals. In addition, many individuals and divisions have been involved in running national and international meetings, with many also carrying positions of responsibility in international societies.

Future developments 2010/11
KCH has identified nine strategic objectives for the coming year, as outlined in the annual plan. All developments will be in the context of driving forward these objectives.

- **Improve patient-centred care and patient experience at King's –** specific initiatives include work on patient and public involvement, Maternity redevelopment and work with SLaM to better integrate psychological and physical care.

- **Provide high quality, safe and effective services that meet patient expectations, and the requirements of commissioners and regulators** – reducing average length of stay, reducing infection and improving performance on mortality measures.

- **Develop the King's specialist hospital by strengthening the key tertiary services at King's including liver, neurosciences, and haemato-oncology–** specific developments include increasing the capacity for these services (e.g. dedicated liver theatres, additional critical care) and supporting research and educational activity in these services.

- **Develop the King's major acute and specialist emergency hospital** - specifically complete the implementation of the MTC and HASC, and support the academic activity of these services.

- **Develop King's community and local services by delivering more care out of the hospital and more integrated care across acute, primary, community, mental health and social care services –** including establishing local poly-systems hubs, and working in partnership with GSTT to deliver the vertical integration with Lambeth and Southwark community services.

- **Achieve financial sustainability –** through increased operational efficiency, delivering efficiencies across KHP and raising the proportion of commercial income that King's generates.

- **Contribute to the delivery of King's Health Partners vision including strengthening the research and education activity at King's** – specifically developing CAGs and improving corporate functions through greater collaboration, and building the research and teaching capability of KCH clinical services.

- **Adapt and develop our workforce skills, competencies and capacity in line with changes in service delivery and care pathways –** by establishing effective workforce planning, designing roles and career pathways aligned to service need and educating and training our staff to lead high quality service delivery.

- **Establish Trust-wide systems that support high quality, safe, effective and efficient patient care -** implementing governance systems, performance systems and IT solutions that better support clinical services and academic programmes across our networks of care.

Workforce

Staff Development

King's places great emphasis on the welfare of every person employed by the Trust. By continually investing in training and development, by encouraging people to innovate and by retaining a fresh approach to what we do, our staff continue to deliver better care, year-on-year, to the communities we serve.

Our staff's commitment was validated during the year in the results of our staff survey which placed us in the top 20% nationally for training, appraisals and recommending the Trust as a place to work.

Our workforce is large and growing, the headcount in March 2010 was 6959. An increase of 5.8% in the year can be attributed to growth in activity of 9% and in business locations such as Sydenham and Lewisham.

New management development programmes launched

We want our staff to realise their full potential and encourage them to take advantage of continued professional development, qualifications and training.

We added new courses to our extensive catalogue of staff and management development programmes during the year. New training included:

- Joint management qualification training with KHP partners at GSTT and SLaM for staff to undertake Masters of Business Administration or Diploma in Management Studies courses at Westminster University.

- The third cohort of the Senior Management Development Programme (in which clinical directors also participate) run with the King's Fund, which includes a work-based project designed to encourage good management practices that can improve patient outcomes and experiences.

- We are in the third year of the Keele Clinical Leadership Programme, developed in conjunction with Keele University to help clinical leads and directors to manage and embrace change.

- The Keele SpR)Management/Leadership Programme, has built on the success of the Clinical Leadership Programme, with a two day course for SpRs developed in conjunction with Keele University to introduce doctors to management/leadership within the NHS.

- The launch of the first four cohorts of a front line leadership programme in conjunction with GSTT.

- A shadowing and leadership programme for BME staff aimed at giving them exposure to senior leaders within King's.

We have continued to provide vocational training to our unqualified staff in the past year, including providing 46 new apprenticeships, and continue to encourage their progression on our established careers escalators.

Medical staff development
During 2009 there has been an emphasis on faculty development and the accreditation of Educational Supervisors in line with the PMETB Standards for Trainers. A rolling programme of courses has been run in-house and where possible courses have been taken to divisional meetings to provide flexible access to the training.

The New Consultant Programme continues to be well evaluated, with the three modules running on an annual basis.

Commendation awards
During the year we presented commendation awards to 17 individuals and three teams, in recognition of their outstanding contribution to the hospital and our patients. Awardees included:

- A maternity support worker in the Community Midwives Office who recognises the importance to women and their families of the finer points of healthcare, is unfailingly polite, shows amazing thoroughness and attention to detail in all that she does, and intuitively knows how her role and those of her midwifery colleagues fit together. As a consequence, she has been able to support their work with unfailing care and thoroughness for over 25 years.

- A ward manager commended by a group of colleagues for her inspirational leadership and outstanding contribution to hospital service and patient care. Her hard-working, caring and sensitive approach combined with superb management skills make her a formidable (in the very best sense of the word) role model. She gives 110% to staff and patients and never fails to find time to address any concerns that they might have.

- Two meticulous, conscientious and diligent housekeepers commended by a number of clinical colleagues for the pride that they take in keeping their ward areas spotlessly clean and their willingness to go beyond their regular duties for the benefit of patients, staff and visitors. Their dedication to King's is appreciated by everyone on the wards.

Positive about disabled people
King's has been re-accredited with the nationally recognised 'Two Ticks' disability symbol signifying good practice in the employment, retention, training and career development of employees with a disability. We will continue to meet these commitments including:

- Interviewing all applicants with a disability who meet the essential criteria for a post and consider them on their abilities.

- Ensuring there is a mechanism in place to discuss with disabled employees at any time, and at least once a year, how they can develop and use their abilities.

- Making every effort when an employee becomes disabled to ensure they are able to stay in employment.

- Taking appropriate action to ensure that all employees develop the appropriate level of disability awareness needed to make the commitments work.

- Reviewing the Trust's commitments each year, including what has been achieved, planning ways to improve and letting employees know about future plans and progress.

The Trust published a Disability Charter, which sets out our ethos and firm commitment to disability equality, and a Disability and Deaf Guide which outlines the responsibilities and behaviours expected of staff and managers. Both documents were developed in partnership with the Deaf and Disability Staff Group.

All recruiting managers must attend a formal Trust recruitment and selection training course to understand the significance of the DDA and how it works in practice. Recruiting managers must select for interview or assessment all candidates who meet the essential requirements for the role and have indicated they have a disability, as defined in the DDA. At the interview, discussions can also take place on reasonable adjustments that may be necessary for a candidate to perform effectively in their new role.

Occupational health and safety
Occupational health and safety is overseen by our Health and Safety Committee.

Key performance in 2009/10 included:

- In 2009/10 health and safety training data significantly improved. The Electronic Staff Record pilot identified staff requiring training to divisional heads on a quarterly basis. Management training focused on each division having completed the IOSH Managing Safely (safety and risk in healthcare) course and disability training for managers. A new Staff Management Scorecard was introduced incorporating new health and safety training targets. Current figures for health and safety stand at 32% (target 70%) for Clinical staff and 63% (target 80%) for Non-Clinical staff all within assessed need, however short of the new Trust targets.

- Pandemic flu training: During 2009 the Trust, as part of its emergency planning preparation, trained a number of volunteer staff to undertake some basic clinical duties, e.g. portering assistants, clinical support workers, cleaners and receptionists.

- Reducing levels of blood borne virus exposures remains an important priority. In the past year, reporting procedures have been tightened with a new follow-up protocol developed. Overall reports of total incidents-plus-near misses remain static at 257. However there is a welcome reduction in number of confirmed needle-stick and body-fluid exposures to blood borne viruses from 37 in 2007/8 to 24 in 2008/9 and 15 in 2009/10.

- The Trust has maintained its comprehensive safety prompts through a checklist system to ensure a wide range of safety controls. 83% of departments have formally returned safety self-assessment checklists. Local action plans are reviewed by division risk leads.

- This year 29 notifiable incidents were reported under the *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995*, sharply down from the 46 of 2008/9 and a peak of 61 in 2007/8. Levels fluctuate and improvements are best judged on overall incident levels, but this is very welcome. A mid-year review established that the trust benchmarks well compared to the social care

sector. A new metric "all health and safety reported incidents" was established to support the work of the Health and Safety committee and is now incorporated into the Trustwide Staff Management Performance Scorecard. Historic trends and performance data will now be available for 2010 onwards.

- In 2009/10 the security team recorded a total of 127 physical assaults (mostly minor scratches, knocks, pushes, etc.) This is up on 2008/9 (66 instance) and is attributable to a continued drive to encourage staff to report more instances via the incident system as well as through security desk requests. The 1379 other types of security incidents include threatening behaviour, arguments, suspicious behaviour, theft, criminal damage, etc. The Safer Neighbourhood Panel with a seconded police officer has been integrated into the Trust's Violence and Aggression Working Group.

- 2009/10 saw a dramatic improvement for staff immunisations. Firstly the swine flu pandemic prompted a large scale programme prioritising frontline staff and resulting in 1,986 swine flu vaccinations and 1,927 seasonal flu vaccinations - a sharp increase on the seasonal flu immunisations for 2008/2009 -736 staff. Secondly a programme of recalling staff Trust-wide with expired immunisations was extended. Areas targeted to date (Jan – Sep 2009 include: Child Health – 75% staff attendance, Renal – 80% attendance, Women's Health – 18% attendance. Further work is under review. Service alterations resulted in appointment times for vaccination clinics has reduced waiting times from five to six weeks for a blood test/vaccination to two to three weeks.

- A health trainer seconded from Southwark PCT completed delivery of a pilot lifestyle advisory service giving information on diet, exercise, stress management and smoking cessation. A trial staff occupational therapist service was complete and a model produced for service development in 2010/11.

- The annual sickness rate for 2009/10 was 3.39% (2008/09 3.12%) which benchmarks well in comparison to public and private sectors organisations and falls within the top performance quartile for NHS organisations in London.

- In April 2009, a manual handling equipment audit process was established with a Trustwide benchmark and area upgrade plans. Priority was given to hoists past their average life expectancy and the stocking of sufficient slings in preparation for a reduced laundry service. Slide sheets and shower chairs were also advised. Re-audit later in the year identified several areas have increased equipment provision. Equipment plans for 2010/11 were being established. Patient handling training continues and non-clinical moving and handling training courses were established.

- King's Radiation Protection Service has maintained its training, inspection, audit and monitoring service. In 2009/10 the service produced a new Trust 'Policy for Medical Laser and Intense Light Source Safety' due for implementation shortly. Risks from all relevant optical sources of radiation must be assessed and necessary controls put in place.

- This year the Trust significantly strengthened fire safety. 177 of 179 fire compartment evacuation plans have been received from across the Trust. 95% of all areas have had Fire Risk Assessments reviewed or established and areas of concern prioritised for action by Facilities Project's Team. There were 154 unwanted fire alarm signals received in the past twelve month period, this is an

increase of 16 alarm signals on the previous twelve months but sharply down from the 300 plus several years ago.

Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees

- Corporate induction and local induction is mandatory for all new members of staff.
- Key messages to staff are communicated via the monthly Chief Executive's Brief.
- Clear management/committee structure which ensures that key issues can be cascaded throughout organization.
- King's has a strong culture of regular team meetings - King's rated as above average nationally for effectiveness of team working in national staff survey.
- Well attended JCC meetings were held every month, except December, with regular updates on the Trust's business plans, in particular with respect to the development of the AHSC, and regular updates on the Trust's financial position.
- The Chair of the JCC is automatically a Staff Governor on the Trust's Board of Governors.
- Representatives of the Trust's three staff lead diversity groups sit on the Equality and Diversity Committee of the Board of Directors.
- Regular briefings from executive directors.
- All new members of staff receive a King's email account at the time of induction.
- There is a staff magazine – *King's News*, which is published throughout the year.
- A special e-magazine has been introduced to keep staff updated on AHSC issues in particular. This is made available across all KHP organisations.

Actions taken in the financial year to encourage the involvement of employees in the NHS foundation trust's performance

- 90% of staff with 12 months service on 31 March 2010 had a performance appraisal.
- In 2009/10 the Trust made improving the quality of appraisals a priority – the 2009 NHS national staff survey the proportion of staff reported they had a well structured appraisal increased.
- King's was in the top 20% of NHS staff survey results for staff able to contribute towards improvements at work .
- Frequent presentations on Trust performance at team meetings and within Trust publications.

Actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the NHS foundation trust.

- Regular presentations on the Trust's financial position at the JCC and in Trust publications.

- Cost improvement requirements clearly discussed and communicated to staff via team meetings. A Chief Executive briefing note on the need to achieve significant cost reduction was cascaded to all team meetings in January 2010.

Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests.

- Management representatives and representatives from recognised trade unions meet once every two months as part of the JCC.

- In addition there is JCC sub group, which also meets once every two months, which is primarily focused on policy development and review.

- Well attended JCC meetings took place throughout 2009/10.

- In 2009/10 the JCC continued its rolling review of workforce policies. New versions of policies included sickness absence, organisational change, special leave and unpaid leave.

- Development of the AHSC is a standing item on JCC agenda.

- In addition the Trust's self organised equality groups, the Cultural Diversity Group and Disability and Deaf Staff Group, met on a regular basis and invited senior members of staff to discuss issues of interest to the groups.

Information Governance
The Information Governance Steering Group is responsible for reviewing the effectiveness of our information governance systems and processes. The Trust's Senior Information Risk Owner, Caldicott Guardian and Information Security Manager together with other colleagues play a key role in ensuring the highest practical standards and systems for the confidential handling of patient information and personal data within the Trust. During the year one serious incident occurred which was reported to the Information Commissioner and to our commissioning Primary Care Trust and which was fully investigated.

Date of incident	**Nature of Incident**	**Nature of data involved**	**Number of people potentially affected**	**Notification steps**
June	Loss of inadequately protected laptop from outside secured NHS premises	Name, d.o.b, ethnicity, blood test result.	1,000	Police notified Individual patients notified by post

Further action on information risk

The Trust will continue to monitor and assess its information risks, in light of the events noted above in order to identify and address any weaknesses and ensure continuous improvement of its systems.

Planned steps for the coming year include:

The Trust is committed to the migration of the present email platform to the nationally provided secure NHSmail system, this provision will allow for the transfer of encrypted clinical data and appropriate data sharing.

We will continue to oversee the encryption program with improvements in laptop and memory stick management and the ongoing action to secure data centrally away from workstations across the organisation.

Mandatory information governance training has been implemented for all staff groups and will be rolled out across the organisation.

There were no other serious incidents relating to information governance in 2009/10.

QUALITY REPORT

Part 1. Statement on quality from the Chief Executive

King's College Hospital NHS Foundation Trust has responded very positively to the NHS-wide drive to make 'Quality the organising principle'.

Since our first Quality Report 12 months ago, we have increased our nursing establishment and improved the cleanliness of the hospital. The numbers of MRSA and C. diff cases and pressure sores have decreased. We are using feedback received from our monthly internal patient surveys to continue to improve patients' experience. We have improved our mortality rate and we have had zero 'Never Events'[1]. All of this has been achieved through a systematic analysis of data, benchmarking and learning from peer organisations.

But we have a long way to go to be among the best, which is where we aspire to be, and where our patients need us to be. We will focus on hygiene and on safety practices to further reduce MRSA cases towards zero. We have targeted also a reduction in falls and medication errors. In addition, we are determined that ALOS in all our specialties will be in the upper quartile compared with peer hospitals.

Our innovative 'Board Go-See' programme[2] will continue to engage each and every Board member in hygiene, safety, and patient experience issues every month. This enables us to ensure that staff and patients have a voice in the Boardroom.

We are proud of the fact that the hospital and all its staff have taken the quality agenda to heart. The Board will continue to champion quality and safety issues, and be intolerant of poor standards.

This Quality Report reflects our ambition and determination to challenge ourselves. I hope you find it interesting. To the best of my knowledge, the information contained in the following Quality Report is accurate.

Timothy Smart
Chief Executive
KCH's College Hospital NHS Foundation Trust

[1]Never Events are defined by the National Patient Safety Agency (NPSA) as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
[2]Refer to Appendix 5 for details.

Part 2. Priorities for improvement and statements of assurance from the Board

2.1 Progress on quality priorities for improvement in 2009/10

Four key quality priorities for 2009/10 were approved by KCH Board in its Quality Report 2008/09. Significant progress has been achieved in all areas.

2.1.1 Quality Priority 1 - achieve zero Never Events[3]

No Never Events were reported at KCH in 2009/10. KCH has taken the following actions to prevent any Never Events from happening.

- A review of operational procedures and "fail safe" mechanisms with reference to national guidance was conducted at Trust and divisional level.
- WHO Surgical Safety Checklist is used in all main theatres and regular audits are built into the system to ensure the checklist is being used for all operations. The April 2010 audit showed 99.28% compliance in main theatres, Cardiac, Neuro and Obstetrics theatres.
- A policy on safe placement and use of Naso- and Oro- gastric tubes was developed and communicated to staff.

2.1.2 Quality Priority 2 - enhance mortality performance

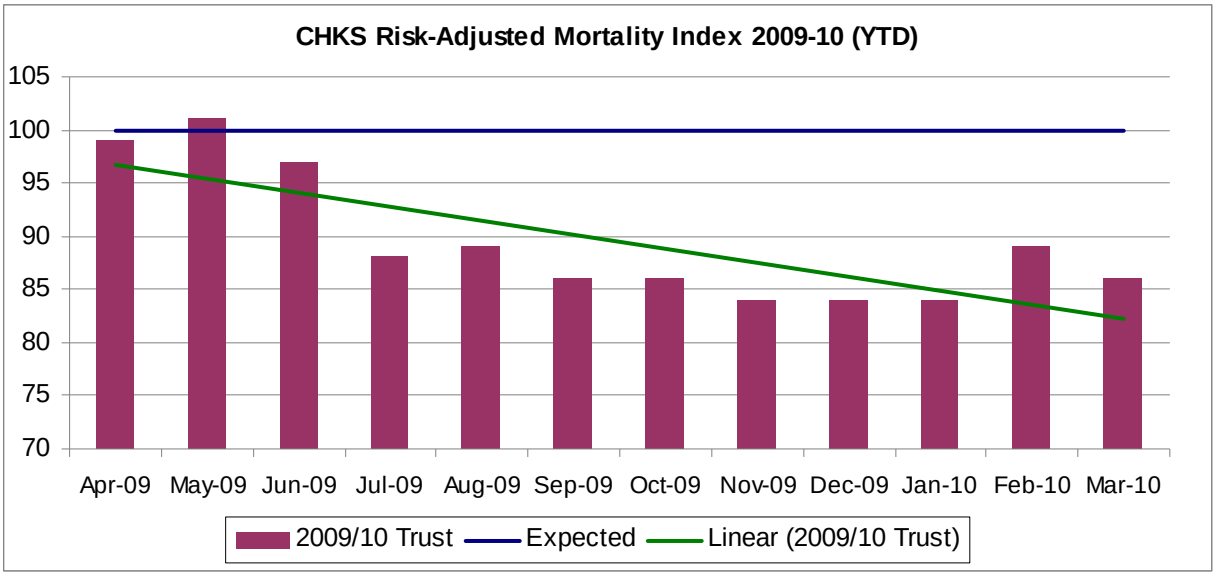
For the first time at KCH, mortality rate is monitored monthly at Trust, Division and specialty level. Governance structures, processes and systems have been strengthened as follows to ensure actions are being taken to continuously improve clinical outcomes in all clinical services at KCH:

- More than 30 clinicians were involved in reviewing and establishing the KCH mortality performance framework;
- Coding of deaths was reviewed and refined. A structured Mortality Review Form was developed jointly with colleagues at King's PSSQ[4] and piloted in four Divisions;
- The first MMC was established at KCH and chaired by the Medical Director to oversee mortality performance;
- An early warning scoring system named POTTS was launched Trust wide on 6 January 2010 to ensure appropriate care is provided to patients whose condition is deteriorating.

As a result of the above actions and KCH's other initiatives to reduce infection and prevent harm, KCH's year to date mortality rate was 86[5] at the end of March 2010

[3]The six Never Events that apply to KCH are: 1). Wrong site surgery; 2) Retained instrument post-operation; 3). Wrong route administration of chemotherapy; 4). Misplaced naso or orogastric tube not detected prior to use; 5). In-hospital maternal death from post-partum haemorrhage after elective caesarean section; 6). Intravenous administration of mis-selected concentrated potassium chloride.
[4] PSSQ is a partnership between KCH and KCL. It is funded by the NIHR. It was established to drive improvements in the safety, quality and effectiveness of the services the NHS provides to its patients and the public.

compared with 106 for the same period in 2009 under the CHKS risk adjusted mortality ratio. This indicates a 19% improvement in 2009/10 compared to 2008/09. Please see Graph 2-1 for KCH's monthly risk adjusted mortality rate in 2009/10.



Graph 2-1: KCH's monthly risk adjusted mortality rate in 2009/10

2.1.3 Quality Priority 3 - reduce infection

Following the CQC's Hygiene Code inspections at KCH in May 2009, an improvement action plan was developed and implemented to improve the environment and reduce infections at KCH. The CQC confirmed that KCH had addressed all areas for improvement in its follow up report.

- A major review of infection control governance structures was conducted and new arrangements are now in place;
- MRSA screening for emergency cases started in February 2010;
- C. diff ward rounds were commenced to ensure actions from root cause analysis are followed up;
- An intravenous line team was established in October 2009 to focus on reducing line infection;
- The role of Infection Control Link Nurse is being strengthened to enhance infection control capability across the Trust;
- A revised environmental audit has been implemented.

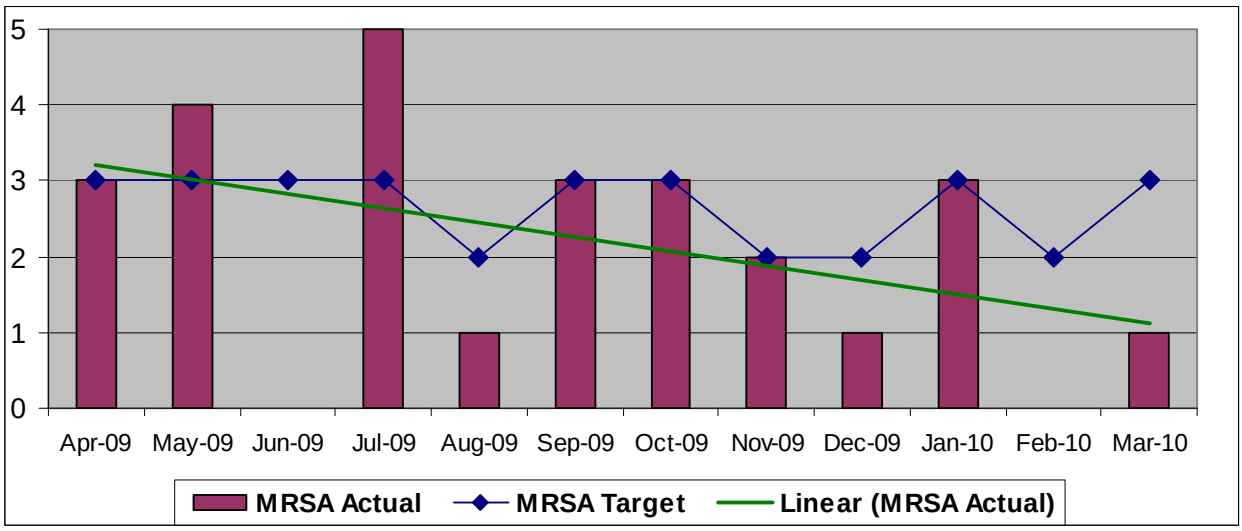
As a result of the above initiatives and actions taken, KCH has further reduced MRSA numbers by 33% and C. diff by 32% in 2009/10 compared with the figures in 2008/09. Please see table 2-1 for details.

[5] A risk adjusted mortality ratio of 100 means the number of observed deaths equals the number of expected deaths, allowing for variations in cases treated. A ratio of 86 means that there were 14 per cent fewer deaths than were expected.

	2008/09		2009/10		Improvement
	Target	Performance	Target	Performance	
MRSA	43	39	32[6]	26	33%
C. diff	242	199	162[7]	135	32%

Table 2-1: MRSA and C. diff figures at KCH in 2009/10 and 2008/09

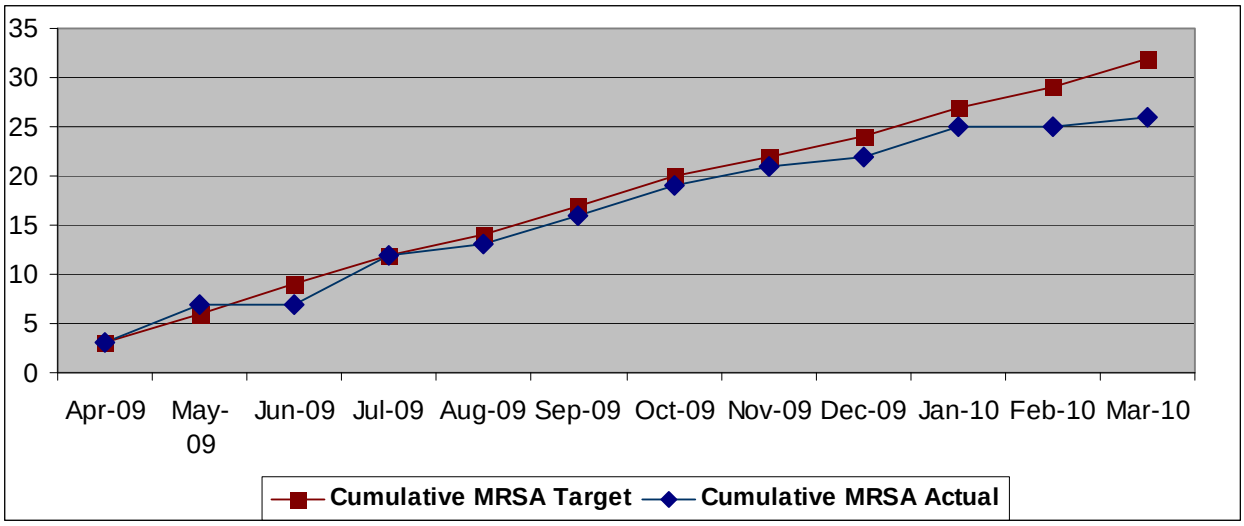
Please refer to Graph 2-2 below for details of KCH's monthly MRSA figures in 2009/10:



Graph 2-2: KCH's monthly MRSA figures in 2009/10

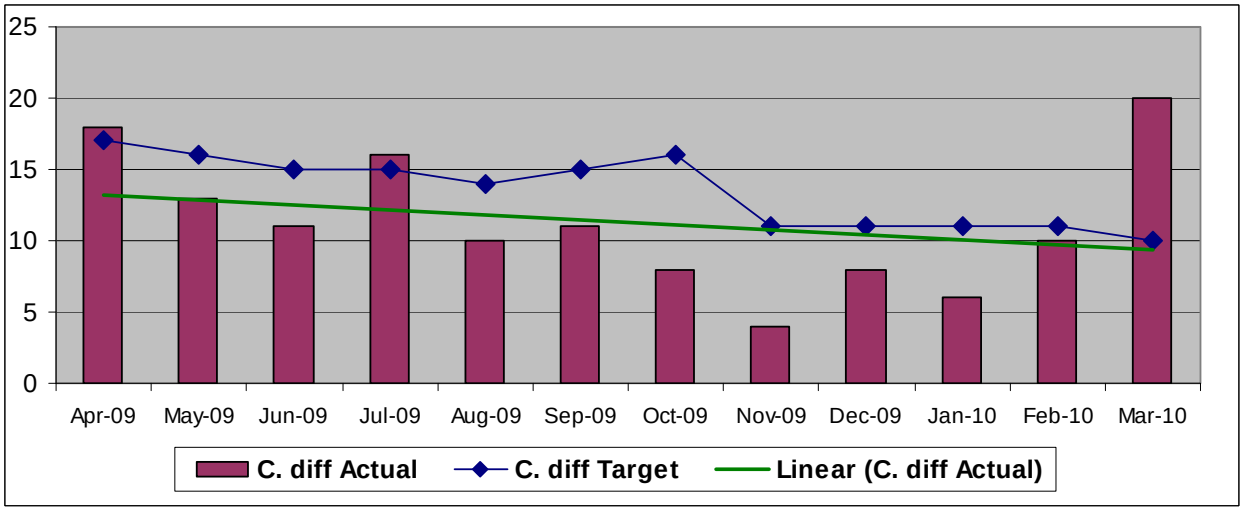
Please refer to Graph 2-3 below for details of KCH's cumulative MRSA trend in 2009/10:

[6]The target of 32 MRSA cases is a stretch target agreed between KCH and the commissioners in 2009/10. The national target is 43 for KCH in 2009/10.
[7]The target of 162 C. diff cases is an internal stretch target at KCH. The national target for KCH is 202 in 2009/10 and 162 in 2010/11.



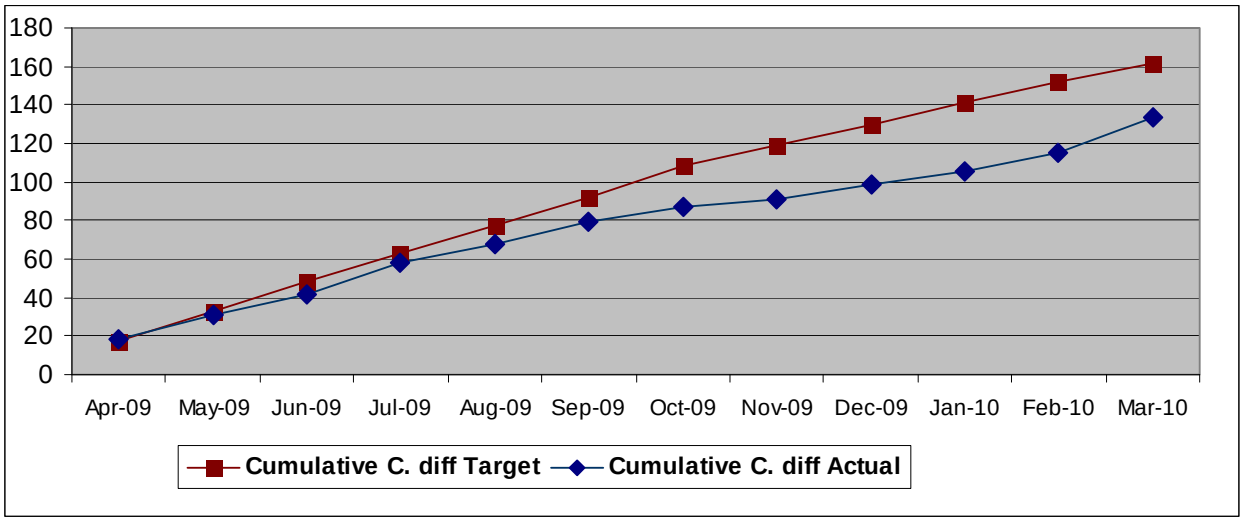
Graph 2-3: KCH's cumulative MRSA trend in 2009/10

Please refer to Graph 2-4 for details of KCH's monthly C. diff figures in 2009/10:



Graph 2-4: KCH's monthly C. diff figures in 2009/10

Please refer to Graph 2-5 for details of KCH's cumulative C. diff trend in 2009/10.



Graph 2-5: KCH's cumulative C. diff trend in 2009/10

2.1.4 Quality Priority 4 - improve patient experience

In 2009/10, KCH implemented a number of initiatives to improve the patients' experience at KCH.

- Dignity Month was launched in January 2010 to raise awareness and improve dignity of care. The joint winners at the Trust dignity event were:
  - the Health and Ageing Unit on using patient stories to learn more about patient experience and promote person-centred care.
  - Specialist Medicine on having an adolescent room with entertainment system for teenage cancer patients, having lightboxes to provide a more natural light and a two way bedside intercom system to improve communication between staff and patients who are immuno-compromised and therefore barrier nursed
- Board 'Go & See' programme was re-launched in February 2010 to include questions on patient experience and staff experience.
- Governors are involved in some of the 'Quality Ward Rounds' which promote a quality improvement culture at KCH.
- King's Values were launched in November 2009 and plans are being implemented to further embed King's Values. It is important to engage and motivate staff in order to ensure continuous quality improvement. In line with national staff survey results, KCH has developed comprehensive action plans to improve staff satisfaction in a number of areas.
- Admission and discharge processes are being reviewed in all Divisions to develop seamless pathways for all patients.
- The opening of the MAU has improved the pathway for medical emergency patients and enhanced patient experience.
- Patient feedback in outpatient services was successfully piloted in Suite 3 General Medicine. The roll out to all outpatient areas and the Emergency Department began in February 2010.
- The number of formal complaints dropped by 23% in 2009/10 compared to the previous year.

- As part of the "Contacting King's" project, standardised outpatient appointment letters were piloted and are now being rolled out trust-wide. An indicator on unanswered calls was introduced on the monthly Divisional performance scorecard to improve communication with patients and relatives. This has led to some improvement although there is further to go.

In the 2009 National Outpatient Survey[8], KCH was ranked top among London acute hospitals and third among all London NHS trusts. Please see Table 2-2 for details.

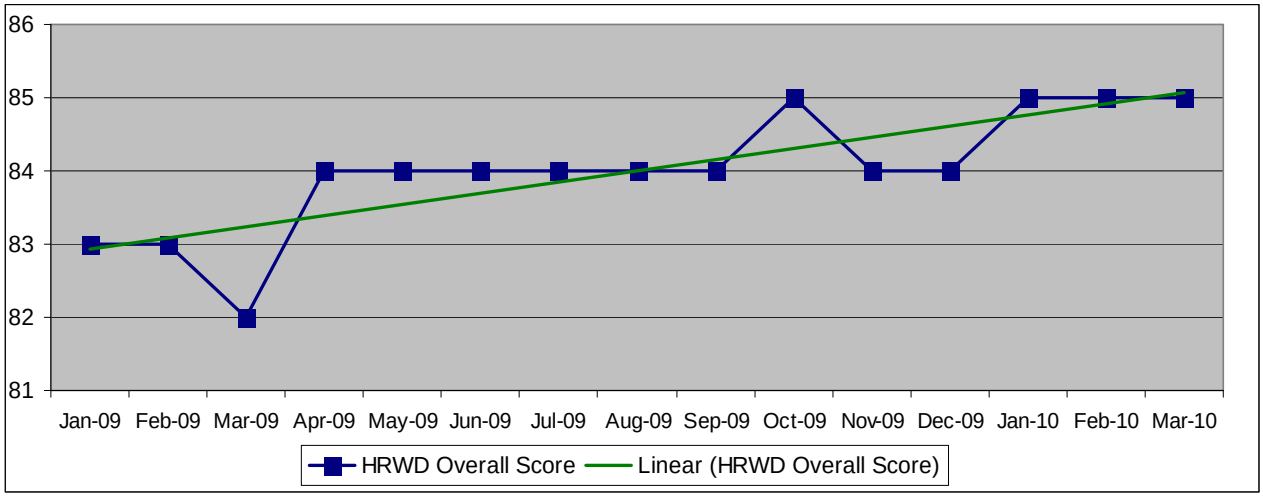
[8]The benchmark scores of the 2009 National Outpatient Survey are calculated by converting responses to particular questions into scores. For each question in the survey, the individual responses were scored on a scale of 0 to 100. A score of 100 represents the best possible response. Therefore, the higher the score for each question, the better the trust is performing.

Rank	Hospital	Overal Scores
1	The Royal Marsden NHS Foundation Trust	86.2
2	Royal Brompton and Harefield NHS Trust	81.1
3	**King's College Hospital NHS Foundation Trust**	**80.1**
4	University College London Hospitals NHS Foundation Trust	79.2
5	Guy's and St Thomas' NHS Foundation Trust	79.0
6	St George's Healthcare NHS Trust	78.6
7	Barts and The London NHS Trust	78.3
8	Royal National Orthopaedic Hospital NHS Trust	78.1
9	South London Healthcare NHS Trusts	77.5
10	Royal Free Hampstead NHS Trust	77.1
11	West Middlesex University Hospital NHS Trust	77.0
12	Mayday Healthcare NHS Trust	76.7
13	Epsom and St. Helier University Hospitals NHS Trust	76.6
14	Chelsea and Westminster Hospital NHS Foundation Trust	76.5
15	Imperial College Healthcare NHS Trust	76.2
16	Kingston Hospital NHS Trust	76.1
17	The Hillingdon Hospital NHS Trust	76.0
18	The Whittington Hospital NHS Trust	75.6
19	Whipps Cross University Hospital NHS Trust	75.4
20	Homerton University Hospital NHS Foundation Trust	75.2
21	North Middlesex University Hospital NHS Trust	75.0
22	Barnet and Chase Farm Hospitals NHS Trust	74.6
23	The Lewisham Hospital NHS Trust	73.7
24	North West London Hospitals NHS Trust	73.6
25	Ealing Hospital NHS Trust	73.1
26	Barking, Havering and Redbridge Hospitals NHS Trust	72.6

Table 2-2: 2009 National Outpatient Survey - KCH and other London hospitals

In the 2009 National Inpatient Survey[9], KCH was ranked 10th among all London NHS trusts. KCH continues to monitor inpatient experience through a monthly HRWD survey. Scores improved during the year, reaching 85% (top quartile score among peer group of London teaching hospitals. Please see Graph 2-6 for monthly HRWD scores.) in the last quarter of 2010. However, some improvements were identified from the HRWD survey in the areas of cleanliness, help with feeding and noise at night. Action is being taken to make sure these issues are addressed.

[9]For each question in the survey, the individual responses were converted into scores on a scale of 0 to 100. A score of 100 represents the best possible response. Therefore, the higher the score for each question, the better the trust is performing.



Graph 2-6: KCH's monthly HRWD scores 2009/10

2.2 Priorities for improvement

After discussions with staff, governors and patient experience groups over the last few months, the following quality improvement priorities are proposed for 2010/11 at KCH.

- Safety
  - Reduce infection rate
  - Reduce the number of serious incidents
- Patient experience
  - Improve patient experience by using HRWD survey
  - Eliminate mixed sex accommodation
- Clinical Effectiveness
  - Enhance mortality performance
  - Ensure patients are VTE risk assessed

KCH involved staff, governors and members in deciding what the key quality improvement areas are. Regular updates on progress against 2009/10 quality priorities were presented at Board meetings, governor meetings and made available to all staff through a dedicated KCH Quality Improvement intranet page. Comments and suggestions on quality priorities received from colleagues at PCTs, LINks, OSCs, governors and KCH Patient Experience Group have been incorporated into the final version of this Quality Report.

Please refer to Table 2-3 for further details on KCH's quality priorities in 2010/11.

Quality Priorities		Rationale for Selection	Objectives in 2010/11
Safety	Infection control	Hospital acquired infection will not only affect clinical outcomes but also create an unnecessary burden to patients and their families. Adults with hospital acquired infection stay in hospital 2.5 times longer than patients with no hospital acquired infections.	To meet/exceed target reductions set by national bodies. MRSA target – 9 C. diff target - 162 (national) C Diff target - 88 (locally agreed)
	Serious Incidents	It is important for any hospitals to do no harm to patients. KCH needs to make sure robust arrangements are in place to investigate incidents, identify and use learning opportunities to prevent reoccurrence.	To reduce the number of incidents with a high degree of harm.
Patient Experience	Improve patient experience by using HRWD results.	Care needs to be organised around the individual, meeting their needs not just clinically, but also in terms of dignity and respect. By actively seeking patients' views and listening to their feedback on care received, KCH can take appropriate actions to improve patient experience.	- Transformation programme to improve patient experience - Achieve target satisfaction scores for CQUIN patient experience metrics - To achieve HRWD inpatient benchmark - Implement outpatient survey in main outpatient Suites and the Emergency Department
	Eliminate mixed sex accommodation	Sleeping in the same room or bay as people of the opposite sex is upsetting for many patients, creating anxiety and undue stress for people, often when they are at their most vulnerable. This unease is likely to impact on their recovery. This may result in a longer stay in hospital.	To virtually eliminate mixed sex accommodation by April 2011.
Clinical Effectiveness	Mortality	Clinical outcome is one of the most important factors for patients when deciding which hospital to choose. KCH needs to demonstrate that it provides excellent clinical outcomes in all specialties.	To achieve top 20% benchmark performance in all specialties compared to our peers in South East London on the risk-adjusted mortality rate.
	VTE risk assessment	VTE is a significant patient safety issue. However, outcome data on VTE is poor – post mortem studies suggest that only 1-2 in every 10 fatal pulmonary emboli is diagnosed. Whilst work is underway to improve the reliability of outcome data, measuring of VTE risk assessment will set an effective foundation for appropriate prophylaxis. This gives the potential to save thousands of lives each year.	To ensure at least 90% of all adult inpatients are VTE risk assessed before discharge.

Table 2-3: Quality priorities - rationale for selection and initiatives in 2010/11

All of the above quality priorities will be monitored through KCH's Quality & Governance Committee and monthly performance meetings. Regular reports on progress against these priorities will be reported to the directors and governors and made available on KCH website.

Lambeth, Southwark and Lewisham (LSL) Alliance has bi-monthly quality meetings in place to ensure KCH is making good progress on the above quality priorities.

2.3 Statements of assurance from the Board of Directors

2.3.1 Information on the review of services

During 2009/10, KCH provided and/or sub-contracted the following seven types of NHS services as indicated in KCH's profile for registration with the CQC:

- Acute services.
- Hospice services.
- Rehabilitation services.
- Community healthcare services.
- Diagnostic & screening services.
- Long-term conditions services.
- Blood and transplant services.

Quality indicators covering the three dimensions of quality – patient safety, clinical effectiveness and patient experience were identified and built into KCH's monthly performance scorecards at trust, divisional and team level. KCH has reviewed all the data available on the quality of care in all of the above seven types of services.

The income generated by the NHS services reviewed in 2009/10 represents 100 per cent of the total income generated from the provision of NHS services by KCH for 2009/10.

2.3.2 Information on participation in clinical audits and national confidential enquiries

During 2009/10, 31 national clinical audits (see *Appendix* 1 for details) and five national confidential enquiries (see Table 2-4) covered NHS services that KCH provides. KCH participated in 84% of national clinical audits and 100% of the national confidential enquiries for which it was eligible to participate in 2009/10.

Confidential Enquiries	KCH participation	Reporting period	Number of cases submitted as a percentage of the number of cases required
1. National Confidential Enquiry into Patient Outcome and Death (NCEPOD)			
Parenteral Nutrition	Yes	Sample: January – March 2008 Data collected: 1 February 2009 – 30 November 2009	16%
Elective and emergency surgery in the elderly	Yes	Sample: April – June 2009 Data collected: December 2009	Clinicians: 82% Anaesthetists: 55%
Surgery in children	Yes	April 2009 – March 2010 still in progress	Study ongoing
Peri-operative surgery	Yes	Pilot data submitted December 2009 Main dataset to be submitted end of May 2010	Study ongoing
2. Centre for Maternal and Child Enquiries (CMACE)			
All maternal and child deaths are submitted to CMACE	Yes	Ongoing	100%

Table 2-4: KCH's Participation in Confidential Enquiries 2009/10

The reports of 18 national clinical audits were reviewed in 2009/10. The results of clinical audits are being used at KCH to inform quality improvement initiatives. Please refer to *Appendix 2* for the detailed actions KCH intends to take to further improve the quality of care provided.

Over 194 local clinical audits were reviewed in 2009/10. Please refer to *Appendix* 3 for the detailed actions KCH intends to take to further improve the quality of healthcare provided.

2.3.3 Information on participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by KCH in October 2009 - October 2010, that were recruited during that period to participate in research approved by a research ethics committee, was estimated to be 9,842[10].

There was a 37% increase in the recruitment to NIHR adopted studies from 2008/09 to 2009/10. This level of participation in clinical research demonstrates KCH's commitment to improving the quality of care, and KCH's R&D team is working to further increase patient recruitment to research studies in the future.

KCH was involved in 547 clinical research studies in 2009/10, of which an estimated 11% were completed within the agreed time and to the agreed recruitment target. Investment in the central R&D team during 2009/10 will enable us to improve on this level of performance. Forty seven of the studies were established and managed

[10]Based on extrapolated data from part year submission.

under national model agreements (i.e. commercial studies). In 2009/10, 39 Research Passports were issued, and the NIHR supported 120 of these studies through its research networks.

In the last three years approximately 1,200 publications have resulted from KCH's involvement in NHS ethics approved research, helping to improve patient outcomes and experience across the NHS.

2.3.4 Information on the use of the CQUIN framework

0.5% of KCH's contract income in 2009/10 was conditional upon achieving quality improvement and innovation goals agreed with NHS Southwark and London Specialist Commissioning Group through the CQUIN payment framework. This equals to a total of £2,292,400 in 2009/10. Please see Table 2-5 on the detailed KCH CQUIN indicators in 2009/10. KCH has delivered significant quality improvements under the CQUIN scheme as shown in Table 2-5. Action plans are developed to ensure all emergency and elective patients are screened for MRSA. KCH is on target to receive 90% of the total CQUIN income in 2009/10 and is in discussion with NHS Southwark to finalise the proportion of the rest 10% of CQUIN income to KCH depending on audit results of some CQUIN indicators.

	CQUIN Indicators	**Domain**	**Target 09/10**	**Performance**
1a	Smoking cessation in pregnancy[11]	Effectiveness	5.2% or below	5%
1b	Caesarean section rates[12]	Effectiveness	12 month average less than 10%	8.9%
1c	1:1 midwifery care in established labour	User Experience	90%	99.3%
1d	Timely access to maternity services[13]	Innovation	80%	75%
2	MRSA screening for emergency admissions	Safety	75%	50.4%
3	Smoking cessation	Effectiveness	Data collection	Achieved agreed action plans
4	Patient experience[14]	User Experience	Question 2: 81% Question 5a: 83% 5b: 76% Question 18: 93%	Question 2: 82% Question 5a: 84% 5b: 77% Question 18: 92%
5	Reduction in hospital turnaround times[15]	User Experience	Less than 15 minutes	Average handover time of 15 minutes was achieved

Table 2-5: KCH CQUIN scheme 2009/10

[11]Defined as smoking rates at delivery.
[12]Defined as the percentage of women who have elective caesarean sections.
[13]Measured by the percentage of women who have their initial health and social care risk assessment by 12 weeks plus 6 days.
[14]Question 2: Were you involved as much as you wanted to be in decisions about your care?
Questions 5a & 5b: Cleanliness of room and toilets.
Question 18: Was the patient treated with dignity and respect during their stay?
[15]Defined as time from arrival at hospital to the completion of clinical handover by ambulance crew. The target is to have the average handover time less than 15 minutes. An additional target was agreed to have 70% of all patients' handover time within 15 minutes in March 2010.

KCH is currently in discussion with LSL Alliance to finalise the CQUIN scheme for 2010/11. Please see *Appendix 4* for a summary of the draft CQUIN scheme 2010/11.

2.3.5 Information relating to registration with the CQC and periodic/special reviews

KCH is required to register with the CQC and its current registration status is unconditional. The CQC has not taken any enforcement action against KCH during 2009/10. 2009/10 is a transitional year between the previous system of the annual health check and the implementation of CQC's systems of registration and periodic review. KCH has not participated in any special reviews or investigations by the CQC during the 2009/10 reporting period.

KCH was inspected on Hygiene Code compliance on 14 May 2009, followed up with enhanced visits on 5 and 9 June 2009. The CQC provided six recommendations to KCH in its inspection report on 6 July 2009. KCH conducted a comprehensive review on its compliance with the Hygiene Code and submitted an improvement action plan to the CQC. KCH implemented the action plan and the CQC confirmed that KCH had addressed all areas for improvement in its follow up report published on 23 September 2009.

2.8 Information on the quality of data

KCH submitted records during 2009/10 to the SUS for inclusion in the HES which are included in the latest published data[16]. The percentage of records in the published data which included the patient's valid NHS Number was: 93.5%for admitted patient care; 85% for outpatient care; and 75.3% for accident and emergency care.

The percentage of records in the published data which included the patient's valid general practitioner registration code was: 99.8% for admitted patient care; 100% for outpatient care; and 100% for accident and emergency care.

In 2009/10, KCH's overall score for information quality and records management, assessed using the information governance toolkit was 79%.

KCH was subject to the PbR clinical coding audit during the reporting period by the Audit Commission. An independent clinical coding audit on inpatient activity at KCH was carried out in November 2009 on data from 1 July to 30 September 2009. 1,188 diagnoses and procedures were audited. The clinical coding error rate was 23.2%, the majority of which were coder errors. An action plan has been jointly developed between KCH and commissioners to improve coding accuracy. The action plan is being monitored at bi-monthly quality meetings with LSL.

The audit covered 300 FCEs, of which 100 were selected from the national theme of General Medicine. The remaining 200 FCEs were selected by KCH and NHS Southwark as recommended by the National Benchmarker for the sub chapter area. The Specialty and HRG areas are obstetrics; mouth, head, neck and ears procedures and disorders; kidney or urinary tract infections with major complications. The results of the audit should not be extrapolated further than the actual sample audited.

[16]Data period is March 2009 to January 2010 as used by the CQC for annual health check.

Part 3. Other information

3.1 An overview of the quality of care offered by KCH based on performance in 2009/10 against indicators

KCH has engaged extensively with staff, governors, members and the Board of Directors in identifying quality indicators in 2009/10. A list of quality indicators were signed off by the Board of Directors and incorporated into monthly Trust, divisional and team level scorecards. The scorecard approach to embed quality into operational delivery and the Board 'Go & See' programme were both quoted as good practice case studies (see *Appendix* 5) in the DH Quality Account Toolkit[17] published in February 2010.

Quality performance on safety, patient experience and clinical effectiveness has been monitored monthly at trust, divisional and team level since June 2009. Please see table 3-1 for KCH's performance on the quality indicators identified. The definitions and targets for these indicators are defined in line with national guidance where available and through local discussions with clinical teams and managers. The data reported in this report is consistent with KCH's 2008/09 quality report.

KCH has delivered significant improvement on a number of quality indicators shown in Table 3-1. Action plans have been developed by each Division to address areas shown red in Table 3-1.

With timely and accurate information provided to divisional teams, performance on quality indicators is reviewed on a monthly basis. Both the Medical Director and the Director of Nursing and Midwifery regularly attend monthly divisional Performance meetings chaired by the Director of Operations to provide constructive challenge and appropriate support on quality issues.

[17]Quality Accounts Toolkit: Advisory guidance for providers of NHS Services producing Quality Accounts for the year 2009 / 2010 is available at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_112359

Trust Scorecard	Mar-10						
	Metric	Units	Last Yr	Last Mnth	This Mnth	Target	Status R G
Clinical Effectiveness	Risk adjusted mortality (YTD)	Index	106	89	86	100	
	Death in low mortality HRG's	Number	3	0	0	0	
	Average Length of Stay - Elective ALoS	Days	5.4	6.0	5.2	5.0	
	Average Length of Stay - Non - Elective ALoS	Days	6.5	6.0	5.9	5.8	
	Daycase Rate for BADS Trolley procedures (YTD)	%	91	92	93	92	
	Readmissions within 14 days (YTD)	%	2.9	3.2	3.1	3.2	
	Unplanned admissions to ICU/HDU	Number	-	29	39	-	
	Cancer Waiting list - 2 Week Wait (QTD)	%	-	94.4	96.0	93.0	
	Cancer Waiting list - 31 Day Target (QTD)	Index	-	104.2	104.2	100.0	
	Cancer Waiting list - 62 Day Target (QTD)	Index	-	114.3	111.5	100.0	
	Admitted Patients Treated < 18 weeks	%	92	94	94	90	
	Non-Admitted Patients Treated < 18 weeks	%	97	97	98	95	
	Emergency Care Performance	%	98.2	98.1	98.0	98.0	
	Time from admission to treatment for #NOF < 48 hrs	%	100	100	100	98	
	Delayed Discharges to Primary/ Social Care	Number	52	52	45	53	
Safety	Infection Control (YTD)	Cases	277	182	205	246	
	MRSA (YTD)	Cases	39	25	26	34	
	VRE (YTD)	Cases	39	42	44	50	
	CDT (YTD)	Cases	199	115	135	162	
	MRSA Screening - Elective	%	23	89	94	100	
	Hand Hygiene Audit	%	95	96	95	95	
	Slips, Trips & Falls	Number	14	8	13	7	
	Red Adverse Incidents (including medication errors)	Number	1	1	1	0	
	Pressure Sores - Hospital Acquired	Number	-	15	11	15	
	H&S - reported BBV incidents (YTD)	Number	223	218	238	227	
	Number of births on William Gilliatt	Number	11	3	2	0	
Patient Experience	How are we doing?	%	84	85	85	85	
	Care Perceptions	%	86	87	87	87	
	Patient Engagement	%	85	86	86	85	
	Environment	%	72	75	74	73	
	Number of Inpatient Cancellations	Number	23	14	19	27	
	Outpatient Cancellations - by Hospital	Number	8,101	7,080	8,657	7,348	
	Number of Complaints (YTD)	Number	985	603	660	974	
	Timely response to complaints (YTD)	%	75	65	64	80	
	Calls Answered	%	-	66	67	90	

Note: Data for last year refer to performance in March 2009 except those marked with YTD (year to date) and QTD (quarter to date)

Table 3-1: KCH Quality Performance as of March 2010

3.2 Performance against key national priorities and National Core Standards

The CQC is the independent regulator of health and adult social care in England. The CQC assesses and inspects organisations to ensure high quality care is provided to patients. KCH achieved "Excellent" rating on quality of services in 2008/09. Please see details in Table 3-2 below:

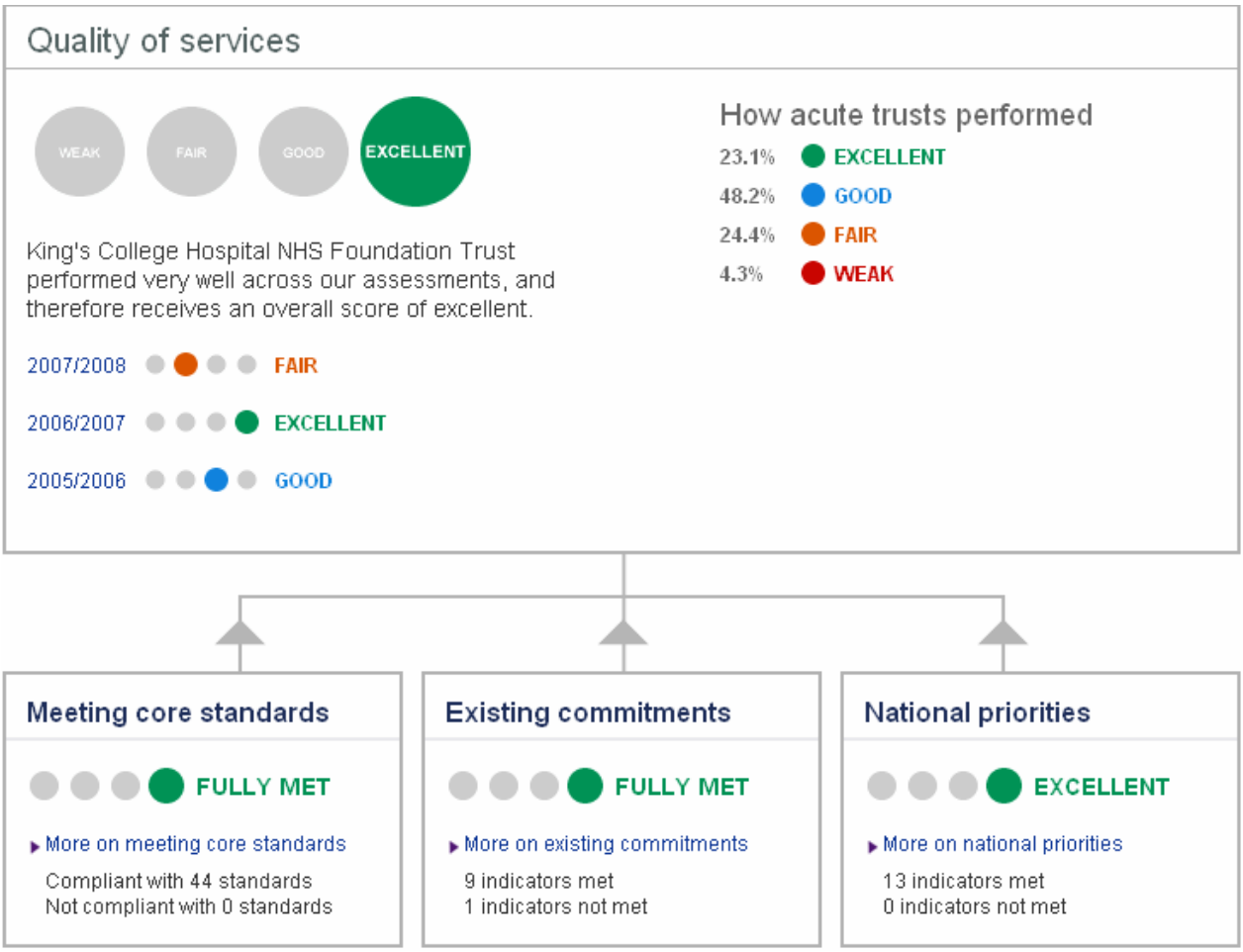


Table 3-2: KCH Annual Check results on Quality of Services

KCH performed well against the relevant indicators and performance thresholds set out in Appendix B of Monitor's Compliance Framework. Please see Table 3-3 for details.

Target	Threshold	Quarter 4 Performance	Data Period
Clostridium difficile year on year reduction	202	135	April 09 - March 10
MRSA - maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level	43	26	
31 day wait for second or subsequent treatment: surgery	94%	100%	January - March 10
31 day wait for second or subsequent treatment: anti cancer drug treatments	98%	100%	
62 day wait for first treatment from urgent GP referral to treatment: all cancers	85%	89%	
62 day wait for first treatment from consultant screening service referral: all cancers	90%	100%	
31 day wait from diagnosis to first treatment: all cancers	96%	100%	
Two week wait from referral to date seen: all cancers	93%	97.10%	
For admitted patients, maximum time of 18 weeks from point of referral to treatment	90%	93.72%	March 10
For non-admitted patients, maximum time of 18 weeks from point of referral to treatment	95%	96.40%	
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	98%	98.12%	April 09 - March 10
People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	68%	N/A	N/A
Screening all elective inpatients for MRSA	Published Policy	Published Policy	April 09 - March 10

Table 3-3: KCH's performance against Monitor's Governance Compliance Framework

Please see Table 3-4 below for KCH's performance against all existing commitments in 2009/10.

Indicator Name	Measure		Data Source	Time Period	Threshold	Expected Trust Score
Access to Genito-urinary Medicine (GUM) Clinics	%		DH GUM clinics waiting times collection	Financial Year 2009/10 Quarters 1 to 4	98.00%	**100%**
Data Quality on ethnic group	%		Hospital Episode Statistics (HES)	April 2009 to December 2009	85.00%	**94.2%**
Time to reperfusion for patients who have had a heart attack	The number of eligible patients with acute myocardial infarction who received thrombolysis treatment within 60 minutes of calling professional help	%	Myocardial Ischaemia National Audit Project	Financial year 2008/09	N/A[18]	NA
	The number of eligible patients with acute myocardial infarction who received primary Percutaneous coronary intervention (PCI) within 150 minutes of calling for professional help	%	British Cardiovascular Intervention Society National Audit	April 2009 to December 2009	To be published	To be published
	Assessment of the completeness of data	%			≥90% in each field	**≥90% in each field**
Delayed transfers of care	%		DH SitReps and Hospital Episode Statistics (HES)	April 2009 to December 2009	TBC	**0.39%**
Total time in A&E	%		Quarterly Monitoring of A&E return	Financial year 2009/10	98%	**98.3%**
Inpatients waiting longer than the 26 week standard	%		Monthly monitoring return and Monthly activity return	Financial year 2009/10	≤0.03%	**0%**
Outpatients waiting longer than the 13 week standard	%		Monthly monitoring return and Monthly activity return	Financial year 2009/10	≤0.03%	**0%**
Patients waiting longer than 3 months for revascularisation	%		Monthly monitoring return	Financial year 2009/10	≤0.1%	**0%**
Waiting times for Rapid Access Chest Pain Clinic	%		Vital Signs Monitoring Return	Financial year 2009/10	≥98%	**100%**
Cancelled operations and those not admitted within 28 days	The number of patients whose operation was cancelled on the day of admission.	%	Monthly activity return and QMCO quarterly monitoring	Financial year 2009/10	≤0.8%	**0.26%**
	The number of patients whose operation was cancelled and were not treated within 28 days.	%		Financial year 2009/10	≤5%	**1.07%**

Table 3-4: KCH's performance against all existing commitments

[18]As thrombolysis treatment is not the treatment for patients with acute myocardial infarction at KCH.

Please see Table 3-5 below for KCH's performance against all national priorities in 2009/10.

Indicator Name	Calculating the indicator	Time Period	Threshold	Expected Trust Score
Infant health & inequalities: smoking during pregnancy and breastfeeding initiation	The actual number of women known to be smokers at the time of delivery divided by the actual number of maternities	Financial Years 2008/09 and 2009/10	6.6%	**5.7%**
	The actual number of mothers who initiate breastfeeding, within first 48 hours divided by the actual number of maternities. (2009/10 v 2008/09)		92.7%	**93.6%**
	Data quality on smoking status not known	Financial Year 2009/10	≤5%	**0.0%**
	Data quality on breastfeeding status not known		≤5%	**0.0%**
Participation in heart disease audits	Greater than or equal to 90% completion for the key fields in Myocardial Ischaemia National Audit Project (MINAP). Data completeness is measure in 19 key fields.	Financial year 2009/10	≥90% in each field	**≥90% in each field**
	Whether a Trust achieved an agreement score of at least 80% as part of the 2009 MINAP data validation exercise. Evidence of participation in audit will be based on validation of a minimum of 15 records in the MINAP annual data validation study.	End of 2009	80%	**81.80%**
	Whether a Trust that provides PCI procedures participated in the BCIS-CCAD audit project with the uploading of individual procedural data to the Central Cardiac Audit Database (CCAD) servers	Calendar year 2009	Participation	**Yes**
	Greater than or equal to 90% completion of the key fields recorded by BCIS-CCAD audit project. Data completeness is measured in 12 key fields.		≥90% in each field	**≥90% in each field**
	Participation in adult cardiac surgery audit	Financial year 2009/10	≥66%	**100%**
	Participation in congenital heart disease audit			
	Participation in heart failure audit			
	Participation in cardiac rhythm management audit	Calendar year 2009		
Engagement in clinical audits	Did the Trust participate in local and/or national audits of the treatment and outcomes for patients in each clinical directorate covered by the trust?	Financial year 2009/10	Yes	**Yes**
	Did the Trust have a clinical audit strategy and programme related to both local and national priorities with the overall main aim of improving patient outcomes?		Yes	**Yes**
	Did the Trust have in place suitable governance systems and arrangements to involve and support all clinicians to participate in clinical audit?		Yes	**Yes**
	Did the Trust ensure that all clinicians and other staff responsible for or participating in clinical audits were given appropriate time, knowledge and skills to facilitate the successful completion of the audit cycle?		Yes	**Yes**
	Did the Trust review the results and recommendations of local and national audits undertaken in the trust, as well as other relevant national findings, to identify required actions and ensure they are reflected in the organisations aims and objectives as part of the trusts responsibility to quality improvement?		Yes	**Yes**
	Did the Trust's management or governance leads receive regular reports on the progress being made in implementing the outcomes of relevant national clinical audits and other national findings, including reviews of the outcomes and any re-audits being conducted where necessary?		Yes	**Yes**

Table 3-5: KCH performance against all national priorities

Table 3-5 continued

Indicator Name	Calculating the indicator	Time Period	Threshold	Expected Trust Score			
Stroke Care	The percentage of stroke patients who spend at least 90% of their time on a stroke unit	Financial year 2009/10	TBC	**89.00%**			
Maternity Hospital Episode Statistics: data quality indicator	Numerator: Number of mandatory fields not complete within all Maternity Finished Consultant Episodes (FCEs). Denominator: Number of mandatory fields within all Maternity FCEs.	HES: April - December 2009	≤15%	**5.6%**			
	Ratio of birth episodes to number of babies recorded on delivery episodes		0.9 to 1.1	**0.95**			
Incidence of MRSA Bacteraemia	60% Reduction on 2003/04 performance = 43 cases.	Financial year 2009/10	43	**26**			
	Data Quality - 15th of month sign off		100%	**100%**			
Incidence of Clostridium Difficile	Trusts total trajectory for 2009/10 = 202 cases.		202	**135**			
	Data Quality - 15th of month sign off		100%	**100%**			
				Q1	**Q2**	**Q3**	**Q4**
18 week referral to treatment times	The percentage of patients who were admitted in Q1, Q2, Q3 and Q4 who waited 18 weeks or less	National referral to treatment time data collection and National Direct Access Audiology Waiting Times Dataset (Financial year 2009/10)	90%	**94.1%**	**93.7%**	**98%**	**94%**
	18 weeks referral to treatment admitted patients data quality		80%-120%	**80%-120%**	**80%-120%**	**80%-120%**	**80%-120%**
	The percentage of non-admitted patients with completed pathways in Q1, Q2, Q3 and Q4 who waited 18 weeks or less with completed pathways		95%	**96%**	**96.5%**	**95%**	**98%**
	18 weeks referral to treatment non-admitted patients data quality		80%-120%	**80%-120%**	**80%-120%**	**80%-120%**	**80%-120%**
	The number of treatment functions achieving the 90% standard for admitted patients plus the number of treatment functions achieving the 95% standard for non-admitted and direct access audiology over the fourth quarter of the year		TBC	**N/A**	**N/A**	**N/A**	**100%**
All cancers: 2 week wait	The percentage of patients first seen by a specialist within two weeks when urgently referred by their GP or dentist with suspected cancer	Cancer waits database (Financial year 2009/10)	≥93%	**94.6%**			
	The percentage of patients first seen by a specialist within two weeks when urgently referred with any breast symptom except suspected cancer	Cancer waits database January - March 2010	≥93%	**93.4%**			

Table 3-5 continued

Indicator Name	Calculating the indicator	Time Period	Threshold	Expected Trust Score
All cancers: one month diagnosis to treatment (including new cancer strategy commitment)	The percentage of patients receiving their first definitive treatment within 31 days of a decision to treat (as a proxy for diagnosis) for cancer	Cancer waits database (Financial year 2009/10)	≥96%	**98.5%**
	The percentage of patients receiving subsequent surgery treatment within 31 days of a decision to treat		≥94%	**98.3%**
	The percentage of patients receiving subsequent drug treatment within 31 days of a decision to treat		≥98%	**95.8%**
All cancers: 2 month GP urgent referral to treatment (including new cancer strategy commitment)	The percentage of patients receiving their first definitive treatment for cancer within 62 days of GP/dentist urgent referral for suspected cancer	Cancer waits database (Financial year 2009/10)	≥85%	**85.4%**
	The percentage of patients receiving their first definitive treatment for cancer within 62 days of urgent referral from the national screening service		≥90%	**92.6%**
	The percentage of patients receiving their first definitive treatment for cancer within 62 days of urgent referral from a consultant for suspected cancer		≥90%	**100.0%**
Experience of patients	Selected questions from the inpatient survey will be used to calculate an overall score for this indicator	Autumn 2009	To be published	**74.3**
NHS staff satisfaction	Selected questions from the NHS staff survey are used to calculate an overall job satisfaction score	Autumn 2009	To be published	**3.52**

PATIENT CARE

How King's is using its Foundation Trust status to develop its services and improve patient care

We are continuing to develop and enhance the involvement of our Foundation Trust members and governors in helping us to improve the patient experience at King's.

King's governors are playing an increasingly active role in a range of groups, committees and quality initiatives focussed on the patient experience. These include the Patient Carer Experience Group, the Food Service and Nutrition Support Group and the Public Health Committee. Governors are also represented on the Steering Group for the King's PSSQ Centre, a collaboration with KCL, which is leading research on patient safety and quality.

Quality is at the top of the policy agenda and over the last year, we have invited our governors to become involved, alongside staff, in a range of quality initiatives.

Quality Ward Rounds: King's 'Quality Ward Rounds' were launched in 2009 and bring together a number of nursing audits focussed on patient safety, clinical effectiveness and the patient experience. Each ward carries out the monitoring rounds weekly and includes discussion with two patients about their experience on the ward covering issues such as pain management, involvement in care, information and staff attitude. A number of our governors have been accompanying members of the senior nursing team on the ward rounds and providing valuable independent feedback. The results are shared with ward teams so that they can take actions to make improvements where appropriate. The governors' comments are a valuable part of this feedback and also inform their work on the governors Patient Experience and Safety Committee.

PEAT inspections: As in previous years, two of our governors have taken part in the annual PEAT inspections.

Director's 'Go & See' visits: In 2010, governors will also accompany senior trust staff, including Trust directors, on a programme of 'Go & See' visits to wards and outpatient areas. The "Go & See" programme was introduced in August 2009. The visits are not designed to be formal audits but are an opportunity for senior staff to listen to our front line staff, patients and relatives to see how we can support staff to further improve quality of care in an efficient way. The 'Go & See' visit is for setting the right behaviour and creating visible leadership. During each visit staff will look at issues such as the general atmosphere on the ward, the environment and hygiene. Staff also talk to patients about their experiences, what works well and what could be improved. The results of 'Go & See' visits are sent to the Divisional General Manager, Head of Nursing and Clinical Director. In order to communicate the commitment to staff and promote learning across wards, all results are also posted on the Trust's intranet site.

Governor working groups and committees: governors have also continued to have their own working groups and committees which have been expanded this year to include a Strategy Group to complement the existing Membership, Patient Experience and Safety, and Transport Groups.

The Membership Committee oversees our member involvement programme and the Patient Experience and Safety Committee is a key forum for involving governors in improving the patient experience. Part of its programme of work this year has been to co-ordinate the governors' commentary on our Standards for Better Health submission. To inform this work, governors used their knowledge and experience gained on the Quality Ward Rounds and PEAT inspections, nursing audits, observations and ward visits. One of our governors also carried out a substantial piece of work in our Maternity Service which included observations in inpatient and outpatient maternity settings as well as tracking an expectant mother through the latter part of her pregnancy and the birth of her baby.

This has also been an exciting year in terms of engaging with our membership to improve both services at the hospital but also for the local community.

Involving members in developing King's Values
During 2009, King's embarked on a Trust wide project to develop a set of core values for the organisation. The aim was to develop a set of values that are unique to the trust and embody what is so special about King's. The first phase of this project involved talking to over 200 staff in all roles and levels across the hospital. This provided us with some outline values but we wanted to make sure that these matched what was valued by our patients. We held a series of 'In Your Shoes' events including one for members who had either been patients, relatives or carers of patients treated at King's. These events allowed patients to share their stories with staff. We asked patients to tell us about their experience at King's – both the good and the not so good, how they felt at different times during their care with us and what behaviours made a difference to them. Similar events were held with our governors and Trust volunteers. The stories that people shared and the values that they felt were important helped the trust to refine its values and to ensure that the final values had the priorities of our patients at their heart.

Community events
In April and May 2009 the Trust held a series of community events for members. The dates were publicised in our spring 2009 members' newsletter. These meetings were held for each of the constituencies to inform the membership about the Trust's plans for the future and give them the opportunity to feedback on their experiences and to and raise issues of concern. The meetings also provided an opportunity for members to meet the governors, their elected representatives and also Trust non-executive directors and directors and a range of Trust staff. The timing of the meetings was scheduled a month later this year when the weather is more favourable to boost attendance further.

As well as presentations on the Trust's strategy and forward plans, each meeting featured exhibitions about a range of conditions and services at King's, for example diabetes, respiratory and infection control teams as well as how members can become involved in fund-raising for the Trust. The events have always been well received by members who attend. Members are positive about being able to meet their governors and increase their understanding about services at King's

South London Line campaign
In 2009, we involved our members in a grassroots lobbying campaign to try and influence the Mayor of London and the Transport Secretary to protect a vital rail service via Denmark Hill, our main serving station. For this campaign, members were encouraged, via email, to sign an online petition to save the South London

Line. Members were also mobilised by a lobby postcard campaign, asking them to fill the cards out and send them to their local MPs, so they could make representations on King's behalf. Local MPs have reported that they received hundreds of postcards from our members and have facilitated a meeting between campaign stakeholders and the Rail Minister. Our local GLA members also co-ordinated a meeting with the Mayor of London. Following these meetings Transport for London was instructed to carry out a review into local rail services and we are waiting to hear the outcome of that review.

Involving members in teaching health professionals of the future – in collaboration with KCL

In our Winter 2009 members' newsletter we invited members to take part in a project being run by KCL involving the use of patient stories as part of multidisciplinary training seminars for health professionals. The teaching sessions involve medical, nursing and allied health profession students. The sessions enable the students to learn more about their roles. By giving them the opportunity to learn together, we hope they will gain a better understanding and appreciation of the work of different health professionals and what they each contribute to the patient experience of the health service. Getting health professionals to work well together will help to improve the quality of care for patients. We asked members who had been a patient at King's in the last two years to volunteer to share their patient story of the care they received, both the good and not so good, or of living with long-term health difficulties. The sessions allow students to ask questions. After the session, the patient stories are used as case studies so that students can explore issues within the group and to discuss their different roles and responsibilities and how working together effectively would be helpful. We had a tremendous response from our members with over twenty members willing to take part in the project. So far two sessions have been run where members have shared their stories and the programme is set to continue and grow. The sessions are proving very popular with both students and the members who take part.

Lambeth College Partnership

King's has continued the partnership it began in 2008 with Lambeth College, one of our local further education colleges. Students continue to become volunteers at the hospital and also take part in work experience. This year King's again took part in a careers fair at the college. An exciting part of the programme is the King's Partnership Challenges which really took off this year with the 'Research and Communication Challenge' took place in the autumn 2009. Health and Social Care students were given the challenge of working with King's award winning Sexual Health Centre. One of the services of the Sexual Health Centre is to provide self testing kits for chlamydia and gonorrhoea. The testing kits currently come with the manufacturer's information which is highly technical. The aim of this "Research and Communication Challenge" was to encourage more young people to use the kits by getting the students to design a new, more user friendly guide. The students worked in teams to produce new guides, and a poster, and their work was judged by a panel from King's and Lambeth College in January 2010. The winning team will be working with the King's communications team to build on their work which will then be used by the Sexual Health Centre.

Involvement going forward

There are a number of other involvement opportunities being explored for members, for example:

- Partnership working with Southwark FE College to both recruit and involve young people following the Lambeth College model.
- Involving members in a project to improve the experience of inpatients who have diabetes.
- Involving members in sharing their experiences with patients as part of a new King's Management and Leadership programme for Lead Registrars.
- Involving members in a number of 'In Your Shoes' events focused on improving the experience of our patients.

Service improvements following staff or patient surveys or comments and Healthcare Commission reports

The involvement of our governors has resulted in a number of key changes and improvements to services. For example, the introduction of children's portions in the King's restaurant, refurbishment of our bereavement offices and of the public toilets in the Hambleden Wing.

The Trust has continued to develop its HRWD patient feedback programme. In addition to its inpatient, day surgery and dental surveys, a real time electronic HRWD survey was piloted in outpatients and began roll-out across outpatient areas in early 2010. The survey is already providing valuable feedback from our outpatients and actions have already been implemented to improve waiting times in our clinics.

A range of changes have been made as a result of patient feedback, including:

- **Haematology**
  - During building works in haematology, windows were blocked out to lessen the noise and impact of the building works on patients. This made the area rather dark and depressing. To counteract this, light boxes were purchased and used for two or three hours each day to provide patients with the feeling of natural light.
  - The adolescent room was refurbished with the help and advice of some of our younger patients and the Teenage Cancer Trust. The room has been re-decorated and equipped with games including Nintendo Wii and X Box 360s
  - The patient bedside buzzer system was upgraded to improve communication between staff and patients who are in side rooms. Each bed now has a two way intercom. This allows staff and patients to talk to each other to find out what the patient needs. The intercom means that staff can find out how urgent the call is and to let the patient know when they will be with them.
- **Sexual Health**
  - A new evening clinic has been set up for our HIV patients.
- **Paediatrics**
  - A graffiti board has been put up on the ward. Patients and relatives can now write suggestions on post-it notes and put the on the board. One idea taken up has been to provide more books on the ward.
- **Day Surgery**
  - Patients now bring in dressing gowns to wear as they walk to theatre to enhance dignity.

During this year we have continued to build on the First Choice programme of work introduced in 2008 to improve various aspects of the patient experience.

The Patient Experience Report continues to provide integrated monthly data on complaints, PALS contacts and patient comments. From 2010 this the report will be included as part of regular feedback to the Board of Directors.

The Contacting King's Programme has resulted in improved outpatient appointment letters which are now being rolled out across the trust. Based on feedback from patients, four standard letter templates have been designed. These will replace the four hundred different outlines which are currently used, ensuring that all patients are given essential information about their appointments in a format that is easy to understand. Considerable work has also been done to improve telephone contact with King's for our patients. Figures for the percentage of unanswered phone calls are now included as a measure on the monthly Trust scorecard and each division also has a "telephone" lead who is responsible for driving improvements, supported by the Trust's switchboard team. Between July 09 and March 10, there was a 44% improvement in call answer rates.

Details of any consultations completed in the previous year and forthcoming consultations

Redevelopment of King's Emergency Department
As part of a large scale engagement and consultation process, a formal 12 week consultation took place on options for redeveloping King's Emergency Department. This was a joint project between Southwark and Lambeth PCTs and King's and SLaM. As a result of the consultation and follow-up work with staff and key stakeholders, a number of changes were made to the plans including the allocation of more space and provision for a designated area for mental health patients. The revised plans were agreed by the Boards of the four partnership organisations in late 2009. Users and key stakeholders were involved in each stage of the project which is overseen by a Project Board which includes lay representation and members from the LINks.

King's Health Partners
As King's Health Partners moves forward with the development of CAGs both King's and GSTT will work together to ensure appropriate involvement of patients and the public to ensure any developments to clinical services meet patients' needs.

Service Improvement
In the current climate of change within the NHS, King's is mindful of the need to engage and consult with patients, LINks and OSCs to ensure that any changes in services are fully informed by patients, the public and key stakeholders.

Responding to complaints
The Trust welcomed the changes to the NHS and Social Care complaint procedures which came into force on 1 April 2009 streamlining the process for patients with the emphasis on effective local resolution. Good complaint handling is taken seriously at King's because we recognise concerns and complaints as a valuable source of patient feedback and they continue to provide us with the opportunity to reflect on and learn from patients' experiences.

Our complaints process is well managed throughout the organisation so that decisions are taken quickly, things put right where necessary and lessons are learnt for service improvements. Since April, our complaint handling procedures have adopted a responsive and patient centred approach to resolving concerns and complaints working collaboratively with PALS.

The Trust received 718 patient complaints during 2009-10 of which approximately 50% raised issues of an unsatisfactory experience which were considered to be well founded. All complaints and concerns have provided helpful feedback and the opportunity to reflect on our services and the standard of care we provide.

PALS had its busiest year since 2006 speaking with over 4,500 patients, families and visitors. As a front line drop in service, PALS listen and proactively respond to the experiences of our patients and give advice and help to resolve and remedy concerns and problems quickly and efficiently.

As a result of the concerns raised by patients and relatives the Trust has introduced and run further training and support for nursing staff from various specialties to improve the standard of care provided. These include:

- Reinforcing the King's behavioural standards and King's Values.
- Complaints have been used as case studies for improvement and learning in ward team meetings.
- Sensitive and good communication skills in deeply distressing situations.
- Enhanced training for midwives in providing support and counselling to women in labour in their choice of delivery.
- Reinforcing correct clinical practice in checking cannulas to reduce the risk of incidences of cross infection.

We have rolled out Trust wide, the implementation of the POTTS and provided a programme of training for staff in its correct use to ensure deteriorating patients are escalated to senior medical and nursing staff. POTTS is a nationally approved patient safety instrument endorsed by the Institute for Healthcare Improvement.

King's has introduced a Trust policy which outlines the responsibilities and specialties with regard to assessment, review and admission of patients to the Emergency Department, with the aim of improving the emergency pathway for patients.

Patient focused information leaflets and clinic boards have been updated to provide current information, for example:

- The electronic information board in the Sexual Health Clinic now informs patients that if they wish to see the same gender health professional, that they must make this request known to a member of staff.
- A paragraph has been added to an exercise programme informing patients not to continue with an exercise if it exacerbates their condition.
- Information for patients undergoing a lumbar epidural is to be improved, to ensure patients are well informed prior to the procedure.

Since 1 April 2009 the Trust was informed of 19 cases referred to the Health Service Ombudsman for independent review in the final stage of the complaints process. The Trust was advised of 12 cases which had no grounds for further investigation and seven cases remain under consideration.

STAKEHOLDER RELATIONS

KHP development

KHP was formally accredited in March 2009. Considerable progress was made in establishing a successful academic health sciences centre during 09/10, including ongoing development of CAGs, and initiating the process for appointing leaders to these groups. The clinical services strategy teams have been working closely to support proposals for the greater integration of clinical services between the two acute trusts, KHP research committee has been established and KHP bid successfully, together with St. George's and a large number of health and education providers, for a Health Innovation and Education Cluster across South London.

Sector strategy development

King's, together with KHP colleagues, has participated in the development of a strategy for the South East London Sector, in a formal process commissioned by NHS London, and led locally by Simon Robbins. 'KHP' now forms one of four main implementation programmes of this strategy, and KCH/KHP also have appropriate representation on the other three programmes of work (Poly-systems, Staying Healthy, and A Picture of Health)

Shifting activity to new locations and developing new service models

King's continues to work with primary care (PCTs and GPs) to redesign care pathways that enable the shift of care closer to home, in a primary care, community setting or at home where possible. In examining specialty care pathways with clinicians and commissioners, we are identifying patient groups that could be managed in primary care, those who need specialist opinion but not necessarily in a hospital and exploring alternative ways in which specialist opinion can be provided e.g. remote monitoring, telephone and email consultation. King's continues to evaluate new service models to ensure they are high quality and affordable.

Community provider services integration with KHP

GSTT on behalf of KHP has been selected as the preferred partner for Lambeth and Southwark Community Provider Services. This is subject to agreement from the Cooperation and Competition Panel over the coming year. King's will work with GSTT to ensure their involvement during the due diligence process making sure we retain and enhance our relationships with community services to improve integrated patient care pathways.

University Hospital Lewisham

King's has worked closely with UHL over the last year and made use of UHL spare ward capacity particularly over the winter months. We have now transferred the Frank Cooksey specialist neuro-rehabilitation service to the UHL site where facilities are much improved. The ward and gym facilities at UHL are modern and designed to meet the special needs of patients needing to stay in hospital for several weeks or months.

Commercial relationships

MediHome are an independent sector multidisciplinary homecare team who King's has contracted with to enable patients to be cared for out of hospital. Many patients are receiving multiple visits in their home to provide agreed packages of care such as

intravenous antibiotics, complex wound care, physiotherapy. This service has been well evaluated by patients and enables earlier discharge from hospital.

NHS FOUNDATION TRUST CODE OF GOVERNANCE

The Trust became an NHS Foundation Trust on 1 December 2006 under the Health and Social Care (Community Health and Standards) Act 2003, as superseded by the National Health Service Act 2006. This report covers the period 01 April 2009 – 31 March 2010.

The Board of Directors

The Board of Directors is responsible for the management and governance of the Trust. It provides leadership within a framework of prudent and effective controls that enables risk to be assessed and managed. It is responsible for ensuring compliance with the terms of authorisation, including the constitution, with mandatory guidance issued by Monitor, and with relevant statutory requirements and contractual obligations. Made up of the Chair, six non-executive directors and six executive directors, it also has three other directors who regularly attend meetings in an advisory capacity.

All Trust directors have joint responsibility for decisions. The executive directors manage the day-to-day running of the Trust, while the Chair and non-executive directors provide operational and board level experience gained from other public and private sector bodies. Among their skills are accountancy, audit, education, management consultancy, engineering and medicine.

The full-time executive directors have extensive experience as NHS directors, in addition to significant public and private sector experience. They have a deservedly high reputation in their respective professional fields and the Board of Directors considers that there is a good balance of skills represented by both non-executive and executive board members.

The Board of Directors has a Vice-Chair, who has been designated as the Senior Independent Director. One of the six non-executive directors is a representative of KCL, the Trust's university medical and dental school. All non-executive directors are considered by the Board of Directors to be independent. Non-executive directors' terms of office are currently four years. They are appointed by the Board of Governors who may also terminate their appointment.

Evaluation of Performance

The Board of Directors and Board of Governors jointly undertook a programme of evaluation in October 2009 with an independent review facilitated by the Audit Commission, reviewing issues such as roles and responsibilities, based on Monitor's Code of Governance. The programme included a survey completed by directors and governors, followed by a facilitated workshop.

In Spring 2010, the Board of Directors participated in a Board development programme facilitated by 'The Diversity Practice', commissioned by the NHS Institute for Innovation and Improvement. The programme included individual self-assessment, one on one interviews with members of the Board of Directors, and 360° appraisal, followed by a facilitated workshop.

Following recent changes to executive and non-executive membership of the Board, the Board of Directors will undertake a further programme of evaluation in October 2010, when all new Board appointments are completed.

All executive and non-executive directors have an annual performance appraisal and a personal development plan, which forms the basis of their individual development. The performance of executive directors is reviewed by the Chief Executive and considered by the Remuneration and Appointments Committee in relation to remuneration. During 2009/10, a process has been followed for the evaluation of the Chair and non-executive directors, having been agreed in consultation with the governors.

A copy of the register of interests for members of the Board of Directors and the Board of Governors, and a record of attendance at Board of Directors, Board of Governors and Board Committee meetings is kept by the Trust Secretary. Arrangements to view the register may be made by contacting the Secretary on 020 3299 4939.

BOARD OF DIRECTORS

Non-Executive Directors

Michael Parker (Chair) is a Fellow of the Association of Chartered Certified Accountants. He served as a non-executive director and Vice Chair of Guy's and St. Thomas's NHS Trust before being appointed as Chair of King's in 2002. Michael is a director of KCH Commercial Services; He is the President of the Sickle Cell Society and Treasurer of the Mary Seacole Memorial Statute Appeal. Michael is also a Board member of the Food Standards Agency; an external advisor to the Royal College of Nurses' Audit Committee and Pension Committee; Chair of NHS London's Diversity Reference Group and a member of it's Leading for Health Reference Group; Acting Chair of ACCA's Corporate Governance & Risk Management Committee and a member of ACCA's Health Panel. Michael's term of office will end in November 2011.
F (Chair), I (Chair), R (Chair), and E.

Robert Foster is a Commissioner of the National Lottery Commission; a non-executive director of the Jersey Competition Regulatory Authority, and a member of the Advisory Council of Oxford Capital Partners. Previously, he was Chief Executive of the UK Competition Commission; and a Senior Civil Servant in the Cabinet Office and DBIS. He is a Chartered Engineer and was an engineering manager in the electronics and telecommunications industries. Robert is Vice Chair and Senior Independent Director. Robert was originally appointed as non-executive director on 18 March 2004, and was re-appointed in March 2008. His current term of office will end in 2012.
P (Chair), A and R.

Professor Alan McGregor is Professor of Medicine at KCL and Campus Dean for the Denmark Hill site. In addition, he is an Honorary Consultant Physician at King's College Hospital. Nationally he has chaired numerous Boards and Committees for bodies including the Medical Research Council and the Department of Health. Alan has been a non-executive director of King's since 2003. He was re-appointed in 2007 and his current term of office will end in October 2011.
G (Chair), P and R.

Maxine James is an IMC registered consultant who has been involved in management development for voluntary and community organisations and small businesses for over 20 years. She was a member of DTI's Ethnic Minority Business Forum for four years, and is Chair of Ethnic Mutual, a community development finance initiative and Vice Chair of Julian's Primary School. Maxine has been a non-executive director of King's since 2004 and was re-appointed in May 2008 and her current term of office will end in 2012.
E (Chair), G, F and R.

Martin West is a qualified management accountant and chartered civil engineer. He is a director in the Real Estate Strategy & Finance Team at Drivers Jonas Deloitte and was, until recently, an independent board member and Chair of the services committee for Willow Housing & Care Ltd. Martin joined the Board in July 2007 and his current term of office will end in 2011.
A (Chair), F, I , E and R.

Sir Jonathan Michael was appointed as a director of King's on 1 September 2009. He has a distinguished track record as both a clinician and senior manager in the NHS. He originally qualified as a doctor from St Thomas' Medical School and KCL, and worked in nephrology in several London teaching hospitals before moving to Birmingham as a consultant. He later became Medical Director and then Chief Executive of University Hospitals Birmingham NHS Trust. He became Chief Executive at Guy's and St Thomas' NHS Foundation Trust in 2000 before taking up a post as Managing Director of BT's Health business in 2007. Sir Jonathan also led the Independent Inquiry into Access to Healthcare for People with Learning Disabilities, which reported in 2008. Sir Jonathan resigned with effect from 31 March 2010 to take up the post of Chief Executive at Oxford Radcliffe Hospitals NHS Trust.
A, G, P and R.

Rita Donaghy joined the Board as a non-executive director in 2005. She was Chair of the Advisory, Conciliation and Arbitration Services until November 2007. Prior to her appointment, she was President of the TUC and served on the National Executive Council of NALGO/UNISON, the Low Pay Commission and the Committee on Standards in Public Life where she also served as Acting Chair in 2007. Her term of office ended on 31 October 2009. Rita was created a Labour Working Peer in May 2010.
A, F, G and R.

Guide to Committees
A - Audit
R - Remuneration & Appointments
F - Finance
I - Investment
G - Governance
P - Performance
E - Equality & Diversity

Executive Directors

Tim Smart (Chief Executive) has had a successful career with Shell and BT before joining KCH as Chief Executive in November 2008. He brings with him a wealth of experience in customer service and satisfaction, developing commercial partnerships, and team and people development. He has worked in the Middle East, the Netherlands and the US. He also has experience as a non-executive director of a US-listed financial services company, he is a Trustee of two UK charities and a member of the Foundation Trust Network Board.

Simon Taylor (Chief Financial Officer) has worked at King's for 19 years holding positions as Financial Controller and Deputy Director of Finance before becoming Director of Finance in 2002. He is also responsible for overseeing the Trust's commercial developments. Simon is a director of KCH Commercial Services and its subsidiary, Agnentis Limited.

Roland Sinker (Executive Director of Operations from 6 July 2009) joined the Trust in 2005 as Director of Strategy for KCH and latterly as Joint Director of Strategy for KCH and Guy's and St Thomas'. Prior to joining the NHS, Roland worked as a lawyer and management consultant.

John Watson (Acting Director of Operations to 5 July 2009).

Professor John Moxham (Executive Medical Director to 20 September 2009) has been at King's in a number of different roles since 1982. He became Executive Medical Director in 2003 after having served some years as a non-executive director representing the medical school.

Michael Marrinan – (Acting Medical Director from 21 September 2009 and Executive Medical Director from 3 February 2010), Consultant Thoracic Surgeon, was appointed as the Trust's Executive Medical Director in February 2010 following two years' service as Deputy Medical Director. Michael has worked at King's for nearly 20 years, and has previously chaired both the Consultants' Committee and the Patient Records Committee. He was also heavily involved in the development of King's activity based costing system.

Angela Huxham's (Executive Director of Workforce Development from 4 May 2009) career in people management began in manufacturing and insurance followed by public service in local government and the NHS. A former Director of Human Resources at Cambridge University Hospitals, she has experience across primary and secondary care and on national programmes with NHS Employers; she is currently co-chair of the NHS Pension Scheme Governance Group. She joined King's College Hospital as Director of Workforce Development in 2009.

Marion Lorman (Acting Director of Human Resources to 3 May 2009)

 **Geraldine Walters** (Executive Director of Nursing and Midwifery from 7 September 2009) was previously Director of Nursing and Patient Involvement, and Director of Infection Prevention and Control at St George's Healthcare NHS Trust. Geraldine also chairs the London Network for Nurses and Midwives, is Visiting Professor at Buckinghamshire New University and a member of the National Clinical Audit Advisory Group.

Geraldine worked in a variety of hospitals in her early career, including King's, and subsequently gained a PhD and an MBA.

Paula Townsend (Acting Director of Nursing to 6 September 2009).

Non-Voting Directors

 **Ahmad Toumadj** (Director of Capital, Estates and Facilities) is a Post-graduate from the Bartlett School of Architecture at UCL and a Fellow of Chartered Institute of Building. After working in the construction industry, he joined the NHS in 1980 and King's in 1997.

 **Jane Walters** (Director of Corporate Affairs and Trust Secretary) has worked at King's since 1992, holding positions as Business Manager and Head of Corporate Services. Her earlier career was in local government, where she held a variety of roles in corporate governance and quality assurance. She was appointed Director of Corporate Affairs at King's in 2004.

 **Jacob West** (Director of Strategy from 1 February 2010) was Deputy Director and latterly Acting Director at the Prime Minister's Strategy Unit before joining King's. His role was to advise Number 10 and the Prime Minister on a range of public service reform issues, and was lead adviser on health policy since 2007.

Prior to this he worked as a consultant to a number of government agencies in the United States on a range of public service reform issues and was a senior policy adviser in the UK government.

Zoe Lelliott (Acting Director of Strategy to 31 January 2010).

MEETINGS AND COMMITTEES

The Board of Directors held 12 meetings during 2009/10. Some of the work of the Board of Directors is delegated to committees, which also meet regularly and are each chaired by a non-executive director of the Trust. There is a standing item at every Board of Directors meeting to receive reports and minutes of meetings from Board Committees.

The Audit Committee is responsible for monitoring the externally reported performance of the Trust and provides independent assurance to the Board of Directors on a range of areas including internal control; external assurance of our risk management processes; internal and external audit, and financial reporting.

The Remuneration and Appointments Committee agrees, on behalf of the Board of Directors, the remuneration and terms of service of the executive directors, and, together with the Chief Executive, forms the panel for executive director appointments.

The Governance Committee is responsible for monitoring and reviewing the effectiveness of governance and risk management structures and systems, to ensure they are embedded across the Trust.

The Performance Committee reviews the performance of the Trust and makes recommendations to the Board of Directors for approval.

The Finance Committee reviews financial matters in detail and make recommendations to the Board of Directors for approval.

The Investment Committee advises the Board on the Trust's investment strategy.

The Equality & Diversity Committee monitors equality and diversity issues relating to the provision of services to patients, employment and procurement practice within the context of the Trust's Diversity Strategy.

Attendance at Board of Directors and Committee Meetings

Board member	Board of Directors (Actual/ Possible)	Audit Committee [2] (Actual/ Possible)	Remuneration & Appointments Committee [2]
Michael Parker	12/12		2/2
Alan McGregor	11/12		1/2
Robert Foster	12/12	4/4	1/2
Rita Donaghy	7/7	2/2	2/2
Maxine James*	11/12		2/2
Martin West	12/12	4/4	2/2
Jonathan Michael	7/7	1/2	1/1
Tim Smart	12/12		
John Moxham	5/5		
Angela Huxham	9/11		
Geraldine Walters	7/7		

Simon Taylor	12/12
Roland Sinker	7/8
Jane Walters [1]	12/12
Ahmad Toumadj [1]	12/12
Paula Townsend	3/5
John Watson	3/4
Zoe Lelliott [1]	8/10
Michael Marrinan	6/7
Jacob West [1]	2/2
Marion Lorman	1/1

1 Non-voting directors.
2 Attendance of non-members is not shown.
* Part of the January Board of Directors meeting was attended.

AUDIT COMMITTEE

The Chair and members of the Audit Committee in 2009/10 were:

Martin West (Chair) – Non-Executive Director
Robert Foster – Trust Vice Chair
Rita Donaghy - Non-Executive Director (to 31 October 2009)
Sir Jonathan Michael – Non-Executive Director (from 1 September 2009)

Other persons may attend at the invitation of the Chair but they are not members of the Committee.

The Audit Committee meets at least quarterly and comprises independent non-executive directors only. The Board of Directors is satisfied that at least one member of the Audit Committee has recent and relevant financial experience. The Chief Executive, Chief Financial Officer and Director of Corporate Affairs regularly attend meetings by invitation, together with representatives of external and internal audit and the manager of the local counter fraud team.

The Audit Committee monitors the externally reported financial performance of the Trust and provides independent assurance to the Board on a range of areas. These include internal control and risk management, internal audit, external audit and financial reporting. King's continued to closely monitor the effectiveness of internal control and audit processes during 2009/10.

The Committee undertook an annual self-assessment, reviewed its terms of reference and presented an annual report of its activity to the Board of Directors. The Committee oversees the work of the Trust's Counter Fraud team. The Trust has a policy of zero tolerance towards fraud and always prosecutes if economically viable to do so.

During the 2009/10 reporting year, the Audit Committee considered the following issues:

<u>Internal Audit</u>

- Internal auditors' review of operational, corporate and support systems.
- Board assurance framework, statement of internal control and Standards for Better Health.
- Financial reporting.

- Core financial systems.
- Recruitment procedures.
- Compliance with terms of authorisation.
- Business planning.
- Information lifecycle management.
- PFI hard facilities management provision.
- Complaints.

External Audit

- Audit process – changes in accounting standards and codes of practice.
- Risk assessment.
- Reviews of internal controls that significantly affect financial statements.
- Review of accounts prior to Board of Director approval.

Independence of external auditor

The Trust's external auditors, the Audit Commission, have communicated the following matters to the Audit Committee:

- The principal threats, if any, to objectivity and independence identified by the auditor, including consideration of all relationships between the Trust, directors and the auditor.
- Any safeguards adopted and the reasons why they are considered to be effective.
- Any independent partner review.
- The overall assessment of threats and safeguards.
- Information about the general policies and processes for maintaining objectivity and independence.

The Audit Commission are not aware of any relationships that may affect the independence and objectivity of the team, and which are required to be disclosed under auditing and ethical standards.

NHS FOUNDATION TRUST CODE OF GOVERNANCE – COMPLIANCE STATEMENT

Principles of the Code

The Board of Directors considers that it was compliant with the Principles of the NHS Foundation Trust Code of Governance during the period 01 April 2009 – 31 March 2010.

The Board of Directors

The Board of Directors of King's is responsible for the exercise of the powers and the performance of the Trust, for ensuring the highest standards of corporate governance, and that the Trust operates within a framework of prudent and effective controls which enables risk to be assessed and managed.

The Board comprises the Chair, six executive directors and six non-executive directors and is collectively responsible for the success of the Trust. The directors have a range of skills and experience and each brings independent judgment and expertise to the Board's discussions and decision making.

The composition of the Board of Directors and the experience of the directors are described on page 57 of the annual report, which also includes information about the committees of the Board, their membership and attendance by individual directors.

The Board meets regularly and has a formal schedule of matters specifically reserved for its decision. The Board delegates other matters to the executive directors and other senior managers. The Board has 12 scheduled meetings each year.

The Board of Governors

The Board of Governors is responsible for representing the interests of NHS Foundation Trust members and stakeholder organisations in the governance of the Trust. They exercise statutory powers, such as the appointment of non-executive directors and the external auditor.

The Board of Governors comprises 12 elected Public Governors, six elected Patient Governors, six elected Staff Governors and nine appointed Stakeholder representatives.

The Board of Governors met four times a year in the period from 1 April 2009 to 31 March 2010. Its sub committees, the Nominations Committee, Membership Committee, Patient Experience and Safety Committee and Strategy Committee met as required, and other working groups also met, including the Transport Group.

Details of the composition of the Board of Governors, governor attendance at meetings and the activities of the Board of Governors are included in pages 81-84 of the annual report.

Information, development and evaluation
The Boards of Directors and Governors are supplied with information in a timely manner and in an appropriate form and quality to enable them to discharge their duties. The information needs of both Boards are subject to periodic review.

The Board of Directors keeps its performance, that of its committees and individual directors under regular review. Page 55 of the annual report contains details of the processes the Trust has followed.

Accountability and Audit
The Board of Governors has appointed the Audit Commission as the Trust's external auditor. The Board of Directors maintains a sound system of internal control and has appointed KPMG as its internal auditors. The Board of Directors presents a balanced and understandable assessment of the Trust's position and prospects, and ensures effective scrutiny of finance and operational matters through regular reporting through its designated committees to the Board of Directors.

Relations with Stakeholders
The Board of Directors recognises the importance of effective communication with a wide range of stakeholders, including members of the Trust.

The annual public meeting is used as an opportunity to communicate with members, in addition to regular written communication and member events. A series of community events are held annually, to enable member feedback into the Trust's annual plan.

The Board of Directors and Board of Governors enjoy a close working relationship. Members of the Board of Directors regularly attend Board of Governors meetings, and governors are actively encouraged to attend Board of Directors meetings. The annual plan submitted to Monitor has had regard to the views of the Board of Governors and members.

Provisions of the Code

The Board of Directors considers that it was from 01 April 2009 – 31 March 2010 fully compliant with the provisions of the NHS Foundation Trust Code of Governance with the following exceptions:

A.3.1 and A.3.2	**Independent Non-Executive Directors and Non-Executive Director majority** ***The Board of Directors should identify in the annual report each Non-Executive Director it considers to be independent. The Board should determine whether the Director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. Such reasons include being an appointed representative of the Foundation Trust's university medical or dental school.*** As a university teaching hospital, one of the Board's non-executive directors, Professor Alan McGregor, is a representative of King's College, University of London. However, the Board is confident that Professor McGregor is independent in character and judgement, and declines to describe this non-executive director as 'non-independent'. ***At least half the Board, excluding the Chairman, should comprise Non-Executive Directors determined by the Board to be independent.*** The Board comprises six executive directors and six non-executive directors considered by the Board to be independent, excluding the Chair. The constitution gives the Chair a second and casting vote.
A.3.3	***The Board should appoint one of the independent Non-Executive Directors to be the Senior Independent Director. The Senior Independent Director could be the deputy chairman.*** The Board has appointed a Vice-Chair, who is also designated as the Senior Independent Director. It has not appointed a separate Senior Independent Director.
C.2.1	***The Chief Executive and other executive directors should be subject to re-appointment at intervals of no more than 5 years.*** Executive directors are employed on substantive contracts and are not subject to reappointment at intervals of no more than five years. The exception is the Executive Medical Director, who is appointed on a fixed term three year contract, which may be renewed by agreement.

C.2.2	***Non-Executive Directors, including the Chairman, should be appointed by the Board of Governors for specified terms subject to re-appointment thereafter at intervals of no more than three years.*** The Board of Governors has approved four year terms of office for Non-Executive appointments, subject to a maximum of two four-year terms (except in exceptional circumstances).

REMUNERATION REPORT

The remuneration and expenses of the Chair and non-executive directors are determined by the Board of Governors, taking account of relevant market data, including the Foundation Trust Network's remuneration survey.

Remuneration for the Trust's most senior managers (directors accountable to the Chief Executive) is determined by the Trust's Remuneration and Appointments Committee, which consists of the Chair and the non-executive directors. The table on pages 61-62 records meeting attendance.

The Remuneration and Appointments Committee is informed by executive salary surveys, by periodic assessments conducted by independent remuneration consultants and by the salary awards and terms and conditions applying to other NHS staff groups. Affordability together with an assessment of both individual and collective performance are also taken into account. For the financial year 2009/10, there was no increase in basic pay for existing executive directors, with the exception of the Director of Corporate Affairs whose salary was adjusted to remain within the relevant quartile. The Trust's strategy and business planning process sets key business objectives which, in turn, inform individual and collective objectives for senior managers. Performance is closely monitored and discussed throughout the year and is also part of the annual appraisal process.

Details of remuneration, including the salaries and pension entitlements of the Board of Directors, are published in the annual accounts on page 139. Remuneration of the most senior managers includes a bonus of up to 10% of basic salary, which is performance related and reflects achievement during the previous financial year. However, from 1 April 2009 the bonus scheme has been withdrawn. The only non-cash element of the most senior managers' remuneration packages is pension related benefits accrued under the NHS Pension Scheme. Contributions are made by both the employer and employee in accordance with the rules of the scheme.

The Executive Medical Director is a consultant within the Trust, whose role is undertaken on a fixed term, three-year contract which may be renewed by agreement. This contract is next due for review/renewal in February 2013. Additional paid programmed activities are provided in the job plan to enable the fulfillment of these additional responsibilities. In addition the Medical Director receives a pay supplement.

Executive Director	Date in post	Unexpired Term	Notice
Executive Medical Director	2 February 2010	3 years	3 months

All of the other most senior managers are substantive employees of the Trust employed on open-ended contracts of employment which can be terminated by the Trust with up to twelve months' notice.

Signed: Timothy Smart
Chief Executive

SUSTAINABILITY/CLIMATE CHANGE REPORT

King's has continued to work towards reducing its impact on the environment and to introduce sustainable initiatives wherever possible.

King's has developed a carbon management plan in order to ensure that it hits the targets that have been set for the reduction of CO_2 emissions. Along with these targets, King's has introduced some key objectives to the organisation, which will enable it to become more sustainable, thus reducing the impact on the local environment and King's contribution to global warming. This plan forms a key part of King's aim to be a good neighbour, an excellent and sustainable organisation and a critical partner in the AHSC initiative.

Baseline and project implementation is reviewed on an annual basis and the plan revised accordingly. The implementation of the plan is monitored and reviewed via the Environmental Committee (which reports directly to King's Executive).

Summary of performance

Carbon reduction

King's is required to become a part of the Carbon Reduction Commitment Scheme as of 1 April 2010.

King's continues to work towards its own set target of 25% reduction of CO_2 emissions from the set 2007/8 baseline plus anticipated new builds. In 2008/9 we recorded a baseline of 23,620 tonnes which is an 8% reduction. In 2009/10 we recorded a baseline of 23,547 tonnes which is a reduction of 73 tonnes.

Projects that have been completed this year towards the carbon reduction management plan are as follows:

- Combined heat and power plant installed. This became operational on 11 March 2010.
- Recruitment of a Carbon Reduction Officer in November 2009.
- Passive infra red lighting controls installed into waste and store rooms.
- Increased co-mingled recycling scheme by over 50% in 2009.

Waste minimisation

In 2009/10 King's has produced 1192 tonnes of clinical waste, of which 389 tonnes were incinerated at a waste to energy plant and the remaining 803 tonnes were treated at an autoclave plant. We produced 1,032 tonnes of domestic waste which was sent to landfill and managed to recycle 351 tonnes (34%). King's produced 171 tonnes of electronic and electrical waste. This is a 6% decrease on waste that was produced in 2008/9.

Area		Non-financial data (applicable metric)	Non-financial data (applicable metric)		Financial data (£k)	Financial data (£k)
		2008/09	2009/10		2008/09	2009/10
Waste minimisation and management	Absolute values for total amount of waste produced by the Trust	1238 Tonnes (clinical) 1278 Tonnes (domestic) 28.85 tonnes (electrical) 369 tonnes (recycling)	1192 tonnes (clinical) 1032 tonnes (domestic) 171 tonnes (electrical) 351 tonnes (recycling)	Expenditure on waste disposal		
Finite resources	• Water • Electricity • Gas	91058 cubic metres 23,304,444 kWh 43,225,000 kWh	246127 cubic metres 28,257,212 kWh 47405882 kWh	• Water • Electricity • Gas	£103,976 £2,608,419 £1,296,987	£222,337 £2,413,421 £1,068,093

Future priorities and targets

King's will continue to work towards targets as laid out in its carbon management plan, as well as developing new carbon reduction opportunities via the Environmental Committee. These projects will be implemented via the Trust's Energy Project Group. Projects for 2009/10 include:

- Carbon Trust standard accreditation
- Installation of automatic meter reading
- Continued work on energy saving lighting.

Likewise waste minimisation targets have been set, which will be rolled out via the Trust's Waste Project Group, to minimise waste by looking at the following projects in 2009/10:

- Re-usable consumables instead of single use.
- Reduction in food waste via introduction of steamplicity system and composting of residual waste.
- KCH aims to improve on site recycling by 5%.

King's is committed to driving sustainability throughout the organisation. KCH is in the process of implementing an offsite consolidation contract covering the storage and delivery of non supply chain medical consumable supplies. Products are held off site by a neutral wholesaler who then provides a just-in-time stock control service into the hospital. In addition to reducing on-site stock levels, on-site handling and avoidance of supplier delivery charges it is anticipated that the service will also

reduce the hospitals carbon footprint by reducing the risk of unnecessary waste, reducing the volume of vehicle deliveries and therefore CO_2 emissions, and backhauling packaging for off-site recycling. The Trust also continues to work with a base of local suppliers to ensure that we support the local economy and keep CO_2 emissions to a minimum.

EQUALITY AND DIVERSITY REPORT

King's is located in one of London's – if not the UK's – most diverse areas. For this reason, we ensure that equality and diversity issues remain front-of-mind for everyone who works for King's.

Changing policies to reflect our equality commitments

We review all existing and planned services and policies, against equality and diversity indicators, on a three year cycle. A number of major equality-related changes have been introduced.

We have provided staff with 24/7 access to an independently-run harassment and bullying helpline. We also revised our policy on sickness absence so that staff returning from periods of absence could benefit from phased returns to work on full pay and we expanded Kingsflex, our flexible working scheme, to help staff balance family and work commitments.

Setting the pace

King's was one of four London sites participating in the in the national Pacesetters Programme which ended in March 2010. This programme is a Department of Health initiative designed to tackle health and workplace inequalities caused by discrimination and disadvantage.

A number of new equality-led projects have been implemented as a result of our involvement in the programme including:

- Implementation of British Dental Association case mix toolkit to help measure impairment and disability reflecting the additional time and resources required to provide care for patients with a disability or special needs.
- A programme that encourages healthier lifestyle choices amongst women with gestational diabetes to reduce their risk of developing type 2 diabetes.
- We have worked with local young people to film and produce a DVD, to provide high-quality advice and information about sexual health services to young people
- Introduction of a network of disability advisors. Members of King's Deaf and Disability Staff Group is comprised of staff with a wide range of disabilities, they act as advisors and provide a user perspective offering guidance to staff with disabilities and their managers.
- Launch of a buddy scheme to help new staff to settle into working life at King's. It is particularly aimed at staff in junior grades.
- Introduction of a shadowing scheme to provide support and guidance for BME staff in band 7 positions.

We are Positively Diverse

The Trust's commitment to promoting equality and diversity has been recognised through the award of *Positively Diverse* lead site status.

Our equality and diversity training programme helps ensure staff have the skills and knowledge they need to provide all of our patients with consistently high standards of care. Equality and diversity training is mandatory for all new staff and the Trust is in track for ensuring that 100% of all staff have received equality and diversity training by 2012.

Our equality agenda features heavily in the recruitment & selection training, which is mandatory for all those taking part in recruitment panels. It also informs our 'Effective Management' training course which is aimed at ensuring that all line managers receive training on applying the Trust's key workforce policies such as the disciplinary and grievance procedures. We also provide training to front line staff in deaf and disability awareness, and training for managers in managing deaf and disabled staff appropriately. We provide self-marketing courses to help all staff improve their prospects within the Trust. We provided training last year for Disability Network Advisors, these staff will support both staff with a disability and line managers in to help improve the experience of those working in the Trust with a disability**.** We also provide training for staff working with people who may have learning disabilities. There are also e-learning programmes available regarding a range of diversity issues as well as an introductory British sign language e-learning programme.

Networks help ensure all voices are heard
King's has three staff-led diversity groups: the Cultural Diversity Group, the Disability and Deaf Staff Group and the Lesbian, Gay, Bisexual and Transgender Forum. The focus of the Cultural Diversity Group is primarily on issues relating to ethnicity and culture in the workplace. All three groups perform a vital function in providing support to and network opportunities for group members whilst at the same time holding the Trust to account on its equality and diversity commitments.

King's commitment
King's is committed to employing a workforce that reflects the diverse communities we serve. Our recruitment policies support this. 48% of our staff are from BME backgrounds. The proportion of middle/senior staff from BME backgrounds has also increased from 29% in 2002 to 36% in 2010.

Workforce statistics

	2008/09		2009/10	
	headcount	%	headcount	%
Age				
0-16	0	0%	0	0%
17-21	85	1%	71	1%
22+	6550	99%	6888	99%
Ethnicity				
White	3338	50%	3495	50%
Mixed	278	4%	241	3%
Asian or Asian British	1148	17%	1201	17%
Black or Black British	1572	24%	1738	25%
Other	152	2%	137	2%
Unknown	147	2%	147	2%
Gender				
Male	1734	26%	1862	27%
Female	4901	74%	5097	73%
Recorded disability				
Yes	91	1%	232	3%
No	1432	22%	5773	83%
Unknown	5112	77%	954	14%
Total staff numbers	**6635**		**6959**	

STAFF SURVEY REPORT

For the 2009 staff survey, questionnaires were sent to 812 staff and we had a response rate of 45% (365) compared to the national average of 55%. Our response rate for the 2008 Survey was 53%.

The 2009 staff survey results reported on 40 key findings: King's was ranked in the top 20% nationally for 14 and in the worst 20% for 10. Areas where King's performed well included questions related to staff satisfaction with their jobs and ability to contribute to improvements, the quality of work and patient care they deliver; feeling there are good opportunities to develop their potential, annual appraisals and effective action on violence and bullying.

The staff survey also found that the Trust has a top 20% rating for staff who would recommend the Trust as both a place to work and a place to receive treatment. An overall staff engagement score was calculated for the first time for the 2009 results and King's scored 3.76 which was also a best 20% rating.

Although the Trust scored well on staff confidence in the Trust's handling of violence and bullying towards staff, the proportion of King's staff reporting bullying at work remains too high. The results were also less encouraging in some areas such as the take up of flexible working options, the availability of hand washing materials and the numbers witnessing potentially harmful errors, near misses or incidents, although we rated as a best performing Trust for the fairness and effectiveness of procedures for reporting errors and near misses.

In 2009/10, the 2008 staff survey results were discussed widely and presentations were made to the Board, the Board of Governors, the Joint Consultation Committee and other management groups. An action plan was drawn up which focused on five priority areas: staff on staff bullying, work related stress, well structured appraisals, heath and safety training and staff reporting work related injuries. The Trust 2009 results were an improvement on the 2008 results in all five areas.

Action plan - 2010

The Trust will continue to focus on addressing discrimination, violence, harassment and bullying at work as a key priority for 2010. In addition, we will relaunch KingsFlex, our flexible working options scheme and promote a better work-life balance culture within the Trust. We have also well developed plans to address the concerns relating to the patient safety aspects of the survey results.

Summary of Performance – Tables

Response rate compared with previous year.

	2008/09		2009/10		Trust improvement/ deterioration
Response rate	Trust	National average	Trust	National average	
	53%	n/k	45%	55%	8% decrease

Top ranking scores - 2009

	2008/09		2009/10		
	Trust	National Average	Trust	National Average	Trust Improvement/ Deterioration
KF.5 - Quality of job design	3.41	n/k	3.51	3.38	Increase 0.10 points
KF.33 - Contribution to work improvements	64%	n/k	68%	61%	Increase 4%
KF.1 - Satisfied - quality work/patient care	78%	n/k	82%	74%	Increase 4%
KF.28 - Effective action - bullying/ harassment	3.58	n/k	3.70	3.55	Increase 0.12 points

Bottom ranking scores - 2009

	2008/09		2009/10		
	Trust	National average	Trust	National average	Trust improvement/ deterioration
KF.20 - Availability of hand washing materials	54%	n/k	52%	69%	Decrease -2%
KF.10 - Using flexible working options	65%	n/k	62%	70%	Decrease -3%
KF.21 - Witnessing errors, near miss - in	46%	n/k	43%	37%	Decrease -3% (improvement)
KF.40 - Experience discrimination at work	15%	n/k	14%	7%	Decrease -1% (improvement)

Note: *Two additional themes, staff satisfaction and equality & diversity were added for the 2009 survey. Although the Trust scores were recalculated to reflect this for comparison with 2008 results, the national average scores were not updated.*

Key areas of improvement from previous year.

	2008	2009
KF.34 - Staff job satisfaction	3.41	3.52
KF.5 - Quality of job design	3.41	3.51
KF.28 - Effective action - violence & harassment	3.58	3.70
KF.6 - Work pressure felt by staff	3.05	2.96

Improvements and deteriorations – year on year.
King's improved its scores for 26 key findings (green) and it got worse in seven key findings (red).

Best 20% scores	**2008**	**2009**
KF1. Feeling satisfied with the quality of work and patient care they deliver	78%	82%
KF2. Agreeing that their role makes a difference to patients	92%	92%
KF5. Quality of job design	3.41	3.51
KF6. Work pressure felt by staff	3.05	2.96
KF11. % feeling there are good opportunities to develop their potential	46%	47%
KF12. Receiving job-relevant training, learning or development in last year	82%	82%
KF13. Appraised in last 12 months	77%	79%
KF23. Fairness and effectiveness of procedures for reporting errors, near misses or incidents	3.47	3.51
KF24. Experiencing physical violence from patients / relatives in last year	11%	9%
KF28. Perceptions of effective action from employer towards violence & bullying	3.58	3.70
KF30. Feeling pressure in last 3 months to attend work when feeling unwell	-	23%
KF32. Agreeing that they understand their role and where it fits in	56%	58%
KF33 Able to contribute towards improvements at work	64%	68%
KF36. Recommending the trust as a place to work or receive treatment	-	3.75
Above average scores		
KF 7. Working in a well structured team environment	41%	40%
KF 14 Having well structured appraisals in last 12 months	33%	35%
KF15. Appraised with personal development plans in last 12 months	62%	64%
KF18. Suffering work-related injury in last 12 months	17%	16%
KF22. Reporting errors, near misses or incidents witnessed in the last month	91%	95%
KF 31. Reporting good communication between senior management and staff	33%	30%
KF34. Staff job satisfaction	3.41	3.52
KF37. Staff motivation at work	-	3.89
KF38. Equality and diversity training in last 12 months	34%	45%
Average		
KF3. Feeling valued by their work colleagues	73%	77%
KF29. Impact of health and well being on ability to perform work	-	1.58
Worse than average		
KF8. Trust commitment to work-life balance	3.40	3.37
KF16. Support from immediate managers	3.55	3.58
KF17. Receiving health and safety training in last 12 months	66%	71%
KF19. Suffering work-related stress in last 12 months	34%	30%
KF26. Harassment, bullying or abuse from patients / relatives last 12 months	26%	23%
Worst 20% Scores		
KF4. Agreeing that they have an interesting job	80%	77%
KF9. Working extra hours	75%	73%
KF10. Using flexible working options	65%	62%
KF20. Availability of hand washing materials	54%	52%
KF21. Witnessing potentially harmful errors, nr misses / incidents in last month	46%	43%

KF25. Experiencing physical violence from staff in last 12 months	5%	3%
KF27. Harassment, bullying or abuse from staff in last 12 months	28%	22%
KF35. Staff intention to leave jobs	2.67	2.69
KF39. Believing trust provides equal opportunities for career progression	78%	85%
KF40. Experiencing discrimination at work in last 12 months	15%	14%

Partnership working with staff side representatives

To maintain our reputation as a model employer, our JCC meets monthly to enable Trust managers and staff representatives to review employment policies and practices. Managers and consultants also meet at monthly Consultants' Committee meetings to ensure that close working relationships are maintained.

REGULATORY RATINGS REPORT

The Trust experienced 2 quarters in 2009/10 where its governance rating was classified as amber. The amber ratings in Q2 and Q3 were due to non-achievement of elements of the cancer wait targets. Although a lot of the non-achievement on these key indicators was due to patients choice, KCH did have some issues with capacity for certain services, for example chemo-embolisation. This was recognised by the Trust and increased capacity introduced part way through Q3, which led to the trust finishing Q4 with a green rating, achieving against all cancer wait indicators.

	Annual plan 2008/09	**Q1 2008/09**	**Q2 2008/09**	**Q3 2008/09**	**Q4 2008/09**
Financial risk rating	4	4	4	5	5
Governance risk rating	Green	Green	Green	Green	Green
Mandatory services	Green	Green	Green	Green	Green

	Annual plan 2009/10	**Q1 2009/10**	**Q2 2009/10**	**Q3 2009/10**	**Q4 2009/10**
Financial risk rating	4	4	3	3	3
Governance risk rating	Green	Green	Amber	Amber	Green
Mandatory services	Green	Green	Green	Green	Green

BOARD OF GOVERNORS

The Board of Governors comprises twelve public, six patient and six staff representatives elected by membership constituencies, and nine representatives nominated by stakeholder partners. In February 2009, the Board of Governors agreed to the appointment of an additional stakeholder representative from GSST to the Board of Governors and it is expected that this new appointment will come into effect in the 2010/11 financial year. As guardians of the community interest, the Board of Governors ensures that the needs of members are considered in the planning of future services. Governors also feed back information to their members about the Trust, its vision and performance.

No Governor elections were held in 2009/10. There were two governor resignations in 2009/10 and the Trust is following its election rules in relation to those vacancies.

The Board of Governors is responsible for the appointment, remuneration and removal of the Chair and other non-executive directors. During 2009/10, the Board of Governors approved the reappointment (to 30 November 2011) of Michael Parker, Chair, and agreed remuneration for the Chair and non-executive directors.

Other duties include appointment of the Trust's auditors, and receipt and consideration of the annual report, annual accounts and auditor's report to the accounts. Throughout the year, governors received regular updates on the Trust's business planning process and their comments were incorporated into the Trust's annual plan submitted to Monitor in May 2010.

In order to fulfil their duties, governors need to understand how the Trust operates and the external factors that influence its development. During 2009/10, governors have been involved in a wide variety of activities, including membership of governor committees and working groups, sitting on Trust committees such as patient /carer experience and participation in the staff awards scheme and in work which informed the governor commentary on Standards for Better Health. There is a regular programme of ongoing induction for all governors via 'Directors' Surgeries'.

The Trust's growing alliance with nearby healthcare and research organisations, notably the partners that make up KHP AHSC and following formal accreditation of our AHSC by the Department of Health in March 2009, offers an opportunity to create truly world-class services bringing the best of research and clinical advances to our local population and patients.

Governors have been involved in discussions about the AHSC throughout, and fully support its development. Member events were again held across Lambeth and Southwark to hear at first hand the views of members on these developments and to provide information about King's strategy and future service plans to Trust members. These events were in the main well attended, and they also gave governors and directors an opportunity to come together and communicate King's vision and future plans.

Directors' surgeries for governors are held on issues of interest, such as the AHSC, performance, finance and the annual report and accounts. These are timed to link with the governors' work programme. There is also, a 'governor-only' area on the Trust's website for sharing information electronically and for online discussion. Many governors have also attended external events hosted by the Foundation Trust

Governor's Association, the Foundation Trust Network and the Audit Commission during 2009/10.

	Constituency	Attendance at meetings (Actual/Possible)
PUBLIC		
Mr Rashmi Agrawal	Lambeth Central	4/4
Mr Andy Alatise	Southwark Central	4/4
Ms Hedi Argent	Southwark Central	4/4
Ms Cherry Forster	Lambeth Central	3/4
Mr Tom Hoffman	Southwark North	4/4
Ms Saleha Jaffer	Lambeth South	3/4
Mrs Anne Macnaughton (resigned 5 November 2009)	Southwark North	2/3
Mr Timothy Mason	Lambeth South	3/4
Mr Michael Mitchell	Southwark South	4/4
Mrs Ann Mullins	Lambeth North	4/4
Mrs Christiana Okoli	Lambeth North	2/4
Ms Michelle Pearce	Southwark South	3/4
PATIENT		
Mr Paul Corben	Patient	3/4
Mr Thomas Duffy	Patient	4/4
Mr Andy Glyn	Patient	4/4
Ms Pida Ripley	Patient	3/4
Mrs Jan Thomas	Patient	4/4
Mrs Sue Yoxall (resigned February 2010)	Patient	3/3
STAFF		
Mr Anthony Agosu	Nurses and Midwives	3/4
Professor Bruce Hendry	Medical & Dentistry	3/4
Mrs Rowenna Hughes	Support Staff	4/4
Mrs Fiona Hunter	Nurses and Midwives	4/4
Dr Mark Monaghan	Allied Health Professionals	3/4
Mr Brady Pohle	Administration, Clerical and Managerial	3/4

NOMINATED

Mr Kevin Barton (resigned January 2010)	Lambeth Primary Care Trust	0/3
Ms Caroline Hewitt (nominated January 2010)	Lambeth Primary Care Trust	1/1
Mr Stuart Bell	South London & Maudsley NHS Foundation Trust	3/4
Mr David Noakes	Southwark Council	4/4
Professor Sir Lawrence Freedman (resigned July 2009)	KCL	0/1
Mr Chris Mottershead (nominated July 2009)	KCL	0/1
Ms Mee Ling Ng	Southwark Primary Care Trust	4/4
Cllr Betty Evans-Jacas (resigned January 2010)	Lambeth Council	1/2
Cllr Marcia Cameron (nominated January 2010)	Lambeth Council	0/1
Professor David Sines (resigned June 2009)	London South Bank University	2/3
Ms Anne Garvey (appointed June 2009)	London South Bank University	1/1
Mr Frank Wood	Joint Staff Committee	4/4

To view the register of interests for our Board of Governors, please contact the Trust Secretary 020 3299 4939.

GOVERNOR GROUPS AND COMMITTEES

Nominations Committee

The Nominations Committee of the Board of Governors, was established in 2007 and comprises:

Michael Parker	Trust Chair (and Chair of the Committee)
Ann Mullins	Public Governor (and Vice Chair of the Committee)
Dr Mark Monaghan	Staff Governor
Tom Hoffman	Public Governor
Tim Smart (from 01 November 2008)	Chief Executive
Angela Huxham	Executive Director of Workforce Development

The Committee met three times in 2009/10. The work of the Committee this year has included the following:

- Review of remuneration for the Chair and non-executive directors.

- The recruitment of a non-executive director to fill the vacancy open from 1 November 2009.

- The reappointment of Michael Parker, Chair (including the process of reappointment).

The agreed process of appointment to non-executive director posts includes open advertising and the use of an external search consultancy.

Governors contribute to a variety of issues through working groups and committees. These include:

Transport Working Group, which assesses local transport issues and is developing a lobbying strategy to influence key decision-makers and help improve access to King's. The group has helped to speed up the re-development project for Denmark Hill railway station and to press for the continuation of rail services for patients and staff.

Patient Experience and Safety Committee, to act as an expert reference group for the Trust's planned activity around patient experience and safety and to act as a focal point for the governors' commentary to the Trust's Standards for Better Health annual declaration.

Membership Committee, which reviews the membership development strategy ensuring that membership continues to be representative; identifies ways in which the membership can be more actively involved and facilitates communication between governors and the membership.

Strategy Committee, which reviews the Trust's strategy and annual plan, and feeds back to the Board of Governors.

MEMBERSHIP REPORT

Membership development

The Trust's membership development strategy was reviewed during the year. The three year strategy (2008-11) outlines our plans for involving and growing the membership.

This strategy is based on the following principles:

- To make King's College Hospital a successful membership organisation.
- Our membership is as representative as possible in terms of disability, age, gender, sexuality, ethnic background and faith, reflecting the local community which King's serves.
- Our membership is involved in the work of King's and has a real say in how the organisation develops.
- The Board of Governors has a key role in overseeing the development of the membership and reviewing progress against targets.
- King's is committed to achieving our objectives but recognises that the process of building an active membership requires long term commitment, resources, and investment.
- King's aims to promote understanding of how membership links local people to King's.

The following objectives are the main focus for membership development over the three years of the strategy:

- To develop a membership that is representative and reflective of the communities served by King's.
- To develop an informed membership by providing appropriate, accurate and timely information to our members to assist them in making informed contributions.
- To develop an involved membership where as many members as possible are actively engaged in the development of King's and its activities.
- To maintain an efficient and cost-effective structure for managing and developing our membership systems.

These objectives are supported by a membership development action plan which will be reviewed by the Membership Committee of the Board of Governors who will report progress annually to the Board of Governors.

Our membership is split into three constituencies: public, patient and staff.

Public membership - anyone who is 16 years old or over and lives within the Boroughs of Lambeth or Southwark is entitled to become a public member.

Patient membership - anyone who is 16 years old or over and lives outside of Lambeth and Southwark and has been a patient of King's in the last six years or has been a carer of a patient of King's in the last six years can become a member.

Staff membership - all staff of the Trust who have contracts with no fixed term are automatically members unless they choose to opt out. Staff membership also includes employees of other companies based at King's who provide services for the Trust.

At 31 March 2010 the Trust had 14,487 members, comprising:

- 6431 - Staff
- 4027 - Public
- 4029 - Patient

A representative membership
Our public and patient membership is largely representative of the communities King's serves in terms of ethnicity and gender. However, King's has fewer members in the 16-35 age category than in the local area. King's has been trying to address this by collaborative working with local universities and further education colleges including KCL, London South Bank University and Lambeth College to promote membership and involvement to younger people. King's also aims to increase membership through wider distribution of application forms with patient surveys and publications.

King's is tracking progress using a more detailed age breakdown than the standard age categories required by Monitor. We recruited 122 members younger members aged 16 - 35 during the year. There was a slight overall reduction in this age category from 1,046 in 2008/09 to 929 in 2009/10. A decision to recruit using cost neutral methods in the coming year may impact on our ability to achieve the target of 1,000 new younger members by March 2011.

An involved membership
King's undertakes a number of regular initiatives. These include:

- A regular newsletter, which updates the membership on events at King's and highlights opportunities to get more involved in the Trust.

- A programme of members' seminars on public health and how services are structured and delivered.

- A digest of our annual report and notification of all Board of Governor meetings.

- A members' section on the website giving useful up-to-date information and news.

Members have also been asked to identify clinical areas of interest to them and King's has recorded this information on its database. By targeting those members who already have an established interest in particular areas, King's can both address their desire for further involvement and our wish to get more user involvement in the day-to-day running of different areas of the hospital.

Our annual programme of members' seminars, now in its third year, has provided information about specific services and conditions and King's has sought to deepen understanding about King's with a series of community events.

These were organised with a primary focus on:
- Engaging the membership and consult with our constituencies about our plans for the future

- Providing an opportunity to introduce King's members to the governors - their elected representatives.
- Demonstrating how King's anticipates its relationship with stakeholders will develop.

In 2010 King's held three community meetings at the hospital and in our membership constituencies for foundation trust members. The aim of these meetings was to allow members to engage with their governors and senior managers, give feedback on the Trust's forward plans and learn about key clinical services.

Members can contact their governors via the King's website, or through the Foundation Trust Office.

Foundation Trust Office
King's College Hospital
FREEPOST NAT 7343
London SE5 9BR

Email: members@kch.nhs.uk <mailto:members@kch.nhs.uk>

Tel: 020 3299 4939

APPENDICES TO THE QUALITY REPORT

Annex: Statements from PCTs, LINks and OSCs

A copy of KCH's draft Quality Report was sent to colleagues at NHS Southwark, Southwark OSC, Lambeth OSC, Southwark LINk and Lambeth LINk. Please see below detailed statements from these organisations.

Annex 1: Statement from NHS Southwark[19]

"In line with the NHS (Quality Accounts) Regulations 2010 (1/4/2010), NHS Southwark gratefully receives the draft Quality Report for 2009/10 FROM King's College Hospital NHS Foundation Trust (KCH). NHS Southwark has checked the accuracy of the information contained in the draft document and can confirm the accuracy of the content provided.

The KCH Quality Report for 2009/10 will be formally presented to the Integrated Governance Committee of NHS Southwark on 24th June 2010. NHS Southwark has defined monitoring arrangements agreed with the Governance Leads at KCH. These currently consist of the attendance of the Medical Director, Associate Director of Quality & Governance and the Head of Risk Management at KCH's Patient Safety & Quality Committee, Governance Committee, Director's meetings and Round Table discussions for Serious Untoward Incidents (SUIs). The Head of Risk Management at KCH promptly notifies all SUIs to NHS Southwark as they occur and provides the full SUI report on completion of the investigations with root causes identified.

KCH has participated well in national clinical audits and national confidential enquiries and demonstrates commitment to improving quality through participation in clinical research. KCH has delivered significant improvements under the CQUIN scheme. KCH implemented an improved action plan addressing 6 recommendations made by the CQC on its inspection on Hygiene Code compliance.

NHS Southwark contributes to the arrangements that were set up through the LSL Alliance. The LSL alliance was set up to lead on commissioning acute services for the residents of Lambeth, Southwark & Lewisham. The LSL Alliance's paper "Higher Quality Acute Care" outlined the cornerstones of the quality approach including a Quality Schedule, a Quality Portal, Quality Summit, Quality Commissioning Structure, CQUINs and Quality Accounts. Quality Review meetings were set up to assure the contents of the Quality Accounts. NHS Southwark is committed to work closely with KCH and sector colleagues to ensure high quality services and enable continuous improvement.

Four key quality priorities were approved by KCH Board of Directors and key positive results at KCH showed that:

- There have been no 'Never Events' (serious largely preventable patient safety incidents that should not occur of preventable measures by healthcare providers. KCH has taken action to prevent Never Events from happening;
- Enhanced mortality performance through monthly monitoring via the monthly Mortality Monitoring Committee and strengthened governance structures,

[19]Statement received from Maggie Aiken, Associate Director of Governance at NHS Southwark.

processes and systems, Physiological Observation Track and Trigger system (POTTs) and strengthened coding system resulting in a 19% improvement in 2009/10 compared to 2008/09;

- Reductions in Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C.diff); and
- Patient experience has improved and an innovative 'Board Go & See' programme has been established. KCH ranked the top among London Acute Teaching Hospitals and 3rd among all London Trusts on the 2009 National Outpatient Survey."

Annex 2: Statement from NHS Lambeth[20]

"The draft King's College Hospital (KCH) Quality Report 2009/10 was considered by NHS Lambeth. We welcome the opportunity to feed back on this document.

NHS Lambeth enjoys an excellent relationship with KCH and are committed to working closely with sector colleagues to ensure the ongoing delivery of high quality services. NHS Lambeth has a process for regularly reviewing quality issues with each of our main providers at our Quality and Governance Committee meeting and received a presentation from KCH in February 2010.

The Trust has worked hard to address issues highlighted in the Care Quality Commission Hygiene Code compliance visits during 2009 and it is pleasing to note the objective to exceed infection control target reductions as one of its chosen priorities for 2010/11.

KCH participated with a significant proportion of national clinical audits and all relevant confidential enquiries in the year April 2009 to March 2010. The identified actions taken as a result of both national and local clinical audits to improve services and inform further quality improvement developments are encouraging."

Annex 3 Statement from Southwark LINk[21]

"LINk Southwark would like to thank King's College Hospital Foundation Trust for providing a copy of their draft Quality Account 2009/10. However, the LINk Southwark does not have any comments to submit. The LINk looks forward to receiving the Trust's Quality Account for 2010/11 which will be presented to the LINk members for comment."

Annex 4: Statement from Lambeth LINk[22]

"We are immensely proud that King's College Hospital in Lambeth is rated as the top one "among London acute hospitals and the 3rd among all London trusts on "(sic)" 2009 national outpatient survey although it seems a pity to present its 6 rivals anonymously (page 7 of the draft Quality Report). If they too quoting their own ranking they will not be anonymous but the readers has the trouble of searching through separate reports to find out[23].

[20] Statement received from Marion Shipman, Assistant Director of Clinical Quality and Governance at NHS Lambeth.
[21] Statement received from Southwark LINk.
[22] Statement received from Michael English, Chair of Lambeth LINk.
[23] Added names of all London trusts on the 2009 outpatient survey results (page 9).

This report is of a high standard, like its subject matter, but it is a pity that we were only given 13 days (9 working days) to consider it and respond by 17 May as KCH requested. In spite of several requests by us to KCH, after Quality Reports had been received from other Trusts in Lambeth, we only received KCH's draft on 4th May. We hope that this response time is increased next year, which will enable us to comment upon the report more fully.[24]

We would make one general comment upon this and all other Quality Reports. When they were considered by focus groups before being required by law after the Health Act 2009, a comparison was made with financial accounts which are published together with, at least, an auditor's general view after an audit report. A focus group recommended that NHS quality accounts should similarly be accompanied by an independent view from an organisation which is not the trust reporting. We concur with this recommendation and invite KCH to consider it.[25]

"Regular reports on progress … will be reported to the Board of Directors and governors and available on KCH intranet." Fine, but is there any reason not to put requests (as most of them) on the web generally and provide hard copies to individuals not able to access them? Lambeth and Southwark are central London boroughs with large numbers of citizens using up-to-date technology AND large numbers of relatively poor people on benefits[26].

We note (page 12 of the draft Quality Report, paragraph 2, 3 &4) that KCH did not apparently agree its 2009/10 CQUIN quality improvement and innovation goals with Lambeth PCT, though most of KCH is in Lambeth. We welcome the proposal to agree the CQUIN scheme for 2010/11 with Lambeth, Southwark and Lewisham (Page 13 of the draft Quality Report). Because, under certain NHS administrative arrangements, KCH is accountable to Southwark PCT, KCH staff occasionally deny that KCH is in Lambeth, which irritates Lambeth residents. Bureaucracy does not alter geography.

We hope that in future years some clarification will be given to every sentence included in the appendices to the report, e.g. "KCH's average waiting time for MRI is under 4 weeks for weekends (national average = 32%) and weekends (national average = 20%)" (page 24 of the draft Quality Report) does not convey a clear meaning. "Patients receiving primary angioplasty at KCH was "(sic)" 98%" (national average = 49%) of what? is neither grammatical nor mathematically clear.[27]

Nevertheless, subject to the above, it was a pleasure to read the KCH Quality Report 2009/10 by comparison with some others."

Annex 5: Statement from Southwark OSC[28]

"Thank you for forwarding a copy of King's draft 2010 Quality Account (QA).

[24]KCH will ensure future draft Quality Report is sent to Lambeth LINk in April.
[25]KCH piloted an independent audit of its Quality Report 08/09 and the audit report concluded that "an assessment of **substantial assurance** has been made". KCH Quality Report 09/10 will be audited independently prior to publication.
[26]KCH Quality Account 09/10 will be available on NHS Choices and hard copies will be available on requests.
[27]Changes have been made as suggested.
[28]Statement received from Shelley Burke, Head of Scrutiny at London Borough of Southwark.

Unfortunately, the DH prescribed timescale for the 2009/10 QAs prevents a Southwark OSC review and comment on this year's QA from being feasible. In view of the request to provide feedback by 14 May, this afforded only a short window of time in which the sub-committee could review the QA, agree and prepare a response.

Under more ordinary circumstances, a request for swift feedback may be manageable by the committee agreeing to a special meeting. During the recent Purdah period, however, this was not viable. In accordance with Southwark's Purdah rules, and advice from the council's Monitoring Officer, no scrutiny meetings were scheduled between 29 March and the 6 May election. Moreover, in view of the constitutional formalities required post elections and new member induction, scrutiny members are not likely to consider actual scrutiny issues until late June.

It may be reasonable to integrate a review process into the committee's work programme for future annual QA cycles (subject to members' approval), and we look forward to discussing this with you.

As we understand that the imposed QA timescale is not something that you have been able to control, we are forwarding a copy of this letter to the Department of Health. We would similarly welcome you to refer to our concerns in feedback that you may provide to the DH on the 2010 QA process.

In view of the reasons outlined above, we regret that Southwark's OSC will not be submitting a statement on the KCH Quality Account for 2010. "

Annex 6: Statement from Lambeth OSC[29]

"Thank you for inviting Lambeth Council's Health and Adult Services Scrutiny Sub Committee to comment on the draft King's College Hospital Quality Report 2009/10.

In view of the difficult timeline associated with the process this year, including the late issue of guidance and the May local council elections, I regret that the committee is not in a position to formally consider the report. However I am sure that the scrutiny committee will welcome early engagement on the development of trust's Quality Report next year."

Annex 7: Statement from KCH to set out key changes made following receipt of written statements

KCH acknowledges and appreciates the written statements received from PCTs, OSCs and LINks. The following key changes have been made in the final version of this Quality Report:

- Added the audit results for WHO Surgical Safety Checklist on page 26.
- Included names of London Trusts on the 2009 Outpatient Survey results. Please see Table 2-2 on page 32.
- Added explanation for the 2009 National Outpatient Survey scores. Please refer to footnote 8 on page 31.

[29] Statement received from Tom Barrett, Scrutiny Manager at London Borough of Lambeth.

- Added a summary of KCH's 2009 National Inpatient Survey results on the last paragraph of page 32.
- Added a summary of KCH's quality priorities in 2010/11 in Section 2.2 on page 33.
- Updated the objectives for quality priorities 2010/11 in line with KCH's Annual Plan. Please see Table 2-3 on page 34.
- Added the arrangements in place with LSL on quality monitoring in 2010/11 on the second paragraph of page 35.
- Added the exact wording instead of a summary of Mr Michael English's statement on behalf of Lambeth LINk on page 89-90.
- Grouped national audits under key headings and added additional national audits in Appendix 1.

Appendix 1: KCH's Participation in National Audits 2009-10

The national clinical audits in which KCH was eligible to participate, in which KCH actually participated and for which data collection was completed during 2009/10, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audits	KCH participation	Reporting period	Number of cases submitted as a percentage of the number of cases required by the terms of the audit
1. Cancer			
Head and Neck (DAHNO)	N/A	Head and neck cancer patients are treated at Guy's and St Thomas'.	N/A
National Lung Cancer Audit	Yes	January - December 09	100%
National Mastectomy and Breast Reconstruction Audit	Yes	1 January 08 – 31 March 09	38 cases submitted; information on the number of cases required/expected is not provided in report.
National Oesophago-gastric Cancer Audit	Yes	All patients diagnosed up until 31/3/09 and all treatments received by patients diagnosed up until 30/9/08	8 cases
National Bowel Cancer Project	Yes	April 06 to July 08	80.2%
2. Cardiac			
Adult cardiac surgery: CABG and valvular surgery	Yes	to March 08	Information not provided in national audit report.
Cardiac Ambulance Services	N/A	This audit is only applicable to ambulance services	N/A
National Infarct Angioplasty Project (NIAP): Adult cardiac interventions: coronary angioplasty	Yes	2009-10	Audit report not yet available.
Congenital Heart Disease: paediatric cardiac surgery	Yes	2009-10	Audit report not yet available.
Heart Failure Audit	Yes	2009-10	Audit report not yet available.
Heart Rhythm Management	Yes	2009-10	Audit report not yet available.
Myocardial Ischaemia National Audit Project (MINAP)	Yes	2009-10	Information not provided in national audit report.
3. Long-term conditions			

National Audits	KCH partici-pation	Reporting period	Number of cases submitted as a percentage of the number of cases required by the terms of the audit
National Diabetes Audit (NDA)	No	KCH has participated in the National Inpatient Diabetes Audit, coordinated by NHS Diabetes; the national audit of DAFNE – the diabetes patient education programme; and the Association of British Clinical Diabetologists Exenatide Audit. In addition, the diabetes team undertake a comprehensive rolling programme of clinical audit including insulin initiation; continuous subcutaneous insulin infusion 'CSII pump' treatment; and care of pregnant women with diabetes. KCH intends to participate in this project in 2010-11.	n/a
Inflammatory Bowel Disease (IBD)	Yes	1st September and 31st December 2008	Audit report not yet available.
National Pain Database Audit	Yes	First cycle.	Audit report not yet available.
Renal Registry: renal replacement therapy	Yes	2009-10	98.7% (average data completeness)
4. Mental Health			
National Audit of Dementia	Yes	2009-10	Audit report not yet available.
Psychological therapies	N/A	Not applicable to acute trusts	
Treatment Resistant Schizophrenia (TRS)	N/A	Not applicable to acute trusts	
5. Older People			
Carotid Interventions (preventing stroke)	Yes	1st January 08 and 30 September 09	Audit report not yet available.
RCP Continence Care Audit	Yes	December - March 2010	125% - 100 cases submitted, 80 required.
National Falls and Bone Health Audit: 1). Hip fracture 2). Organisational 3). Patient experience	Yes	2008	Information not provided in national audit report.
National Hip Fracture Database (NHFD): hip fracture	Yes	Oct-07 to Sep-08	Information not provided in national audit report.
National Sentinel Stroke Audit	Yes	Apr-09 to May-09	100%
6. Women and Children's			
Epilepsy 12	Yes	First cycle	Audit report not yet available.
Heavy Menstrual Bleeding	Yes	First cycle	Audit report not yet available.

National Audits	KCH partici-pation	Reporting period	Number of cases submitted as a percentage of the number of cases required by the terms of the audit
National Neonatal Audit Programme (NNAP)	Yes	Jan-06 to Jan-08	100%
Paediatric Intensive Care Audit Network (PICA Net)	Yes	2009-10	Information not provided in audit report.
National Audits as advised by the National Clinical Audit Advisory Group (NCAAG)			
Case Mix Programme Database (CMPD) ICNARC: adult critical care units	No	KCH plans to submit data from April 2010	n/a
National Elective Surgery PROMs: 1). Hip replacement 2). Knee replacement 3). Hernia 4). Varicose Vein	Yes	1 April 09 to 30 November 09	All procedures: 42.6% Hip Replacement: 71.2% Knee Replacement: 62.7% Varicose Vein: 29.2% Groin Hernia: 22.4%
National Vascular Database VSD - Vascular Society of Great Britain and Ireland (VSSGBI)	Yes	2009-10	7 submissions; information on the number of cases required/expected is not provided in report.
CEMACH: perinatal mortality	Yes	2009-10	100%
National Joint Registry (NJR): hip and knee replacements	Yes	2009-10	Information not provided by Registry
Pulmonary Hypertension Audit	No		n/a
Trauma and Audit Research Network (TARN): severe trauma	Yes	2009-10	21-40%
NHS Blood & Transplant: intra-thoracic; liver; renal transplants	No	KCH has signed-up to participate in the liver transplant project from 1 Apr-10	n/a
NHS Blood & Transplant: potential donor audit	Yes	Apr–Sep 09	20% - data currently being verified
2. Intermittent samples of patients			
National Kidney Care Audit (2 days): Patient Transport	Yes	15-16 Oct-08.	80%

National Audits	KCH partici-pation	Reporting period	Number of cases submitted as a percentage of the number of cases required by the terms of the audit
National Comparative Audit of Blood Transfusion: 1). Audit of the Blood Collection Process 2). Audit of the use of red cells in neonates & children 3). Repeat use of 'O' Negative blood audit 4). Re-audit of the use of platelets	Yes	1. Jun-09 2. KCH will be participating 2010 3. Information not currently available 4. Jun – Oct-06	1. 100% 2. n/a 3. n/a 4. 100%
British Thoracic Society: respiratory diseases 1). Adult Community Acquired Pneumonia 2). Non-invasive ventilation (Adult) 3). Paediatric Pneumonia 4). Adult Asthma 5). Emergency Oxygen 6). Paediatric Asthma 7). 2010 National Pleural Procedures audit	Yes	1). In progress 2). Information not currently available 3). Information not currently available 4). 1 Sep-09 to 15 Jan-10 5). Information not currently available 6). Nov-09 7). Information not currently available	National audit reports not yet available
College of Emergency Medicine: pain in children; asthma; fractured neck of femur	Yes	2009-10	Pain in children – 100%; Asthma – 100%; Fractured neck of femur – 88%

Appendix 2: Actions taken as a result of KCH's participation in national audits 2009-10

National Audit	Headline results and actions taken
Heart Rhythm Management	Data submission was increased to quarterly for 2009. KCH now has the appropriate database and is capturing and validating the data for more detailed data completeness and quality audit.
Paediatric Intensive Care Audit Network (PICA Net)	The 2009 report did not provide any recommendations or quality of care information.
National Elective Surgery PROMs: 1). Hip replacement 2). Knee replacement 3). Hernia 4). Varicose Vein	The survey processes have been improved in all areas, especially day surgery, in order to improve response rates.
National Infarct Angioplasty Project (NIAP): Adult cardiac interventions: coronary angioplasty	Results from the 2008 report of the National Infarct Angioplasty Project did not provide any recommendations or any quality of care information.
National Vascular Database VSD - Vascular Society of Great Britain and Ireland (VSSGBI)	The Vascular Database Report 2009 is a national registry of activity and does not provide recommendations or quality of care information for local implementation
CEMACH: perinatal mortality	The Perinatal Mortality 2007 report, published in 2009, highlights risk factors associated with the death of babies during or shortly after birth. These are well known to KCH's and already influence our services, e.g. specialist care for teenage mothers, transfers to the neonatal team, assessment of maternal risk factors. The following key actions have been taken specifically as part of the implementation of the recommendations from this report: • First appointments are now given to all women within 10 working days of receipt of the referral, including self-referral. • The KCH's maternity booking letter has been changed to advise GPs that they must perform physical health checks, BMI measurements and obtain sickle status for all migrant women. • An early warning score has been implemented within maternity services. • Guidelines for the care of women with a high BMI have been produced.
NJR: hip and knee replacements	The National Joint Registry records activity but does not provide recommendations for local implementation. It does show, however, that KCH's consent-taking has improved from 81% in 2009 to 89% in 2010.
Renal Registry: renal replacement therapy	The Renal Registry records activity but does not provide recommendations for local implementation.
National Lung Cancer Audit	In the National Lung Cancer Audit report 2008 (published 2009) KCH scored above the national average in the following areas: • Histological diagnosis made (best practice) – KCH's: 76.2% (national average: 67.7%) • Discussed at multi-disciplinary team meeting – KCH's: 99% (national average: 87.2%) • Resection rate: KCH: 13% (national average: 10%). Action is being taken to improve the proportion of patients receiving active treatment.

National Audit	Headline results and actions taken
National Bowel Cancer Project	In the National Bowel Cancer Audit Report 2009, KCH's scored 100%, or near 100%, against national standards in several areas: • Patients seen by specialist nurse: KCH: 97.6% (national average: 51%) • Patients requiring surgical treatment had a CT scan: KCH: 100% (national average: 62%) • Patients requiring surgical treatment had an MRI scan: KCH: 100% (national average: 52.3%) • Patients had pre-operative radiotherapy: KCH: 100% (national average: 32%) There are some key areas in the national audit report that do not reflect KCH's actual practice and the bowel cancer team have worked hard over the past year to improve the data returns to the national audit.
Adult cardiac surgery: CABG and valvular surgery	Results for 2004-08 were of activity and did not include recommendations or quality of care information for local implementation or action.
Myocardial Ischaemia National Audit Project (MINAP)	MINAP results 2008/9 show that: • 98% of patients suffering from Myocardial Ischaemia at KCH received primary angioplasty (nationally 47%) • 82% of nSTEMI patients were seen by a cardiologist at KCH (nationally: 80%) • Patients discharged on the appropriate secondary prevention drugs: - Aspirin: KCH's score was 100% (national average: 99%) - Beta blockers: KCH's score was 97% (national average: 93%) - Statins: KCH's score was 100% (national average: 97%) - ACE inhibitor: KCH's score was 80% (national average: 92%) - Clopidogrel: KCH's score was 99% (national average: 94%) KCH is working to improve the number of patients discharged on an ACE inhibitor.
National Hip Fracture Database (NHFD): hip fracture	A number of measures have been instituted as a result of the 08/09 report including: • extra trauma lists to reduce waiting times to surgery • reduced waits in A&E • improved ward rounds with Care of the Elderly. These have resulted in improved mortality rates this year. KCH has internally audited several of the 6 main guideline outcome measures at least twice this year, with improved results on last year.
Trauma Audit Research Network (TARN): severe trauma	TARN data 2006-09 demonstrates that KCH achieved: • 2.8 additional survivors out of every 100 patients, i.e. for every 100 patients, nearly 3 patients survived who, due to their injuries, were not expected to survive • This amounts to a total of 33 people, who were not expected to survive, survived at KCH • The median time for head injury patients to have a CT scan at KCH was 1.27 hours (national average: 1.32 hours).

National Audit	Headline results and actions taken
National Kidney Care Audit (2 days): Patient Transport	The results for KCH reported in 2010 (survey undertaken in 2008) show that waiting times for renal patients for hospital transport are very similar to the national average: • % patients who are picked up from home within 30 minutes: KCH scored 72% (national average: 74%) • % patients who wait 30 minutes or less after completing dialysis before commencing journey home: KCH scored 63% (national average: 62%). Renal service at KCH is working with Patient Transport to improve upon these waiting times. Actions taken so far include: • patient appointment times are in place • shift coordinators are improving the way appointments are organised for patients who travel together, to reduce waits at the end of the session.
National Sentinel Stroke Audit	The results from the National Sentinel Audit of Stroke report 2009 demonstrate that: • KCH provides all of hyperacute, acute and rehab services (nationally: 48% of sites provide all) • KCH admits all patients to a specialist Acute Stroke Unit (ASU) (nationally: 24% of sites admit to a specialist ASU) • KCH provides thrombolysis for all relevant stroke patients (nationally: 66% of sites provide thrombolysis) • KCH provides 24 hour thrombolysis (nationally: 27% of sites have 24 hour thrombolysis) • The average waiting time for CT scanning is under 4 hours for weekdays at KCH (nationally: 32% and 20% of sites achieve 4 hours average waiting time during weekdays and weekends respectively. • KCH's average waiting time for MRI is under 4 hours for weekdays and weekends (nationally: 5% and 1% of sites achieve 4 hours average waiting time during weekdays and weekends respectively. • The average waiting time for carotid doppler is under 4 hours for weekdays at KCH (nationally: 10% and 0.1% of sites achieve 4 hours average waiting time during weekdays and weekends respectively. KCH is the only site that achieves this standard. • The average time between diagnosis and carotid surgery is under 1 week at KCH (nationally: 18% of sites achieve the 1 week target) For the organisational audit, KCH scored 93/100 (the average national score: 74.8)
National Comparative Audit of Blood Transfusion: 1). Audit of the Blood Collection Process 2). Audit of the use of red cells in neonates & children 3). Repeat use of 'O' Negative blood audit 4). Re-audit of the use of platelets	Trustwide compliance with 100% 'tag' return for positive confirmation of blood transfusion was not achieved (Trust position circa 98%). Actions taken to improve include: fridge locks in place, monthly feedback to Divisions provided along with mini forums to support change, business case approved for full electronic tracking system facilitating compliance with EU requirements, 100% of staff to have blood transfusion competency assessed by November 2010. Transfusion Training classes and competence set up. The other audit results are not yet available.
National Mastectomy and Breast Reconstruction Audit	The estimated case ascertainment at KCH was 76-100%, above the national average of 74%. The report states that this 'reflects considerable leadership amongst breast surgeons, plastic surgeons and breast care nurses.'

National Audit	Headline results and actions taken
National Oesophago-gastric Cancer Audit	An internal review underway to ascertain why the sample submitted by KCH appears to be low - clinicians estimate that it is probably accurate and is due to casemix.

Appendix 3: Actions taken as a result of KCH's participation in local audits 2009-10

Clinical Audit	Actions to improve quality of care
Programme of Hand Hygiene and Saving Lives Audits	Currently exploring other platforms for use with Saving Lives programme to ensure easy extraction of information
Risk assessment model for venous thromboembolism in hospitalised medical patients	To introduce electronic risk assessments
Documentation of drug allergy status	To continue ongoing monitoring.
Infection rates following dermatological surgery	Grade IV procedures and above all to have TTA topical antibiotic. Continue MRSA screening in planned Mohs cases.
Intra-op complications - cataract surgery	To review local guidelines, especially around fluid prescriptions and the use of NAC.
Stroke Thrombolysis	Continue monthly meetings and involve staff at all levels.
Epidural Analgesia audit of practice	Continued training sessions-deadlines for completion/review. Re-audit annually
First evaluation of Diabetes and Mental Health	To train diabetes specialist nurses in psychological skills and to provide more psychological treatments by the clinical psychologist.
Myocardial ischemia - STEMI vs. nSTEMI	To devise a prospective protocol to study conditions events in the immediate post-infarct period. To fast-track echocardiography for all Acute Coronary Syndromes (ACS) in the future.
Phlebotomy	To collect data more efficiently with new software and continuously monitor implemented changes.
Physiological Observation Track and Trigger System (POTTS) chart	All staff involved with taking and recording patient observations to receive the appropriate training. To review and improve POTTS chart.
Theatre Safety Checklists - Safe Surgery Saves Lives	To create further opportunities for clinicians to be more engaged in embedding the use of the Checklist. Day Surgery Unit to pilot a new format of the Checklist which includes a team briefing before the start of a list – this incorporates some aspects of the existing 'Sign In' and 'Time Out' checks. This will allow a more streamline process for use in a high surgical volume area by reducing unnecessary repetition where it is safe to do so and improving staff communication and team work. Theatre IT system provider to review electronic capture facility as part of the theatre record in conjunction with other Trusts. This initiative will continue to roll over into 2010.
Resuscitation	Resuscitation department will continue to do spot checks of suction and will report back to Assistant Director of Nursing. 242 staff have been trained and are going to cascade training to the other members of their teams. To implement a new IT system in the next six months.
New Clinical Procedures	Implementation of divisional feedback through divisional reports/scorecards.

Public Health: alcohol	Action plan in place to carry out a census on patients with alcohol-related health problems which will then support service development.
Consent	New post-mortem consent form and pilot of paperless post-mortem consent on EPR. New Form 4. Improvement in monitoring of staff training. New 'paperless' consent form being prepared for pilot on EPR. To undertake a trust-wide audit of consent and implement improvements as appropriate.
JACIE Accreditation for Bone Marrow Transplant service	Ongoing audits to be done in accordance with JACIE accreditation requirements (79 audits on total).
Directors' Go See/patient safety' inspections	Local action plans created and being followed up.
Colposcopy peer review	Action plans to address DNA rate and waiting times in place. Working collaboratively with colleagues at Guy's & St Thomas's on joint peer review process.
Telemetry audit	Telemetry audit highlighted a number of concerns, action plans being developed to bring about improvements.
Blood transfusion	Work on-going to reduce wastage.

Appendix 4: Draft KCH CQUIN Scheme 2010/11

National CQUIN

Description of goal	Quality Domain	Indicator name
Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety	VTE risk assessment
Improve responsiveness to personal needs of patients	Patient experience	Composite indicator on responsiveness to personal needs from Adult Inpatient Survey

Regional CQUIN

Description of goal	Quality Domain	Indicator name
To improve patient safety through the systematic implementation of validated approaches	Safety, effectiveness, experience	Implement the IHI Global Trigger Tool
		Implement the Enhanced Recovery Programme (ERP)
Increase effectiveness of **inpatient** discharge information	Safety / Effectiveness	• Improve quality of discharge summaries • Majority of discharge summaries to be sent electronically
Supporting effective discharges within a hospital setting	Safety / Effectiveness	Increase in numbers of patients going home on their agreed date, percentage of discharges that occur by twelve noon and increased percentage of weekend discharges
Increase effectiveness of **outpatient** care planning	Effectiveness	• Improved quality of discharge letter for new outpatients • Significant increase in new out-patients who have a letter sent to their GP and any other relevant primary care clinician within five days
Implement HfL dementia pathway in acute hospitals	Effectiveness Patient Experience	HfL, Dementia Services Guide: Achievement of milestones in the implementation of the general hospital care pathway
To improve the care, safety and experience of patients with defined long-term conditions: diabetes, COPD and heart failure**.**	Effectiveness Safety Patient Experience	Reduction in emergency re-admissions within 14 and 28 days for the following long-term conditions as primary diagnosis: COPD, heart failure and diabetes, by optimising care for these patients through following evidence-based practice and engaging with primary and community care.

Appendix 4 continued

Local CQUIN

Description of goal	Quality Domain(s)	Indicator name
A&E to emergency admissions conversion rate	Effectiveness	Action to reduce the A&E attendance to emergency admissions conversion rate to % over 2010/11.
Consultant to Consultant referrals	Effectiveness	Action to reduce the absolute numbers of Trust-wide consultant to consultant referrals to first outpatient attendances relative to 2009/10 by %.
Follow-up to new ratios	Effectiveness	Action to reduce the absolute numbers of Trust wide outpatient follow ups
The provision of outpatient subspecialty audit data	Effectiveness	The provision of outpatient subspecialty audit data
To improve the effectiveness of A+E discharge information	Patient Experience Effectiveness	Improved quality of information
		Increased timeliness – electronic sending of A+E discharge information to GPs
To improve the health of the population by delivering effective stop smoking advice to smokers	Patient Experience	To establish referral pathways to improve the health of the population by delivering effective smoking cessation advice to smokers

Specialist Commissioning Services – CQUIN

Description of goal	Quality Domain(s)	Indicator name
Adult BMT	Clinical Effectiveness	Data Collection for Adult BMT activity – Med A and Med A annual follow up
HIV	Patient experience	Patients involved in decisions about their care and supported to self manage
	Effectiveness	Patients failing therapy re-suppressed within 6 months
		All patients with a CD4 <200 on therapy
		HIV patients with positive STI results accessing health advisor support
Neuro Rehab	Experience Effectiveness	Assessments will be carried out within two weeks
	Effectiveness	Inclusion, in the discharge report, of the measured change in patient's key rehabilitation scores (i.e. complexity and outcome) on discharge relative to scores on admission
PICU	Efficiency and productivity	To reduce the number of occupied bed days associated with LOS above 14 days

Appendix 5: KCH features good practice case studies in DH Quality Account Toolkit

King's College Hospital NHS Foundation Trust – board 'Go & See' initiative

In addition to the review of data around the board table, at King's College Hospital NHS Foundation Trust each board member sponsors three wards, which they are tasked to go out and see as part of the board 'Go & See' initiative. The focus of this is to offer the board the opportunity to talk to frontline staff, patients and relatives of the wards, giving them first hand knowledge of improvements being made and where further improvements are needed. The checklist focused on hygiene and environment initially. This is also replicated at senior nurse and divisional level, to ensure that the leadership of the organisation, both the board and the senior clinicians, are aware, assured and taking actions to improve hygiene levels and reduce infection rates.

Geraldine Walters, Director of Nursing

"The board 'Go & See' programme has been very helpful in enhancing board to ward communication and understanding. Ward staff have been very pleased to introduce members of the board to their areas and have found their interest and input both supportive and encouraging. This initiative is something we want to build on and expand in the future, widening the focus to incorporate safety and operational efficiency in addition to hygiene and cleanliness."

Rachael Wood, Matron in Gynaecology

"The 'Go & See' visits have been a powerful tool in making the Trust's quality agenda tangible to ward staff, prompting us to take ownership of our areas in a new way. This initiative has been of great value in assisting clinical staff in achieving the highest quality environment possible in a very visible way."

King's College Hospital NHS foundation trust – development of clinical scorecards

King's College Hospital has taken a structured approach to demonstrating clear leadership from the board in terms of reviewing the services provided by the organisation. It has incorporated quality measures into scorecards at trust, divisional and team level, and is in the process of finalising ward-level scorecards. At trust level, the scorecard pulls together a balanced list of national indicators of quality, which are reviewed monthly by the board. Clinical divisions, focusing on specific areas, also review performance on quality indicators monthly to ensure regular scrutiny of quality. A simple traffic light system helps identify areas that are weaker in performance and if an indicator is red for two months running, an action plan must be brought to the monthly performance meetings, chaired by the Director of Operations and regularly attended by the Medical Director and the Director of Nursing.

The divisional scorecards include trust-wide indicators, plus others chosen which relate specifically to quality of the services offered in that division. Team-level scorecards go into more detail on top of this. By reviewing data at all levels, the scheme allows individual teams and divisions to take action to improve quality in their areas. The standardised approach also allows comparison across divisions, so that where a low performance score occurs across all divisions on a particular area, it can be escalated through the scorecard system and a trust-wide approach can be taken.

Tim Smart, Chief Executive of King's College Hospital

"There is no doubt in my mind that as a result of the board focusing far more on quality, King's College Hospital delivers better care and is a better place to work."

Roland Sinker, Director of Operations

"By providing the right information to the right people at the right time, the performance and quality scorecards have enabled staff at all levels to focus on improving quality and efficiency at the same time."

7.32 NHS Connecting for Health is embarking on a pilot phase to develop Clinical Dashboards with providers of NHS services. Clinical Dashboards act as enablers to improve clinical quality and productivity. They provide a visual display of information, typically taken from a range of existing systems

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Trust name:	King's College Hospital NHS Foundation Trust
This year	2009/2010
Last year	2008/2009
This year ended	31 March 2010
Last year ended	31 March 2009
This year beginning	1 April 2009

FOREWORD TO THE ACCOUNTS

King's College Hospital NHS Foundation Trust

These accounts, for the year ending March 31 2010, have been prepared by King's College Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Signed: Date: 3 June 2010

Timothy Smart
Chief Executive Officer

Statement of Chief Executive's responsibilities as the accounting officer of King's College Hospital NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the National Health Services Act 2006, Monitor has directed King's College Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of King's College Hospital NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

- make judgements and estimates on a reasonable basis;

- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and

- prepare the financial statements on a going concern basis.

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

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

Signed:  Date: 3 June 2010

Timothy Smart
Chief Executive Officer

Statement of Internal Control

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of King's College Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in King's College Hospital NHS Foundation Trust for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust Board has overall accountability for the Trust's Risk Management Strategy through the Trust's Executive Directors. The Trust's Medical Director provides the lead, and is supported by a centralised Risk team. The Chief Financial Officer has accountability for the development, implementation and testing of the Trust's business continuity plan. The Trust operates a unified approach covering both clinical and non-clinical risks which are recorded on a computerised risk register. The Trust is committed to providing a learning environment for all levels of staff, to ensure that good practice is developed and disseminated to all areas of the organisation. This is achieved by;

- A commitment to individual appraisal and personal development planning for all staff
- Policies to encourage the reporting and investigation of adverse incidents (inc. near misses)
- A commitment to root cause analysis of problems and incidents and the avoidance of blaming and 'scape-goating'.
- A range of problem resolution policies and procedures, including capability, raising concerns, harassment and discipline, which are designed to identify and remedy problems at an early stage.
- A range of individual support mechanisms to encourage individuals to raise concerns about the own performance in ways which will not threaten their security or livelihood, e.g. appraisal, substance abuse policies, professional counselling and occupational health services.
- A range of clinical and non-clinical audit mechanisms.
- All staff are trained in these policies as part of the corporate and local induction policies and updated via regular staff briefings and the Trust intranet

The risk and control framework

The Trust operates a cyclical mechanism for the identification, evaluation and control of risk, facilitated by means of a central risk register. Local Risk Groups identify risks and potential hazards and formulate actions plans to deal with them. Each risk is scored on a common basis across the Trust for likelihood and potential impact. If risks cannot be satisfactorily resolved at a local level, they are considered by the relevant corporate risk management group. Unresolved risks are passed to the Governance Committee for either acceptance or resolution. If additional resources are required to reduce the risk to an acceptable level, this is considered by the Business Resource and Strategy Group and, if necessary by the Trust Finance Committee. Risks that have an above average consequence and likelihood are given priority in the resource allocation process.

In July 2009, the Board of Directors undertook an exercise to**:**

- Identify the key strategic, emerging and longer term risks to King's achieving its objectives
- Prioritise those risks in terms of impact and likelihood
- Assign risk owners

• Identify the next steps to integrate the risks identified into ongoing processes

The deliverable from the session was a top: down view of risk from the Board's perspective to complement the bottom: up view of risk, achieved through existing risk management processes.

These are regularly reviewed at meetings of the Board of Directors to ensure that these reflect the current priorities for the Trust and to incorporate any potential additional risks arising from the Trust's membership of the King's Health Partners Academic Health Sciences Centre and the current economic climate. These risks are also cross referenced to Standards for Better Health to ensure comprehensive coverage of the Trust's quality control obligations. An Assurance Framework has been developed to provide a system of independent assurance that the key risks are identified, managed and reviewed. These are then cross-referenced to internal control mechanisms designed to manage these risks and identify any shortfalls. Finally, the means by which the Board can receive independent assurance by various regulatory organisations is linked to each control and the effect on the overall risk rating for each risk achieved by successful operation of the control is quantified. The Board is, therefore, able to assure itself that the key risks to its strategic objectives are identified, managed, monitored and independently reviewed.

The Trust is currently conducting a review of its overall governance arrangements to ensure that responsibility and accountability of all aspects of its assurance processes are clear and defined.

In a review concluded in March 2010, the Trust's internal auditors provided 'substantial assurance' regarding the operation of the Trust's internal control and risk management framework.

You have reviewed and strengthened your process for determining compliance with SfBH. Accountability for each standard and the provision of evidence is clearly defined with each core standard having responsible officer and an implementation lead. A core review team was set up to review the evidence provided to support the declaration for each standard and risk ratings were used to focus attention on those standards considered more at risk. For seven standards we reviewed the evidence lists and the evidence provided, to ensure that the conclusions reached by the Trust were appropriate based on the evidence provided. In all cases we agreed with your conclusions. You have changed the format of your BAF so that it now includes an analysis of both gross and net risk, thus providing more transparency to users. Our review identified that the identification of risks is both top down and bottom up and that there is appropriate oversight of the key risks facing the Trust at Board and executive level.

KPMG – March 2010

During the past year, the Trust has continued undertaking substantial work in strengthening its Business Continuity Plans, including the implementation of a new computer based system to ensure that individual plans are coordinated across the Trust and that they are regularly tested. The Trust was accredited for its plans under British Standard BS25999 within the Emergency Department, the first NHS organisation to be accredited.

Information Governance is reviewed by the Governance Committee, who are advised by the Caldecott Guardian and the Senior Information Risk Owner. The Trust completes the annual Information Governance toolkit and received a 'Green' rating in March 2010. The Trust was made significant efforts to ensure the security of the information it holds and that is transmitted to and from its systems. These include the enforcement of encryption for any portable devices used on Trust systems, encryption for all Trust laptop computers and the implementation of 'remote wipe' functionality for smart phones in the effort of their loss or theft.

The Trust is fully compliant with the core standards for better health and has received an unconditional registration from the Care Quality Commission.

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

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

The Trust's Board of Governor's are regularly consulted regarding the risks that the Trust are managing and regular stakeholder meetings are held with patient groups, other user groups, the local authority Overview and Scrutiny Committees and the local Primary Care Trusts.

Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

In order to provide assurance to the Board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data, the Trust commissioned KPMG, the trust's internal auditor, to conduct an independent audit. The audit report was presented to the Trust's Audit Committee on 4 March 2010.

KPMG concluded that "on the basis of this review, an assessment of substantial assurance has been made, which agrees with management's anticipated assurance for this review". KPMG also "found that robust controls around monitoring your performance against both national and local indicators, primarily the Trust-wide performance scorecard, submitted to the Board monthly. Our review of Board minutes found regular review and challenge of performance as reported in the scorecards. Feeding into the Trust scorecard are monthly divisional scorecards, ensuring completeness of information".

King's College Hospital NHS Foundation Trust has reviewed its governance structures to ensure greater Board assurance in the key areas of quality performance. A new Quality & Governance Committee is being established to provide Board assurance that the trust has the policies, systems, processes, skills and capabilities for delivering high quality of care. Three sub committees are also being established, with a specific focus on the three core aspects of quality - patient experience, clinical outcomes and patient safety. The current Patient Safety and Quality Committee receives a monthly 'Staff Management Performance' scorecard which tracks the Trust's compliance with statutory/ mandatory training and key indicators in professional registration, personal development, health and safety, etc. The new structures were approved by the Board of Directors on the 27th of April 2010 and the structure will come into effect fully from July 2010.

In addition to the above arrangements, the Trust launched a Board "Go & See" programme in 2009 which involves Board members, Governors and senior managers conducting monthly visits to clinical areas. The focus of the programme is to offer Board members the opportunity to talk to frontline staff, patients and relatives on the wards, giving them first hand knowledge of improvements being made and identifying where further improvements are needed. This programme is also replicated at senior nurse and divisional level, to ensure that the leadership of the organisation, both the board and the senior clinicians, are aware, assured and taking actions to improve quality of care.

The Trust's Board of Governor's are regularly consulted regarding the risks that the Trust is managing and regular stakeholder meetings are held with patient groups, other user groups, the local authority Overview and Scrutiny Committees and the local Primary Care Trusts.

Review of effectiveness

King's College Hospital NHS Foundation Trust's assurance arrangements include monthly Board-level monitoring of progress against all national and local quality targets. Feeding into Board level monitoring is reporting from Board sub-committees, helping to ensure multi-level performance monitoring. The Trust has actioned the five recommendations from the KPMG audit report, most of which related to refining quality indicators on the trust performance scorecard.

Review of economy, efficiency and effectiveness of the use of resources

The Board of Directors ensures that resources are used economically, efficiently and effectively by means of monthly Finance and Performance reports. These are considered in detail by the Performance and Finance Committees which are committees of the Board, chaired by Non-Executive Directors. The Audit Committee receives regular reports from the Trust's Internal Auditors, KPMG, and its External Auditors, the Audit Commission. The Local Counter Fraud Specialist has direct access to the Audit Committee and regularly reports on both proactive and investigative work undertaken. The Trust has made a number of investments in the past year for the purpose of improving the overall efficiency and safe delivery of services including automated cabinets for the distribution of consumables and the implementation of electronic patient status boards on all wards.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The action plans are set out in the Board Assurance Framework, together with timescales for implementation and the responsible Directors. The BAF is linked to the Risk Register and maps the controls to the source of assurance. It is directly linked to the Trust's Internal Audit Plan. The Board reviews the proceedings of all its committees at every meeting and considers and approves the arrangements for risk management in the Trust including the risk framework incorporated in the Trust's Risk Management Strategy. Committee Chairs draw the Board's attention to any matters arising from the proceedings of their committees which have risk implications at each Board meeting. The Board has reviewed and amended the Assurance framework to ensure it is comprehensive in its coverage of risks and assurance methodologies and directly related to the management of key risks to its strategic objectives.

During the year, the Board of Directors placed increased emphasis on managing risks in the following areas:

a) Compliance with the Hygiene Code and ensuring that compliance was sustained and embedded within the organisation. The Board gained additional assurance of this process by instituting a programme of 'go and see' visits by all Directors to enable them to assure themselves of the compliance of individual ward and other clinical areas.
b) A detailed review of the Trust's overall Standard Mortality Rates and a case by case analysis of any *prima facie* outliers.

Signed:  Date: 3 June 2010

Timothy Smart
Chief Executive Officer

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

I have audited the financial statements of King's College Hospital NHS Foundation Trust for the year ended 31 March 2010 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out within them.

I have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of remuneration of senior managers on page 33 and
- the table of pension benefits of senior managers on page 34.

This report is made solely to the Board of Governors of King's College Hospital NHS Foundation Trust as a body in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My work was undertaken so that I might state to the Board of Governors those matters I am required to state to it in an auditor's report and for no other purpose. In those circumstances, to the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for the audit report or for the opinions I form.

Respective responsibilities of the Accounting Officer and auditor

The Accounting Officer's responsibilities for preparing the financial statements in accordance with directions made by the Independent Regulator of NHS Foundation Trusts (Monitor) are set out in the Statement of Accounting Officer's Responsibilities.

My responsibility is to audit the financial statements in accordance with statute, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I report whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I also report to you whether, in my opinion, the information which comprises the commentary on the financial performance included within the Directors' Report included in the annual report, is consistent with the financial statements.

I review whether the Accounting Officer's Statement on Internal Control reflects compliance with the requirements of Monitor contained in the NHS Foundation Trust Annual Reporting Manual 2009/10. I report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information I are aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the Accounting Officer's statement on internal control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information compromises the Annual Report, except for the commentary on financial performance included within the Directors' Report, and the audited part of the Remuneration Report. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

I conducted my audit in accordance with the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with International Standards on Auditing (United Kingdom and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements and the part of the Remuneration Report subject to audit. It also includes an assessment of the significant estimates and judgments made by the directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that:

- the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error; and

- the financial statements and the part of the Remuneration Report subject to audit have been properly prepared.

In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report subject to audit.

Opinion

In my opinion:

- the financial statements give a true and fair view of the state of affairs of King's College Hospital NHS Foundation Trust as at 31 March 2010 and of its income and expenditure for the year then ended in accordance with the accounting policies adopted by the Trust;

- the financial statements and the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- information which comprises the commentary on the financial performance included within the Directors' Report included in the annual report, is consistent with the financial statements.

Certificate

I certify that I have completed the audit of the accounts in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Phil Johnstone
Officer of the Audit Commission
1st Floor Millbank Tower, Millbank
London SW1P 4HQ

Date: 3 June 2010

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2010

	note	2009/2010 £'000	2008/2009 £'000
Operating Income from continuing operations	2	**566,013**	517,518
Operating Expenses of continuing operations	3	**(550,486)**	(488,078)
OPERATING SURPLUS / (DEFICIT)		**15,527**	29,440
FINANCE COSTS			
Finance income	5	**66**	1,228
Finance expense - financial liabilities	6.1	**(9,241)**	(10,838)
Finance expense - unwinding of discount on provisions	18	**(189)**	(201)
PDC Dividends payable		**(7,549)**	(8,740)
NET FINANCE COSTS		**(16,913)**	(18,551)
Share of Profit / (Loss) of Associates/Joint Ventures accounted for using the equity method		**0**	0
Corporation tax expense		**0**	(9)
Surplus/(Deficit) from continuing operations		**0**	(9)
Surplus/(deficit) of discontinued operations and the gain/(loss) on disposal of discontinue operations		**0**	0
SURPLUS/(DEFICIT) FOR THE YEAR		**(1,386)**	10,880
Other comprehensive income			
Share of comprehensive income from associates and joint ventures		**0**	0
Revaluation gains/(losses) and impairment losses on intangible assets		**7**	10
Revaluation gains/(losses) and impairment losses property, plant and equipment		**(13,065)**	272
Revaluation gains/(losses) and impairment losses arising from classifying non current assets a Assets Held for Sale		**0**	0
Fair Value gains/(losses) on Available-for-sale financial investments		**0**	0
Recycling gains/(losses) on Available-for-sale financial investments		**0**	0
Increase in the donated asset reserve due to receipt of donated assets		**1,844**	882
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposa of on donated assets		**(538)**	(507)
Additions/(reduction) in "Other reserves"		**0**	0
Other recognised gains and losses		**0**	0
Actuarial gains/(losses) on defined benefit pension schemes		**0**	0
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE PERIOD		**(11,752)**	657
Prior period adjustments		**0**	0
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**(13,138)**	11,537
Allocation of Profits/(Losses) for the period:			
(a) Surplus/(Deficit) for the period attributable to:			
(i) minority interest, and		**0**	0
(ii) owners of the parent.		**(1,386)**	10,880
TOTAL		**(1,386)**	10,880
(b) total comprehensive income/ (expense) for the period attributable to:			
(i) minority interest, and		**0**	0
(ii) owners of the parent.		**(13,138)**	11,537
TOTAL		**(13,138)**	11,537

The notes on pages 13 to 54 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2010

	note	31 March 2010 £'000	31 March 2009 £'000	1 April 2008 £'000
Non-current assets				
Intangible assets	7	**1,620**	1,010	751
Property, plant and equipment	8	**337,246**	327,168	314,629
Investment Property		**0**	0	0
Investments in associates (and joined controlled operations)		**0**	0	0
Other Investments		**0**	0	0
Trade and other receivables	11	**4,774**	5,018	4,958
Other Financial assets		**0**	0	0
Tax receivable		**0**	0	0
Other assets		**0**	0	0
Total non-current assets		**343,640**	333,196	320,338
Current assets				
Inventories	10	**11,243**	9,433	8,673
Trade and other receivables	11	**38,339**	37,979	29,691
Other financial assets		**0**	0	0
Tax receivable		**0**	0	0
Non-current assets for sale and assets in disposal groups		**0**	0	0
Cash and cash equivalents	20	**12,838**	33,886	26,087
Total current assets		**62,420**	81,298	64,451
Current liabilities				
Trade and other payables	12	**(39,569)**	(46,993)	(44,363)
Borrowings	14	**(1,782)**	(4,761)	(123)
Other financial liabilities		**0**	0	0
Provisions	18	**(939)**	(1,484)	(3,934)
Tax payable	12	**(6,892)**	(6,468)	(6,043)
Other liabilities	13	**(2,751)**	(1,919)	(1,033)
Liabilities in disposal groups		**0**	0	0
Total current liabilities		**(51,933)**	(61,625)	(55,496)
Total assets less current liabilities		**354,127**	352,869	329,293
Non-current liabilities				
Trade and other payables	12	**0**	(587)	0
Borrowings	14	**(91,919)**	(96,189)	(90,002)
Other financial liabilities		**0**	0	0
Provisions	18	**(8,068)**	(8,663)	(9,218)
Tax payable		**0**	0	0
Other liabilities	13	**0**	0	0
Total non-current liabilities		**(99,987)**	(105,439)	(99,220)
TOTAL ASSETS EMPLOYED		254,140	247,430	230,073
Financed by (taxpayers' equity)				
Minority Interest		**0**	0	0
Public Dividend Capital		**135,528**	128,052	122,065
Revaluation reserve	19	**81,114**	91,776	91,637
Donated Asset Reserve		**17,378**	18,785	18,780
Available for sale investments reserve		**0**	0	0
Other reserves		**0**	0	0
Merger reserve		**0**	0	0
Pensions reserve		**0**	0	0
Income and expenditure reserve		**20,120**	8,817	(2,409)
TOTAL TAXPAYERS' EQUITY		**254,140**	247,430	230,073

The financial statements on pages 9 to 13 were approved by the Board on [*date*] and signed on its behalf by:

Signed: ……(Chief Executive) Date: 3 June 2010…

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public Dividend Capital	Revaluation Reserve	Donated Assets Reserve	Income and Expenditure Reserve	Total
	£'000	£'000	£'000	£'000	£'000
Taxpayers' Equity at 1 April 2009	**128,052**	**91,776**	**18,785**	**8,817**	**247,430**
Changes in taxpayers' equity for 2009-10					
Surplus/(deficit) for the year		0	0	(1,386)	**(1,386)**
Share of comprehensive income from associates and joint ventures		0	0	0	**0**
Revaluation gains/(losses) and impairment losses on intangible assets		7	0	0	**7**
Revaluation gains/(losses) and impairment losses property, plant and equipment		(10,352)	(2,713)	0	**(13,065)**
Revaluation gains/(losses) and impairment losses arising from classifying non current assets as Assets Held for Sale		0	0	0	**0**
Fair Value gains/(losses) on Available-for-sale financial investments		0	0	0	**0**
Recycling gains/(losses) on Available-for-sale financial investments		0	0	0	**0**
Increase in the donated asset reserve due to receipt of donated assets		0	1,844	0	**1,844**
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets		0	(538)	0	**(538)**
Additions/(reduction) in Other reserves		0	0	0	**0**
Other recognised gains and losses		0	0	0	**0**
Actuarial gains/(losses) on defined benefit pension schemes		0	0	0	**0**
Transfers to the Statement of Comprehensive Income in respect of assets disposed of		(317)	0	317	**0**
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		0	0	0	**0**
Public Dividend Capital received	7,476				**7,476**
Public Dividend Capital repaid	0				**0**
Public Dividend Capital repayable	0				**0**
Public Dividend Capital written off	0				**0**
Other transfers between reserves	0	0	0	0	**0**
Movements on other reserves	0	0	0	12,372	**12,372**
Taxpayers' Equity at 31 March 2010	**135,528**	**81,114**	**17,378**	**20,120**	**254,140**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public Dividend Capital	Revaluation Reserve	Donated Assets Reserve	Income and Expenditure Reserve	Total
	£'000	£'000	£'000	£'000	£'000
Balance at 31 March 2008					
As previously stated	**122,065**	**81,082**	**18,780**	**23,499**	**245,426**
Prior Period Adjustment	0	10,555	0	(25,908)	**(15,353)**
Taxpayers' Equity at 1 April 2008 - Restated	**122,065**	**91,637**	**18,780**	**(2,409)**	**230,073**
Changes in taxpayers' equity for 2008-09					
Surplus/(deficit) for the year		0	0	10,880	**10,880**
Share of comprehensive income from associates and joint ventures		0	0	0	**0**
Revaluation gains/(losses) and impairment losses on intangible assets		10	0	0	**10**
Revaluation gains/(losses) and impairment losses property, plant and equipment		642	(370)	0	**272**
Revaluation gains/(losses) and impairment losses arising from classifying non current assets as Assets Held for Sale		0	0	0	**0**
Fair Value gains/(losses) on Available-for-sale financial investments		0	0	0	**0**
Recycling gains/(losses) on Available-for-sale financial investments		0	0	0	**0**
Increase in the donated asset reserve due to receipt of donated assets		0	882	0	**882**
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets		0	(507)	0	**(507)**
Additions/(reduction) in Other reserves		0	0	0	**0**
Other recognised gains and losses		0	0	0	**0**
Actuarial gains/(losses) on defined benefit pension schemes		0	0	0	**0**
Transfers to the Statement of Comprehensive Income in respect of assets disposed of		(167)	0	0	**(167)**
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		0	0	0	**0**
Public Dividend Capital received	5,987				**5,987**
Public Dividend Capital repaid	0				**0**
Public Dividend Capital repayable	0				**0**
Public Dividend Capital written off	0				**0**
Other transfers between reserves	0	(346)	0	346	**0**
Movements on other reserves	0	0	0	0	**0**
Taxpayers' Equity at 31 March 2009	**128,052**	**91,776**	**18,785**	**8,817**	**247,430**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2010

	2009/2010 £'000	2008/2009 £'000
Cash flows from operating activities		
Operating surplus/(deficit) from continuing operations	**15,527**	29,440
Operating surplus/(deficit) of discontinued operations	**0**	0
Operating surplus/(deficit)	**15,527**	29,440
Non-cash income and expense:		
Depreciation and amortisation	**13,474**	12,200
Impairments	**4,319**	1,786
Reversals of impairments	**0**	0
Transfer from the donated asset reserve	**(553)**	(507)
Amortisation of government grants	**0**	0
Amortisation of PFI credit	**0**	0
(Increase)/Decrease in Trade and Other Receivables	**(116)**	(8,348)
(Increase)/Decrease in Other Assets	**0**	0
(Increase)/Decrease in Inventories	**(1,810)**	(760)
Increase/(Decrease) in Trade and Other Payables	**(8,011)**	3,217
Increase/(Decrease) in Other Liabilities	**832**	886
Increase/(Decrease) in Provisions	**(1,140)**	(3,005)
Tax (paid) / received	**424**	425
Movements in operating cash flow of discontinued operations	**0**	0
Other movements in operating cash flows	**0**	0
NET CASH GENERATED FROM/(USED IN) OPERATIONS	**22,946**	35,334
Cash flows from investing activities		
Interest received	**75**	1,300
Purchase of financial assets	**0**	0
Sales of financial assets	**0**	0
Purchase of intangible assets	**(1,273)**	(624)
Sales of intangible assets	**0**	0
Purchase of Property, Plant and Equipment	**(42,289)**	(26,074)
Sales of Property, Plant and Equipment	**1,904**	0
Cash flows attributable to investing activities of discontinued operations	**0**	0
Cash from acquisitions of business units and subsidiaries	**0**	0
Cash from (disposals) of business units and subsidiaries	**0**	0
Net cash generated from/(used in) investing activities	**(41,583)**	(25,398)
Cash flows from financing activities		
Public dividend capital received	**7,476**	5,987
Public dividend capital repaid	**0**	0
Loans received	**10,373**	9,393
Loans repaid	**(4,500)**	0
Capital element of finance lease rental payments	**(124)**	(123)
Capital element of Private Finance Initiative Obligations	**(554)**	0
Interest paid	**(592)**	0
Interest element of finance lease	**(43)**	(53)
Interest element of Private Finance Initiative obligations	**(8,616)**	(9,019)
PDC Dividend paid	**(7,615)**	(8,740)
Cash flows attributable to financing activities of discontinued operations	**0**	0
Cash flows from (used in) other financing activities	**1,784**	418
Net cash generated from/(used in) financing activities	**(2,411)**	(2,137)
Increase/(decrease) in cash and cash equivalents	**(21,048)**	7,799
Cash and Cash equivalents at 1 April	**33,886**	26,087
Cash and Cash equivalents at 31 March	**12,838**	33,886

NOTES TO THE ACCOUNTS

1. Accounting Policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2009/10 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts.

The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going concern

After making enquiries, the Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in the preparation of the accounts.

1.2 Accounting convention

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

1.3 Acquisitions and discontinued operations

Activities are considered to be 'discontinued' where they meet all of the following conditions:

a) The sale (this may be at nil consideration for activities transferred to another public sector body) or termination is completed either in the period or before the earlier of three months after the commencement of the subsequent period and the date on which the financial statements are approved.

b) If a termination, the former activities have ceased permanently.

c) The sale or termination has a material effect on the nature and focus of the reporting NHS Foundation Trust's operations and represents a material reduction in its operating facilities resulting either from its withdrawal from a particular activity or from a material reduction in income in the NHS Foundation Trust's continuing operations.

d) The assets, liabilities, results of operations and activities are clearly distinguishable, physically, operationally and for financial reporting purposes.

Operations not satisfying all these conditions are classified as continuing.

Activities are considered to be 'acquired' whether or not they are acquired from outside the public sector.

1.4 Consolidated Accounts

Subsidiaries

Subsidiary entities are those over which the Trust has the power to exercise control or a dominent influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a seperate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year.

Where subsidiaries' accounting policies are not aligned with those of the Trust then amounts are adjusted during consolidation where the differences are material.

The Trust has a wholly owned subsidiary company, KCH Commercial Services Ltd, who wholly own Agnentis Ltd. The accounts for this company have been consolidated into the Foundation Trust annual accounts. They are not shown separately in the segmental analysis note to the accounts (note 2) as the figures were immaterial.

1.5 Income Recognition

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is from contracts with commissioners in respect of healthcare services provided under the Department of Health's Payment by Results rules-based system and local agreements for non-mandatory tariff activity.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

The Foundation Trust accrues income for incomplete spells of patient activity as at 31st March. The work in progress is derived from patients admitted before the year end but not discharged as at 31st March. The calculation is based on the number of bed days and the average specialty bed day price. The value as at 31st March 2010 was £2.720m, an increase of £138k from 31st March 2009.

The provision for irrecoverable debts is based on outstanding debts greater than 6 months which have not been agreed the respective debtor. Due to the complexities of Private Patient debt recovery the bad debt provision for Private Patients is based on outstanding debts greater than 1 year. The irrecoverable debt provision figure is disclosed in note 11 - Trade receivables and other receivables.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.6 Expenditure on Employee Benefits

i Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

ii Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsba.nhs.uk/pensions. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify is share of the underlying scheme liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period. The total employer contribution payable in the year ended 31 March 2010 was £27,213,101 (31 March 2009: £24,770,589).

Employers pension cost contributions are charged to operating expenses as and when they become due.

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

The Scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and a FRS17 accounting valuation every year. An outline of these follows:

i Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

ii Accounting valuation

A valuation of the Scheme liability is carried out annually by the Scheme Actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the Scheme Actuary. At this point the assumptions regarding the composition of the Scheme membership are updated to allow the Scheme liability to be valued.

The valuation of the Scheme liability as at 31 March 2010, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2010 with summary global member and accounting data.

The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

iii Scheme provisions

In 2008-09 the NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last 3 years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.

Pensions Indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Lump Sum Allowance

A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill-Health Retirement

Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

Death Benefits

A death gratuity of twice their final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Additional Voluntary Contributions (AVCs)

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Transfer between Funds

Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits

Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Compensation for Early Retirement

Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

1.7 Expenditure on other goods and services

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

1.8 Property, Plant and Equipment

i Recognition

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably;

and

- individually have a cost of at least £5,000; or
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

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

ii Measurement

Valuation

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

All land and buildings are restated to current value using professional valuations in accordance with FRS15 every five years. A three year interim revaluation is also carried out.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last asset valuations were undertaken in 2010 as at the prospective valuation date of 31 March 2010.

The valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property (e.g. NHS patient treatement facilities) and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Market Value.

The Department of Health has agreed it will now adopt the Modern Equivalent Asset approach (MEA) for its DRC valuations rather than continuing with identical replacement.

The MEA approach used to value the property will normally be based on the cost of a modern equivalent asset that has the same service potential as the existing asset and then adjusted to take account of obsolescence. In the past, functional obsolescence has not been reflected in asset valuations for the NHS.

Functional obsolescence examines a building's design or specification and whether it may no longer fulfil the function for which it was originally designed or whether it may be much more basic than the MEA. The asset will still be capable of use but at a lower level of efficiency than the modern equivalent asset, or may be capable of modification to bring it up to a current specification. Other common causes of functional obsolescence include advances in technology or legislative change. The obsolescence adjustment will reflect either the cost of upgrading, or if this is not possible, the financial consequences of the reduced efficiency compared with the modern equivalent.

The MEA approach incorporates the Building Cost Information Service Index to determine an increase or decrease in building costs which impact on the asset valuation.

The carrying values of property, plant and equipment are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. The costs arising from financing the construction of the property, plant and equipment are not capitalised but are charged to the Statement of Comprehensive Income in the year to which they relate.

Additional alternative Open Market Value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

The revaluation resulted in a decrease of £339k in the value of land owned by the Trust and an overall decrease to buildings and dwellings net book value of £17.518m.

A decrease in value of certain buildings resulted in an impairment of £4.319m being charged to the Statement of Comprehensive Income (see Note 5.1). These buildings were Units 1, 2, 4, 5, 6, & 8 King's Business Park (£3.033m), the Day Surgery (£837k), the Camberwell Building (£222k), Jennie Lee House (£199k) and Binfield Court (£28k).

All impairments resulting from price changes are charged to the Statement of Comprehensive Income. If the balance on the revaluation reserve is less than the impairment the difference is taken to the Statement of Comprehensive Income.

Assets in the course of construction are valued at cost and are valued by professional valuers when brought into use.

The valuation included the Trusts PFI scheme (note 16)

Operational equipment other than IT equipment, which is considered to have nil inflation, is valued at net current replacement cost through annual uplift by the change in the value of the GDP deflator. Equipment surplus to requirements is valued at net recoverable amount.

Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. Depreciation is calculated from the start of the month following the month in which the asset first became available for use.

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

Property, Plant and Equipment in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the District Valuer. Leaseholds are depreciated over the primary lease term.

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

- Short life engineering plant and equipment - 5 years
- Medium life engineering plant and equipment - 10 years
- Long life engineering plant and equipment - 15 years
- Vehicles - 7 years
- Furniture - 10 years
- Office and IT equipment - 5 years
- Soft furnishings - 7 years
- Short life medical and other equipment - 5 years
- Medium life medical equipment - 10 years
- Long life medical equipment - 15 years
- Mainframe-type IT installations - 8 years

Revaluation and Impairment

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

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

iii De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
- management are committed to a plan to sell the asset;
- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

iv Donated assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the Donated Asset Reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the Donated Asset Reserve and, each year, an amount equal to the depreciation charge on the asset is released from the Donated Asset Reserve to the Statement of Comprehensive Income. Similarly, any impairment on donated assets charged to the Statement of Comprehensive Income is matched by a transfer from the Donated Asset Reserve. On sale of donated assets, the net book value of the donated asset is transferred from the Donated Asset Reserve to the Income and Expenditure Reserve.

v Government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Grants from the Department of Health are accounted for as Government grants, as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset on a basis consistent with the depreciation charge for that asset.

vi Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. The underlying assets are recognised as Property, Plant and Equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for the services. The finance cost is calculated using the implicit interest rate for the scheme.

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

Phase 1 of the PFI scheme, the construction and management of a new clinical wing, was the 'Golden Jubilee Wing', and this building was made available to the Trust in September 2002. Phase II of the PFI scheme was the refurbishment of the Ruskin Wing, and this wing became operational on 1st May 2004.

The total PFI scheme is subject to a finance lease and is deemed to be 'on-Statement of Financial Position'. The capital element of the lease has been recorded as a tangible fixed asset for which depreciation will be charged to the Statement of Comprehensive Income over the life of the asset. A payable was raised for the capitalised amount representing the fair value of the asset at inception of the lease. The finance charge element of the lease payments is charged to the Statement of Comprehensive Income over the period of the lease.

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

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

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

Other assets contributed by the Trust to the operator
Assets contributed (e.g. cash payments, surplus property) by the trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.9 Intangible fixed assets

i Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:
- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

ii Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

iii Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.10 Inventories

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

1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. These balances exclude monies held in the NHS Foundation Trust's bank account belonging to patients (see third party assets below). Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within payables. Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, interest receivable and interest payable in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.12 Financial Instruments and Financial Liabilities

i Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

ii De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

iii Classification and Measurement

Financial assets are categorised as Loans and receivables or 'Available-for-sale financial assets'.

Financial liabilities are classified as 'Fair Value through Income and Expenditure' or as 'Other Financial liabilities'.

iv Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments with are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash at bank and in hand, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

v Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the balance sheet date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised in reserves are included in the Statement of Comprehensive Income.

vi Financial liabilities

All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs.

vii Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined using discounted cash flow analysis.

viii Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' is impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly or through the use of a bad debt provision.

1.13 Leases

i Finance Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

ii Operating Leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

iii Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.14 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is material, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.2% in real terms.

i Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 18.

Since financial responsibility for clinical negligence cases transferred to the NHSLA at 1 April 2002, the only charge to operating expenditure in relation to clinical negligence in 2009/10 relates to the Trust's contribution to the Clinical Negligence Scheme for Trusts.

ii Non-clinical risk pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS Foundation Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses as and when the liability arises.

1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 23 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 23, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.16 Public Dividend Capital (PDC)

Public Dividend Capital (PDC) is a type of public sector equity based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the forecast cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out on 'pre-audit' version of the annual accounts.The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.17 Value Added Tax

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

1.18 Corporation Tax

The Finance Act 2004 amended S519A Income and Corporation Taxes Act 1988 provided power to the Treasury to make certain non-core activities of Foundation Trusts potentially subject to corporation tax. This legislation is effective from September 12 2005. Any outstanding payments of corporation tax as at the end of the financial year are provided for in the Statement of Comprehensive Income.

The Foundation Trust incurred Corporation Tax of £425 through its commercial subsidiary organisations.

1.19 Foreign Exchange

The Trust's functional currency and presentational currency is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.20 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, third party assets are disclosed in Note 26 to the accounts in accordance with the requirements of the HM Treasury Financial Reporting Manual.

1.21 Losses and Special Payments

Losses and Special Payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and Special Payments are charged to the relevant functional headings in the expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

2. Segmental Analysis

King's College Hospital NHS Foundation Trust has only one business segment being the provision of healthcare. The Trust does provide Research and Development and Training and Education services within the healthcare sector. They do not have a material impact and therefore do not require separate reporting. Note 2 entitled "Other Operating Income" includes the relevant income figures for these services.

The Trust also generated income from its King's subsidiary commercial company of £249k, generating a surplus of £4k.

2. OPERATING INCOME

2.1 Income from Activities by classification	2009/2010 £'000	2008/2009 £'000
Elective income	**86,459**	89,229
Non elective income	**103,451**	100,362
Outpatient income	**84,346**	67,410
A & E income	**11,575**	12,413
Other NHS clinical income *	**187,080**	159,513
Private patient income	**14,529**	14,115
Total income from activities	**487,440**	443,042
Other operating income		
Research and development	**5,386**	7,630
Education and training	**47,108**	44,414
Charitable and other contributions to expenditure	**1,094**	1,319
Transfer from donated asset reserve in respect of depreciation on donated assets	**553**	507
Non-patient care services to other bodies	**15,000**	12,346
Other **	**9,432**	8,260
Total other operating income	**78,573**	74,476
TOTAL OPERATING INCOME	**566,013**	517,518

* Other NHS clinical income includes HIV/AIDS funding, NCG funding for Liver services, Bone Marrow Transplant funding, Critical Care funding from PCTs including consortia PCT leads, Off-tariff drugs and devices, Renal Dialysis, Direct Access, Community Midwifery, Community Dental services, National Screening programmes,
RTA funding and IVF services.

** Other income includes NHS Provider-to-provider Services, Clinical Excellence Awards, Staff Nursery, Car Parking, Accommodation and Commercial Rents.

Income received for NHS seconded staff is included in Non-patient care serves to other bodies.

2.2 Private patient income	2009/2010 £'000	2008/2009 £'000
Private patient income	**14529**	14,115
Total patient related income	**487440**	443,042
Proportion (as percentage)	**2.98%**	3.19%

Section 44 of the 2006 Act requires that the proportion of private patient income to the total patient related income of the NHS Foundation Trust should not exceed 3.5 per cent, its proportion when the organisation was an NHS Trust in 2002/03.

2.3 Income from Activities by type	2009/2010 £'000	2008/2009 £'000
Income from activities		
NHS Foundation Trusts	**1,089**	479
NHS Trusts	**1,209**	637
Strategic Health Authorities	**27,634**	23,691
Primary Care Trusts	**437,111**	348,451
Department of Health - other	**1,009**	52,934
NHS Other	**2,995**	558
Non NHS: Private patients	**14,529**	14,115
Non-NHS: Overseas patients (non-reciprocal)	**411**	608
NHS injury scheme *	**1,120**	1,099
Non NHS: Other **	**333**	470
Total income form activities	**487,440**	443,042

* NHS Injury Scheme income is subject to a provision for doubtful debts of 7.8% to reflect expected rates of collection. The total outstanding claims against this scheme at 31 March 2010 were £3.555m, and a provision of £277k was raised against this amount.

** Non-NHS other income includes patient care provided to devolved administrations, personal contributions for IVF treatment and services to prisons.

3. OPERATING EXPENSES

3.1 Operating Expenses comprise:	2009/2010 £'000	2008/2009 £'000
Services from NHS Foundation Trusts	**616**	444
Services from NHS Trusts	**2,028**	1,812
Services from other NHS Bodies	**5,421**	4,680
Purchase of healthcare from non NHS bodies	**1,092**	1,817
Employee Expenses - Executive directors	**1,441**	1,198
Employee Expenses - Non-executive directors	**140**	125
Employee Expenses - Staff	**334,133**	296,251
Drug costs	**58,752**	49,117
Supplies and services - clinical	**50,590**	48,574
Supplies and services - general	**2,667**	2,586
Establishment	**4,570**	4,070
Transport	**5,762**	4,342
Premises	**21,532**	16,460
Increase / (decrease) in bad debt provision	**632**	509
Depreciation on property, plant and equipment	**12,804**	11,825
Amortisation on intangible assets	**670**	375
Impairments of property, plant and equipment	**4,319**	1,786
Audit fees - Statutory Audit	**81**	81
Other auditors remuneration - other services	**16**	20
Clinical negligence	**6,156**	5,144
Loss on disposal of other property, plant and equiment	**119**	25
Other	**36,945**	36,837
TOTAL	**550,486**	488,078

* Other Auditors remuneration included a review of the IFRS Restated Accounts and a Board-to-board survey and workshop.

* Other operating expenses includes expenditure on PFI service costs, leasing costs, training and legal fees.

Research and Development costs have been included in the categories above.

3.2 Operating Leases

3.2.1 Opreating expenses include:

	2009/2010	2008/2009
	£'000	£'000
Hire of plant and machinery	**5,266**	5,496
Operating lease rentals for land and buildings	**2,859**	1,225
TOTAL	**8,125**	6,721

3.2.2 Arrangements containing an operating lease:

	Land and buildings		**Other Leases**	
	2009/2010	2008/2009	**2009/2010**	2008/2009
Future minimum lease payments due:	**£'000**	£'000	**£'000**	£'000
- not later than one year;	**0**	0	**261**	421
- later than one year and not later than five years;	**264**	1,080	**4,932**	4,104
- later than five years.	**237**	676	**1,131**	812
TOTAL	**501**	1,756	**6,324**	5,337

3.3 Better Payment Practice Code - measure of compliance

	2009/2010		2008/2009	
	Number	**£'000**	Number	£'000
Total Non-NHS trade invoices paid in the year	**123,610**	**259,304**	106,991	214,044
Total Non NHS trade invoices paid within target	**68,824**	**183,052**	87,187	184,430
Percentage of Non-NHS trade invoices paid within target	**56%**	**71%**	81%	86%
Total NHS trade invoices paid in the year	**3,163**	**62,841**	2,966	51,202
Total NHS trade invoices paid within target	**1,174**	**45,109**	1,231	35,563
Percentage of NHS trade invoices paid within target	**37%**	**72%**	42%	69%

The Better Payment Practice Code requires the Foundation Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

3.4 The Late Payment of Commercial Debts (Interest) Act 1998

	2009/2010	2008/2009
	£'000	£'000
Interest Payable arising from claims made under this legislation	**0**	4
Compensation paid to cover debt recovery costs under this legislation	**21**	5
	21	9

3.5 Salary and pension entitlements of senior managers

A) Remuneration

Name	Title	2009/2010 Salary (bands of £5000) £'000	2009/2010 Other Remuneration (bands of £5000) £'000	2009/2010 Benefits in Kind Rounded to the nearest £100	2008/2009 Salary (bands of £5000) £'000	2008/2009 Other Remuneration (bands of £5000) £'000	2008/2009 Benefits in Kind Rounded to the nearest £100
Chariman and Non-Executive Directors							
M. Parker	Chairman	55 - 60	0	0	50 - 55	0	0
M. James	Non-Executive Director	10 - 15	0	0	10 - 15	0	0
R. Foster	Non-Executive Director	10 - 15	0	0	10 - 15	0	0
A. McGregor	Non-Executive Director	10 - 15	95 - 100	0	10 - 15	85 - 90	0
R. Donaghy	Non-Executive Director	5 - 10	0	0	10 - 15	0	0
Sir J. Michael	Non-Executive Director	5 - 10	0	0	0	0	0
M. West	Non-Executive Director	10 - 15	0	0	10 - 15	0	0
Executive Directors							
M. Lowe-Lauri	Chief Executive	0	0	0	30 - 35	0	0
T. Smart	Chief Executive	225 - 230	0	0	90 - 95	0	0
J. Docherty	Acting Chief Executive	0	0	0	20 - 25	0	
J. Docherty	Director of Operations & Nursing	0	0	0	165 - 170	0	0
J. Watson	Acting Director of Operations	25 - 30	0	0	5 - 10	0	0
R. Sinker	Executive Director of Operations	110 - 115	0	0	0	0	0
P. Townsend	Acting Director of Nursing	35 - 40	0	0	5 - 10	0	0
G. Walters	Executive Director of Nursing & Midwifery	75 - 80	0	0	0	0	0
J. Moxham	Director of Medicine	30 - 35	65 - 70	0	55 - 60	100 - 105	0
M. Marrinan	Executive Medical Director	35 - 40	0	0	0	0	0
S. Taylor	Director of Finance & ISD	165 - 170	15 - 20	0	140 - 145	10 - 15	0
M. Griffin	Director of Human Resources	0	0	0	125 - 130	0	0
M. Lorman	Acting Director of Human Resources	5 - 10	0	0	0	0	0
A. Huxham	Executive Director of Workforce Development	105 - 110	0	0	0	0	0
Co-opted members of the Trust's Board							
A. Toumadj	Director of Facilities	140-145	0	0	130 - 135	0	0
J. Walters	Director of Corporate Affairs	100-105	0	0	90 - 95	0	0
R. Sinker	Director of Strategic Development	0	0	0	115 - 120	0	0
Z. Lelliott	Acting Director of Strategic Development	80-85	0	0	5 - 10	0	0
J. West	Director of Strategy	20-25	0	0	0	0	0

R. Donaghy	Non-Executive Director	01 April 2009 - 31 October 2009
Sir J. Michael	Non-Executive Director	01 September 2009 - 31 March 2010
M. Lowe-Lauri	Chief Executive	01 April 2008 - 05 May 2008
J. Docherty	Acting Chief Executive	05 May 2008 - 31 October 2008
J. Docherty	Director of Operations & Nursing	01 April 2008 - 23 February 2009
J. Watson	Acting Director of Operations	01 April 2009 - 05 July 2009
R. Sinker	Executive Director of Operations	06 July 2009 - 31 March 2010
P. Townsend	Acting Director of Nursing	01 April 2009 - 06 September 2009
G. Walters	Executive Director of Nursing & Midwifery	07 September 2009 - 31 March 2010
J. Moxham	Director of Medicine	01 April 2009 - 20 September 2009
J. Marrinan	Executive Medical Director	21 September 2009 - 31 March 2010
M. Griffin	Director of Human Resources	01 April 2008 - 31 March 2009
M. Lorman	Acting Director of Human Resources	01 April 2009 - 03 May 2009
A. Huxham	Executive Director of Workforce Development	04 May 2009 - 31 March 2010
Z. Lelliott	Acting Director of Strategic Development	01 April 2009 - 31 January 2010
J. West	Director of Strategy	01 February 2010 - 31 March 2010

M. West's role as Non-Executive Director is charged to the Trust through his employing organisation.

3.5 Salary and pension entitlements of senior managers

B) Pension Benefits

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

Name	Title	Real Increase in pension and related lump sum at age 60 (bands of £2,500)	Total accrued pension and related lump sum at age 60 at 31 March 2010 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2009	Real increase in Cash Equivalent Transfer Value
		£'000	£'000	£'000	£'000	£'000
Executive Directors						
T. Smart	Chief Executive	0.0 - 2.5	5 - 10	66	18	47
J. Moxham	Director of Medicine	0	335 - 340	0	0	0
S. Taylor	Director of Finance & ISD	7.5 - 10	170 - 175	805	680	108
J. Watson	Acting Director of Operations	2.5 - 5	100 - 105	418	333	14
A. Huxham	Executive Director of Workforce Development	52.5 - 55	140 - 145	865	451	355
G. Walters	Executive Director of Nursing & Midwifery	12.5 - 15	160 - 165	876	670	100
M. Lorman	Acting Director of Human Resources	0.0 - 2.5	100 - 105	603	567	1
M. Marrinan	Executive Medical Director	0.0 - 2.5	80 - 85	490	450	14
P. Townsend	Acting Director of Nursing	(2.5) - (5)	90 - 95	444	458	(27)
R.Sinker	Executive Director of Operations	0.0 - 2.5	0 - 5	16	0	0
Co-opted members of the Trusts Board						
A. Toumadj	Director of Facilities	62.5 - 65	185 - 190	0	0	0
J. Walters	Director of Corporate Affairs	2.5 - 5	130 - 135	809	713	79
Z. Lelliott	Acting Director of Strategic Development	0 - 2.5	80 - 85	323	285	18
J.West	Director of Strategy	0 - 2.5	0 - 5	43	0	7

R. Sinker, J. West and T. Smart are new pension scheme members and have no accrued lump sum.

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

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

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

4 Employee Expenses

4.1 Staff Costs

	Permanently Employed	Other	2009/2010 Total	2008/2009 Total
	£'000	£'000	£'000	£'000
Salaries and wages	**271,957**	**0**	**271,957**	243,849
Social security costs	**20,644**	**0**	**20,644**	18,926
Employers contributions to NHS Pensions	**27,213**	**0**	**27,213**	24,787
Pension Cost - other contributions	**716**	**0**	**716**	713
Agency and contract staff	**0**	**15,044**	**15,044**	9,174
TOTAL	**320,530**	**15,044**	**335,574**	297,449

4.2 Average number of persons employed

	2009/10 Total	2008/09 Total
	Number	Number
Medical and dental	**1,142**	1,033
Administration and estates	**1,518**	1,347
Healthcare assistants and other support staff	**613**	546
Nursing, midwifery and health visiting staff	**2,142**	1,921
Nursing, midwifery and health visiting learners	**6**	6
Scientific, therapeutic and technical staff	**1,328**	1,199
Social care staff	**3**	3
Other	**6**	6
TOTAL	**6,758**	6,061

4.3 Management costs

	2009/2010	2008/2009
	£'000	£'000
Management costs	**26,309**	24,101
Income	**566,009**	517,518
Management costs as a percentage	**4.65%**	4.66%

Management costs are defined as those on the management costs website at www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSManagementCosts/fs/en The general rule is that if a post falls within the Board or Corporate functions, the salary cost of all staff must be included. Only the most senior manager must be included within clinical and operational or support functions. These costs are also applied to contracted out services and management consultancy services.

4.4 Early retirements due to ill health

During the year to 31 March 2010 there were 2 (2008/09: 3) early retirements from the NHS Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £110,493 (2008/09: £113,107). The cost of these ill-health retirements will be borne by NHS Pensions.

These retirements represented 0.31 (2008/09: 0.47) per 1000 active scheme members.

5. Finance income

	2009/2010 £'000	2008/2009 £'000
Interest received on cash deposits	66	1,228
	66	1,228

6. Finance Costs

6.1 Interest expense

	2009/2010 £'000	2008/2009 £'000
Loans from the Foundation Trust Financing Facility	**575**	210
Overdrafts	**7**	0
Finance leases	**43**	53
Finance Costs in PFI obligations		
Main Finance Costs	**7,691**	10,575
Contingent Finance Costs	**925**	0
	9,241	10,838

6.2 Impairment of assets

	2009/2010 £'000	2008/2009 £'000
Changes in market price	**4,319**	1,786
	4,319	1,786

7. Intangible assets

7.1 Intangible assets 2009/2010	Software licences £'000	Development expenditure £'000	Total £'000
Gross cost at 1 April 2009	1,767	653	**2,420**
Revaluation surpluses	0	17	**17**
Additions - purchased	1,273	0	**1,273**
Additions - donated	0	0	**0**
Gross cost at 31 March 2010	3,040	670	**3,710**
Amortisation at 1 April 2009	1,025	385	**1,410**
Provided during the year	533	137	**670**
Revaluation surpluses	0	10	**10**
Amortisation at 31 March 2010	1,558	532	**2,090**
Net book value			
Purchased at 1 April 2009	742	268	**1,010**
Donated at 1 April 2009	0	0	**0**
Total at 1 April 2009	742	268	**1,010**
Net book value			
Purchased at 31 March 2010	1,482	138	**1,620**
Donated at 31 March 2010	0	0	**0**
Total at 31 March 2010	1,482	138	**1,620**

The implementation cost of the Activity Based Costing (ABC) project completed in 2006/07 was capitalised under SSAP 13 as Research and Development costs. ABC was been introduced as a result of the implementation of Payments by Results using the National Tariff.

7. Intangible assets

7.2 Intangible assets 2008/2009	Software licences £'000	Development expenditure £'000	Total £'000
Gross cost at 1 April 2008	1,143	636	**1,779**
Revaluation surpluses	0	17	**17**
Additions - purchased	624	0	**624**
Additions - donated	0	0	**0**
Gross cost at 31 March 2009	1,767	653	**2,420**
Amortisation at 1 April 2008	784	244	**1,028**
Provided during the year	241	134	**375**
Revaluation surpluses	0	7	**7**
Amortisation at 31 March 2009	1,025	385	**1,410**
Net book value			
Purchased at 1 April 2008	359	392	**751**
Donated at 1 April 2008	0	0	**0**
Total at 1 April 2009	359	392	**751**
Net book value			
Purchased at 31 March 2009	742	268	**1,010**
Donated at 31 March 2009	0	0	**0**
Total at 31 March 2010	742	268	**1,010**

The implementation cost of the Activity Based Costing (ABC) project completed in 2006/07 was capitalised under SSAP 13 as Research and Development costs. ABC was been introduced as a result of the implementation of Payments by Results using the National Tariff.

8. Property, plant and equipment

8.1 Property, plant and equipment at 31 March 2010 comprise the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under Construction	Plant & Machinery	Information Technology	Furniture & Fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2009	48,390	243,629	3,536	12,245	38,539	17,286	688	**364,313**
Additions - purchased	2,909	1,495	0	27,776	6,562	1,361	342	**40,445**
Additions - donated	0	303	0	1,220	321	0	0	**1,844**
Impairments charged to revaluation reserve	(397)	(16,143)	(55)	0	0	0	0	**(16,595)**
Reclassifications	358	11,224	319	(11,901)	0	0	0	**0**
Revaluation surpluses	58	(9,483)	(134)	0	948	0	18	**(8,593)**
Disposals	0	0	0	0	(3,749)	(38)	(1)	**(3,788)**
Cost or valuation at 31 March 2010	**51,318**	**231,025**	**3,666**	**29,340**	**42,621**	**18,609**	**1,047**	**377,626**
Accumulated depreciation at 1 April 2009	0	1,727	0	0	20,061	15,143	214	**37,145**
Provided during the year	0	8,395	201	0	3,271	851	86	**12,804**
Impairments recognised in operating expenses	0	4,292	27	0	0	0	0	**4,319**
Revaluation surpluses	0	(12,388)	(228)	0	488	0	5	**(12,123)**
Disposals	0	0	0	0	(1,757)	(8)	0	**(1,765)**
Accumulated depreciation at 31 March 2010	**0**	**2,026**	**0**	**0**	**22,063**	**15,986**	**305**	**40,380**
Net book value								
Owned at 1 April 2009	46,276	149,746	3,169	11,070	16,722	2,085	471	**229,539**
Finance Lease at 1 April 2009	0	77,656	0	0	1,188	0	0	**78,844**
Donated at 1 April 2009	2,114	14,500	367	1,175	568	58	3	**18,785**
Total at 1 April 2009	**48,390**	**241,902**	**3,536**	**12,245**	**18,478**	**2,143**	**474**	**327,168**
Net book value								
Purchased at 31 March 2010	49,185	139,307	3,114	26,944	18,684	2,583	739	**240,556**
Finance Lease at 31 March 2010	0	78,248	0	0	1,064	0	0	**79,312**
Donated at 31 March 2010	2,133	11,444	552	2,396	810	40	3	**17,378**
Total at 31 March 2010	**51,318**	**228,999**	**3,666**	**29,340**	**20,558**	**2,623**	**742**	**337,246**

8.2 Analysis of property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under Construction	Plant & Machinery	Information Technology	Furniture & Fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Net book value								
Protected assets at 31 March 2010	51,318	225,016	3,666	0	0	0	0	**280,000**
Unprotected assets at 31 March 2010	0	3,983	0	29,340	20,558	2,623	742	**57,246**
Total at 31 March 2010	**51,318**	**228,999**	**3,666**	**29,340**	**20,558**	**2,623**	**742**	**337,246**

Of the totals at 31 March 2010, £nil (31 March 2009: £nil) related to dwellings valued at open market value.

8. Property, plant and equipment 2008/2009

8.3 Property, plant and equipment at 31 March 2009 comprise the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under Construction	Plant & Machinery	Information Technology	Furniture & Fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2008	54,921	232,789	3,573	6,362	32,392	16,785	491	**347,313**
Additions - purchased	0	1,361	0	17,001	6,145	501	184	**25,192**
Additions - donated	0	22	0	860	0	0	0	**882**
Impairments charged to revaluation reserve	(34)	(2,996)	0	0	0	0	0	**(3,030)**
Reclassifications	0	11,978	0	(11,978)	0	0	0	**0**
Revaluation surpluses	(6,497)	475	(37)	0	812	0	13	**(5,234)**
Disposals	0	0	0	0	(810)	0	0	**(810)**
Cost or valuation at 31 March 2009	**48,390**	**243,629**	**3,536**	**12,245**	**38,539**	**17,286**	**688**	**364,313**
Accumulated depreciation at 1 April 2008	0	784	0	0	17,646	14,094	160	**32,684**
Provided during the year	0	8,012	112	0	2,602	1,049	50	**11,825**
Impairments recognised in operating expenses	0	(1,244)	0	0	0	0	0	**(1,244)**
Revaluation surpluses	0	(5,825)	(112)	0	427	0	4	**(5,506)**
Disposals	0	0	0	0	(614)	0	0	**(614)**
Accumulated depreciation at 31 March 2009	**0**	**1,727**	**0**	**0**	**20,061**	**15,143**	**214**	**37,145**
Net book value								
Owned at 1 April 2008	52,454	144,556	3,195	3,540	12,741	2,614	327	**219,427**
Finance Lease at 1 April 2008	0	75,110	0	0	1,312	0	0	**76,422**
Donated at 1 April 2008	2,467	12,339	378	2,822	693	77	4	**18,780**
Total at 1 April 2008	**54,921**	**232,005**	**3,573**	**6,362**	**14,746**	**2,691**	**331**	**314,629**
Net book value								
Purchased at 31 March 2009	46,276	149,746	3,169	11,070	16,722	2,085	471	**229,539**
Finance Lease at 31 March 2009	0	77,656	0	0	1,188	0	0	**78,844**
Donated at 31 March 2009	2,114	14,500	367	1,175	568	58	3	**18,785**
Total at 31 March 2009	**48,390**	**241,902**	**3,536**	**12,245**	**18,478**	**2,143**	**474**	**327,168**

8.4 Analysis of property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under Construction	Plant & Machinery	Information Technology	Furniture & Fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Net book value								
Protected assets at 31 March 2009	48,390	238,637	3,536	0	0	0	0	**290,563**
Unprotected assets at 31 March 2009	0	3,265	0	12,245	18,478	2,143	474	**36,605**
Total at 31 March 2009	**48,390**	**241,902**	**3,536**	**12,245**	**18,478**	**2,143**	**474**	**327,168**

9. Finance Leases

Note 9.1 Net book value of assets held under finance leases at 31 March 2010

	Land	Buildings excluding dwellings	Dwellings	Assets under Construction	Plant & Machinery	Information Technology	Furniture & Fittings	PFI arrangements	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£0	£'000
Cost or valuation at 1 April 2009	0	0	0	0	1,436	0	0	77,656	**79,092**
Additions - purchased	0	0	0	0	0	0	0	0	**0**
Revaluation surpluses	0	0	0	0	0	0	0	592	**592**
Cost or valuation at 31 March 2010	**0**	**0**	**0**	**0**	**1,436**	**0**	**0**	**78,248**	**79,684**
Accumulated depreciation at 1 April 2009	0	0	0	0	248	0	0	0	**248**
Provided during the year	0	0	0	0	124	0	0	2,176	**2,300**
Revaluation surpluses	0	0	0	0	0	0	0	(2,176)	**(2,176)**
Accumulated depreciation at 31 March 2010	**0**	**0**	**0**	**0**	**372**	**0**	**0**	**0**	**372**
Net book value									
Purchased at 1 April 2009	0	0	0	0	1,188	0	0	77,656	**78,844**
Donated at 1 April 2009	0	0	0	0	0	0	0	0	**0**
Total at 1 April 2009	**0**	**0**	**0**	**0**	**1,188**	**0**	**0**	**77,656**	**78,844**
Net book value									
Purchased at 31 March 2010	0	0	0	0	1,064	0	0	78,248	**79,312**
Donated at 31 March 2010	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2010	**0**	**0**	**0**	**0**	**1,064**	**0**	**0**	**78,248**	**79,312**

9. Finance Leases

Note 9.1 Net book value of assets held under finance leases at 31 March 2009

	Land	Buildings excluding dwellings	Dwellings	Assets under Construction	Plant & Machinery	Information Technology	Furniture & Fittings	PFI arrangements	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£0	£'000
Cost or valuation at 1 April 2008	0	0	0	0	1,436	0	0	76,560	**77,996**
Additions - purchased	0	0	0	0	0	0	0	0	**0**
Revaluation surpluses	0	0	0	0	0	0	0	1,096	**1,096**
Cost or valuation at 31 March 2009	**0**	**0**	**0**	**0**	**1,436**	**0**	**0**	**77,656**	**79,092**
Accumulated depreciation at 1 April 2008	0	0	0	0	124	0	0	1,450	**1,574**
Provided during the year	0	0	0	0	124	0	0	2,055	**2,179**
Revaluation surpluses	0	0	0	0	0	0	0	(3,505)	**(3,505)**
Accumulated depreciation at 31 March 2009	**0**	**0**	**0**	**0**	**248**	**0**	**0**	**0**	**248**
Net book value									
Purchased at 1 April 2008	0	0	0	0	1,312	0	0	75,110	**76,422**
Donated at 1 April 2008	0	0	0	0	0	0	0	0	**0**
Total at 1 April 2008	**0**	**0**	**0**	**0**	**1,312**	**0**	**0**	**75,110**	**76,422**
Net book value									
Purchased at 31 March 2009	0	0	0	0	1,188	0	0	77,656	**78,844**
Donated at 31 March 2009	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2009	**0**	**0**	**0**	**0**	**1,188**	**0**	**0**	**77,656**	**78,844**

10. Inventories

	31 March 2010	31 March 2009
	£'000	£'000
Materials	11,243	9,433
Work in progress	0	0
Finished goods	0	0
TOTAL INVENTORIES	**11,243**	9,433

11. Trade receivables and other receivables

	31 March 2010	31 March 2009	31 March 2008
	£'000	£'000	£'000
Current trade and other receivables			
NHS Receivables	**21,487**	22,200	15,616
Other receivables with related parties	**100**	183	1,430
Provision for impaired receivables	**(2,860)**	(2,533)	(2,024)
Prepayments	**3,194**	1,819	1,432
Accrued income	**2,708**	3,236	2,739
PDC receivable	**66**	0	0
Other receivables	**13,644**	13,074	10,498
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**38,339**	37,979	29,691
Non-Current trade and other receivables			
NHS Receivables	**2,333**	2,464	2,519
Other receivables	**2,441**	2,554	2,439
TOTAL NON CURRENT TRADE AND OTHER RECEIVABLES	**4,774**	5,018	4,958

The NHS Debtor falling due after more than one year (and £118,169 included NHS debtors falling due within one year) reflect agreements with commissioners to cover creditors for early retirements and their related unwinding of discount.

11.2 Provision for impairment of receivables	**2009/2010**	2008/2009
	£'000	£'000
At 1 April	**2,533**	2,024
Increase in provision	**921**	2,531
Amounts utilised	**(305)**	0
Unused amounts reversed	**(289)**	(2,022)
At 31 March	**2,860**	2,533

11.3 Analysis of impaired receivables	**31 March 2010**	31 March 2009
	£'000	£'000
Ageing of impaired receivables		
Up to three months	**0**	0
In three to six months	**0**	0
Over six months	**2,860**	2,533
Total	**2,860**	2,533
Ageing of non-impaired receivables past their due date		
Up to three months	**35,168**	21,037
In three to six months	**1,333**	2,085
Over six months	**6,612**	10,282
Total	**43,113**	33,404

12. Trade and other payables

	31 March 2010	31 March 2009	31 March 2008
	£'000	£'000	£'000
Current trade and other payables			
Receipts in advance	**1,511**	2,764	578
NHS payables	**11,253**	10,877	11,991
Amounts due to other related parties	**0**	0	0
Trade payables - capital	**1,448**	2,076	707
Other trade payables	**7,929**	6,775	12,132
Taxes payable	**6,892**	6,468	6,043
Other payables	**6,112**	5,839	6,333
Accruals	**11,316**	18,662	12,622
PDC payable	**0**	0	0
TOTAL CURRENT TRADE AND OTHER PAYABLES	**46,461**	53,461	50,406
Non-current trade and other payables			
NHS payables	**0**	587	0
TOTAL NON-CURRENT TRADE AND OTHER PAYABLES	**0**	587	0

13. Other liabilities

	31 March 2010	31 March 2009	31 March 2008
	£'000	£'000	£'000
Current other liabilities			
Deferred Income	**2,546**	1,657	715
Deferred Government Grant	**205**	262	318
TOTAL OTHER CURRENT LIABILITIES	**2,751**	1,919	1,033
Non-current other liabilities			
Deferred Income	**0**	0	0
Deferred Government Grant	**0**	0	0
TOTAL OTHER NON CURRENT LIABILITIES	**0**	0	0

14. Borrowings

	31 March 2010	31 March 2009	31 March 2008
	£'000	£'000	£'000
Current borrowings			
Loans from Foundation Trust Financing Facility	**1,012**	4,637	0
Other Loans	**38**	0	0
Obligations under finance leases	**124**	124	123
Obligations under Private Finance Initiative contracts	**608**	0	0
TOTAL CURRENT BORROWINGS	**1,782**	4,761	123
Non-current borrowings			
Loans from Foundation Trust Financing Facility	**13,888**	4,756	0
Other Loans	**118**	0	0
Obligations under finance leases	**124**	249	373
Obligations under Private Finance Initiative contracts	**77,789**	91,184	89,629
TOTAL OTHER NON CURRENT LIABILITIES	**91,919**	96,189	90,002

15. Finance lease obligations

	31 March 2010	31 March 2009
	£'000	£'000
Gross lease liabilities	**334**	**502**
of which liabilities are due		
- not later than one year;	**167**	177
- later than one year and not later than five years;	**167**	325
- later than five years.	**0**	0
Finance charges allocated to future periods	**(86)**	(129)
Net lease liabilities	**248**	373
of which liabilities are due		
- not later than one year;	124	124
- later than one year and not later than five years;	124	249
- later than five years.	0	0

16. PFI obligations on Statement of Financial Position

	31 March 2010	31 March 2009
	£'000	£'000
Gross PFI liabilities	**230,875**	**380,824**
of which liabilities are due		
- not later than one year;	**8,246**	9,245
- later than one year and not later than five years;	**32,982**	39,351
- later than five years.	**189,647**	332,228
Finance charges allocated to future periods	**(152,478)**	(289,639)
Net PFI liabilities	**78,397**	91,185
of which liabilities are due		
- not later than one year;	608	0
- later than one year and not later than five years;	3,087	0
- later than five years.	74,702	91,185

16.2 The trust is committed to make the following payments for on-Statement of Financial Position PFIs obligations during the next year in which the commitment expires:

	31 March 2010	31 March 2009
	Total	Total
	£'000	£'000
Within one year	**0**	0
2nd to 5th years (inclusive)	**0**	0
6th to 10th years (inclusive)	**0**	0
11th to 15th years (inclusive)	**0**	0
16th to 20th years (inclusive)	**0**	0
21st to 25th years (inclusive)	**0**	0
26th to 30th years (inclusive)	**29,230**	24,095
31st to 35th years (inclusive)	**0**	0
36th year and beyond	**0**	0

The estimated annual payments in future years are not expected to be materially different from those which the Trust is committed to make during the next year.

The project enables the centralisation of acute services in new and refurbished buildings on the Denmark Hill site following the transfer of services from Dulwich Hospital and Mapother House. The construction and provision of site-wide catering, domestic and portering services will be undertaken by Hpc (King's College Hospital) Plc. The project is being financed by means of a wrapped, index linked bond guaranteed by MBIA-AMBAC and debt and equity capital provided by Costain, Skanska, Sodexho and Edison Capital. The contract period is 38 years including the construction phase. Annual payments by the Trust will be dependent on availability and service quality standards being met by the contract.

Phase 1 of the PFI scheme, the construction and management of a new clinical wing, was the 'Golden Jubilee Wing', and this building was made available to the Trust in September 2002.

Phase II of the PFI scheme was the refurbishment of the existing Ruskin Wing.

As part of the total scheme, HpC assumed responsibility for the provision of site-wide catering, domestic and portering services from April 2000. The cost of these services were £19,765k for the period to 31 March 2010 and they were included within the revenue operating expenses of the Trust. The expected cost for 2010/11 is £19,754k.

	£'000
Net book value of the PFI scheme	78,248

17. Prudential borrowing limit

The NHS Foundation Trust is required to comply and remain within a prudential borrowing limit.

This is made up of two elements:

i the maximum cumulative amount of long-term borrowing that enables the NHSFT to remain within the limit set by Monitor.

A Tier 1 Limit is set by Monitor for NHSFTs based on their annual plans and in accordance with the ratios below. This limit applies for the whole year, subject only to material changes in the financial position of the NHSFT during the year.

A Tier 2 Limit is available, in appropriate circumstances, to accommodate affordable 'major investments' including PFI schemes. When an NHSFT is planning a transaction that would exceed its Tier 1 Limit, it is required to submit a request to Monitor for a Tier 2 Limit, which, if approved, will replace the Tier 1 Limit. The Tier 2 limit will be subject to a maximum cap, determined through the ratio tests used in setting the Tier 1 limit, but with the thresholds shown below.

Financial Ratio	**Actual Ratio 2009/2010**	Actual Ratio 2008/2009	**Tier 1 PBC Ratio Thresholds**	**Tier 2 Cap Ratio Thresholds**
Minimum dividend cover	**2.60**	3.98	**>1x**	**>1x**
Minimum interest cover	**3.02**	25.30	**>3x**	**>2x**
Minimum debt service cover	**2.57**	16.80	**>2x**	**>1.5x**
Maximum debt service to revenue	**1.98%**	0.41%	**<2.5%**	**<10%**

ii the amount of any working capital facility approved by Monitor.

The limit on the Working Capital Facility is set annually by Monitor, although variations can be requested within the year by an NHSFT or proposed by Monitor. The size of the facility will vary according to individual circumstances of each NHSFT. The Working Capital Facility is available, up to its own limit, for for short-term cash flow management.

	31 March 2010	31 March 2009
	£'000	£'000
Total long term borrowing limit set by Monitor	**108,000**	98,000
Working capital facility agreed by Monitor	**25,000**	25,000
TOTAL PRUDENTIAL BORROWING LIMIT	**133,000**	123,000
Long term borrowing at 1 April	**96,189**	90,003
Net actual borrowing/(repayment) in year - long term	**(4,270)**	6,186
Long term borrowing at 31 March	**91,919**	96,189
Working capital borrowing at 1 April	**0**	0
Net actual borrowing/(repayment) in year - working capital	**0**	0
Working capital borrowing at 31 March	**0**	0

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

18. Provisions for liabilities and charges

	Pensions relating to other staff	Legal claims	Other	Total
	£'000	£'000	£'000	£'000
At 1 April 2009	9,376	303	468	**10,147**
Arising during the year	0	99	71	**170**
Utilised during the year	(715)	(4)	(468)	**(1,187)**
Reversed unused	(66)	(246)	0	**(312)**
Unwinding of discount	189	0	0	**189**
At 31 March 2010	**8,784**	**152**	**71**	**9,007**

Expected timing of cashflows:	**Current**			**Non-current**		
	31 March 2010	31 March 2009	31 March 2008	**31 March 2010**	31 March 2009	31 March 2008
	£'000	£'000	£'000	**£'000**	£'000	£'000
Pensions relating to other staff	**716**	713	700	**8,068**	8,663	9,218
Other legal claims	**152**	303	313	**0**	0	0
Agenda for Change	**0**	0	300	**0**	0	0
Other	**71**	468	2,621	**0**	0	0
	939	1,484	3,934	**8,068**	8,663	9,218

Clinical Negligence

£43,136,263 is included in the provisions of the NHS Litigation Authority at 31 March 2010 in respect of clinical negligence liabilities of the trust. The NHS Litigation Authority is carrying provisions with a value of £748,897 in relation to ELS and £42,387,366 in relation to CNST for King's College Hospital NHS Foundation Trust. The ELS (Existing Liabilities Scheme) was superceded by the CNST (Clinical Negligence Scheme for Trusts).

Pensions

The measure of the Trust's pension liability for early retired staff was recalculated in 2001/02. The NHS Pension Agency capitalisation tables for the NHS Pension Scheme were used to determine the full liability rather than using the average retirement age of the employees minus average current cost of these employees.

Legal Claims

The provision is based upon information provided by the NHS Litigation Authority and refers to non-clinical claims against the Trust (e.g. Public and Employers Liability cases)

Other

The Foundation Trust has provided £71k for Paediatric Surgeon pay arrears (£50k) and for Consultant pay arrears (£21k).

19. Revaluation reserve

	Revaluation Reserve - intangibles	Revaluation Reserve - property, plant and equipment	31 March 2010 Total Revaluation Reserve	31 March 2009 Total Revaluation Reserve
	£'000	£'000	£'000	£'000
Revaluation reserve at 1 April	**37**	**91,739**	**91,776**	91,637
Revaluation gains/(losses) and impairment losses on intangible assets	**7**		**7**	10
Revaluation gains/(losses) and impairment losses property, plant and equipment		**(10,352)**	**(10,352)**	642
Transfers to the income and expenditure account in respect of assets disposed of	**0**	**(317)**	**(317)**	(167)
Other transfers between reserves	**0**	**0**	**0**	(346)
Revaluation reserve at 31 March	**44**	**81,070**	**81,114**	91,776

20. Cash and cash equivalents

	31 March 2010	31 March 2009
	£'000	£'000
At 1 April	**33,886**	26,087
Net change in year	**(21,048)**	7,799
At 31 March	**12,838**	33,886
Broken down into:		
Cash at commercial banks and in hand	**8,586**	4,202
Cash with the Government Banking Service	**4,252**	29,684
TOTAL CASH AND CASH EQUIVALENTS	**12,838**	33,886

21. Contractual capital commitments

Commitments under capital expenditure contracts at 31 March 2010 were £10.033million (31 March 2009: £10.228m).

These contracts comprise the completion of the New Energy Centre (£550k) and the Energy Saving Scheme (£304k), Infill Block 3 (£7.463m), Sydenham Renal Dialysis Unit (£177k), Bereavement Offices (£7k), Dental extension including Medical Photography (£251k), Programme Investigation Unit (£319k), the Clinical Trials Unit (£7k), refurbishment of Breast Screening Unit (£87k), Dental front entrance (£32k), Unit 3 Coldharbour Lane (£547k), Unit 7 Coldharbour Lane(£5k), GJW conversion (£5k) and the redevelopment of 65-67 Coldharbour Lane (£279k)

It is anticipated that all these projects will be completed in the next financial year.

22. Events after the reporting period

There are no post Statement of Financial Position events having a material effect on the accounts. (31 March 2009: there were no post Statement of Financial Position events having a material effect on the accounts.)

23. Contingent (Liabilities) / Assets

	31 March 2010 £'000	31 March 2009 £'000
Contingent liabilities	**(63)**	(115)
Amounts recoverable against contingent liabilities	**0**	58
Net value of contingent liabilities	**(63)**	(57)

The above contingencies refer to non-clinical legal claims, dealt with by the NHS Litigation Authority on behalf of the Trust.

In common with many other Trusts, it is possible that other claims could arise in the future due to incidents which have already occurred. The future expenditure which may arise from such incidents cannot be determined until such time as a claim is formally made.

24. Related Party Transactions

King's College Hospital NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

The Department of Health is regarded as a related party. During the year King's College Hospital NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

The main local commissioners are Lambeth PCT, Southwark PCT and Lewisham PCT. Additionally the Trust has transacted with a large number of other PCTs and NHS Trusts as well as the NHS Litigation Authority and NHS Purchasing and Supply Agency. The Trust has also received revenue and capital payments from a number of charitable funds, principally the King's College Hospital Charitable Trust.

Value of transactions/balances (other than salary) with related parties in 2009/10	**Income £'000**	**Expenditure £'000**	**Receivables £'000**	**Payables £'000**
Department of Health	4,454	11	130	200
Other NHS Bodies	546,295	38,485	21,461	11,053
Charitable Funds	1,894	2	173	0

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. There were also many transactions with King's College London in respect of education, training and research and development.

During the year none of the Board Members, the Foundation Trust's Governers, members of the key management staff or parties related to them has undertaken any material transactions with King's College Hospital NHS Trust.

25. Financial Instruments

IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The Trust does not have any complex financial instruments and does not hold or issue financial instruments for speculative trading purposes. Because of the continuing service provider relationship that the NHS Foundation Trust has with Primary Care Trusts and the way those Primary Care Trusts are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities.

Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The NHS Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

The Foundation Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Foundation Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Foundation Trust treasury activity is subject to review by the Trust's internal auditors.

Liquidity risk

The Foundation Trust's net operating costs are incurred under annual service agreements with Primary Care Trusts, which are financed from resources voted annually by Parliament. The Foundation Trust also largely finances its capital expenditure from funds made available from Government under an agreed borrowing limit. King's College Hospital NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

Interest-Rate Risk

68% of the Foundation Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. King's College Hospital NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk. The two tables belwo show the interest rate profiles of the Foundation Trust's financial assets and liabilities.

Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Credit Risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2010 are in receivables from customers, as disclosed in the Debtors note (Note 13).

25.1 Financial Assets

					Fixed rate		
Currency	**Total**	**Floating rate**	**Fixed rate**	**Non-interest bearing**	**Weighted average interest rate**	**Weighted average period for which fixed**	**Non-interest bearing weighted average term**
	£'000	**£'000**	**£'000**	**£'000**	**%**	**Years**	**Years**
At 31 March 2010							
Sterling	47,466	12,838	2,451	32,177	0.7%	unlimited	0
Gross financial assets	**47,466**	**12,838**	**2,451**	**32,177**			
At 31 March 2009							
Sterling	69,521	33,886	2,579	33,056	3.3%	unlimited	0
Gross financial assets	**69,521**	**33,886**	**2,579**	**33,056**			

25.2 Financial Liabilities

					Fixed rate		
Currency	**Total**	**Floating rate**	**Fixed rate**	**Non-interest bearing**	**Weighted average interest rate**	**Weighted average period for which fixed**	**Non-interest bearing weighted average term**
	£'000	**£'000**	**£'000**	**£'000**	**%**	**Years**	**Years**
At 31 March 2010							
Sterling	140,331	0	102,708	37,623	3.8%	unlimited	0
Gross financial liabilities	**140,331**	**0**	**102,708**	**37,623**			
At 31 March 2009							
Sterling	154,527	0	111,097	43,430	0.5%	unlimited	0
Gross financial liabilities	**154,527**	**0**	**111,097**	**43,430**			

25.3 Foreign currency risk

The Trust has no/negligible foreign currency income or expenditure.

25.4 Financial instruments by category

	31 March 2010 £'000	31 March 2009 £'000
Financial assets		
Loans and receivables (including cash and cash equivalents)	47,466	69,521
	47,466	69,521
Financial Liabilities		
Other financial liabilities	140,331	154,528
	140,331	154,528

25.5 Fair values of financial instruments at 31 March 2010

Financial assets	**Book Value £'000**	**Fair value £'000**	**Basis of fair valuation**
Non current trade and other receivables excluding non financial assets	2,441	2,441	Note a
Other	12,838	12,838	
Total	15,279	15,279	
Financial Liabilities			
Provisions under contract	9,007	9,007	Note b
Loans	15,056	15,056	
Other	78,645	29,411	
Total	102,708	53,474	

Notes

a. These recievables reflect agreements with commissioners to cover payables over 1 year for early retirements and provisions under contract, and their related interest charge/unwinding of discount. In line with note b, below, fair value is not significantly different from book value.

b. Fair value is not significantly different from book value since, in the calculation of book value, the expected cash flows have been discounted by the Treasury discount rate of 2.2% in real terms.

26. Third Party Assets

The Trust held £6,483 cash at bank and in hand at 31 March 2010 (£4,770 at 31 March 2009) which relates to monies held b the NHS Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

27. Losses and Special Payments

There were 157 cases of losses and special payments (655 cases in 2008/09) totalling £388,164 (£688,071 in 2008/09) paid during the year ending 31 March 2010.

28. Corporation Tax

	31 March 2010 £'000	31 March 2009 £'000
UK Corporation tax expense	**0**	(9)
Adjustments in respect of prior years	**0**	0
Total income tax expense in Statement of Comprehensive Income	**0**	(9)

29. Reconciliation from UK GAAP to IFRS

International Financial Reporting Standards (IFRS) are accounting standards issued by the International Accounting Standards Board (IASB). The Treasury announced that public sector bodies (including NHS Foundation Trusts) will be required to follow IFRS from 2009-10. Although 2009-10 is the first year of accounting using IFRS, comparative figures are required for 2008-09. To produce the 2008-09 figures an IFRS compliant balance sheet is required as at 1 April 2008.

The following summarises the impact of the key adjustments made to the Trust's primary statements as a result of the restatement of the accounts under International Financial Reporting Standards.

Employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. Under IAS 19 the cost of annual leave entitlement earned but not taken by employees at the end of period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Accounting for Leases

International Accounting Standard 17 provides updated guidance on the categorisation of leases. IAS 17 outlines criteria which have been used to assess whether the Trust's current lease agreements are operating or finance leases and these leases have been reclassified where necessary.

Accounting for Private Finance Initiatives

IFRIC Interpretation 12 provides guidance on the accounting for public-to-private service concession arrangements. IFRIC 12 applies to operators, however the Treasury has used this as the basis to determine whether PFI schems should be recognised on-Statement of Fnancial Position if leasing bodies. As the Trust's PFI scheme fall within the remit of IFRIC 12, Phase I of the PFI Scheme has been reclassified as on-Statement of Financial Position and the changes have been applied retrospectively. The Trust has followed the PFI model issued by the Department of Health in accounting for the PFI scheme.

Presentation of Financial Statements

International Accounting Standard 1 sets overall requirements for the presentation of financial statements, guidelines for their structure and minimum requirements for their content. IAS 1 has been implemented in the production of the financial statements for the financial year ended 31 March 2010.

29.1 Reconciliation of reported profits for the year ended 31 March 2009

	UK GAAP			IFRS
	2008/2009 £'000	Accrual for unused annual leave £'000	PFI and other finance lease adjustments £'000	2008/2009 £'000
Income from activities	443,042			443,042
Other operating income	74,476			74,476
Operating expenses	(492,726)	(191)	4,864	(488,053)
OPERATING SURPLUS/(DEFICIT)	24,792	(191)	4,864	29,465
Profit/(loss) on disposal of fixed assets	(25)			(25)
SURPLUS/(DEFICIT) BEFORE INTEREST	24,767	(191)	4,864	29,440
Finance income	1,228			1,228
Finance costs - interest expense	(1,384)		(9,454)	(10,838)
Other finance costs - unwinding of discount	(201)			(201)
SURPLUS/(DEFICIT) BEFORE TAXATION	24,410	(191)	(4,590)	19,629
Taxation	(9)			(9)
SURPLUS/(DEFICIT) AFTER TAXATION AND MINORITY INTEREST	24,401	(191)	(4,590)	19,620
PDC dividends payable	(8,740)			(8,740)
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR	**15,661**	**(191)**	**(4,590)**	**10,880**

29. Reconciliation from UK GAAP to IFRS

29.2 Reconciliation of equity and net assets as at 31 March 2009

	UK GAAP Audited Accounts 31 March 2009 £'000	Presentation of Financial Statements IAS1 £'000	Accrual for unused annual leave IAS19 £'000	PFI and other finance lease adjustments IAS17 IFRIC12 £'000	IFRS 31 March 2009 £'000	UK GAAP Audited Accounts 31 March 2008 £'000	Presentation of Financial Statements IAS1 £'000	Accrual for unused annual leave IAS19 £'000	PFI and other finance lease adjustments IAS17 IFRIC12 £'000	IFRS 31 March 2008 £'000
Non-current Assets										
Intangible assets	1,010				1,010	751				751
Tangible assets	265,507			61,661	327,168	252,429			62,200	314,629
Trade and other receivables		5,018			5,018		4,958			4,958
Total Non-current assets	266,517	5,018	0	61,661	333,196	253,180	4,958	0	62,200	320,338
Current assets										
Stocks and work in progress	9,433				9,433	8,673				8,673
Trade and other receivables	42,997	(5,018)			37,979	34,649	(4,958)			29,691
Cash at bank and in hand	33,886				33,886	26,087				26,087
Total current assets	86,316	(5,018)	0	0	81,298	69,409	(4,958)	0	0	64,451
Current liabilities										
Trade and other payables	(59,427)	13,746	(1,312)		(46,993)	(51,037)	7,795	(1,121)		(44,363)
Provisions		(1,484)			(1,484)		(3,934)			(3,934)
Borrowings		(5,359)		598	(4,761)		(719)		596	(123)
Tax Payable		(6,468)			(6,468)		(6,043)			(6,043)
Other Liabilities		(1,919)			(1,919)		(1,033)			(1,033)
Total current liabilities	(59,427)	(1,484)	(1,312)	598	(61,625)	(51,037)	(3,934)	(1,121)	596	(55,496)
Total assets less current liabilities	293,406	(1,484)	(1,312)	62,259	352,869	271,552	(3,934)	(1,121)	62,796	329,293
Non-current liabilities										
Trade and other payables	(17,595)	17,008			(587)	(12,974)	12,974			0
Borrowings		(17,008)		(79,181)	(96,189)		(12,974)		(77,028)	(90,002)
Provisions	(10,147)	1,484			(8,663)	(13,152)	3,934			(9,218)
Total non-current liabilites	(27,742)	1,484	0	(79,181)	(105,439)	(26,126)	3,934	0	(77,028)	(99,220)
TOTAL ASSETS EMPLOYED	**265,664**	**0**	**(1,312)**	**(16,922)**	**247,430**	**245,426**	**0**	**(1,121)**	**(14,232)**	**230,073**
Financed by (taxpayers' equity)										
Public dividend capital	128,052				128,052	122,065				122,065
Revaluation reserve	79,321			12,455	91,776	81,082			10,555	91,637
Donated asset reserve	18,785				18,785	18,780				18,780
Income and expenditure reserve	39,506		(1,312)	(29,377)	8,817	23,499		(1,121)	(24,787)	(2,409)
TOTAL TAXPAYERS' EQUITY	**265,664**	**0**	**(1,312)**	**(16,922)**	**247,430**	**245,426**	**0**	**(1,121)**	**(14,232)**	**230,073**