

KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST ANNUAL REPORT AND ACCOUNTS 2018-19

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***King's College Hospital NHS Foundation Trust
Annual Report and Accounts 2018/19***

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(a) of the National Health Service Act 2006***

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GLOSSARY

ACRONYM	MEANING
BAF	Board Assurance Framework
BREEAM	Building Research Establishment Environmental Assessment Method
BAME	Black and Minority Ethnic
CCS	Crown Commercial Services
CCU	Critical Care Unit
CHP	Combined Heat and Power
CIP	Cost Improvement Programme
CO2	Carbon Dioxide
COO	Chief Operating Officer
CQC	Care Quality Commission
CQRG	Clinical Quality Review Group
CQUIN	Commissioning for Quality and Innovation
DHSC	Department of Health and Social Care
DIPC	Director of Infection Prevention and Control
DNA	Did Not Attend
DSPT	Data Security and Protection Toolkit
ECS	Emergency Care Standard (4 hour target)
ED	Emergency Department
EDS	Equality Delivery System
EMS	Environmental Management Scheme
EPR	Electronic Patient Record
ERAS	Enhanced Recovery after Surgery
ESR	Electronic Staff Record
FFT	Friends and Family Test
FSM	Financial Special Measures
FSUG	Freedom to Speak Up Guardian
GIRFT	Getting It Right First Time
GMC	General Medical Council
GSTT	Guys and St Thomas' NHS Foundation Trust
H&S	Health and Safety
HFMA	Health Finance Managers Association
HIN	Health Innovation Network
HR	Human Resources
ICO	Information Commissioner's Office
ICT	Information Computer Technology
IFRS	International Financial Recording Standards
IGSC	Information Governance Steering Committee
ISO	International Organisation for Standardisation
IT	Information Technology
JSCC	Joint Staff Consultative Group
KCH	King's College Hospital

ACRONYM	MEANING
KCL	King's College London
KE	King's Executive
KFM	King's Interventional Facilities Management
KHP	King's Health Partners
KITE	King's Improvement Through Engagement
KWfW	King's Way for Wards
LGFC	Lambeth GP's Food Co-op
LGBT	Lesbian, Gay, Bisexual, Transgender
MBSS Curriculum	
MRSA	Methicillin-resistant staphylococcus aureus
NCEPODS	National Confidential Enquiry into Patient Outcome and Death Studies
NED	Non-Executive Director
NHSI	NHS Improvement
NICE	National Institute for Clinical Excellence
OHSEL	Our Healthy South East London
PRUH	Princess Royal University Hospital
PSF	Provider Sustainability Fund
PTL	Patient Treatment List
QARC	Quality Assurance and Research Committee
QI	Quality Improvement
R&I	Research and Innovation
RGD	Regulatory Governance Department
RIDDOR	Reporting of Injuries, Dangerous Diseases and Dangerous Occurrences Regulations
RTT	Referral to Treatment
SDMP	Sustainable Development Management Plan
SDU	Sustainable Development Unit
SHMI	Standardised Hospital Mortality Index
SIRO	Senior Information Risk Owner
SLAM	South London and the Maudsley NHS Foundation Trust
SOF	Single Oversight Framework
UCC	Urgent Care Centre
ULEZ	Ultra Low Emission Zone
USP	Unique Selling Point
VBHC	Value Based Healthcare
VR	Virtual Reality
WRA	Workplace Risk Assessment
WRES	Workforce Race Equality Scheme

INTRODUCTION

Interim Chair's Statement

Since before my appointment as Interim Chair of King's College Hospital NHS Foundation Trust in February 2019, I have had a strong personal association with the hospital. As a local resident my family has used the hospital's services and since March I have had the opportunity to meet more staff across the Trust. It is evident that despite the challenges of the past few years, their dedication to our patients is inspiring.

Unfortunately, 2018/2019 was another disappointing year. While King's did identify and begin to tackle some of the underlying problems that led to the imposition of Financial Special Measures in December 2017, it has not been enough. Once again, the Trust significantly exceeded its original control total and ended the year £43.7 million adverse to plan with an adjusted Group deficit of £189.8 million. Additionally, the Trust did not meet all of the operational targets originally agreed with the regulator.

That is not to say that King's has not achieved some notable successes during the year. King's remains driven by a desire to do the very best for its patients. Together with the rest of the country, we commemorated the NHS' 70th anniversary, celebrating seven decades of compassionate and dedicated patient care; teaching and education that has created generations of clinical staff; and innovation that has made a huge difference to our patients. It was also a year of significant achievement in terms of further improving outcomes and standards of care. Last year, King's led a global research study that will improve the prognosis for patients with brain tumours; applied artificial intelligence technology to dramatically improve the diagnosis rate for people with a deadly fibrotic lung disease and was also the first London hospital to secure helicopter night flights thereby ensuring that critically injured patients can be ferried to our major trauma centre at Denmark Hill 24-hours a day.

However, looking to the future we must do better. It is now evident that our current situation is the cumulative result of poor operational and financial performance over a number of years and it is imperative that we halt further decline. Unequivocally, the continued delivery of high quality, safe patient care remains a priority but we must be realistic in our ambitions. We must focus on stabilising our operational and financial performance and meet the targets and trajectories set out in our 2019/20 operational plan.

The challenges that King's faces are not completely unique and the Trust must fully recognise that partnerships are a critical part of its solution. King's must strengthen and leverage existing partnerships as well as seek out new opportunities across the healthcare system. As a member of King's Health Partners as well as Our Healthier South East London, there is an opportunity for King's to play an even greater and more engaged, involved role. I also welcome the partnerships that the Princess Royal University Hospital is forging as part of the One Bromley integrated care system. Without a doubt, closer collaboration and co-operation will not only benefit the long-term recovery and sustainability of King's but also further improve the health and care for local residents across south-east London.

Finally, I would like to take this opportunity to welcome Dr Clive Kay as the new permanent Chief Executive for King's. Since his arrival in April not only has he demonstrated the leadership that King's needs but also made clear his commitment to both our staff and patients.

Sir Hugh Taylor
Interim Chair

PERFORMANCE REPORT

PERFORMANCE REPORT

Chief Executive's Statement

Since I arrived at King's in April 2019, I have spent time listening to and talking to staff across the Trust. Without exception, I have been impressed by their determination to do what is right for patients and to support one another. However this year King's fell short of its own expectations and those of our colleagues and partners across the healthcare system.

Our financial and operational performance in the last year has been amongst the worst in the country. While the Trust made savings of £56 million during the year, once again we have deviated significantly from our original control total and ended the year with an adjusted Group deficit of £189.8m million. Similarly, our operational performance was poor. While quality and safety were maintained overall, we have to quickly demonstrate sustainable improvement in both our financial and operational performance if we are to create a more stable future for our patients and staff.

But we should not forget the many achievements of the past year. As well as NHS 70 and the clinical innovations and innovations highlighted by our Chair, Sir Hugh Taylor, we continue to serve some of the most diverse local communities in the UK. From the pioneering work of The Havens and the partnership with charity Redthread in our Emergency Department at Denmark Hill, we are committed to improving access to services to local residents as much as possible. In the last year, we opened a new dialysis unit in Thamesmead and are also working with partners to lay the Foundations for integrated care systems that will transform healthcare provision for thousands of people.

However, in the short few months that I have been Chief Executive, it is clear to me that a great deal of work still needs to be done. To continue to deliver high quality care underpinned by robust financial management, King's must concentrate on what it can deliver and deliver it to the highest standards possible.

We cannot do this alone. I am grateful for the support of NHS Improvement, our Clinical Commissioning Groups and other partners across the network. Greater collaboration and partnership working will not only drive more positive change for patients by improving the services we provide but will also benefit our staff. It will create opportunities to share expertise and knowledge as well as contribute to their development.

Critically, our staff are vital to our future success. In the past year we have embarked on a long-term strategy to improve the workplace and increase opportunities for staff. As well as leadership training for our managers, we launched King's Stars our Trust-wide staff recognition programme and enabled and supported a number of staff networks which provide a platform for two-way and constructive discussion. We need to maintain the momentum we have created, and find a way to balance achieving financial and operational security with supporting and empowering our staff. This will take time but I am committed to involving as many of our staff as possible in the key decisions that we must make if we are to secure a more positive future for King's.

I joined King's because I believe that it is a great Trust and because recovery is both possible and critical. Not only will it benefit our patients and partners but also it will also strengthen the local, regional and national healthcare system we are part of.

Dr Clive Kay
Chief Executive

Overview of Performance

The overview is a summary providing information about the Trust, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

Purpose

King's College Hospital NHS Foundation Trust has as its principal purpose the provision of goods and services for the purposes of the health service in England.

Activities

King's College Hospital NHS Foundation Trust is renowned for the international reputation of its speciality services. These included the tertiary services for liver disease and transplantation, neurosciences, diabetes, cardiac services, haematology and foetal medicine.

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

King's provides services to local residents of the London Boroughs of Lambeth, Southwark, Bromley, Bexley and Lewisham from its sites at Denmark Hill, the Princess Royal University Hospital Farnborough Common, Queen Mary's Hospital Sidcup, and Orpington Hospital. These include accident and emergency services, maternity, care of the elderly, orthopaedics, diabetes, ophthalmology, oncology, dermatology, and many more.

King's has a reputation as pioneers in medical research, with a record of innovation in a number of key fields. The hospital is home to a number of leading clinical units and research centres, such as the Clinical Age Research Unit, the HIV Research Centre, and the Harris Birthright Centre. Developments have recently begun to build a new leading-edge Haematology Institute.

Brief History

King's College London was founded in 1829. Clinical teaching in the medical faculty was dependent on the Middlesex Hospital until 1839 when King's College London gained its own hospital in Portugal Street, which was rebuilt in 1861. The hospital moved to the Camberwell site in 1913.

It became part of the NHS in 1948 as a teaching hospital. The 1960s saw the introduction of a new dental school, maternity block (now the Ruskin Wing) and the King's liver unit. This was followed by the Normanby College of Nursing, Midwifery and Physiotherapy. In 1995 the UK's first specialist Motor Neurone Disease Care and Research Centre was established, and the Weston Education Centre was opened in 1997, accommodating the medical school, library and lecture theatres. A new Accident and Emergency Department was opened in the same year.

King's College Hospital received Foundation Trust status on 1 December 2006. Following the dissolution of South London Healthcare Trust, King's took over the Princess Royal University Hospital (PRUH) in October 2013.

Following a financially challenged 2017/18 the Trust was placed in Financial Special Measures on 11 December 2017 for breach of its NHS Provider Licence, having been in enhanced oversight for some years before that. Enforcement undertakings were issued in February 2018 and updated in August 2018.

Structure

In January 2017 the Trust moved from six to three clinical divisions/sites. They are

- Urgent Care, Planned Care and Allied Clinical Services (UPACs)
- Networked Care
- Princess Royal University Hospital and South Sites (PRUH)

By aligning the divisions in this way, the Trust was able to group the resources required for delivering similar types of care so that it could improve patient pathways and increase the efficiency of service delivery. It also aimed to provide clearer accountability. Alongside this, the Trust has a corporate centre that provides HR, finance, IT and other support to the organisation.

More about the Trust governance model can be found on page 31.

Our 5 Year BEST Strategy Goals

The following paragraphs outline the Trust's strategic goals. These were agreed in 2014/15 as part of a 5 year strategic plan. During 2018/19 the Trust strategy has been refreshed and new priorities will guide activity in 2019/20.

Best Quality of Care aims to deliver: services amongst the safest in the NHS; outcomes as good as the best in the NHS and globally; and patient satisfaction amongst the best in the NHS;

Excellent Teaching and Research aims to deliver: King's Health Partners research globally recognised; the Trust participating significantly in new GSTT/SLAM Biomedical Research Centres; Top performing Trust for clinical trials; Substantial growth in research income: Global USP in translational research using our clinical research and clinical trials facilities to maximum potential; Student ratings on educational experience amongst top 10% in NHS.

Skilled 'Can-Do' teams to support staff and provide a safe working environment by providing: Effective talent management; Skill development and resource planning; Vacancy rate no more than 3%; Embedding performance management culture and systems; Working well across teams, professions, wider health system.

Top Productivity aimed at improved and sustainable performance including: Fully embedding 'The King's Way'; Clinical and back office services redesigned using lean principles; Continuous improvement embedded at the front line - achieving productivity levels amongst top 10% in NHS; at least half of our staff trained in lean continuous improvement principles and techniques.

Risks to achieving our strategic goals

The Trust's approach to managing risk is outlined in the accountability report later in this document (page 84). The Trust has identified a number of risks that could affect the delivery of its strategy including:

- Financial constraints: the Trust has recorded a significant budget deficit in recent years.
- Increased demand for health services and a constrained site so opportunities for expansion are limited and the Trust's ability to meet access targets is more difficult.
- Capital constraints: the Trust has limited access to capital monies and a significant maintenance backlog.

These are covered in more detail on page 87 in this report.

King's Health Partners

The Trust is part of King's Health Partners (KHP), one of the UK's first and foremost Academic Health Science Centres. The partnership was established in 2009, incorporating King's College Hospital, King's College London, Guy's and St. Thomas', and South London and Maudsley.

Sustainability and Transformation Partnership

King's is a partner in *Our Healthier South East London* (OHSEL), the Sustainability and Transformation Partnership that covers London boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark. The organisations coming together comprise Clinical Commissioning Groups, local authorities, Foundation Trusts, Bromley Healthcare and primary care.

Details of Overseas Operations and Subsidiaries

King's Commercial Services Limited is the company established to oversee some key commercial operations on behalf of the Trust. It has continued to diversify income by expanding commercial activities both in the UK and overseas. It has now been in operation for ten years.

During that time, the first of the operating companies, Agnensis Limited, successfully established itself as a market leader in patient costing and benchmarking solutions before divesting the associated products in 2012. KCH Management Limited continues to develop a hospital management and consultancy business both in the UK and overseas, predominantly in the Middle East. There are currently three outpatient clinics open in the UAE, one in Abu Dhabi and one in Dubai. In early 2019 a full scale inpatient hospital opened in Dubai. The company operates a successful international recruitment business covering nurses and doctors for both King's and other healthcare organisations. In 2018/19 the recruitment team brought in 780 nurses into the UK and 329 into Kings supporting the nurse vacancy rate.

Viapath LLP is a pathology venture jointly owned by King's, Guy's and St Thomas' and Serco plc. The venture delivered a surplus attributable to King's in Viapath's 2018 financial year of £1.12m.

King's Interventional Facilities Management

King's College Hospital Interventional Facilities Management LLP (KFM) was created to provide a fully managed service across nine diagnostic and treatment facilities. These include theatres; adult critical care, radiology, cardiac catheter laboratories, liver laboratories, endoscopy, renal dialysis, children's critical care and dental. KFM maintains these facilities and equipment; and provides consumables, implants and devices used during clinical procedures.

Separately, KFM provides an end-to-end procurement and supply chain function for the Trust, working with operational leads to identify future requirements for equipment and consumables. KFM seeks to contribute to the Trust through the identification and delivery of cost improvement programme savings through more focussed contract management.

The Trust has consolidated a contribution of £0.5m from KFM for 2019/20.

Financial Performance and Sustainability

2018/19 remained a challenging year for the Trust's finances as the Trust continued its focus on financial control, recovery and improvement. The financial improvement plan was underpinned by an improved approach to budget setting that included pay reductions against run rate, mainly in agency spend, and a CIP. The Trust has continued development of the programme management of the financial improvement plan to mitigate either slippage on particular savings projects or the need to cover the impact of cost pressures.

The control total provided by NHS Improvement (NHSI) at the start of 2018/19 was a deficit of £146m. This included £75m of an overall financial improvement plan made up of pay reductions and the cost improvement projects. The Trust and NHSI recognised at the time of accepting the control total that there was a risk of £10m under delivery against the financial improvement plan and this materialised during the year with an overall saving of £56m achieved. In addition, there was a shortfall of NHS clinical income, partly due to unforeseen ward closures and delay to the opening of the new Critical Care Unit, as well as non-pay cost pressures such as consultancy spend associated with improving financial control. Although the control total was not varied formally it was understood that the Trust would not be able to achieve the control total by the middle of the year. The final outturn was a control total deficit of £189.8m (excludes Provider Sustainability Funding (PSF), impairment costs and the impact of capital donations/grants) slightly better than the year end forecast submitted at the end of the third quarter.

Liquidity and Capital

In 2018/19 the Trust drew down £145.7m of interim revenue and capital support loans. £134.8m represented cash support against the Trust 2018/19 deficit, with the remaining £10.9M designated as approved funding against 2017/18 capital projects which were carried forward for completion in the current financial year.

Total capital expenditure in 2018/19 was £33.1m. Significant areas of expenditure included the continued construction of the CCU, the reconfiguration of the Emergency Department at Denmark Hill, Electronic Patient Records system upgrade, ICT infrastructure and device upgrades and medical equipment. The Trust also continued to invest in the buildings infrastructure to ensure the most pressing maintenance needs were addressed.

Borrowings and Capital Plan

Due to the adoption of International Financial Reporting Standards (IFRS), the Trust's reported total borrowings include past expenditure on the private finance initiative schemes for the Golden Jubilee Wing and Ruskin Wing at Denmark Hill and the Princess Royal University Hospital and total £147.1m.

The majority of the Trust's borrowings are with the Department of Health and Social Care (DHSC) and comprise capital loans of £139.6m and revenue / working capital loans of £514.2m.

Going Concern

Due to the size of the financial deficit, the Board has carefully considered whether the accounts should be prepared on the basis of being a 'Going Concern' and whether there are uncertainties which may impact on the entity's ability to continue as a going concern.

The annual accounts provide a detailed analysis of the Trust's financial position. The Trust is reliant on Department of Health and Social Care and faces a number of risks, which represents a material uncertainty that may cast significant doubt as to the Trust's ability to continue as a going concern and therefore it may be unable to realise its assets and discharge its liabilities in the normal course of business. The financial statements do not include any adjustments that would result if the going concern basis were not appropriate.

After making enquiries, the directors have concluded that there is sufficient evidence that services will continue to be provided and that there is financial provision within the forward plans of commissioners. This provision will also be dependent on both acceptance and delivery of the financial recovery plans and continuation of support from the Department of Health and Social Care. The Directors have a reasonable expectation that this will be the case and have therefore prepared these financial statements on a going concern basis.

More information on going concern can be found in the notes to the Annual Accounts later in this report (see section 1.27).

PERFORMANCE ANALYSIS

Operational and Performance Highlights

Summary of performance

Kings College Hospital continued to have one of the highest levels of acute bed occupancy on its acute sites at Denmark Hill and PRUH throughout 2018/19, which restricted our ability to be able to respond to peaks in demand above expected levels. During 2018/19 the Trust struggled to maintain and improve patient access standards for emergency, elective and diagnostic care. We continued to see more elderly patients attending our emergency department (ED) on both acute sites, and an increase in the number of elderly patients who require subsequent admission to the hospital. This places additional pressure on wider capacity within the Trust across beds (including step-down beds at Orpington Hospital that we provide), outpatient clinics and diagnostic services.

Cancer referral demand into the Trust continued to increase with an 11% referral increase during 2018/19 which puts pressure on our ability to deliver the two week waiting time and 62-day time to first treatment cancer standards.

For 2018/19 the Trust continued to be monitored by its regulator, NHSI via the Single Oversight Framework reporting structure. The table below summarises the monthly performance achievement for the performance measures that are assessed in the Single Oversight Framework.

Single Oversight Framework performance for 2018/19

Single Oversight Framework Indicator		Kings College Hospital NHS Foundation Trust												Total for 2018/19
	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	
RTT Incomplete Performance	92.0%	80.6%	81.2%	80.9%	80.6%	80.6%	79.4%	79.1%	79.0%	78.0%	77.9%	78.1%	77.6%	79.4%
Cancer 62 day referral to treatment - GP Referral	85.0%	93.7%	95.3%	85.8%	85.9%	80.5%	76.0%	89.8%	90.0%	93.1%	91.2%	91.2%	92.1%	88.5%
Cancer 62 day referral to treatment - Screening Service	90.0%	94.3%	92.7%	84.9%	83.6%	85.9%	87.3%	84.3%	92.6%	90.8%	87.5%	86.5%	90.3%	87.4%
Diagnostic Waiting Times Performance < 6 Wks	> 99%	96.3%	96.6%	96.0%	94.5%	94.2%	92.9%	91.4%	88.9%	85.2%	87.3%	90.8%	92.7%	92.2%
A&E 4 hour performance (Sitrep)	95.0%	77.9%	79.8%	82.7%	78.0%	80.5%	76.3%	78.1%	73.8%	71.7%	69.6%	70.4%	73.7%	76.0%
Summary Hospital-level Mortality Indicator (SHMI)	< 1	0.94	0.95	0.96	0.97	0.97	0.97	0.96	0.95	0.95				0.95
VTE Risk Assessment	95.6%	96.2%	96.7%	96.9%	96.8%	97.1%	97.0%	97.6%	97.8%	97.6%	97.8%	97.7%	97.7%	97.3%
Clostridium difficile rates	71	6	2	6	13	9	7	5	7	5	5	6	9	80

Emergency Care Standard (ECS) '4-Hour Wait' Performance

Achievement of the Emergency Care Standard (ECS) four-hour performance standard continues to be a significant challenge among London Trusts as well as at Kings, on both its Denmark Hill and PRUH sites. An overall lack of patient flow within both of our acute sites is preventing any positive impact on performance improvement.

The Trust has recognised that a culture change that achieves site-wide engagement is a key enabler for both sites with targeted actions to deliver the recovery plan that has been agreed with NHSI. There are at least weekly reviews of actions through working groups on each site, with increased Board and Kings Executive (KE) oversight provided through monthly Board reporting and fortnightly KE reporting on progress against our recovery plan.

In the latter half of the year, the Trust has worked with Hunter Consulting to provide additional support to the Emergency Care Recovery Programme. The focus of this work is to improve end-to-end flow and achieve sustainable results. The team from Hunter were based across both of our acute sites with dedicated support to the challenges that are faced on each site. Hunter have also reviewed the Trust's governance framework structure and recommended a new governance structure which was signed off by the executive sponsor, and these arrangements were implemented in the last quarter of 2018/19.

On the Denmark Hill site the key areas of focus for flow improvement include ED flow and escalation processes, ambulatory care and front end assessment, improving site function and operational control, and a refresh of the Ward Board round standard.

On the PRUH site the key areas of focus include ED flow and escalation, and rollout of Board Round Standards and Content.

Referral to Treatment (RTT) 18 Week Access Targets

Achievement of the Referral to Treatment (18 Weeks) performance standard continues to be a challenge for the Trust. We continue to work closely with our regulator, local and national commissioners to develop and invest in plans to improve our overall RTT compliance and elimination of over 52 week breaches. These plans link with outpatient and theatre productivity improvement programmes to maximise the use of our day case theatres and outpatient clinics in-week, as well as use day case theatres and main theatres on the Orpington site at the weekend. We have also continued to use an insourcing provider to deliver additional weekend capacity in outpatients and day case theatres, specifically in Ophthalmology and Dermatology specialties, as well as endoscopy provision.

We are also working with other NHS and independent sector provider to provide additional capacity in bariatric surgery and elective Orthopaedics to reduce the number of over 52 week breach patients which was increasing during the first half of the year. The number of breaches has been reduced from 457 breaches reported in August to 192 breaches reported for the end of March 2019.

RTT data quality and validation has been a key area of focus for the year, and we have published a number of data quality reports within our operational PTL (patient tracker lists) system which can be accessed by our central validation team as well as divisional PTL users. We have been recruiting additional staff to the central validation team in the latter part of the year to focus on validation of 'lost to follow-up' pathways and the closure of these pathway referrals on our Patient Administration System.

Cancer Waiting Time Access Targets

Referral demand for cancer services has continued to increase in recent years including 2018/19. As a result, we have not been compliant with the two week wait GP referral standard since May 2018. Performance has gradually improved in the second half of the year, driven in part by the reduction in appointment polling ranges across all tumour groups at PRUH, with service areas in Gynaecology, Head & Neck and Urology all down to 8 days.

There are a number of high impact actions which the Trust has delivered throughout the year to improve performance, not only for the two week standard but also for the 62-day time to first definitive treatment standards. These form part of a comprehensive action plan which is reviewed weekly on both acute sites.

Urology at the PRUH have moved to delivering local anaesthetic template biopsies in an outpatient setting which creates more capacity and removes the constraints of running the service in theatres. Pathology turnaround times have been another constraint in the prostate pathway and this has been resolved by bringing reporting back in-house from an outsourced provider.

Additional virtual clinic capacity has been put into place on the Denmark Hill site for colorectal pathways which has resulted in a circa 300 patient reduction in the patient tracker list (PTL) size.

Diagnostic Waiting Time Access Targets

The Trust has not been compliant against the 99% target since December 2017, with performance worsening throughout 2018/19 due to capacity constraints and demand exceeding available capacity in a couple of diagnostic test areas.

Endoscopy demand at PRUH for both surveillance and diagnostic patients has outstripped capacity and during periods where emergency demand exceeds the available acute beds within our wards, we have been forced to admit patients to planned escalation areas such as our Endoscopy Suite overnight. This has a significant impact on our ability provide our endoscopy services as planned on the PRUH site. The South East London Cancer Alliance have supported the Trust and all local partners by funding operational management at PRUH as well as additional capacity in the Endoscopy Unit at Croydon University Hospital.

The Trust has become very concerned about the situation and a programme has been put in place to provide additional capacity in the private sector as well as making best use of capacity across the Trust and to ensure that patients are being properly prioritised. The Trust has also commenced a full review of all patients that have waited longer than they should have to understand whether they have come to harm as a result of their extended wait.

Radiology continues to utilise additional capacity including the use of independent sector providers, mobile imaging scanners and by providing additional sessions in-house. PRUH and South sites have also seen an increase in non-obstetric ultrasound breaches linked to the termination of a community scanning service.

Infection Prevention and Control

The Trust continues to monitor all other instances of healthcare-associated infections as a matter of priority. In 2018/19 there were six cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) at Denmark Hill and one case at the PRUH.

In 2018/19 there were 80 cases of C. difficile across the Trust. This was unfortunately, higher than the target set by the Department of Health and Social Care of 71 cases but lower than the previous year when there were 88 cases.

C. difficile Performance

	Cases in 2018/19	DHSC site quota for 2018/19	Cases in 2017/18
C. difficile cases at Denmark Hill	63	52	62
C. difficile cases at PRUH	17	19	26
Total C. difficile cases at King's	80	71	88

Clinical Outcomes

Kings continues to report excellent outcomes in relation to mortality. As a Trust, its mortality as assessed using by the NHS Digital Summary Hospital-level Mortality Indicator (SHMI) is trending in the right direction with our Shelford ranking improved from 7th to 6th during the course of the year.

Mortality is lower than expected, or as expected, for: trauma, stroke, acute myocardial infarction, pneumonia, sepsis, acute kidney injury, hip fracture, endocrine surgery, bariatric surgery, nephrectomy, hip and knee replacement surgery, emergency laparotomy and renal replacement therapy.

In 2018-19 Quarter 2, 110 (20%) of the 547 deaths at KCH were subject to a protocolised case record review and/or investigation. None of these were judged to be more likely than not to have been due to problems in the care provided to the patient.

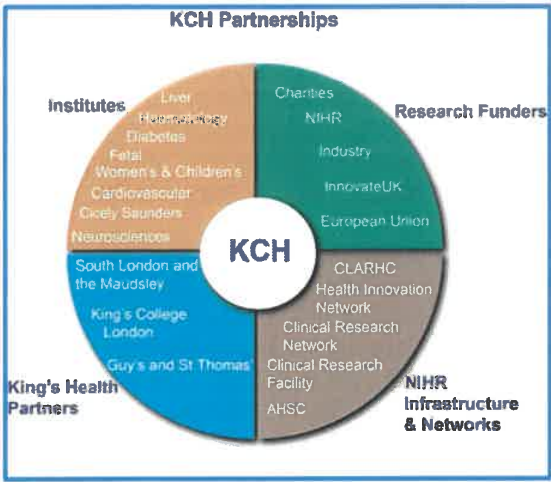
Research and Innovation

Research and Innovation (R&I) is one of King's defining characteristics. It is a central part of the offer of care we make to our patients and their families, and our staff. This year, there have been significant changes within R&I with considerable strengthening of the Leadership, Governance, Quality and Contracts teams and the development of the Trust's R&I Strategy which was approved by the Board in December 2018.

The R&I Strategic Vision

- As a world class innovator in research we will drive the development of treatments for tomorrow; cell based, clinical and surgical.
- Building on our international reputation for research, through our centres of excellence, industry partnerships and academic networks we will deliver world class research across our key clinical areas: critical care & trauma medicine, haematology, neurosciences, liver disease, transplantation, fetal medicine, metabolic, paediatrics and end of life services
- We will do this to drive new and improved specialist treatments and innovations for the benefit of patients locally, nationally and globally.

In order to realise the R&I vision, KCH needs to be part of strong and effective partnerships. These partnerships will enable us to enhance the research portfolio for patient benefit through working across organisational boundaries, realising opportunities to access a broader range of resources and expertise and providing us with a competitive advantage.



Our work is funded by a mixture of government allocations and research grants, charitable grants, European Union partnership grants (Horizon 2020) and partnerships with commercial partners.

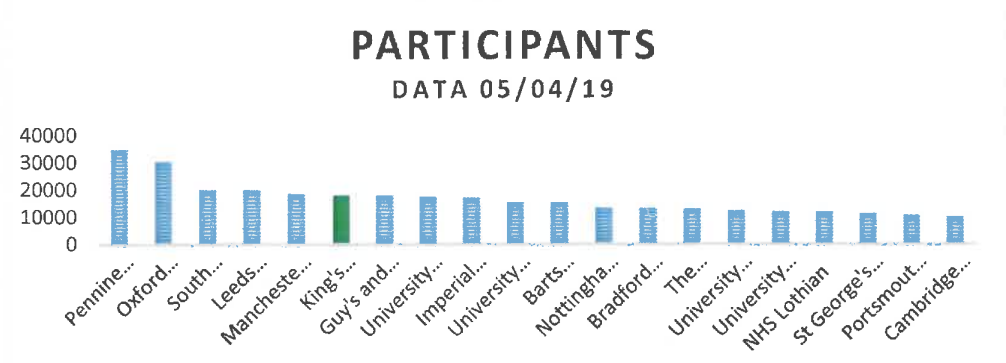
R&I Performance

During the year patients have had the opportunity to participate in 356 academic studies in over 30 research-active specialties.

KCH has had a successful year with respect to commercial research with 291 patients enrolled into 74 commercial studies. Commercial trials at KCH in 2018/19 generated income of £5,456,419. In February 2019 KCH became a certified Flagship Site for Medpace, which will bring more commercial trials to the Trust going forward.

The work has been translated also to several esteem related factors, publications in high impact factor journals (Lancet Neurology, Movement Disorders, European Journal of Neurology), academic grants including European Union Horizon 2020 grants (PD-PAL for instance), and international awards (Van Andel, NIHR/RCP awards).

Kings was rated 6th highest recruiting hospital in all of England in 2018/19 recruiting 16,602 patients into clinical studies and trials, an improvement of 2 places from 2017/18.



Quality Improvement

King's aims to deliver excellent outcomes and experience for our patients and to take a patient-focused approach to all that we do. Our quality improvement (QI) approach is based on lean methodology and we have clearly defined methods for project delivery and embedding continuous improvement. At King's, services and pathways are being redesigned around what is of value to patients, standardising to best practice, reducing waste, introducing 'pull' and continuous improvement. This leads to greater safety and enhanced experience for patients, more productive use of staff and resources, and more engaged staff. The Trust has developed its approach to quality improvement in line with the CQC's recent publication 'Quality improvement in Hospital Trusts' (2018). Over the last year the following improvements have been made as a result of our QI approach:

- **Continuous improvement on a daily basis through the application of lean philosophy and techniques and closely linked to an accreditation programme**– The King's Way for Wards (KWfW) programme is being rolled out on our wards. It is linked to a ward accreditation scheme, which, in turn, has been designed around the CQC domains of Safe, Effective, Caring, Responsive and Well-Led. This programme is designed to address culture and behaviours in addition to making practical changes so that we run our services in the most efficient and effective way.
- **The King's Academy, Multi-Layered Continuous Improvement Training** – a capability building programme developed to equip our people with the skills, confidence and tools they need to deliver King's-wide service redesign and continuous improvement. To date, 1,953 people have attended White Belt, 176 have attended Yellow Belt and 38 have attended Green Belt. Yellow and Green Belt improvement projects have been completed across a wide range of departments and services. While these have largely been chosen by individual students based on their personal preferences future projects could be chosen to support the Trust's quality priorities.
- **Quality Improvement for medical teams** – Educational supervisors and doctors in training have access to continuous improvement training and are encouraged to undertake QI projects during their time at KCH. Speciality Lead Registrar Programmes and King's Improvement through Engagement (KITE). The KITE leadership course provides a forum for formal QI training and an opportunity for junior doctors from a wide range of specialties to work together to devise solutions to projects informed by patient safety issues. KITE projects have been showcased at the King's Trainees Awards Ceremony in July 2018.
- **Redesign across clinical settings** – The Trust's project management approach is D5, a lean methodology which supports a systematic approach to embed lean and project management methodology within a clinical setting. Examples of where lean redesign is currently being used are Enhanced Recovery after Surgery (ERAS), Outpatients Transformation, Getting it Right First Time (GIRFT) and Emergency Flow.
- We have started our **Value based healthcare (VBHC) programme**, picking up on the award winning approach adopted between 2012 and 2015. This involves working with providers and commissioners to develop a blueprint for clinical pathway improvement that considers all aspects of the pathway and delivering value for the health economy.
- We have set up the VBHC Diabetes programme with KHP and the Health Innovation Network (HIN) and we are working with KHP on building in the 'vital 5' (smoking cessation, reduced alcohol consumption, reduction in obesity, reduction in blood pressure and increased awareness and treatment of mental health conditions) into every pathway

We also work closely with other leading hospitals in Europe to ensure that we develop the highest level of expertise within the Trust from organisations that are world leaders in healthcare. These include the Karolinska in Stockholm, Assistance Publique in Paris and the Charite in Berlin. The European University Hospital Alliance has been set up for collaborating closely and co-designing value-based health care pathways and outcome measures across specific pathways

throughout Europe. We have been successful in winning two bids to take part in programmes related to value based health care and digital procurement.

Medical Education and Training

KCH's broad range of clinical services, creative use of its educational facilities and its strong faculty of committed trainers/teachers keeps it at the forefront of regular as well as cutting edge medical education and training; both locally within London and nationally. These activities generate an annual income of circa £40million.

Undergraduate

KCH plays a leading role in delivering the clinical component of the KCL medical school curriculum. The Trust oversees the teaching and training of more than 1000 undergraduate medical students in a broad range of specialties, across DH and PRUH every year. Our students regularly rate their experiences as 'very good' to 'excellent' in most of their specialty placements.

This year marks the conclusion of the implementation of the new MBBS curriculum, which is designed to produce doctors who are suitably trained to meet the emerging and future demands of the health service.

Postgraduate

The Trust is also at the forefront of postgraduate training in most medical specialties, offering training experience in secondary, tertiary and quaternary care services to about 800 Doctors-in-Postgraduate Training, as well as around 400 Locally Employed Doctors at all levels of seniority. Our trainees regularly rate their experiences as 'Good' to 'Excellent' in more than 80% of domains within the annual GMC National Training Satisfaction survey. The Trust has achieved a rapid turnaround in the one or two areas where the experiences had been rated less well in the previous year.

Our reputation in Education and Training makes us a popular choice; the Trust is one of only a few Trusts with near 100% fill rate in all specialty recruitments in London. This helps to maintain our low vacancy, high retention rates in most of our specialties, with positive impact on patient care.

Freedom to Speak Up Guardian



All NHS Trusts and NHS Foundation Trusts are required by the NHS contract to have a named Freedom to Speak Up Guardian. The way the role is implemented is up to each individual Trust. There is also a National Freedom to Speak Up Guardian whose role is to advise NHS Trusts and Freedom to Speak Up Guardians on best practice to enable staff to speak up safely in their local Trusts. At King's we have implemented our Freedom to Speak Up model. Jen Watson, Director of Nursing in Networked Care has been the Trust's Freedom to Speak Up Guardian since 2017 and the Trust has a network of ambassadors to promote the importance of being able to speak up across the Trust. In recognition of the importance of the role, a second FSUG, Dr Stefan Karwatowski, a consultant cardiologist, was appointed at the PRUH and south sites: Sue Slipman, Deputy Chair of King's Board of Directors, is the lead Non-Executive Director and chairs the Board's Freedom to Speak Up Committee.

Anti-Bribery Policy

King's has a zero-tolerance policy towards fraud and bribery. Appropriate policies are in place and the Counter Fraud Team ensures compliance, overseen by the audit committee.

Community engagement

The Trust recognises the importance of working with patients, stakeholders and the wider community to ensure that service delivery meets their needs. A summary of how the Trust has met this goal in the last year can be found on pages 50-51.

Equality and Human Rights

Patient safety, outcome quality and experience are at the centre of everything we do at King's. The creation of an inclusive, fair and equal employment and care environment is a critical part of our strategy. Our patient population, and our staff body, is more diverse than the UK's national population. For all these reasons, we have a moral and ethical, as well as a legal duty, to treat everyone fairly and without discrimination. So our vision, which applies to staff, patients, and patients' families, is to be 'effortlessly inclusive'.

Our aims and our objectives in pursuit of that vision are:

1. To treat everyone with respect and dignity at all times
2. To challenge discriminatory behaviour and practice
3. To recognise and embrace diversity
4. To ensure equal and easy access to services
5. To ensure equal access to employment and development opportunities
6. To consult and engage with staff, patients and their families to ensure that the services and the facilities of the Trust meet their needs.

We have a number of policies in place that ensure we deliver this aim, and human rights and equality implications are core to our decision making processes.

Caring for the Environment

Summary of performance

Sustainability reporting is an important element of King's performance and the need to minimise negative impacts on the environment and to operate as a sustainable and efficient organisation is recognised.

In 2019 King's was recognised for excellent sustainability reporting as part of their annual report, receiving a certificate of excellence, awarded by the Sustainable Development Unit (SDU), NHS Improvement and the Healthcare Financial Management Association (HFMA). High quality reporting on sustainability is recognised as a fundamental way in which organisations can demonstrate their commitment to embedding environmental, social and financial sustainability.

2018/19 was another positive year for the Trust in terms of environmental performance. Both Total Net Energy consumption and Carbon emissions related to energy use reduced. Energy consumption reduced by 4%, Carbon emissions reduced by 8% and Gas consumption decreased by 6%. Waste generated decreased by 9% and water consumption decreased by 4%. Energy costs were impacted by commodity price rises with an increase in gas costs of 8% and electricity costs of 17%.

Environmental Performance

	2017-2018	2018-2019	% Change	Variance
Energy Management				
Energy Expenditure (£)	5,516,981	6,216,761	13 %	699,779
Energy Consumption (kWh)	145,642,195	139,109,821	-4 %	-6,532,374
Energy Carbon Emissions(TCO ₂)	30,275	27,782	-8 %	-2,493
Waste Management				
Waste (tonnage)	6,075	5,525	-9 %	-550
Waste Management Expenditure (£)	1,779,157	1,781,684	0.1%	2,526
Water Management				
Water Consumption (m3)	306,634	293,531	-4%	-13,103

Environmental Strategy

King's Environmental Strategy details objectives and targets for the following environmental themes:

1. Improving the patient experience;
2. Designing and maintaining the built environment;
3. Waste management
4. Pollution prevention;
5. Energy and CO₂ management;
6. Water;
7. Sustainable procurement;
8. Low carbon transport and travel;
9. Staff engagement and ownership;
10. Working with our stakeholders; and
11. Governance and finance.

A copy of the Trust's Annual Carbon and Energy Report and Environmental Strategy can be obtained from: kch-tr.foi@nhs.net.

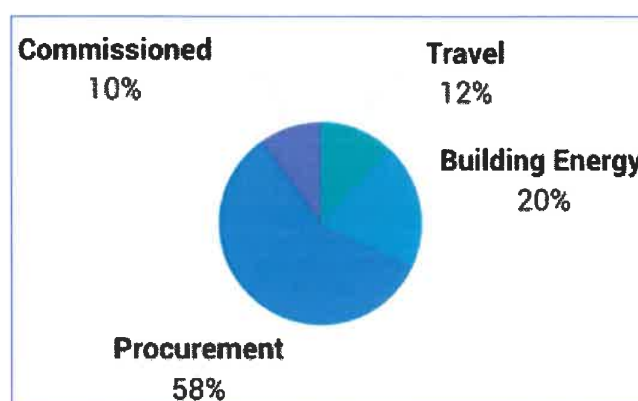
Greenhouse gas emissions

Carbon emissions related to energy use reduced by a substantial 8% or 2,493 tonnes this year. This has been mainly the result of grid electricity becoming cleaner with the reduction in the use of coal fired power stations and increase in offshore wind generation etc. In addition, the Trust imported more grid electricity this year than previously as the Combined Heat and Power (CHP) engines were down for maintenance for twelve weeks in total.

The SDU identified that the NHS needed to achieve a 10% reduction in carbon dioxide (CO₂) emissions by 2015, compared to the CO₂ emissions produced in 2007. This was an interim target to support the NHS in meeting the targets set out under the Climate Change Act (2009) of 34% reduction by 2020 and 80% reduction by 2050.

Progress against carbon reduction targets

To date KCH has achieved a reduction of 21% in CO₂ emissions related to energy use compared to the 2007/08 base-year. The NHS targets above include emissions from energy (20%), procurement (58%), travel (12%) and commissioned (10%). This is shown in the illustration below from the Centre for Sustainable Healthcare. The Trust currently measures and reports progress against energy use, however it will work towards reporting by all areas.



It is increasingly challenging to reduce energy consumption on site because King's is a growing Trust which will increase its energy consumption as it increases in size and activity. Work is well underway on the build of the new CCU phase 1 which is due to open in 2019/20. This will be heated and powered from energy generated sustainably from King's Energy Centre. All new buildings and refurbishments are being designed by the projects team with energy efficiency and sustainability as a priority.

Procurement and Supply Chain:

As a procurement and supply chain organization, KFM recognises a large proportion of our direct carbon footprint originates from delivery vehicles into the Trust, as part of strategy of the future to monitor, review and improve our transport operation, KFM intends to invest in electric delivery vehicles for onsite services.

KFM's operational strategy is to design and implement sustainable operational activities/processes that are solely focused on adding significant value whilst reducing waste across the Trust and by

investing in technologies that reduce carbon footprint, this will focus on suppliers and cardboard waste via the reduction of packaging material.

Waste management

Waste management has improved significantly over the past 12 months as a result of various initiatives and innovations. The total waste produced by the Trust decreased by 9%, however cost overall increased by 0.14% as a result of an increase in RPI of 3.5%.

How has this been achieved?

- Recycling tonnage is up by an average of 8 tonnes per month at the PRUH.
- More engagement between staff and the subcontractors working towards the same goal.
- Recycling at the PRUH has increased dramatically to 36% (16.46 tonnes March 2019) from 20% (5.54 tonnes April 2018). If this progress continues the Trust will achieve the 50% recycling target by April 2019.
- Introducing food waste recycling into the retail and catering units has diverted approx. 3.5 tonnes of waste food per month away from the general waste stream.

What's next?

- The Trust has a plan to increase recycling from the current rate of 36% to 75% by 2020. This will be achieved as a result of the following:
 - o Waste awareness, handling and segregation training for all staff throughout the Trust.
 - o Redesigning the disposal rooms to make it easier for staff to correctly segregate different categories of clinical and domestic waste.
 - o Removal of under desk bins in office areas moving to a centralised bin area
 - o Introduction of a cardboard baler at the PRUH.
 - o Increase the number of offensive waste bins and decrease the number of infectious waste bins in specific areas of the hospital in order to reduce the amount of offensive waste currently being put into infectious waste bins.
 - o Include staff green champions in plans to increase recycling and promote best practice ideas throughout the hospital. This will ensure that the clinical staff and the waste management team communicate and implement innovations efficiently.
 - o Introduce coffee cup recycling in restaurant and café areas.
 - o Promoting the reuse scheme more.

Other improvements

- Unnecessary packaging arriving on site has reduced; diverting non-hazardous waste including bulky waste and furniture for reuse and recycling facilities have been the focus. This has continued to improve the recovery of materials for recycling and reuse as well as incineration with energy recovery.

Environmental management system

King's has successfully operated an Environmental Management System (EMS) accredited to ISO 14001 since October 2012. This covered the activities and responsibilities of the Capital, Estates and Facilities Department on the Denmark Hill site. The scope of the EMS was successfully increased in June 2017 to include the Orpington and PRUH sites which are now audited regularly against the Standard.

The EMS has been a very effective system that enables effective environmental risk management by our staff and contractors and drives continual improvement. King's continued commitment to the maintenance of this accreditation provides a system of assurance that the department is compliant with waste and environmental legislation.

All the main partners of King's are accredited to an EMS, which demonstrates that they take their environmental responsibility seriously. These include Medirest (Compass Group), Veolia, Bywaters, Vinci, ISS and Sodexo.

Energy and CO₂ management

Energy and Carbon Management Strategy

In 2018 detailed energy audits were carried out at the Denmark Hill and Orpington sites by an energy consultancy with specialist expertise in CHP Plants in order to produce an energy strategy specific to each site.

These site specific strategies include an action plan of energy efficiency projects designed to reduce energy consumptions and costs and move us closer towards reaching the target to reduce CO₂ emissions by 34% by 2020. The action plan will enable the Trust to choose from a selection of possible measures and see which make best financial sense to invest in and which save the most carbon and costs.

An energy audit of the PRUH took place in March and April 2019, and is due for publication in June 2019. A Trust energy strategy will then be produced which will summarize the key elements from each site specific strategy in a single document and be presented to the Board for approval in 2019.

Kings has forecast that carbon emissions related to energy consumption will increase by 1% in 2019/20 to a total of 28,087 tonnes. This is as a result of opening the new CCU and link building.

Energy cost inflation

The total cost of energy is now £6,216,761 as a result of an increase in gas costs of 8% and electricity costs of 17%. Gas consumption for the year 2018/19 fell by 6% but due to the increasing cost of energy the total cost of gas increased by 8%. The pence per kWh figure for gas increased from £0.022 in 2017/18 to £0.026 in 2018 - 19, a 15% increase.

Energy costs are set to continue rising with increasing gas and electricity prices forecast. This will result in an increase in gas costs of over 20% and an increase in electricity costs of 10% in the 2019/20 financial year. Utility costs are made up of energy costs and non-energy costs, each year the non-energy cost portion of the invoice grows larger than the energy related costs. For example, the Carbon Tax, Climate Change Levy (CCL) is set to increase by 45% for electricity and 67% for gas.

The Trust ensures value for money by procuring Gas and Electricity through Crown Commercial Service (CCS) Framework agreements. CCS is an executive agency and trading fund of the Cabinet Office of the UK Government. It is the largest buyer of gas and electricity in the UK which aims to deliver savings on costs through significant aggregation. The Trust has applied to join the CCS framework agreement in order to purchase diesel oil which will bring further assurance of value for money.

Demand Side Response and Electricity Penalty Charge Avoidance.

These two schemes involve using the Trust's CHP engines and diesel electricity generators at Denmark Hill in order to generate electricity when called upon because there is stress on the electricity grid. If successful, the Trust receives a refund on its electricity bill. The Trust received a £150,000 credit on its electricity bill in March this year. However due to government legislation this benefit will end in April 2019.

Utility Invoice Audit

The Trust engaged a company that specialises in auditing utility invoices in order to find overbilling areas and reclaim the costs on a gain share basis. This audit identified a historical overcharge of £50,000 on water invoices on a budget of approximately £600,000. The Trust will also save approximately £50,000 on water invoices going forward.

Water efficiency

The Trust's water consumption has decreased by 4% 13,103 cubic meters since last year. This is mainly as a result of upgrading the condensate system and a decline in consumption at Orpington Hospital.

The Trust has applied to access the CCS Water & Waste Water Services framework agreement for April 2019 which aims to deliver expected savings of 2 - 5 % savings against the prevailing rate that retailers would be charging.

King's has been working closely with Veolia to implement water reduction measures. The first stage has been to install water meter data loggers across the Denmark Hill site. This was completed in March 2015 and now all water consumption data is available on the Fusion automatic monitoring and targeting system. This system provides the detailed water consumption data required to carry out leak detection and other consumption analysis later in the project.

In 2018 the second stage involved engaging Veolia Water Services to carry out a Leak Detection Survey of the Denmark Hill, PRU and Orpington Hospitals. The results were very positive as no major leaks were found.

Stage three was also carried out in 2018 whereby water efficiency audits were carried out across the three sites to identify any water efficiency opportunities particularly relating to toilets, showers, urinals and taps. This resulted in three survey reports which recommended the installation of Hydrocell urinal control systems to reduce water wastage. It is thought that these would provide sensible savings for the Trust without compromising patient safety from waterborne infection risks. A number of other water efficiency measures were rejected for infection control reasons as they worked by reducing or slowing the flow of water and therefore increasing the risk of waterborne infections. In 2019 a business case will be produced in order to gain funding to deliver the project.

Energy Efficiency Projects

The Trust has continued to invest in energy efficiency projects in 2018/19

Condensate System Upgrade

Steam is generated by the Denmark Hill Energy Centre in order to supply heat to most of the hospital buildings on the site. An efficient condensate system reuses the heated water that has condensed within the steam pipework. This reuse brings a number of financial, technical and environmental benefits.

The original site steam and condensate distribution was in poor condition as it was inaccessible and difficult to maintain. As a result, the condensate returned to the boiler house was approximately 42 % in 2016. In 2016/17 phase 3 of the condensate system was completed resulting in an increase condensate return rate to 70% in April 2018 and to 87% in March 2019. The final phase has been designed and is planned for delivery in early 2019. The benefits will include improved energy efficiency, reduced chemicals, water use, health and safety risks in plant rooms and will help meet compliance with environmental effluent standards.

Energy Efficient Lighting

King's has continued to replace the old and inefficient external lighting around the Trust by upgrading the lighting on the King's Business Park, on the back Service Road and in the Caldecot Centre. This will greatly improve, Health and safety and Security as well as reducing carbon emissions and cost.

The energy audits carried out in 2018 have identified that LED lighting projects on the Denmark Hill site generally have paybacks of over 11 years making it difficult to justify a business case in many areas of the Trust. We are however, developing a project to install an LED lighting solution for the main PFI hospital building on the Denmark Hill site. This is expected to improve the patient and staff experience and reduce energy costs related to lighting by at least 50%.

Designing and maintaining the built environment

King's has targets in place to attain 'Excellent' under the Building Research Establishment Environmental Assessment method (BREEAM) on all new build projects and 'Very Good' on all major refurbishments.

Greenhouse gas emissions

Greenhouse Gas Emissions (1,000 tCO ₂ e)						
	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	% Change
Total Gross Emissions	36.6	36.0	33.5	32.4	29.6	-8.6
Total Net Emissions	33.5	33.2	31.2	30.3	27.8	-8.1
Gross Emissions (Scope 1 - direct-gas consumption)	23.0	23.4	22.3	23.0	21.5	-6.5
Gross Emissions (Scope 2 - indirect - imported electricity)	13.5	12.6	11.2	9.3	8.0	-13.9
Gross Emissions (Scope 3 - indirect - transmission & distribution losses)	n/a	n/a	n/a	n/a	n/a	0.0
Electricity (non-renewable)	25.4	25.6	27.3	26.5	28.3	6.8
Electricity (renewable)	0	0	0.017	0.028	0.030	6.4
Gas	124.9	126.7	121.2	125	117	-6.4
LPG	0	0	0	0	0	0
Other	0	0	0	0	0	0.0
Expenditure on energy	6.2	5.6	5.04	5.5	6.2	12.7
Expenditure Accredited Offsets	n/a	n/a	n/a	n/a	n/a	n/a
Notes: 1) Confirmation of Energy Costs required from finance.						

Year	Total Gross Emissions	Total Net Emissions	Gross Emissions (Scope 1 - direct-gas consumption)	Gross Emissions (Scope 2 - indirect - Imported electricity)
2014-2015	36.6	33.5	23.0	13.5
2015-2016	36.0	33.2	23.4	12.6
2016-2017	33.5	31.2	22.3	11.2
2017-2018	32.4	30.3	23.0	9.3
2018-2019	29.6	27.8	21.5	8.0

Waste Management

		2014/15	2015-16	2016-17	2017-18	2018-19	Value Change	% Change
Non - Financial Indicators (tonnes)	Total Waste	5,090	6,217	5,900	6,075	5,525	-	-9
	Hazardous Waste	2,596	2,834	2,129	795	13	-	-98
	Landfill	100	48	47	24	23	-	-6
	Reused/ Recycled	779	2,524	811	1,222	1,058	-	-13
	Composted	-	-	-	-	-	-	0
	Incinerated with energy recovery	1,616	812	2,912	4,034	4,354	320	8
Non - Financial Indicators (£s)	Incinerated without energy recovery	-	-	-	-	-	-	0%
	Total Waste (£s)	1,798,537	1,790,818	1,795,147	1,779,158	1,781,684	2,526	0.14

Waste

Year	Total Waste	Hazardous Waste	Landfill	Reused/ Recycled	Composted	Incinerated with energy recovery	Incinerated without energy recovery
2014/15	5,090	2,596	100	779	-	1,616	-
2015-16	6,217	2,834	48	2,524	-	812	-
2016-17	5,900	2,129	47	811	-	2,912	-
2017-18	6,075	795	24	1,222	-	4,034	-
2018-19	5,525	13	23	1,058	-	4,354	-

King's Critical Care Unit

The new King's Critical Care Unit (CCU) has been designed to support world class care and to achieve BREEAM very good rating in support of the Trust's aspirations for an environmentally friendly campus. It has been designed to achieve optimum energy performance by designing a high performance building fabric including integral blinds within the curtain wall that track the sun's path, low air leakage rates, high efficiency lighting solutions with integral Dali control system, energy efficient building services and roof mounted photovoltaics. Energy for space heating, domestic hot water will be provided by connecting to the combined heat and power plant heating and cooling network.

Low carbon transport and travel

Travel Plan

The Trust is updating the Travel Plan for the PRUH. This will be an opportunity to demonstrate the Trust's commitment to sustainability. The overarching aim of the Plan is to support and encourage more sustainable travel for staff, students, patients and visitors to the Princess Royal Site.

Cycle Safety Events

Work has continued to promote activity and wellbeing to staff and the Trust continues to support and promote cycling to work as an alternative low carbon means of transport. King's hosted a successful cycle safety event on March 5th which was supported by the Met Police Cycle Safety Team who are dedicated to reducing injuries and deaths on London's roads.

Staff, patients and the public were invited to take part in the Exchanging Places - a virtual reality (VR) experience in the Golden Jubilee atrium area. Exchanging Places is a road safety educational event run by the Met Police Cycle Safety team. This event allows the use of VR headsets to experience sitting in the driver's seat of a Heavy Goods Vehicle (HGV) to gain a better understanding of what the driver can and cannot see, especially when driving with cyclists and other vulnerable road users on the nearside and directly in front of the vehicle. These VR headsets allow up to 5 people to participate at once, and is accessible for all ages. These headsets highlight the dangers of blind spots in and around large vehicles and highlights road users of the dangers of passing too close to cyclists on the roads.

On the day a qualified Dr Bike mechanic was available to carry out a free bicycle health check and offer advice on bike set up and basic bike maintenance.

Patient Transport

The patient transport service at the Trust is an ever growing service. Since 2011 the number of individual patient transport journeys has increased from 5,500 per month to an average monthly total of 18,600 journeys between 2018/19. There has been an estimated 20% increase in the number of vehicles which has a negative impact on emissions and air quality.

In 2019 to help improve air quality, Transport for London introduced an Ultra-Low Emission Zone (ULEZ) which now operates 24 hours a day, every day within the same area of central London as the Congestion Charge. Most vehicles, including cars and vans, need to meet the ULEZ emissions standards or their drivers must pay a daily charge to drive within the zone. As this impacts on vehicles used by the Trust all vehicles are now being replaced with Euro 6 and Ultra Low emissions compliant vehicles. The Trust will continue aim to replace its vehicles by 2021 with electric vehicles.

As a Trust, we continue to improve on our overall efficiency savings as well as a focus on the environment by reducing the number of driving routes, with the view to minimise the environmental impact and also to realise measurable savings on vehicle costs.

Working with our stakeholders

Lambeth GP Food Co-op

King's has continued to work with the Lambeth GP Food Co-op (LGFC) to deliver a patient-led gardening project. The Food Co-op is a co-operative of patients, doctors, nurses, and Lambeth residents. It seeks to involve patients with chronic conditions from 9 GP surgeries across Lambeth in growing their own crops, encouraging both healthy eating and the physical exercise gained from gardening. The crops are grown on King's land and at local GP surgeries. 8 Large planters for growing vegetables, containing 2 tons of soil each, have been built in the garden of Jennie Lee House at King's. The food co-op is planning to increase food growing over the coming season by adding one or two more planters for growing vegetables. These are all tended by groups of patients led by experienced group leaders.

For patients who are particularly isolated, have lost confidence in leaving their house or those suffering from anxiety or low mood the sessions provide a safe environment to rebuild their confidence. The Food Group provides an alternative option for GPs to offer patients.

One of the attractions of the co-op is that its members get to eat the food they produce. The Co-op operates a monthly market stall selling its produce at King's, Denmark Hill over the summer and autumn. Jennie Lee was visited by NHS England during the year and they have included the work of LGFC at King's in their list of exemplary gardens for health across the NHS. The list can be found on the LGFC website.

Hebe Foundation

2018 was the third year that the Capital Estates & Facilities team at King's hosted a 'Junior Apprentice' event for the Hebe Foundation. The Hebe Foundation is an organisation that works with all young people aged 13-20 years old to help them discover & use their talents. They provide Young People with a safe environment in which to expand their minds, learn new skills and discover their talents in fun creative ways.

The Junior Apprentice, based on the hit television show 'The Apprentice' is an accredited Core Skills, Business & Leadership project active across 6 London boroughs. Beginning with an exciting 3 weeks of full time activities, around 120 young people aged 13 to 19 years battle it out over a series of team challenges designed to develop, teach, and inspire each individual, while bringing forth the talents each one has in a fun, creative and safe way.

The theme in 2018 was 'The Business of the Environment' with the young people engaged in tasks looking at the physical, social and economic aspects of the environment. The teams were given the challenge to work as a design team to research and present environmentally friendly solutions to provide electricity and power to the, soon to be refurbished, Link Building.

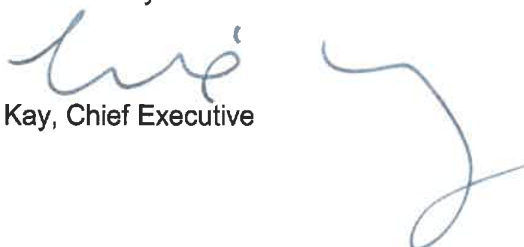
Governance

The Trust's existing Environmental Strategy will be superseded by Sustainable Development Management Plan (SDMP) in order to embed sustainability across the organisation and demonstrate commitment to the Climate Change Act and other legislative drivers. This will include a Sustainable Development Action Plan which identifies, prioritises and monitors the actions needed to improve sustainability performance whilst reducing the carbon footprint. This will be governed by a Sustainability Committee and progress reported to the Board. The SDMP will be submitted to the Board for approval in the summer of 2019.

Significant issues and events since the end of 2018/19

There have been no issues of note.

The performance report was approved by the Board of Directors on 30th May 2019 and signed on its behalf by:


Dr Clive Kay, Chief Executive

Date:

11/6/19

ACCOUNTABILITY REPORT

2018/19

2.1 DIRECTORS' REPORT

Governance framework

King's governance framework comprises its membership body, the Council of Governors and the Board of Directors.

The Trust's membership is drawn from patients, staff and individuals from the local constituencies it serves. More information about recruiting and involving members in the life of King's starts on page 50.

The Council of Governors is elected by the membership or appointed in accordance with the Trust Constitution and the 'fit and proper' persons test described in the provider licence. The Council of Governors is responsible for representing the interests of members and stakeholders in the governance of King's. The Council of Governors exercises statutory powers, such as the appointment or removal of non-executive directors, appointing the external auditor, approving mergers, acquisitions and significant transactions, holding the non-executive directors individually and collectively to account and representing the interests of members and the public. The Council of Governors meets formally four times per year to discharge its duties. The matters specifically reserved for the Council's decision are set out in the Trust's Constitution. More information about the Council of Governors, including its composition and terms of office, can be found on page 46.

Led by the Chair, the Board of Directors sets King's strategy, determines objectives, monitors performance and ensures that adequate systems are maintained to measure and monitor effectiveness, efficiency and economy. It decides on matters of risk and assurance and is responsible for delivering high quality and safe services. It provides leadership and effective oversight of King's operations to ensure it is operating in the best interests of patients within a framework of prudent and effective controls that enables risk to be assessed and managed. Further information about King's internal controls and approach to clinical and quality governance can be found in the Annual Governance Statement starting on page 84.

The Board of Directors, comprising the Chair, non-executive directors and executive directors, are collectively responsible for the success of King's. All directors meet the 'fit and proper' persons test. The terms of office and voting rights of each director is recorded in later in this section of the annual report. The Board considers that all of its non-executive directors are independent in character and judgement, including Professor Richard Trembath, who is the representative from the Medical School at King's College London. Non-executive directors bring a breadth of expertise to the Board and provide objective and balanced opinions on matters relating to King's business. The independence of non-executive directors is tested at interview and at their annual performance review.

The Board meets regularly and has a formal schedule of matters specifically reserved for its decision. The Board delegates some other matters to its committees and the executive directors.

The Board of Directors and the Council of Governors hold joint meetings twice a year to discuss topical and strategic matters.

The Trust's Constitution sets out the roles and responsibilities of the membership body, Council and the Board. It also details the procedures for resolving any disputes between the Council of Governors and the Board of Directors. To develop an understanding of the views of members and governors, Board members attend meetings of the Council of Governors and its committees, the Annual Members Meeting and community events.

Board of Directors

Executive directors are full-time King's employees. Non-Executive directors are appointed by the Council of Governors on a four year fixed-term contract. The Council of Governors has the power to remove non-executive directors. Executive directors manage the day-to-day running of King's whilst the Chair and the non-executive directors provide strategic and board level guidance, support and challenge. The Board of Directors benefits from the wide range of skills and experience of its members, gained from NHS organisations, other public bodies and private sector organisations. The skills portfolio of the directors, both executive and non-executive, includes accountancy, audit, education, management consultancy, commercial, communications, transformation and medicine. This broad coverage of knowledge and skills strengthens the effectiveness of the Board of Directors giving assurance that the Board of Directors is balanced, complete and appropriate to supporting King's in meeting its objectives.

During 2018/19, the Board has been as follows:

Chair	Ian Smith (to 28 th Feb 2019) Sir Hugh Taylor (1 st Mar – 31 st March)
Non-Executive Directors	Faith Boardman Professor Jonathan Cohen Professor Ghulam Mufti Erik Nordkamp (to 31 st July 2018) Dr Alix Pryde Sue Slipman Chris Stooke Professor Richard Trembath
Chief Executive	Nick Moberly (April 2018) Peter Herring (May 2018 to 31 Mar 2019)
Chief Finance Officer	Iain Alexander (to 30 Jun 2018) Lorcan Woods (1 st July 2018 onwards)
Executive Director Workforce	Dawn Brodrick
Chief Operating Officer	Dr Shelley Dolan (to Feb 2019) Bernie Bluhm (from Feb 2019) (DH) Fiona Wheeler (from Feb 2019) (PRUH)
Chief Nurse	Dr Shelley Dolan
Executive Medical Director	Professor Julia Wendon
Director of Strategy	Abigail Stapleton
Director of Capital Estates and Facilities	Jane Bond (to August 2018) Steven Bannister (from August 2018)
Director of Improvement, Informatics and ICT	Lisa Hollins

As can be seen from the table above, there have been a number of changes to the Board Directors during 2018/19. The Trust was delighted to welcome the following new Board Member appointments:

- Sir Hugh Taylor, Interim Chairman
- Peter Herring, Interim Chief Executive
- Steven Bannister, Interim Director of Capital, Estates and Facilities
- Lorcan Woods, Chief Finance Officer
- Bernie Bluhm, Interim Chief Operating Officer (Denmark Hill)
- Fiona Wheeler, Acting Executive Managing Director (PRUH)

During the period, the following resignations were received:

- Chairman Ian Smith February 2019
- Interim Chief Executive Peter Herring in March 2019
- Director of Capital Estates and Facilities Jane Bond in August 2018
- Non-Executive Director Erik Nordkamp in July 2018
- Interim Chief Finance Officer Alan Goldsman in May 2018
- Interim Chief Financial Officer Iain Alexander in June 2018
- Chief Executive Nick Moberly in April 2018

NON-EXECUTIVE DIRECTORS

Sir Hugh Taylor (Interim Chair)

Sir Hugh was appointed as interim Chairman of King's in February 2019 and commenced the role at the beginning of March. He had a long and distinguished career in the civil service which included senior roles in the Department of Health and NHS Executive, the Cabinet Office and the Home Office.

His most recent appointment before joining the Trust was as Permanent Secretary at the Department of Health, from which he retired in July 2010. Sir Hugh is also Chair of Guy's and St Thomas' NHS Foundation Trust.

Voting Board Member. Term in office: March 1st 2019 to Present – (interim appointment to January 2021)

Faith Boardman (Senior Independent Director)

Faith Boardman joined the Trust Board in March 2012. She brings 40 years of public service at both the national and local levels. As a Chief Executive, she has devised and led significant change programmes in 4 large public sector organisations - which have delivered substantial improvements for service users, staff, partners and public finances. These have included rebuilding the Child Support Agency (1997-2000) after its initial collapse; and improving Lambeth Council from having been officially rated as one of the worst 11 councils in the country in 2001 to the middle range.

Faith lives in Lambeth, and is Chair of Trustees of Vauxhall City Farm, Treasurer of the Vauxhall Business Improvement District, and a Board Member of the Safer London Partnership. She also took on the role of Trustee on the Trust's charity from April 2014 to 2016.

Voting Board Member. Term in office: March 2012 to Present – (re-appointed 2016 for a further 4 years)

Professor Jon Cohen

Professor Cohen completed his medical degree at Charing Cross Hospital Medical School in 1975 and has worked in the NHS in the field of infectious diseases for over 30 years, becoming Chair and Head of Department at Hammersmith Hospital and Imperial College School of Medicine. His research interest is severe bacterial infections and he has an international reputation for his work in helping to develop new forms of treatment for sepsis and septic shock.

He was the founding Dean of Brighton and Sussex Medical School, which has already provided over 700 new doctors to the NHS. He has also served as member or Chair for a wide range of national and international bodies, and spent five years as Editor-in-Chief of the International Journal of Infectious Diseases. He is immediate past President of the International Society for Infectious Diseases, a Trustee of Arthritis Research UK and member of the Scientific Advisory Board of the Lister Institute.

Voting Board Member. Term in office: September 2015 to Current – (4 year term)

Professor Ghulam Mufti, OBE

Professor Mufti has worked at the Trust since 1985 when he was appointed as a senior lecturer/consultant haematologist. His current appointment is Professor of Haemato-oncology, Clinical Director of Pathology and Head of the Department of Haematology, one of the largest in Europe. Ghulam is internationally renowned for research and treatment of

myelodysplastic syndromes (MDS) and other pre-leukaemic diseases, and has published over 400 original papers in medical journals.

He is a founding member of the International MDS Foundation Board, Chair of the UK MDS Forum and Member of GSTS Members Board. He was formerly a member of the scientific committee of Leukaemia & Lymphoma Research. In 2017 he was awarded an OBE for services to haematological medicine. He was a nominated Non-Executive Director representing King's College London on the Board of Directors from December 2012 to November 2016. In January 2017 Professor Mufti re-joined the Trust Board as an appointed Non-Executive Director.

Voting Board Member. Term in office: January 2017 to Current – (4 year term)

Dr Alix Pryde

Dr Pryde graduated in Physics from University College London then completed a PhD in Theoretical Physics at the University of Cambridge. She joined McKinsey & Co as a strategy consultant before being hired by the BBC where she enjoyed a range of roles, including Head of Strategy for BBC Radio then BBC News, running the COO's office and ultimately leading the BBC's Distribution team, playing a central role in the delivery of TV Digital Switchover and the BBC's ground-breaking coverage of London 2012. Alix was subsequently recruited by Vodafone UK to lead Consumer Innovation.

In 2016, she joined Sky as a Director in Customer Services and is now Director of Central Services in Sky's technology division.

Alix was born and raised in Bromley and moved to Camberwell in 2000 where she now lives with her husband and two children, who were born under the care of King's. Alix joined the King's Board in November 2015.

Voting Board Member. Term in office: November 2015 to Current – (4 year term)

Sue Slipman (Deputy Chair)

Sue Slipman was the founding Chief Executive of the Foundation Trust Network, the national trade association for authorised and aspirant Foundation Trusts in the NHS. She was also Director of the campaigning charity The National Council for One Parent Families, and ran the Gas Consumers Council.

She was an Executive Director at Camelot where she held the role of Director of Corporate Responsibility before becoming Director of Communications. She has been Chair of the Financial Ombudsman Service, has held a number of non-executive positions in public life.

Voting Board Member. Term in office from July 2012 to Current – (re-appointed 2016 for a 4 year term)

Christopher Stooke

Christopher graduated in economics from Durham University and started his accountancy career at PwC. He was made partner in 1990 and was responsible for the audit of a number of blue chip companies in the UK and Europe, mainly in the financial services sector. From 2003 to 2009 he was Chief Financial Officer of Catlin Group, the FTSE 350 insurer. He is now a non-executive chairman of two companies, a non-executive director at a third company and three charities (including King's College Hospital Charity), in addition to King's. He has lived in south London almost all his life and is now based in Dulwich. Chris joined the Trust Board in November 2011 and his current term of office will end in 2019.

Voting Board Member. Term in office: November 2011 to Current – (re-appointed 2015 for a 4 year term)

Professor Richard Trembath

Professor Trembath completed his medical degree at Guy's Hospital Medical School, University of London in 1981. He is a clinician scientist, internationally recognised for sustained contributions to medical science through the development and application of genetics and genomics to an enhanced understanding of the pathogenesis of rare and common human disease. He has championed translational bio-medical research and provides leadership for academia in the UK and beyond. His research interests include the identification and characterisation of genes and the molecular pathways underlying a range of human common and rare disorders.

Currently, he is the Executive Dean, Faculty of Life Sciences and Medicine, King's College London and Professor of Medical Genetics. From 2011 to 2015 he was Vice-Principal for Health at Queen Mary, University of London and a non-executive director of Barts Health NHS Trust. He was a founding Director of the National Institute for Health Research Comprehensive Biomedical Research Centre in association with Guy's and St Thomas' NHS Foundation Trust. He is a Fellow of the Academy of Medical Sciences and a former Senior Investigator for the National Institute of Health Research.

Voting Board Member. Term in office: December 2016 to Current (4 year term)

To contact a Non-Executive send an email to the Foundation Trust Office on kch-tr.FTO@nhs.net

EXECUTIVE DIRECTORS

Steven Bannister, Interim Director of Capital Estates and Facilities

Steven is currently Director of Capital, Estates and Facilities and has been in post since August 2018. Prior to that he was Managing Director of Northumbria Healthcare Facilities Management Ltd as part of a dual role also encompassing Director of Estates and Facilities at the Trust, since April 2012. In addition, he recently relinquished his interim role as Director of Estates at North Cumbria University Hospitals. Prior to his appointment at Northumbria, he held similar roles at Newcastle University Hospitals NHS Foundation Trust, and Calderdale and Huddersfield NHS Trust. Steven holds several professional memberships including Chartered Builder and Fellow status, in addition to his B.Sc. (Hons) in Building Surveying and Estate management.

Non-Voting Board Member. Term in office: August 2018 to Current (fixed term contract – x month notice period)

Bernie Bluhm, Interim Chief Operating Officer, Denmark Hill site

Bernie began her career in the NHS as a nurse, mainly in Accident and Emergency. She has extensive Board experience not only as a chief operating officer but also in other senior executive roles focused on transformation and service redesign.

Non-Voting Board Member. Term in office: February 11th to Current (fixed term contract)

Dawn Brodrick, CB, Executive Director of Workforce Development

Dawn joined King's in October 2015. Previously she worked at the Department for Communities and Local Government, where she held the position of Director for People, Capability and Change.

Dawn has held director and senior human resources positions at HM Revenue and Customs, the Department for Work and Pensions, and Jobcentre Plus. In 2015 she received an Order of the Bath (CB) in the Queen's Birthday Honours for services to public administration.

Voting Board Member. Term in office: October 2015 to Current (permanent contract 6 month notice period)

Dr Shelley Dolan, Acting Deputy Chief Executive and Chief Nurse

Shelley joined King's in Autumn 2016. Prior to this she was Chief Nurse at Royal Marsden NHS Foundation Trust, where she led on quality, safety and patient experience. A registered nurse, she has over 30 years' experience in hospital care specialising in critical care and cancer nursing, as well as extensive leadership experience in hospital and community care. She has been involved in numerous research studies and papers, and she holds a PhD in the early diagnosis of sepsis in cancer patients.

Voting Board Member. Term in office: October 2016 to Current (permanent contract 6 month notice period)

Lisa Hollins, Director of Improvement, Informatics & ICT

Lisa joined King's in September 2016. She has worked in the NHS for over 20 years and has held senior posts within NHS Trusts and at regional and national level. She has held management roles in primary, community, secondary care and mental health services, giving her a breadth of knowledge of health services. She then undertook service improvement roles, transforming emergency care, community services - for which she won a British Medical Journal (BMJ) award - and as Head of Development for London.

Her most recent roles have been leading quality and efficiency programmes at University College London Hospitals and leading major pathway redesign as Director of Service Development at Barts Health NHS Trust. She has published articles in the BMJ, Health Service Journal, and nursing journals. She has a special interest in patient experience, and has worked closely with voluntary sector organisations to collaborate with patients to test out new ways of working.

Non-Voting Board Member. Term in office: September 2016 to Current (permanent contract – 6 month notice period)

Dr Clive Kay, Chief Executive Officer

Clive has extensive clinical and leadership experience and prior to taking up his position at Kings he was Chief Executive at Bradford Teaching Hospitals NHS Foundation Trust from January 2015. Previously he was Medical Director (2006-14) and before that Clinical Director for Radiology (2001-2006) at Bradford. Prior to working at Bradford, Clive was a visiting associate professor of Radiology at the Medical University of South Carolina. He was a member of Council of the Royal College of Radiologists, and former Chairman of both the Royal College of Radiologist's scientific programme committee and the British Society of Gastrointestinal and Abdominal Radiology. He is currently a Fellow of the Royal College of Radiologists and a Fellow of the Royal College of Physicians of Edinburgh.

Voting Board Member. Term in office: April 1st 2019 to Current – (permanent contract 6 month notice period)

Abigail Stapleton, Director of Strategy and Commercial

Abigail joined King's in October 2017. She is responsible for developing and implementing the Trust's strategic plan, as well as for maintaining our key relationships with King's Health Partners and other external stakeholders, including regulators. She also has responsibility for King's Commercial Services, one of the Trust's wholly owned subsidiaries.

Prior to joining King's, Abigail was Head of Strategy and Development at BUPA UK, where she was responsible for a broad portfolio including commercial and business development, strategic planning, service development and service improvement. She has worked extensively in both the public and private health sectors. Prior to BUPA, she worked in a strategic consultancy for a range of blue chip organisations, and in public affairs for the NHS Confederation. She holds a MSc in International Health Policy from the London School of Economics and Political Science.

Non-Voting Board Member. Term in office: October 2017 to Current (permanent contract – 6 month notice period)

Professor Julia Wendon, Executive Medical Director

Professor Wendon is an Intensive Care Consultant. She has earned a worldwide reputation for the care of critically ill patients, particularly those with liver disease.

Julia joined King's in 1989, became a Consultant in 1992, and more recently served as Clinical Director for Critical Care. She has played a key role in developing King's liver service, including the expansion of the liver intensive care unit from eight to its current 19 beds. She has published over 150 papers on acute liver failure, and between 2008 and 2013 was the Trust's research and development lead.

Voting Board Member. Term in office: November 2015 to Current (Honorary contract – 6 month notice period)

Fiona Wheeler, Acting Executive Managing Director (PRHU site)

Fiona is a very experienced NHS operational leader. She has led the Networked Care division for a number of years and in February 2019, she became the acting managing director at the PRUH.

Non-voting Board Member. Term in office: 11th February 2019 to current.

Lorcan Woods, Chief Finance Officer

Lorcan joined Kings in July 2019, following a career in the private sector. He was a Board Director at Four Seasons Healthcare, an investment held by the private equity firm Terra Firma, where he also held a number of board positions in the healthcare, renewable energy and infrastructure sectors. Prior to this, he worked in senior roles at Unilever internationally.

Voting Board Member. Term in office: July 2018 to current (permanent – 6 month notice period).

To contact an Executive send an email to the Foundation Trust Office on kch-tr.FTO@nhs.net

Board Meetings and Committees

The Board of Directors meets regularly throughout the year. The Board also holds a series of strategy discussions and workshops.

The Board has seven Committees which also meet regularly and are each chaired by a non-executive director. The Board of Directors approves terms of reference for Board committees, which set out the remit and delegated authority of each committee. Each committee completes an annual review and self-assessment which is then presented to the Board of Directors.

In addition to regularly reporting to the Board of Directors, committee minutes are a standing item on each Board agenda. Patient stories and/or video stories were a regular item on agenda.

Audit Committee

The Audit Committee is chaired by non-executive director Dr Alix Pryde and its membership is composed entirely of non-executives, with Christopher Stooke fulfilling the requirement to have a member with financial expertise. It is responsible for providing independent assurance to the Board of Directors in a range of areas including internal control, governance, fraud, corruption, impropriety and externally reported financial performance. The internal audit function is provided by KPMG and the external audit function is provided by Deloitte. Both firms were appointed by tender in 2016 for a period of 3 years, with the option to extend for a further two years. King's has a zero-tolerance policy towards fraud and bribery and this committee is responsible for overseeing the work of the Local Counter Fraud Specialist.

The internal and external auditors regularly attend committee meetings as do the Chief Financial Officer and Chief Executive, although they are not members of the committee. The Trust Chair, the Lead Governor and other members of the executive team attend meetings of the Committee by invitation. The broad knowledge and skills of the members and attendees strengthens the effectiveness of the committee. King's is satisfied that the committee is sufficiently independent.

In April and May 2019 the Committee fulfilled its oversight responsibilities with regard to monitoring the integrity of the financial statements and the annual report and accounts for 2018/19 before submission to the Board and regulators.

During 2018/19 the Committee considered reports covering a variety of financial, operational and compliance matters including: reviews of core financial systems, quality of performance reporting, reconciliation of HR and finance systems, a review of business cases and review of the Trust's compliance with GDPR regulations.

Non-executive members of the Committee held the executive body to account in discussion of the reviews, and the Committee's recommendations were provided to the relevant leads to ensure there was follow-up action. The Internal Audit Plan for 2019/20 was also agreed.

Regular reports on counter fraud investigations and the associated recommendations of the Counter Fraud Specialist were also considered. In line with its delegated authority, the Committee provided oversight of a variety of Trust-level controls, including the Standing Financial Instruction waiver process; the Board Assurance Framework; and reports on losses, special payments and write-offs.

Deloitte presented the Draft External Audit Report for 2018/19. Committee members reviewed and endorsed the methodology deployed; significant risks and the risk assessment process used to identify them; recommendations for key areas of focus and the statement of independence. There are no inconsistencies between APB Ethical Standards for Auditors

and the Trust's policy for the supply of non-audit services. The Trust engaged Deloitte to undertake some non-audit services during 2018/19, at a cost of £13k. Deloitte continues to review its independence and ensure that appropriate safeguards are in place.

Education and Workforce Development Committee

The Education and Workforce Development Committee is chaired by non-executive director Faith Boardman. It provides assurance to the Board on the Trust's strategy and plans for its entire workforce, focusing on education and learning; organisational development; workforce information, planning, resourcing and deployment; staff engagement; reward and recognition; and health and wellbeing. It monitors the efficacy of relevant workforce structures, systems and enablers to drive high performance; quality improvement; a mature organisational culture; safe patient care and compliance with statutory employment responsibilities and public sector equality duties.

Finance and Performance Committee

The Finance and Performance Committee is chaired by non-executive director Chris Stooke. The Committee monitors both the financial and operational performance of the organisation, reviews the associated risks and seeks assurance when there are indicators of downward trends in performance. This includes reviewing the monthly performance submissions to NHS Improvement and monthly monitoring against the Single Oversight Framework (SOF). The Committee also provides oversight of a wide range of financial areas including the Trust's capital programme.

Freedom to Speak Up Guardian Committee

The FSUG role was a recommendation from the final Sir Robert Francis report published in February 2015 into the failings in Mid-Staffordshire. The FSUG recommendation is aimed at fostering a culture of safety and learning that will provide a safe outlet where staff can raise concerns. The Trust has set up a Board Sub-Committee to oversee the work of the FSUG and embed national policy within the Trust. This sub-committee was established in 2017/18, it is chaired by Sue Slipman, Deputy Trust Chair, and its membership includes another NED, Faith Boardman, as well as executive directors, senior managers, two Trust Governors and the Trust's freedom to speak up guardians Jen Watson and Dr Stefan Karwatowski.

Quality Assurance and Research Committee

The Quality Assurance and Research Committee (QARC) is chaired by non-executive director Professor Jon Cohen. The Committee provides assurance to the Board of Directors on the effectiveness of the systems and risk management processes in place relating to patient safety; patient experience; patient outcomes; organisational safety; information governance; and research. In order to do this, it reviews a substantial body of statutory and regulatory reports, and in doing so provides assurance to the Board of Directors that the Trust's services comply with regulatory requirements, including the Care Quality Commission's Fundamental Standards.

The Committee provides vital oversight of the Board's Risk Management Strategy, Board Assurance Framework and the Corporate and Divisional Risk Registers, ensuring cohesion between the different elements of the overall risk management framework and making appropriate recommendations to the Board. The Committee is supported by the Executive Quality Committee and Planning and Delivery Board.

Remuneration and Appointments Committee

The Remuneration and Appointments Committee is chaired by the Interim Trust Chair, Sir Hugh Taylor. On behalf of the Board of Directors, this Committee agrees executive directors' remuneration and terms of service. Together with the Chief Executive, Committee members form a panel for the appointment of executive directors. More information can be found in the Remuneration Report on page XX.

Kings Commercial Ventures Committee

The Kings Commercial Ventures Committee was established in 2017/18. The committee ensures effective scrutiny and oversight of Kings' commercial ventures such as private patients and commercial clinical trials, and its wholly owned subsidiaries including Kings Commercial Services, Kings Interventional Facilities Management and Viapath, Kings' pathology partnership with Serco and Guy's and St Thomas' NHS Foundation Trust.

Evaluation and Development of the Board

Executive directors hold a weekly meeting to monitor and respond to current issues, particularly in relation to quality, performance and finance. The Chair and non-executive directors hold informal meetings regularly to discuss matters relating to the running of King's without the executive directors present.

Collectively the Board holds development sessions periodically throughout the year to allow for deeper discussion and investigation of key topics.

Board members also undertake personal development on an on-going basis. All executive and non-executive directors have an annual performance appraisal and 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.

During 2018/19, the Chair invited Sigurd Reinton, an independent external facilitator to undertake a review of board effectiveness.

The process for evaluating the performance of the Chair and non-executive directors was agreed in consultation with the Council of Governors. The Senior Independent Director undertook the appraisal of the Chair and reported to the October meeting of the nominations committee. In line with the Constitution, only the Council of Governors may terminate the tenure of the Chair and the non-executive directors.

Board of Directors - Meetings, Attendance, Committee Memberships

Board and Committee Attendance 2018/19								
Board of Directors (Current Members)	Board of Directors	Audit Committee	Education & Workforce Development Committee	Finance & Performance Committee	Quality Assurance & Research Committee	Remuneration & Appointment Committee	Kings Commercial Committee	Freedom to Speak up Guardian
Total Number of Meetings Held	9	5	4	11	8	2	5	6
Non-Executive Directors								
Sir Hugh Taylor* Trust Chair (Mar 2019 – present)	1(1)	0(0)				(0)	0(0)	
Sue Slipman Deputy Chair / Non-Executive Director	8			8		1	4	5
Faith Boardman Senior Independent Director / Non-Executive Director	7	5	2		5	1		6
Professor Jon Cohen	7		4		8	2		
Professor Ghulam Mufti	6		2		6	1		
Dr Alix Pryde	9	5				2		
Chris Stooke	7	5		11		1		
Professor Richard Trembath	4				4	1		
Executive Directors								
Peter Herring*/** Interim Chief Executive	8(8)	1	0(4)	5(10)	0	2	4	
Lorcan Woods*/** Chief Financial Officer (from July 2018 – present)	6(6)	4(4)		9(9)			4	
Steven Bannister* Interim Director of Capital Estates & Facilities (August 2018 – present)	5(6)			2(7)				
Bernie Bluhm* Interim Chief Operating Officer (Feb 2019 – present)	1(1)			1(1)	0(0)			
Dawn Brodrick** Executive Director of Workforce Development	7		2	7		1		5
Dr Shelley Dolan Chief Operating Officer and Chief Nurse (to Feb 2019); Acting Deputy Chief Executive Officer and Chief Nurse (from Feb 2019 – present)	9		1	11	7			5
Lisa Hollins Executive Director of Improvement, Informatics & ICT	8			9				
Abigail Stapleton Director of Strategy	9			9			5	
Professor Julia Wendon Executive Medical Director	8		1	8	6		4	
Fiona Wheeler* Acting Executive Managing Director, PRUH (Feb 2019 – present)	1(1)			1(1)				
Board Members no longer in post								
Ian Smith* Interim Trust Chair) (left March 2019)	8(8)	4(5)		10(11)		2	3	
Iain Alexander* Interim Chief Financial Officer	3(3)	1(1)		5(6)				
Erik Nordkamp* Non-Executive Director	1(3)					0(1)	1	
Jane Bond* Director of Capital Estates & Facilities	1(3)			3(3)			1	

* - Board Members who joined/left the Trust at a point during 2018/19; therefore, would not have been able to attend all meetings within the reporting year. The total number of meetings each person attended are indicated in the following format: x(y), with 'x' being the number of meetings attended by the Board member, and 'y' the maximum no. of meetings they would have been able to attend during the reporting period.

**REMCO and Audit Committee Members are all Non-Executive Directors, but the meetings are attended by relevant Executive Members as noted in the table.

Council of Governors

The Council of Governors is made up of elected and appointed stakeholders. Elected governors make up the majority of the Council; appointed stakeholder governors include representatives from clinical commissioning groups, partner health provider organisations Guy's and St Thomas' and South London and Maudsley and local councils, which play an important part in stakeholder relations. Governors are elected by the members of the Trust. The membership constituencies include patients, staff and residents from Bromley, Lambeth, Lewisham and Southwark.

The composition of the Council, names of individual governors and their terms of office can be found in the tables on page 46. To contact a Governor send an email to the Foundation Trust Office on kch-tr.FTO@nhs.net

Function and meetings of the Council of Governors

The Council of Governors met four times during the reporting period. The attendance of individual governors at these meetings, which were held in public, is detailed in tables on page 46.

All directors are invited to attend Council meetings. Individual directors, executive and non-executive, regularly present items at Council meetings, in accordance with the planned agenda.

The Council of Governors has two key functions, which are to hold non-executive directors to account for the performance of the Board and to represent the interests of members and the public. The Council of Governors also has specific responsibilities, which include the appointment, remuneration and removal of the Chair and other non-executive directors.

During the reporting period, the Council of Governors:

- received and considered the Annual Report and Accounts and the auditor's report on the accounts
- received regular updates on the operational and financial performance challenges facing the Trust
- held non-executive director review sessions.

The Council of Governors elects one of its members to be the Lead Governor for a period of one year. The Lead Governor acts as a communication link between Governors and the Board of Directors. In very rare circumstances the Lead Governor will act as a direct communication link between regulators such as NHSI and the Council of Governors where it is inappropriate for regulators to communicate directly with the Trust Chair or Company Secretary. The Governors wrote to NHSI three times during 2018/19 Chris North was Lead Governor throughout 2018/19.

Governors in the Community

Governors are active within the community, helping to facilitate communication between the Trust, members and the local communities of Southwark, Lambeth, Bromley and South East London more widely. Governors are pivotal to sharing the Trust's vision and performance with key stakeholders.

As guardians of the community interest, the Council of Governors ensures that the needs of members are considered in the planning of future services.

Governor Committees

The Council of Governors has committees which provide the opportunity to delve deeper into issues that are of interest to members, patients and the local community. All governors are eligible to sit on governor committees, with the exception of the Nominations Committee for which governors stand and are elected.

Membership and Community Engagement Committee

This committee monitors membership recruitment and reviews the engagement and experience strategy ensuring that membership continues to be representative as well as identifying ways in which the membership can be more actively involved.

Committee members are encouraged to provide feedback about the engagement activity they have been personally involved with, both within and outside the Trust's various sites, and opportunities for facilitating communication between governors and the membership are explored.

Patient Experience and Safety Committee

This Committee acts as a reference group for the Trust's planned activity relating to patient experience and safety. Committee members are involved with a range of initiatives to improve patient experience and safety and to monitor progress against King's quality priorities.

Strategy Committee

This Committee reviews the Trust's strategy and annual forward plan, and feeds back to the Council of Governors.

Nominations Committee

This Committee is responsible for determining and administering the selection process for the appointment and remuneration of the Chair and non-executive directors, and recommending the preferred candidates to the Council of Governors for appointment. This includes consideration of the structure, size and composition of the Board. It also monitors the performance of non-executive directors and makes recommendations to the Council of Governors for the reappointment or removal of individual non-executive directors.

During the period the Committee met once to appraise the Chair and to discuss the appointment of a replacement NED. The committee also received training on recruitment best practice.

The nominations committee would normally lead the appointment of the Chair. However, Sir Hugh's appointment was led by NHSI.

The membership of the Committee is shown in Table 45 overleaf.

Non-Executive Directors Review Sessions

The Council of Governors held two non-executive director reviews sessions during 2018/19, at which non-executive directors were questioned on how they discharged their duties to provide constructive challenge and strategic expertise to the executive team and what level of assurances they received.

Governor Development and Engagement

King's is committed to providing support and training for governors and opportunities to engage with staff, directors, members and one another. Governors were invited to participate in workshops at which topical issues selected by governors themselves were presented by directors and other senior members of staff. Three governor development days were organised in-year. Governors have also received presentations from external speakers invited to committee meetings and workshops in order to give different perspectives on relevant issues.

Governors, members and directors came together to share ideas about King's vision and future plans at community events and the Annual Members' Meeting. There were also two joint meetings of the Board of Directors and Council of Governors. All governors are invited to attend meetings of the Public Board of Directors and the Lead Governor is invited to attend the Private Board Meetings as an observer. Nominated governors are also invited to observe all Board sub-committee meetings.

Governors attended a number of external events hosted by organisations such as Deloitte and NHS Providers during the reporting period.

Current Nominations Committee Membership

Nominations Committee Members	Status	Constituency
Sir Hugh Taylor	Current	King's College Hospital
Pam Cohen	Current	Public Governor Southwark
Emmanuel Forche	Current	Patient Governor
Nicola Bates	Resigned	Patient Governor
Jane Allberry	Current	Public Governor Southwark
Claire Saha	Current	Staff Governor Allied Health Professionals

The Council of Governor's nominations committee did not make any appointments during 2018/19. The interim Chair was appointed by NHS Improvement. The Trust undertook a fit and proper test on appointment.

Council of Governors – Meetings and Attendance (Four Council of Governor meetings during the reporting period)

Council of Governors Tenures and Meeting Attendances, April 2018 – March 2019				
		Constituency	Tenure	Meetings Attended
Patient Governors	Derek St Clair Cattrall	Patient	01/12/2017-30/11/2020	0
	Paul Cosh	Patient	01/12/2017-30/11/2020	3
	Andrea Towers*	Patient	01/12/2016-30/11/2019	3
	Emmanuel Forche	Patient	01/12/2017-30/11/2020	2
	<i>Vacant seat</i>	<i>Patient</i>		
Public Governors	David Jefferys	Bromley	01/02/2017 -31/01/2020	3
	Jane Clark*	Bromley	01/02/2017 -31/01/2020	1(1)
	Diana Coutts-Pauling	Bromley	01/02/2017 -31/01/2020	4
	Penny Dale	Bromley	01/02/2017 -31/01/2020	4
	Alfred Ekellot	Lambeth	01/12/2017 -30/11/2020	1
	Christopher North	Lambeth	01/12/2017 -30/11/2019	4
	<i>Vacant seat</i>	<i>Lambeth</i>	<i>01/12/2017 -30/11/2020</i>	
	Barbara Goodhew	Lambeth	01/12/2017 -30/11/2020	3
	Victoria Silvester	Southwark	01/12/2017 -30/11/2020	4
	Stephanie Harris	Southwark	01/12/2017 -30/11/2020	4
	Jane Allberry	Southwark	01/12/2017 -30/11/2020	4
	Pam Cohen	Southwark	01/12/2017- 30/11/2019	4
	Susan Wise	Lewisham	01/02/2017 -30/01/2020	0
Staff Governors	Kevin Labode	Admin, Clerical and Management	01/12/2017-30/11/2020	2
	Claire Saha	Allied Health Professionals	01/12/2017-30/11/2020	3
	<i>Vacant seat</i>	<i>Nurses and Midwives</i>	<i>01/12/2017-30/11/2019</i>	
	Carole Olding	Nurses and Midwives	01/12/2017-30/11/2020	3
	Ashish Desai	Medical and Dental	01/12/2017-30/11/2020	2
Stakeholder Governors	Anne Marie Rafferty	King's College London	01/10/2016-30/09/2019	2
	Cllr Jim Dickson	Lambeth Council	23/02/2015-22/08/2018	2
	Dr Noel Baxter	Southwark CCG	01/04/2016-31/03/2019	1
	<i>Vacant seat</i>	<i>Lambeth CCG</i>		
	Charlotte Hudson	South London and Maudsley NHS Foundation Trust	14/03/2018-13/03/2021	3
	Phidelma Lisowska	Joint Staff Office	02/07/2016-01/07/2019	3
	Richard Leeming	Southwark Council	03/11/2017-02/11/2020	1
	Cllr Robert Evans	Bromley Council	19/11/2016-18/11/2019	2

* - Completing the tenure of office of a vacant seat left by a governor who demitted, and joined a point during 2018/19; therefore, would not have been able to attend all meetings within the reporting year. The total number of meetings attended are indicated in the following format: x(y), with 'x' being the number of meetings attended by the Board member, and 'y' the maximum no. of meetings they would have been able to attend during the reporting period.

Board Members attend the Public Council of Governor meetings.

Management framework

The Board of Directors is the key decision-making body in King's. It is responsible for ensuring compliance with the Trust's provider licence, constitution, mandatory guidance issued by NHS Improvement, and with relevant statutory requirements and contractual obligations.

Commercial opportunities and activities are subject to scrutiny by the Board of Directors, to ensure that benefits derived from non-NHS income are channelled into supporting King's core NHS activities without incurring significant financial or reputational risk. Information about King's services outside the UK can be found in the performance report on page 46.

Information, development and evaluation

Directors and governors are supplied with information so as to enable them to discharge their duties.

The performance of the Board of Directors, its committees and individual directors are subject to regular review, as outlined on page 41. The Board is committed to the NHS/CQC 'Well-Led' Framework and was inspected by the CQC during January and February 2018/19. Once the Trust has received the findings of that review, an action plan will be implemented.

Company directorships and other significant interests and commitments

King's maintains a register of interests for its directors and governors. Arrangements to view the register can be made by contacting the Foundation Trust Office on kch-tr.FTO@nhs.net. The register is also published on the Trust's website.

Board members and governors are asked to declare any interests and to self-certify that they meet the eligibility criteria set out in the Trust's Constitution. In addition, governors and directors are subject to a check by the Disclosure and Barring Service.

Political Donations

The Trust has made no political donations during 2018/19.

Better Payments Practice Code (BPPC)

King's has a responsibility to meet the Better Payments Practice Code (BPPC). This focuses on the speed at which the Trust pays its invoices to the private sector and to other NHS organisations. The Better Payment Practice Code requires the NHS Trusts to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

The target is to pay 95% of invoices, in terms of value and volume, within 30 days.

	Group 2018-19		Group 2017-18	
	Number	£000	Number	£000
Non-NHS trade invoices:				
Paid in the year	138,757	638,422	157,340	691,415
Paid within target	132,863	586,893	143,587	652,585
Percentage paid within target	96%	92%	91%	94%
NHS trade invoices				
Paid in the year	4,976	112,007	5,382	160,538
Paid within target	4,663	110,478	3,504	147,279
Percentage paid within target	94%	99%	65%	92%
Total trade invoices				
Paid in the year	143,733	750,429	162,722	851,953
Paid within target	137,526	697,371	147,091	799,864
Percentage paid within target	96%	93%	90%	94%

Late Payment of Commercial Debts (Interest) Act 1998**2018-19
£000****2017-18
£000**

Compensation paid to cover debt recovery costs under this legislation

3

7

Cost Allocation Requirements

King's has complied with the cost allocation and charging guidance issued by HM Treasury.

Summary of the Trust's financial performance

The Group's deficit for the year was £177.6m and this figure includes the asset impairment reversal of £0.2m. This charge relates to impairments that arise from a clear consumption of economic benefits or service potential in the asset. The NHS Improvement financial performance control total measures the surplus (deficit) before impairments and after removing the I&E impact of capital donations/grants. The Group's adjusted financial deficit was £189.8m.

Because of the continuing service provider relationship that the Foundation Trust has with NHS England and clinical commissioning groups, and the way those commissioners are financed, the Foundation Trust is not exposed to the degree of financial risk faced by business entities. The Foundation Trust has limited powers to borrow or invest surplus funds and financial assets. Liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Foundation Trust in undertaking its activities.

Full details of financial performance in 2018/19, the responsibilities of the Accounting Officer and a statement from the auditors can be found in the Annual Accounts 2018/19 later in this report

Income Disclosures

King's is a public benefit corporation and its principal purpose is the provision of goods and services for the purposes of the health service in England. During the reporting period, income from the provision of goods and services for the purposes of the health service in England was greater than from the provision of goods and services for any other purpose. Income received from non-NHS services is directly invested in the provision of NHS services and does not impact the services provided to NHS patients. For the financial year 2018/19, no surplus was available for reinvestment.

Full details of financial performance in 2018/19, the responsibilities of the Accounting Officer and a statement from the auditors can be found in the Annual Accounts 2018/19 on pages later in this report.

Responsibility of Directors for Preparing the Annual Report and Accounts

Directors are responsible for preparing the Annual Report and Accounts. The Directors of King's College Hospital NHS Foundation Trust consider that the Annual Report and Accounts 2018/19, taken as a whole, are fair, balanced and understandable, and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

King's Directors have taken all reasonable steps they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information. So far as the Directors are aware, there is no relevant audit information of which the NHS Foundation Trust's auditors are unaware.

Accountability and audit

Deloitte LLP continued as external auditors during 2018/19. The firm was reappointed on 17 March 2016 for a three year term which started in July 2016 with the option to extend a further two years.

The Board of Directors maintained a system of evaluating and continually improving effectiveness of risk management and internal control processes. KPMG continued as internal auditors during 2018/19, having been re-appointed in March 2016, providing a comprehensive internal audit function. The internal audit plan is discussed with executive directors, non-executive directors and the Audit Committee.

The Board of Directors ensures effective scrutiny of financial and operational matters through its designated committees and by receiving reports from the Executive which present a balanced and understandable assessment of King's performance and forward plans. Information about King's financial, quality and operational objectives and performance, including clinical outcome data, is published to allow members and governors to evaluate its performance.

Furthermore, all the Board Directors have made enquiries of fellow directors and the Trust's internal and external auditors through the Board of Directors meeting and Audit Committee and taken any steps required to give effect to their duties to the Trust to exercise reasonable care, skill and diligence.

The Audit Committee is responsible for reviewing the effectiveness of the external auditors and does this via a survey of key stakeholders, which is reported to Board.

Independence of the External Auditor

King's external auditors, Deloitte, 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 King's, directors and the auditor.
- Any safeguards adopted and the reasons why they are considered to be effective.
- Any independent partner reviews.
- The overall assessment of threats and safeguards.
- Information about the general policies and processes for maintaining objectivity and safeguarding independence when undertaking non-audit work.

Ensuring the Trust is 'well-led

The Trust has a governance framework in place that aims to ensure Trust is well led. Quality governance, the approach to risk management and internal control are outlined elsewhere in this report. The Board, through its committee assures itself in relation to patient care. More detail on this can be found in the annual governance statement below and the quality report at section 3 of this document. Details on the development and evaluation of the Board can be found earlier in this section.

Stakeholder engagement

The Trust continues to work with a wide range of stakeholders including local Healthwatch's, CCGs, local MPs and local authorities. The Trust is actively engaged in developing integrated care systems in the relevant local authority areas (Bromley, Lambeth and Southwark). The Trust has good relationships with a number of local charities and community groups.

Putting our Patients and Public in Focus

King's membership

King's membership is split into four constituencies: public, patient, voluntary/community groups and staff.

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

Patient membership - anyone who is 16 years old or over and lives outside the four boroughs but has been a patient of King's in the last six years, or has been the carer of a patient of King's in the last six years, is entitled to become a patient member.

Staff membership - All staff that have employment contracts lasting more than 12 months are automatically opted into membership. They have the option to opt out should they wish to. King's Volunteers and full time employees of King's contractors are also eligible to become members, though they have to opt in to become a member.

Associate membership

Any voluntary or community organisation working in our boroughs or serving our patients and communities can join King's as an Associate member. Associate membership provides an opportunity to increase partnership working and communication between King's and local voluntary and community groups for the benefit of our patients and their families.

Membership strategy 2018-19

King's delivered the second year of our three-year membership strategy in 2018/19.

The vision set out in the Strategy is that, by 2020, the King's membership will be a more representative and active community of patients, citizens and local voluntary and community organisations who work with us to improve and support our services.

At 31 March 2019, our patient and public membership stands at 10,615. This remains within our target of between 9,800 and 11,100 members. Over 50 voluntary and community organisations have joined King's since October 2017 as Associate members. Associate membership has enabled King's to build partnerships with a range of local organisations and increase awareness of King's services and the support available to our patients in the community. For example, we have introduced a monthly carers drop-in service at Denmark Hill with local carers organisations, joined local Dementia Action Alliances across our three main boroughs and improved our links with a range of local mental health and children and young people's groups.

Membership communication

We have produced and distributed new membership leaflets for adults and a dedicated young person's leaflet across our sites, and introduced an improved e-bulletin now reaching over 4,000 members monthly. Associate members also received regular e-bulletins during the year. Three issues of @King's magazine was sent electronically and by post to all patient and public members.

Annual members' meeting and King's strategy workshops

Two Annual Members Meetings were held for the first time in 2018/19, one in Southwark and one in Bromley attended by a total of 123 members/Associate members and volunteers. The meetings included a Trust update on finance and quality and a governors' update, with question and answer sessions. In addition, 44 members attended two workshops in February 2019 across both sites with the strategy team to inform the development of the Trust's next five year strategy.

Members Talk Back programme

A new programme of Members' Talk Back workshops began in January 2018, designed to involve members more proactively in King's service developments. We engaged over 150 members in 12 workshops held across our sites between April 2018-March 2019 on the following topics:

- Physical activity and physiotherapy services
- Cancer care
- Dementia and dementia friendly communities
- Supporting carers
- Older people's care
- Outpatient communications
- Orthopaedics
- Heart failure services
- Critical care
- Discharge from hospital/discharge planning

Member engagement in quality programmes

Over 150 King's members and Associate members also participated in a range of other events to support the development of King's quality priorities and transformation projects across our sites, including:

- Workshops to inform the development of the Trust's quality priorities for 2019-20
- Dedicated events on King's quality priority to improve cancer and haematology patient experience
- A workshop to explore the proposals for a lung and heart centre run by King's Health Partners and the Royal Brompton and Harefield NHS Foundation Trust
- Patient Led Assessments of the Care Environment (PLACE)
- Ward based quality reviews as part of multi-disciplinary teams
- Feedback on the introduction of free patient and visitor Wi-Fi; accessible information; support for carers and Trust signage
- Some of our patient members shared their experiences at the monthly patient story section of the King's Board meetings

Current membership numbers:

Public constituency	Last year (2018/19)
At year start (April 1)	7,939
New members	119
Members leaving	211
At year end (March 31)	7,847
Staff constituency	Last year (2018/19)
At year start (April 1)	11,749
New members	2,519
Members leaving	1,779
At year end (March 31)	12,489
Patient constituency	Last year (2018/19)
At year start (April 1)	2,818
New members	47
Members leaving	97
At year end (March 31)	2,768

Volunteer Services

The King's volunteer service continues to have a significant positive impact across the Trust, in line with organisational priorities to improve patient and visitor experience. Our volunteers have engaged with 108,660 patients and visitors and supported us by giving 32,980 hours of their time.

These figures show the quantitative impact of our volunteers but it is the feedback we receive from patients and their families that show the true measure of the difference our volunteers make.

'He said that he was feeling very anxious and a lady came and introduced herself as A, explaining that she was a volunteer and asked if he would like some company. He said that she sat with him and he was able to talk to her about how he was feeling. He said that A's visit made such a difference to him and that he knew once he was discharged he must let us know the impact she had made. He said that A came across as gentle caring and kind and helped so much in raising his spirits'.

'Please send my sincere thanks to your volunteer yet again. He kindly met me and guide dog at the station; walked me to my appointment; regularly came back to check all was OK; was great company on top of all his other duties that morning; and finally walked me back to the station. All in all, a fabulous service from your volunteer, making things so much less anxious for me'.

Staff also find the support of a volunteer invaluable:

'J's professionalism and commitment has been commended by a number of patients and professionals and I am sure colleagues in the team will agree we are fortunate to have J as a colleague'.

'I would like to take this opportunity to thank all of our pharmacy volunteers for their hard work and dedication. They have given their own time to assist staff and patients coming to the pharmacy as well as their pharmacy colleagues. They have really become an important part of the team and we are most grateful for their contribution'.

Our volunteers reflect our diverse local communities and come with different motivations, whether it is wanting to get experience in the healthcare sector, or to give something back after having been a patient themselves. Here are examples of volunteers who have found the experience of volunteering at the Trust to be beneficial in moving forward with their chosen career path.

'I remember when I first started volunteering back in 2014, I did not have any experience or qualification on health or social care. I was just there to interact with patients, helping them with things that they cannot do by themselves when they are sick. Also, I was there to show appreciation to the NHS as way of me saying thank you for what they did for me when I was critically ill. Today, I am proud to say that the voluntary job I did with you has inspired me to become a nurse. I will start my training in two weeks' time as a student nurse and my placement will be at King's College Hospital.'

'As you are aware the first time I applied to med school I was rejected after my interview and the second time they gave me an offer the next day. I believe the skills I gained through volunteering with you is what made the key difference. It's what allowed me to be able to express myself more freely; unshackled from shyness and to have a more transparent understanding of patients and the NHS. For that, I am eternally grateful'.

In addition to our core volunteering roles, such as befriending, help with mealtimes, supporting the work of the Chaplaincy, we continue to innovate by creating new volunteer roles to respond to the needs of both patients and staff. This year, we have introduced End of Life companions and a volunteer hairdressing service to name but two.

As well as impacting positively on patient experience, volunteers are also supporting operational processes such as reducing Did Not Attend (DNAs). In this role, volunteers contact patients, particularly those who are more likely to DNA, to remind them about their appointments. Volunteers have been

supporting a number of departments including Neuroscience, Nuclear Medicine and Therapies and there has been a notable reduction in the DNA rates in these areas. This initiative both ensures that patients attend their appointments and also saves the Trust money by reducing lost appointments.

Volunteers continue to be involved in one off opportunities such as audits in outpatient departments, fundraising on behalf of the hospital charity, assisting at Trust wide events and also getting the opportunity to display their dramatic skills by being patients for staff undertaking Mock Exams. Volunteers are also assessors helping us with the interview process for potential new volunteers.

The Home Hamper Scheme offers patients a food parcel to take home with them on discharge. There have been 900 referrals at Denmark Hill since the programme began in October 2014 and approximately 200 at the Princess Royal. All food for this initiative has been charitably donated. At Denmark Hill, we are grateful for the support of Morrison's Peckham who generously provide us with the opportunity to host collections at various times of the year. At the Princess Royal, we are thankful to the Friends of PRUH for their ongoing support of the scheme.

Our high profile NESTA funded pilot which ran from July 2017 to the end of April 2018 and launched volunteering in our Emergency Departments, was evaluated very positively by external evaluators. Highlights of the evaluation:

- Volunteers completed 794 shifts, totalling 3,341 hours of volunteer time and had 12,372 patient interactions
- Volunteers' self-reported quality of life and wellbeing improved over the course of the pilot, with volunteers reporting particular improvements in physical health
- Volunteers also reported increased feelings of confidence and connection to the community
- Patients that reported that they had interacted with a volunteer were more likely to say that they would recommend the emergency department compared to patients that had not
- All of the staff surveyed agreed that the volunteering programme improved patient care and made a positive difference to staff and the department.

The King's Volunteer Service is only able to continue to achieve what it does due to the generous support of both the Trust and the King's College Hospital Charity. The Charity has provided a further two year's support. This year, with the support of the Charity we were also successful in bidding for funding from the Pears Foundation and the #iwill campaign fund. We received a grant to pilot a youth social action programme at both Denmark Hill and the PRUH. This is a high profile national project and King's is one of only 25 Trusts across the country to receive funding. Young people will be supported in a range of roles including, 'Boredom Busters', 'Nutrition Support' and 'Public Health Promotion and Fundraising.'

The Trust has also become only the second hospital in the country to be designated a Duke of Edinburgh (DofE) Award approved activity provider. The accreditation means that existing young volunteers at the hospital can use their hours towards the volunteering element of the Silver and Gold DofE Award. Additionally, those looking to volunteer as part of their DofE Award can choose to do this at our hospitals, something they may not have considered previously.

There has also been an emphasis on volunteer experience and engagement. We have refreshed our recruitment event and volunteer training day in line with feedback received from volunteers and staff.

To inform the development of a new three year Volunteer Strategy, we have been listening to the views of volunteers, staff and our Foundation Trust Membership.

We conducted a survey and asked all volunteers about their experience of volunteering at King's. The results were overwhelmingly positive:

- *93.48% of volunteers either agree or strongly agree with the statement, I'm proud to say I'm a volunteer at King's.*

- *92.02% of volunteers either agree or strongly agree with the statement, I would recommend to my friends the Trust as a place to volunteer*
- *87.73% of volunteers either agree or strongly agree with the statement, I feel that my volunteering is making a difference to the lives of patients and visitors*

We also surveyed staff our Members about the Volunteer Service and the information from these three surveys will feed into the volunteer strategy which is due to launch in Spring of 2019

It is always pleasing when the volunteer programme is recognised through nominations and awards and this year has been no exception. Internally, as part of the King's Stars recognition scheme, our Emergency Department volunteers were recognised for their collective efforts. Two of our volunteers were also recipients of Southwark Stars Awards.

We have also continued to receive publicity for the service through local and national media. BBC Radio 5 live recorded live from Denmark Hill in April 2018; Presenter Rachel Burden interviewed volunteers and staff and highlighted the work of King's Volunteers across the Trust. Vanessa Feltz from BBC Radio London, interviewed a King's volunteer and the Head of Volunteering giving them the opportunity to promote the various roles on offer at Kings. Volunteers were also featured in the live feed done by The Guardian as part of the NHS 70 anniversary coverage. Local papers like the Southwark News, have also acknowledged the support provided by King's volunteers.

Externally, we continue to be seen as a centre of volunteer excellence and have had visits from several hospitals and charities. We continue to be a key influencer in volunteering with strong links with key decision makers, including NHS England. The Head of Volunteering sits on the Volunteering Action Group for NHS England and is also on the NHS England/NHS Improvement Employee Volunteering Steering group. We have been delighted to host NHS England staff as volunteers at King's as part of NHS England's corporate volunteering programme. In the coming year, this will be spread to include staff from NHS Improvement.

2.2 REMUNERATION REPORT

The information provided in this part of the remuneration report is not subject to audit.

Foreword

The Trust has had a number of changes at Board level. The Remuneration Committee has worked with the Executive Director of Workforce to ensure that the resilience of the leadership team has been maintained throughout the year. The paragraphs below outline the key activities of the Remuneration Committee during the year.

Sir Hugh Taylor, Chair of the Remuneration Committee

The Annual Statement

The following 'very senior management' (VSM) appointments were 2018/19:

- The appointment of an interim Trust Chair by NHSI in February 2019 (Sir Hugh Taylor)
- The appointment of a permanent Chief Finance Officer, Lorcan Woods, who joined the Trust in July 2018.
- The separation of the Chief Nurse and Chief Operating Officer role (filled by Dr Shelley Dolan). This resulted in the appointment of a new Chief Nurse, who will be joining the Trust later in 2019.
- The appointment of Dr Shelly Dolan as Acting Deputy Chief Executive.
- The appointment of Abigail Stapleton as Managing Director King's Commercial Services (alongside her role as Director of Strategy);
- The strengthening of the operational leadership of the Trust's site operations with the appointment of Fiona Wheeler as Acting Executive Managing Director (PRUH and South Sites) and Bernie Bluhm as Interim Chief Operating Officer (Denmark Hill).
- The appointment of Steven Bannister as interim Director of Capital, Estates and Facilities following the resignation of Jane Bond.
- The appointment of Ashley Parrott as Director of Quality Governance.
- The appointment of Peter Pentecost as Director of Financial Recovery.
- The appointment of Meredith Deane as Director of Operations (PRUH).

Senior Manager Remuneration Policy

There have been no changes to the Trust's remuneration policies during 2018/19. All new appointments were made within standard NHS terms and conditions, this includes establishing earn-back clauses on posts that attract a salary of more than £150k. This could be considered a policy change, but is in line with standard NHS practice.

The remuneration and terms of service of the Chair and non-executive directors (NEDs) are determined by the Council of Governors, taking account of market and survey data from relevant benchmark sources which can include the Foundation Trust Network and the Trust's NHS peer group. More information about this process and the role of the Council of Governors' Nominations Committee can be found on page 45.

Remuneration for the King's most senior managers (directors accountable to the Chief Executive) is determined by the Remuneration and Appointments Committee, which comprises the Chair and the non-executive directors. See page 42 for committee membership and meeting attendance.

The work of the Remuneration and Appointments Committee is informed by relevant benchmark data, periodic assessments conducted by independent remuneration consultants and by salary awards and terms and conditions applying to other NHS staff groups. The work of the committee is supported by the Chief Executive and the Executive Director of Workforce Development who are not members of the committee.

King's strategy and annual planning processes set key business objectives which, in turn, inform individual and collective objectives for senior managers. Individual performance and that of King's as a whole is closely monitored, discussed throughout the year and forms part of the annual appraisal.

Details of senior employees' remuneration can be found on pages 59-60. Note 1.8 in the annual accounts sets out accounting policies for pensions and other retirement benefits.

The Trust has taken a number of steps to ensure that the salaries for Executive Directors are reasonable especially where payment is more than £150,000. These steps include:

Vacant posts at executive level require review in line with Trust requirements:

- posts are evaluated using a recommended independent external agency. The Trust commissions Hays Executive to undertake this task in line with the Hays job evaluation scheme.
- Hays consider a number of factors in the evaluation, comparing similar sized Trusts and functions/complexity, factoring the London market dimension and the relative remuneration amongst the Shelford Group, of which King's is a member. Hays provide the Trust with a salary range and recommendation.
- The remuneration committee agree the salary range and benefits package before the post is advertised based on the advice from Hays Executive and market advice from the executive search organisation.
- Due cognisance is given to the VSM annual pay survey which includes executive pay levels.
- The post is advertised and once appointed and remuneration agreed via the remuneration committee, the Trust seeks the guidance from NHSI to support the salary range.
- Department of Health and Social Care Pay, Pensions and Employment Services Branch is informed and Lord Prior (Formerly Minister for NHS Productivity, Department of Health and Social Care) has in turn provided further guidance as appropriate.
- The only non-cash element of the most senior managers' remuneration packages is pension related benefits accrued during membership of the NHS Pension Scheme. Contributions into the scheme are made by both the employer and employee in accordance with the statutory regulations.
- The Trust does not consult with staff on its senior staff remuneration, this is solely a matter for the Remuneration Committee.

Service Contract Obligations

All senior managers have a standard King's service contract. Each individual Executive Director and Non-Executive Director has their appointment date, contract status and notice period (for Executive Directors only) listed in the Director's report.

Policy on Payment for Loss of Office

All senior managers are required to have a 6 month period in their service contract. Policy for loss of office is in line with the NHSI VSM guidance and the Trust has a policy of not paying over contractual entitlement.

Compensation in the event of early termination for substantive directors is in accordance with contractual entitlements as set out in the Agenda for Change national terms and conditions of service. There were no exceptions to this policy during 2018/9.

Senior Manager Remuneration Framework

	Explanation
Salary	Senior manager pay is awarded on a spot rate and is not subject to incremental increase. Senior managers may, on the discretion of the remuneration committee, be awarded a 'cost of living' increase, in line with the rest of the Trust (in 2018/19 this was 1%).
Pension benefits	Senior managers may opt to be members of the NHS Pension Scheme. Contributions to the scheme are made by the employee and the employer in line with statutory regulations.
Performance Related Pay	In general, senior managers do not receive performance related pay.
Earn-back	In line with NHS policy, directors with salaries above £150k will be subject to 'earn back'. This means that x% of their salary is at risk unless they achieve the objectives agreed at the start of the year.
Other employee benefits	King's does not offer other employee benefits.
Performance Management Framework	Performance is managed on an annual baseline in line with the financial year. Individual objectives are agreed with line managers, in line with the Trust Strategy and monitored throughout the year. The Trust has an online appraisal process which is used by all staff.

Annual Report of the Remuneration Committee

The membership, meetings and attendance of the Remuneration Committee can be found on page 42. The Chief Executive and Executive Director for Workforce Development attended the Committee for relevant agenda items but were not full members. During 2018/19 the Committee took advice from Hay and used executive search agencies to fill key posts.

The committee took a number of reports during the year including:

- The appointments outlined above (see page 55).
- The resignations of a number of directors including the Director of Capital, Estates and Facilities and the Director of Commercial Services.
- The strengthening of operational senior management, which led to the appointments of Bernie Bluhm and Fiona Wheeler in to their current roles.

There have been no other major decisions on senior managers' remuneration or substantial changes relating to senior managers' remuneration in 2018/19.

The committee agreed to award senior managers a 1% pay increase, in line with the national pay award for Agenda for Change staff.

The information in this section of the remuneration report is subject to audit.

Median Salary Disclosures

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/member in their organisation and the median remuneration of the organisation's workforce.

	2018-19 (bands of £5,000)	2017-18 (bands of £5,000)
Band of highest paid director/member's total remuneration	265 - 270	255 - 260
Median total remuneration (£)	25,675	26,002
Ratio	10.4	9.9

In 2018/19, 0 (2017/18: 4) employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £44 to £292k (2017/18: £14 to £329k). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The information in this section of the remuneration report is not subject to audit.

Director and Governor Expenses

Two Executive Directors received travel and subsistence expenses totalling £3,190 in 2018-19 (2017-18: one, £27).

0 Non-Executive Director received travel and subsistence expenses in 2018-19 (2017-18: one, £1,187).

0 Governors received travel and subsistence in 2018-19 (2017-18: two, £604).

The information in this section of the staff report is subject to audit.
Salary and pension entitlements of senior managers
Remuneration

Name		Title		2018-19			2017-18		
				Salary & Fees (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)	Salary & Fees (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Chairman and Non-Executive Directors									
Lord Kerslake			Chair	-	-		40 - 45	-	40 - 45
Ian Smith			Chair	55 - 60	-	55 - 60	15 - 20	-	15 - 20
Sir Hugh Taylor			Interim Chair	0 - 5		0 - 5	-	-	-
Faith Boardman			Non-Executive Director	10 - 15	-	10 - 15	10 - 15	-	10 - 15
Professor Ghulam J Mufti			Non-Executive Director	15 - 20	-	15 - 20	15 - 20	-	15 - 20
Sue Slipman			Non-Executive Director	10 - 15	-	10 - 15	15 - 20	-	15 - 20
Chris Stooke			Non-Executive Director	10 - 15	-	10 - 15	10 - 15	-	10 - 15
Professor Jonathan Cohen			Non-Executive Director	10 - 15	-	10 - 15	10 - 15	-	10 - 15
Dr Alix Pryde			Non-Executive Director	10 - 15	-	10 - 15	10 - 15	-	10 - 15
Erik Nordkamp			Non-Executive Director	0 - 5	-	0 - 5	10 - 15	-	10 - 15
Professor Richard Trembath			Non-Executive Director	10 - 15	-	10 - 15	10 - 15	-	10 - 15
Executive Directors									
Nicholas Moberly			Chief Executive	130 - 135	-	130 - 135	255 - 260	7.5 - 10	260 - 265
Peter Herring			Chief Executive	265 - 270	-	265 - 270	-	-	-
Colin Gentile			Chief Financial Officer	-	-	-	185 - 190	-	185 - 190
			Interim Chief Financial Officer/Director of Financial Recovery/Interim Director of Strategy						
Alan Goldsman				15 - 20	-	15 - 20	175 -180	72.5 - 75	320 - 325
Iain Alexander			Interim Chief Financial Officer	120 - 125	-	120 - 125	-	-	-
Lorcan Woods			Chief Financial Officer	145 - 150	32.5 - 35	180 - 185	-	-	-
Professor Julia Wendon			Executive Medical Director	225 - 230	-	225 - 230	225 - 230	-	225 - 230
Dr Michelle (Shelley) Dolan			Acting Deputy Chief Executive	190 - 195	260 - 262.5	450 - 455	170 - 175	105 - 107.5	275 - 280
Dawn Brodrick			Executive Director of Workforce Development	150 - 155	-	150 - 155	150 - 155	-	150 - 155

Trudi Kemp	Director of Strategy	-	-	-	30 - 35	360 - 362.5	390 - 395
Abigail Stapleton	Director of Strategy	120 - 125	27.5 - 30	150 - 155	50 - 55	10 - 12.5	60 - 65
Amanda (Jane) Farrell	Chief Operating Officer	-	-	-	205 - 210	10 - 12.5	220 - 225
Bernadette Bluhm	Interim Chief Operating Officer	25 - 30	-	25 - 30			
Lisa Hollins	Director of Improvement, Informatics and ICT	140 - 145	15 - 17.5	155 - 160	140 - 145	67.5 - 70	205 - 210
Jane Bond	Director of Capital and Estates	55 - 60	12.5 - 15.0	65 - 70	150 - 155	32.5 - 35	185 - 190
Steven Bannister	Interim Director of Capital, Estates & Facilities	170 - 175	-	170 - 175	-	-	-
Peter Pentecost	Financial Recovery Director	105 - 110	-	105 - 110	-	-	-
Fiona Wheeler	Acting Executive Managing Director PRUH & South Sites	20 - 25	-	20 - 25	-	-	-
Andrew Lockwood	Managing Director Kings Facilities Management	145 - 150	-	145 - 150			

The remuneration of the interim directors include agency fees and VAT

*Salary relating to non-managerial role

Professor Julia Wendon		180 - 185	180 - 185	180 - 185	180 - 185		
Abigail Stapleton		70 - 75	70 - 75				

Alan Goldsman held three roles in the Trust during 2017/18

Alan Goldsman	Interim Chief Financial Officer	80 - 85					
Alan Goldsman	Director of Financial Recovery	65 - 70					
Alan Goldsman	Interim Director of Strategy	25 - 30					

4.5c Remuneration (Cont'd)

Ian Smith	Chair	1 April 2018 - 28 February 2019
Sir Hugh Taylor	Interim Chair	1 March 2019 - 31 March 2019
Faith Boardman	Non-Executive Director	1 April 2018 - 31 March 2019
Professor Ghulam J Mufti	Non-Executive Director	1 April 2018 - 31 March 2019
Sue Slipman	Non-Executive Director	1 April 2018 - 31 March 2019
Chris Stooke	Non-Executive Director	1 April 2018 - 31 March 2019
Professor Jonathan Cohen	Non-Executive Director	1 April 2018 - 31 March 2019
Dr Alix Pryde	Non-Executive Director	1 April 2018 - 31 March 2019
Erik Nordkamp	Non-Executive Director	1 April 2018 - 31 July 2018
Prof Richard Trembath	Non-Executive Director	1 April 2018 - 31 March 2019
Nicholas Moberly	Non-Executive Director	1 April 2018 - 22 April 2018
Peter Herring	Chief Executive	9 May 2018 - 31 March 2019
Alan Goldsman	Chief Executive	1 April 2018 - 30 April 2018
Iain Alexander	Interim Chief Financial Officer	1 April 2018 - 30 June 2018
Lorcan Woods	Chief Financial Officer	2 July 2018 - 31 March 2019
Professor Julia Wendon	Executive Medical Director	1 April 2018 - 31 March 2019
Dr Michelle (Shelley) Dolan	Acting Deputy Chief Executive	1 April 2018 - 31 March 2019
	Executive Director of Workforce Development	
Dawn Brodrick	Director of Strategy	1 April 2018 - 31 March 2019
Abigail Stapleton	Interim Chief Operating Officer	1 April 2018 - 31 March 2019
Bernadette Bluhm	Director of Improvement, Informatics and ICT	11 February 2019 - 31 March 2019
Lisa Hollins	Director of Capital and Estates	1 April 2018 - 31 March 2019
Jane Bond	Interim Director of Capital, Estates & Facilities	1 April 2018 - 12 August 2018
Steven Bannister	Financial Recovery Director	20 August 2018 - 31 March 2019
Peter Pentecost	Acting Executive Managing Director PRUH & South Sites	1 October 2018 - 31 March 2019
Fiona Wheeler	Managing Director Kings Facilities	1 February 2019 - 31 March 2019
Andrew Lockwood	Management	11 May 2018 - 31 March 2019
None of the Non-Executive or Executive Directors received benefits in kind in 2018-19 or 2017-18		

4.5d Pension entitlements at 31 March 2019

Name	Title	Real increase in pension at pension age £000 (bands of £2,500)	Real increase in pension lump sum at pension age £000 (bands of £2,500)	Total accrued pension at pension age £000 (bands of £5,000)	Lump sum at pension age £000 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2019 £000	Employer's Contribution to stakeholder pension £000
Non-Executive Directors									
Non-Executive Directors do not receive pensionable remuneration.									
Executive Directors									
Nicholas Moberly	Chief Executive	(0 - 2.5)	(0 - 2.5)	65 - 70	205 - 210	1,390	0	1,541	55
Alan Goldsman	Interim Chief Financial Officer	(0 - 2.5)	(0 - 2.5)	45 - 50	135 - 140	1,180	0	1,140	2
Dr Michelle (Shelley) Dolan	Acting Deputy Chief Executive	12.5 - 15.0	37.5 - 40.0	75 - 80	235 - 240	1491	-	-	28
Abigail Stapleton	Director of Strategy	0 - 2.5	-	0 - 5	-	6	4	28	18
Lisa Hollins	Director of Transformation & ICT	0 - 2.5	(0 - 2.5)	45 - 50	115 - 120	722	102	866	21
Jane Bond	Director of Capital, Estates and Facilities	0 - 2.5	-	0 - 5	-	46	0	69	8
Lorcan Woods	Chief Financial Officer	0 - 2.5	-	0 - 5	-	-	4	34	21

During the 2018/19 the total value of employer contributions to the pension scheme in respect of Board member directors was £153k (2017/18: £156k).

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 and other disclosures are provided by NHS Pensions, and 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.

Michelle Dolan's CETV Real Increase is not shown here as the guidance states that Senior Managers over NPA will not be applicable.

Remuneration report

The disclosures in the remuneration report fulfil our obligations under the Health and Social Care Act 2012.

Signed: 

Date: 11/6/19

Dr Clive Kay
Chief Executive and Accounting Officer

2.3 Staff Report

The information in this section of the staff report is not subject to audit.

The Trust has continued to support its workforce during a challenging year. In 2018/2019, the Trust implemented 20 local engagement plans that enable leaders and managers to have greater ownership of engagement at a local level.

Trust-wide, King's continued to focus on five key areas:

- Appraisals – The Trust launched a new approach to appraisals which delivered a completion rate of over 90%;
- Bullying and Harassment – As well as specific work with our staff networks, the Trust launched "No a Target" – a campaign and helpline to raise awareness of and reduce bullying and harassment of staff.
- Staff Recognition – With the support of King's College Hospital Charity, the Trust launched King's Staff, a staff recognition programme.
- Health and Wellbeing – Two key campaigns included Younger Lives and Sleepio to support staff mental and physical wellbeing.

The Trust will continue to focus on these themes following the 2018/2019 staff survey results. In total 39.6% of staff responded to the survey. While this was a 4% decrease year on year, eight of the nine new comparable themes remained the same and the Trust's staff engagement score remained (Score: 6.8).

King's remains committed to fostering a culture of inclusion for everyone and in the past year the Trust has worked with its staff networks to promote and support this intention. During 2018/2019, the Trust has held its second BAME Annual Conference and celebrated both Black History Month and LGBT+ Pride. The Trust also launched King's Able, a new disability network for staff which launched in February 2019.

In 2019/20, King's will continue to focus on supporting its staff - creating fair and equal opportunities for training, development and promotion, support staff against bullying and harassment from colleagues and patients and recognising the incredible work that they do in caring for our patients and one another.

The following tables provide information on staff costs and numbers during 2018/19. The Trust is also required to make a number of disclosures in its staff report, these are also detailed below.

The information in this section of the staff report is subject to audit.

Workforce costs

Employee benefits

	Group	
	2018-19 Total	2017-18 Total
	£000	£000
Salaries and wages	524,627	486,182
Social security costs	53,262	49,107
Apprenticeship levy	2,489	2,318
Employer contributions to NHS		
Pensions	60,238	56,783
Temporary staff (including agency)	63,563	89,915
Total gross employee benefits	704,179	684,305
Recoveries from other bodies in respect of staff cost netted off expenditure	-	-
Total employee benefits	704,179	684,305
Of which		
Costs capitalised as part of assets	(750)	(1,619)
Total employee benefits excluding capitalised costs	703,429	682,686

Workforce data

Group	Total 2018/19 No.	Permanent 2018/19 No.	Other 2018/19 No.	Total 2017/18 No.	Permanent 2017/18 No.	Other 2017/18 No.
Medical and dental	2,112	834	1,278	2,114	798	1,316
Administration and estates	2,582	2,258	324	2,525	2,169	356
Healthcare assistants and other support staff	1,340	1,235	105	1,314	1,175	139
Nursing, midwifery and health visiting staff	4,818	3,766	1052	4,870	3,756	1,114
Nursing, midwifery and health visiting learners	11	1	10	13	1	12
Scientific, therapeutic and technical staff	1,556	1,218	338	1,612	1,245	367
Healthcare science staff	337	295	42	289	261	28
Social care staff	15	14.55	0	13	13	0
Grand Total	12,771	9,622	3,149	12,750	9,418	3,332

The information in this part of the staff report is not subject to audit

TABLE : Equality and Diversity Analysis		
2018/2019		
	Headcount	%
Age		
(0-16)	1	0%
(17-21)	95	0.8%
22+	12472	99%
Ethnicity		
White	5817	46%
Mixed	369	3%
Asian or Asian British	2618	21%
Black or Black British	2483	20%
Other	356	3%
Unknown	925	7%
Gender (All staff)		
Male	3047	24%
Female	9521	76%
Gender (Senior Managers)		
Male	26	53%
Female	23	47%
Gender (Directors)		
Male	8	44%
Female	10	56%
Recorded Disability		
Yes	324	3%
No	10723	85%
Not declared	693	6%
Unknown	828	7%
Sexual Orientation		
Bisexual	131	1%
Gay	190	2%
Heterosexual	9683	77%
Lesbian	130	1%
I do not wish to disclose	1736	14%
Unknown	698	6%
Religion		
Atheism	1330	11%
Buddhism	226	2%
Christianity	6435	51%
Hinduism	443	4%
Islam	649	5%
Janism	23	0%
Judaism	40	0%
Sikhism	118	1%
Other	664	5%
I do not wish to disclose	1957	16%
Unknown	683	5%

	2017/18		2018/19	
	Headcount	%	Headcount	%
Age				
(0-16)	0	0%	1	0%
(17-21)	88	0.7%	95	0.8%
22+	12247	99%	12472	99%
Ethnicity				
White	6070	49%	5817	46%
Mixed	372	3%	369	3%
Asian or Asian British	2092	17%	2618	21%
Black or Black British	2409	20%	2483	20%
Other	821	6%	356	3%
Unknown	572	5%	925	7%
Gender (All staff)				
Male	2951	24%	3047	24%
Female	9385	76%	9521	76%
Gender (Senior Managers)				
Male	26	53%	26	53%
Female	23	47%	23	47%
Gender (Directors)				
Male	7	47%	8	44%
Female	8	53%	10	56%
Recorded Disability				
Yes	328	3%	324	3%
No	10863	88%	10723	85%
Not declared	712	6%	693	6%
Unknown	433	4%	828	7%
Sexual Orientation				
Bisexual	117	1%	131	1%
Gay	217	1%	190	2%
Heterosexual	9630	78%	9683	77%
Lesbian	64	0%	130	1%
I do not wish to disclose	1847	15%	1736	14%
Unknown	461	4%	698	6%
Religion				
Atheism	1348	10%	1330	11%
Buddhism	215	2%	226	2%
Christianity	6371	52%	6435	51%
Hinduism	436	4%	443	4%
Islam	592	5%	649	5%
Janism	17	0%	23	0%
Judaism	35	0%	40	0%
Sikhism	118	1%	118	1%
Other	677	5%	664	5%
I do not wish to disclose	2075	17%	1957	16%
Unknown	452	5%	683	5%
Total Staff Numbers	12336		12568	

Sickness Absence data

Staff sickness absence

	2018-19 Number	2017-18 Number
Total days lost	87,795	78,229
Total staff years	11,529	10,953
Average working days lost	7.6	7.1

Average sickness absence days are provided by the Department of Health and Social Care, and are calculated using calendar years, rather than financial years.

The Trust measures sickness by financial year as a %. In 2018/19, the Trust sickness rate was 3.55% which is below the NHS average. This represents a slight increase on the previous year (3.19%).

The information in this section of the staff report is subject to audit.

Termination benefits

By number of cases:	2018-19	2017-18
Exit package cost band (including any special payment element)	Total	Total
Less than £10,000	26	15
£10,000-£25,000	4	3
£25,001-£50,000	-	1
£50,001-£100,000	2	2
£100,001 - £150,000	1	-
£150,001 - £200,000	-	-
Greater than £200,000	1	-
Total	34	21

Exit package cost band (including any special payment element)

By value of payments:	2018-19	2017-18
Exit package cost band (including any special payment element)	Total £000	Total £000
Less than £10,000	95	46
£10,000-£25,000	76	42
£25,001-£50,000	-	30
£50,001-£100,000	161	181
£100,001 - £150,000	117	-
£150,001 - £200,000	-	-
Greater than £200,000	930	-
Total	1,379	299

Two (2017/18: 0) of the above exit packages relate to compulsory redundancies totalling £26k (2017/18: £0k). All other termination benefits related to other agreed departures.

Other departures agreed are as follows:

	2018-19		2017-18	
	Number	£000	Number	£000
Mutually agreed resignations (MARS)				
contractual costs	9	38		
Contractual payments in lieu of notice	19	204	21	299
Exit payments following Employment Tribunal or court orders				
(This figure includes the £930k exit package referred to in the table above)	4	1,111	-	-
Total	32	1353	21	299
Of which:				
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

The information in this section of the staff report is not subject to audit.

Off Payroll Arrangements

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months	
Number of existing engagements as of 31 March 2019	6
Of which...	
No. that have existed for less than one year at time of reporting.	4
No. that have existed for between one and two years at time of reporting.	1
No. that have existed for between two and three years at time of reporting.	1
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0
For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months	
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	3
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	3
Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019	
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	1
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	15

The Trust follows NHSI policy on off-payroll arrangements and any 'highly paid' appointment is subject to NHSI approval and, where necessary Trust Board approval.

Peter Pentecost, Financial Recovery Director, was sanctioned by NHSI as a result of the Trust's financial position as someone with significant experience of working with Trusts in financial difficulty. He is on a 2 year engagement.

During 2018/19, no Board members were 'off-payroll'.

The Trade Union (Facility Time Publication Requirements) Regulations 2017

This is the second year that organisations have been required by law to publish Trade Union (TU) facility time information. Our systems for robustly capturing the required figures will be improved over time and as a result, there will be some changes to these figures in the future. The data below is for the financial year 1 April 2018 to 31 March 2019. The amount of TU facility time during this period has reduced since last year as the Trust has had 6 fewer local TU reps during this period.

Relevant union officials

<i>Number of employees who were relevant union officials during the relevant period (full time equivalent)</i>	<i>Full-time equivalent employee number</i>
32.44	11,633.53

Percentage of time spent on facility time

<i>Percentage of time</i>	<i>Number of employees</i>
0%	0
1-50%	32
51%-99%	0
100%	1

Percentage of pay bill spent on facility time

	<i>Figures</i>
Provide the total cost of facility time	£58,511.53
Provide the total pay bill	£691,230,359
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.0085

Paid trade union activities

<i>Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100</i>	0
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Expenditure on consultancy

On occasion the Trust brings in consultants from outside the Trust to provide advice and support that cannot be provided within the Trust. In 2018/19, the Trust spent £7m on external consultancy. This was to provide specific targeted support in areas such as financial recovery and emergency care.

	Group	
	2018/19	2017-18
	£000	£000
Consultancy costs	7,082	3,401

Our Approach to Staff Engagement

We use the data and commentary from leavers' surveys, the quarterly staff friends and family test (FFT) and the annual staff survey to inform us on how staff feel about working at King's. We also get regular feedback via our Joint Staff Consultative Committee (JSCC) on the key issues and concerns facing staff.

The Trust employs a multitude of methods for ensuring staff are engaged and informed about things that affect them including newsletters, all staff emails, monthly magazines, drop-in sessions and management cascades. The Trust also has a very detailed intranet.

In 2018/19 our approach as a Trust has been to enable leaders and managers to take greater ownership for engagement. We now have a total of 20 local engagement plans. In addition to these local plans the Trust has also prioritised action in the following areas below:

Areas	Progress update
Appraisal	A new approach to appraisals for non-medical staff was launched in April 2018 to ensure regular, meaningful conversations so staff feel valued and recognized for their contribution in King's.
Bullying and harassment	The Trust launched a zero tolerance campaign to address Bullying and Harassment called 'Not a Target' as well as a Bullying and Harassment helpline.
Staff Recognition	The Trust launched a new recognition scheme in 2018 called King's Stars to showcase the outstanding achievement of staff and teams across the organisation
Health and Wellbeing	Various events held this year including a physical activity and Younger Lives programme. The Trust has also procured the Sleepio programme and organised lunchtime walks.
Equality, Diversity and Inclusion	Focus has been on growing the membership and engagement of our 3 Diversity Networks across the Trust (see also section – A Diverse Workforce)

Survey Methodology Changes

Historically the results of the staff survey have been presented as 32 key findings, based on the answers to 90 weighted questions. This methodology is being phased out and replaced with the similar set of questions presented as ten themes that all carry a score out of ten.

The themes are; equality, diversity and inclusion, health and wellbeing, immediate managers, morale, quality of appraisal, quality of care, safe environment – bullying and harassment, safe environment – violence, safety culture and staff engagement.

Summary of Results from the 2018 NHS Staff Survey

The survey was open from 8th October to 30th November 2018 and 11,849 staff were eligible to complete the survey. The survey closed with a 39.6% response rate (n=4692) which is a decrease of 4% from the previous year.

Thematic analysis of the results show that eight themes have remained the same, one theme has worsened and one is not comparable. Our overall staff engagement theme score was 6.8 which is the same as King's score in 2017.

Significantly Improved and Reduced Key Findings

There are four key findings where the Trust has seen a statistically significant increase in performance.

Key Findings	2016	2017	2018
KF5: Recognition and value of staff by managers and organisation	3.34	3.33	3.40
KF11: Percentage of staff appraised in the last 12 months	74%	65%	89%
KF14: Staff satisfaction with resourcing and support	3.14	3.16	3.20
KF30: Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.66	3.67	3.72

It is important to note that the Trust has achieved a consistent appraisal rate of 90% for the last six months which is a significant improvement from the previous year (65%).

There are three key findings where the Trust has seen a statistically significant decrease in performance..

Key Findings	2016	2017	2018
KF1: Staff recommendation of the organisation as a place to work or receive treatment	3.67	3.71	3.66
KF12: Quality of appraisals	3.06	3.21	3.10
KF19: Organisation and management interest in and action on health and wellbeing	3.38	3.43	3.36

With regard to Key Finding 1, 55% of staff recommended King's as a place to work compared to 57% in the 2017 staff survey whereas 68% of staff recommending King's as a place to receive treatment which is 3% less than in the 2017 survey.

What are we doing to address the results?

Based on the findings from this year's survey the Senior Leadership Group is in the process of agreeing the priority areas for improving employee engagement which will inform the People Strategy for 2019/20.

Benchmarking King's staff survey data

The following table shows how the Trust's staff survey results compare nationally in each of the ten themes (Kings is the dark blue line in each table):

Equality, diversity and inclusion

	2014	2015	2016	2017	2018
Best	9.6	9.6	9.6	9.4	9.6
Your org	8.5	9.1	8.6	8.3	8.3
Average	9.1	9.2	9.2	9.1	9.1
Worst	8.3	8.3	8.1	8.1	8.1
No. responses	241	242	3,644	4,648	4,476

Health and wellbeing

	2015	2016	2017	2018
Best	6.8	6.8	6.6	6.7
Your org	5.3	5.3	5.4	5.2
Average	6.0	6.1	6.0	5.9
Worst	5.3	5.3	5.4	5.2
No. responses	241	3,707	4,756	4,526

Immediate managers

	2015	2016	2017	2018
Best	7.3	7.2	7.2	7.3
Your org	6.8	6.5	6.4	6.5
Average	6.6	6.7	6.7	6.7
Worst	6.1	6.2	6.2	6.2
No. responses	243	3,708	4,699	4,562

Morale

	2018
Best	6.7
Your org	5.6
Average	6.1
Worst	5.4
No. responses	4,395

Quality of appraisals

	2015	2016	2017	2018
Best	6.1	6.3	6.4	6.5
Your org	5.5	5.4	5.5	5.4
Average	5.1	5.3	5.3	5.4
Worst	4.2	4.4	4.6	4.6
No. responses	172	2,610	3,006	3,862

Quality of care

	2015	2016	2017	2018
Best	8.3	8.2	8.1	8.1
Your org	7.4	7.4	7.3	7.3
Average	7.5	7.6	7.5	7.4
Worst	6.9	7.0	7.0	7.0
No. responses	215	3,360	4,439	4,233

Safe environment – Bullying & harassment

	2015	2016	2017	2018
Best	8.5	8.6	8.4	8.5
Your org	7.7	7.4	7.4	7.3
Average	7.9	8.0	8.0	7.9
Worst	7.0	7.1	7.2	7.1
No. responses	242	3,637	4,603	4,438

Safe environment – Violence

	2015	2016	2017	2018
Best	9.6	9.7	9.6	9.6
Your org	9.5	9.3	9.3	9.2
Average	9.4	9.4	9.4	9.4
Worst	9.1	9.2	9.1	9.2
No. responses	241	3,645	4,594	4,431

Safety culture

	2015	2016	2017	2018
Best	7.2	7.1	7.0	7.2
Your org	6.6	6.4	6.5	6.5
Average	6.5	6.6	6.6	6.6
Worst	5.9	6.0	5.9	6.0
No. responses	242	3,682	4,689	4,462

Staff engagement

	2014	2015	2016	2017	2018
Best	7.5	7.6	7.4	7.4	7.6
Your org	6.9	7.0	6.9	6.8	6.8
Average	6.8	7.0	7.0	7.0	7.0
Worst	5.9	6.4	6.5	6.4	6.4
No. responses	245	247	3,790	4,878	4,634

A Diverse Workforce

King's College Hospital NHS Foundation Trust is continuing to develop a culture which feels inclusive for everyone and continually celebrates difference. During the period of this report, we have continued to work towards the objectives in our Diversity and Inclusion Matters strategy which is based on the following twin priorities

1. Gaining a better understanding and addressing the needs of under-represented groups in King's and;
2. Cultivating a culture of inclusion.

As part of working towards these twin priorities we continue to use Workforce Race Equality Standard (WRES) and the Department of Health and Social Care's Equality Delivery System (EDS2) to support robust equality objective setting across the four key EDS2 outcomes:

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and inclusive staff
4. Inclusive leadership

Action taken by Staff Led Diversity Groups

During the period of this report the Trust has

- Held its second BAME Annual Conference in July 2018
- Celebrated Pride with 41 members of staff taking part in the annual parade
- Held our first Disability Network launch event in February 2019
- Taken action to encourage staff to declare their diversity information on our Employee Staff Record (ESR)

Race Equality and Inclusion

Building on the BAME Network launch in July 2017 there has been a continued focus on Race Equality and Inclusion over the past 12 months. Initiatives include launching a pre investigation checklist linked to indicator 3 of the WRES, growing the membership of the network and running another round of reverse mentoring.

Positive about disabled people

In addition to launching a Disability Network for staff called King's Able the Trust has become Disability Confident level 1 accredited by the Department for Work and Pensions (DWP). This is in recognition of the Trust's commitment to guaranteeing an interview to disabled applicants that meet the minimum criteria for vacancies. In addition to this and to ensure equality of opportunity the Trust carries out anonymised sifting of job applications.

Training is also provided for staff working with people who may have learning disabilities, and there are e-learning programmes available which relate to a range of diversity issues, plus an introductory British Sign Language e-learning programme.

Staff who become disabled whilst an employee of the Trust will be supported through Occupational Health and all reasonable adjustments will be made to allow the individual to remain at the Trust.

The 2019/20 Equality, Diversity and Inclusion work plan will consider whether more can be done to address disabled staff career development.

Gender Pay Gap

The Trust Gender Pay Gap at the 31 March 2018 was 21.4% (mean figure) and 16.8% when the median calculation is applied. This equates to females earning £5.31 per hour (mean figure) compared to males and £3.56 less than males when the median calculation is applied.

Over the next year we will be partnering with the Behavioural Insights Team in the Government Equalities Office to get a better understanding of the factors contributing towards our bonus pay gap.

Promotion of Dignity and Respect

The Trust has clear processes for dealing with reported cases of bullying and harassment and this year the Trust launched a zero tolerance campaign to address the increase in reported Bullying and Harassment called 'Not a Target'. In addition, the Trust launched a Bullying and Harassment helpline.

The Trust also continues to provide support to staff through the Freedom to Speak Up Guardian and Employee Assistance Programme which staff can access to support them with different issues (e.g. work concerns, financial issues, relationship advice, bullying and harassment etc.).

Learning and Development

To ensure greater equality, diversity and inclusion in the workplace we have launched new video learning on unconscious bias and are working towards mandating the completion of this for all interview panel Chairs.

Governance

We are continuing to embed and monitor inclusion through established governance including the Education & Workforce Development Committee (EWDC), BAME Steering Group and Patient Experience Committee and Board level discussions.

Counter fraud and corruption

The Trust has a number of policies in place to counter fraud and corruption and the Trust has a good track record in reporting suspected fraud. The work of the local counter fraud representative is outlined elsewhere in this report and is reported to the Audit Committee.

Health and Safety Report

2018/19 has been a challenging year for all areas of Health and Safety compliance. There has been an improved focus on the wider health and safety risks of the Trust. The Trust is making progress in both maintenance of the management of health and safety (i.e. local workplace risk assessments etc.) and in improving the monitoring and reporting of the risk profile and where appropriate, expanding the profile. The improved working relationships are supporting all areas to provide assurance of the Trust's position and commitment to complying with HSE Legislation.

Significant Events

- a. The Regulatory Governance Department (RGD) had assumed the responsibility for conducting all Workplace Risk Assessments (WRA) from August 2018. Prior to this, each department had to supply a 'Responsible Person' to attend the Datix course in order to complete a WRA but with the high turnover of personnel and the difficulty in having staff members released to attend, completed risk assessments were falling below the required 80% compliance level. The Trust is now compliant with WRAs.

- b. The Safety Hypodermic Needle Roll Out (SOL-CARE) commenced on 16 October 2018. Clinical staff were trained in approximately 90 Wards/Departments by the company, 'B.Braun', along with the Procurement Department of KFM. This will allow the procurement of standardised safety needles for Trust use.
- c. An incident occurred where a crane load impacted a window on Floor 9 of Ruskin Wing in Nov 2018. The window was shattered by the impact and the incident caused huge distress to the patient and doctor within the vicinity. Although an accident investigation was conducted by the responsible construction company, M&G, it was considered to be weak in all aspects and a more robust and detailed investigation was requested by the Trust. It remains outstanding at present.
- d. HSE visited Viapath Pathology laboratories on 5 Dec 2018. There were concerns raised that security measures were not adequate to protect these Class 3 Laboratories (containing hazardous substances). Several breaches of security were noted and these have now been addressed. No further action was taken by the HSE.
- e. The creation of Safety Rooms for Patients with Mental Health Problems was instigated in Jan 2019. Although these rooms are not ligature-free, they do address a number of other risks and will have laminated windows and window restrictors to prevent window breakages and to deny escape respectively.

Legal Safety Compliance Overview

The table below outlines the main Health & Safety legislation and identifies the proactive work that the Trust has carried out in order to comply.

Legislation	Description of Actions
Health & Safety at Work Act 1974	- Health & Safety Management Strategy ratified and online. - Competent persons in place to provide compliance advice (RGD). - Occupational Health and Safety Committee meetings held 4 times a year - well attended.
Management of Health & Safety at Work Regulations 1999	- Annual H&S Audit programme. - Over 80% WRAs conducted in the Trust. - H&S Champion training implemented in Jan 19. - Divisions responsible for ensuring that they have adequate numbers of Champions. Volunteer numbers are low as revealed by audit and needs to increase.
Display Screen Equipment Regulations 1992	DSE Self- assessment tool has been updated on Kingsweb and OH now has OH Specialists to advise on the DSE recommendations.

Legislation	Description of Actions
Control of Noise at work Regulations 2005	Noise at work policy currently being re-drafted and expected to be ratified by Q2 2019.
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) Health & Safety Consultation with Employees Regulations 1996	92% reported within the HSE's required timeline. - Investigations have been implemented for all RIDDOR incidents and the findings are shared with the Occupational Safety Committee. - Terms of reference have been re-drafted for the H&S Committee
Health & Safety Information for Employees Regulations (Amendment) 2009	- H&S Reps and Trade Union H&S Reps engaged. - Site based Health and Safety Committee (PRUH & ORP) held 6 times a year and is well attended by Managers, Trust Competent Persons, TU Reps and H&S Champions. - Reports on Audits, Action Plan progress and Risk Register.
Safety Representatives and Safety Committees Regulations 1977	

Accident Investigations

One formal investigation occurred over the reporting period:

- A member of staff was struck by a reversing vehicle in the vicinity of Unit 7. On 21 Nov 2018, a staff member was using the side road in the area when the van hit her. A member of public witnessed the incident and was instrumental in stopping the van by attracting the attention of the vehicle's driver. The latter claimed not to have seen the staff member to the rear of the van. Fortunately, the staff member only suffered minor injuries but was shaken by the incident. The investigation concluded that the driver did not take suitable precautions in contemplating pedestrians whilst reversing his vehicle and that the staff member should be mindful of the dangers whilst working on the road instead of using the pedestrian walkway as provided. Also, it was not advisable to be distracted by working on a mobile phone whilst walking in a high traffic density area.

RIDDORs

A total of 33 RIDDORs were reported to the HSE in 2018/19 – an increase of 18% on the previous year's total of 27. The categories where injuries occurred were:

Injury Type	2018/19	2017/2018
Sharps Injuries	12	07
Slips, Trips & Falls	09	07
BBV Splash Injuries	02	07
Others (e.g. Crush, Burns, Assaults)	10	06

All sub-categories saw an upward trend over the reporting period and again, the leading category for reportable injuries remains to be 'Injuries from Dirty Sharps' with the majority of cases being attributed to staff failing to observe and adhere to safe systems of work.

A total of 19 members of staff were absent from work for a period of more than 7 consecutive days. Total accumulated absence = 467 days.

Of all the 4203 H&S incidents reported, RIDDORs accounted for 0.7% of this in 2018/19; this increase on the previous year of 0.5% (2017/18) can probably be attributed to better awareness of the regulations as a result of induction and refresher training sessions.

Violence and Aggression (V&A)

V&A levels have had a minor decrease in the Trust despite a nationwide increase in incidents involving healthcare workers. This trend remains a concern with NHSI. The total amount of V&A Incidents reported were:

Site	2018/19	2017/18
DH	2503	2611
PRUH	549	823
Other Sites	140	77
Total	3192	3511

Pro-Active Monitoring

The RGD continues to undertake site/department inspections as part of the H&S audit process to assist in the identifying of issues/concerns and reporting these to the relevant response team. Datix is scrutinised daily to review incidents and identify any trends from which the Health and Safety Managers trigger communication to the department to review their risk assessments and to take into consideration any lessons learned following the incidents and placing additional controls where required

Reactive Monitoring

Regular inspections (minimum of one per week) of all sites as directed in Management of Health & Safety at Work Regulations 1999 are undertaken by the RGD and concerns are informed to Estates to support their maintenance and repair programme. Reactive inspections following slips, trips & falls incidents to review the area for safety purposes and identify control measures to prevent further incidents; these are undertaken by Estates and/or the Trust Safety Managers. Direction is also taken from claim investigations and outcomes to improve arrangements in place.

Manual Handling

Mandatory (MH) training is provided with integrated courses delivered in some specific areas. The Trust target for staff in date for MH Training is 80%, the current level is 77.25%.

2.4 The Disclosures set out in the NHS Foundation Trust Code of Governance Statutory framework

King's College Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance is based on the principles of the UK Corporate Governance Code, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. The required disclosures in relation to the Board of Directors and Council of Governors are outlined in section 2.1 above.

King's meets all the main principles of the code, especially those relating to the development and management of patient services and accountability for the use of public resources. The composition of the Board and the Council of Governors is laid out in the Director's Report above. The Board has fewer voting executive members than non-executive members (excluding the Chair) and therefore meets the requirement of the code. However, there are a number of non-voting executive members on the Board.

The Trust is required describe how the Trust is able to assure itself of the validity of its corporate governance statement, required under NHS Foundation Trust licence condition FT4. The Board signs this statement in parallel with this annual report, having been appraised of the information provided by external and internal auditors.

2.5 NHS Improvement's Single Oversight Framework

NHSI's single oversight framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability. The table on page 11 shows the Trust's operational performance scores

The Trust was placed in an enhanced regime of Financial Special Measures by NHSI in 2017/18 following a substantial variation to the planned deficit for the year.

Finance and Use of Resources

The finance and use of resources theme is based on the scoring of five measures from 1 to 4 where 1 reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Finance and Use of Resources Scores

Area	Metric	Score	Score	Score	Score
		2018/19 Quarter 1	2018/19 Quarter 2	2018/19 Quarter 3	2018/19 Quarter 4
Financial sustainability	Capital service liquidity	4	4	4	4
	Liquidity	4	4	4	4
Financial efficiency	I&E margin	4	4	4	4
Financial controls	Distance from financial plan	2	4	4	4
	Agency spend	1	1	1	1
Overall scoring		4	4	4	4

2.6 Statement of the 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 the 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 NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require King's College Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. 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 DHSC Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, 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 (and the DHSC Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and

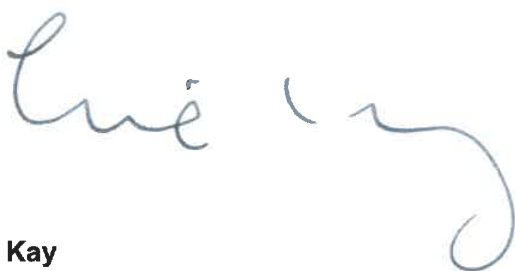
stakeholders to assess the NHS Foundation Trust's performance, business model and strategy; and

- 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 the NHS Foundation Trust Accounting Officer Memorandum.

Signed:



Date:

11/6/19

Dr Clive Kay

Chief Executive and Accounting Officer

2.7 Annual Governance Statement and Enhancing Quality Governance

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 or 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 within the Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts. A review of the effectiveness of the system of internal control can be found on page 95-97.

Capacity to Handle Risk

The Board of Directors develops and has overall accountability for the Trust's Risk Management Strategy which is managed and implemented by the executive directors and senior managers. The current risk management strategy is under review by the new Director of Quality Governance and will aim to encompass a broader Quality Strategy. The current processes are therefore changing while the overarching principles remain the same of managing risk from 'ward to board'.

The Trust operates a unified approach covering both clinical and non-clinical risks which are recorded on an electronic risk register. The Board reviews the risk register quarterly at its Quality Assurance and Risk Committee, supported by the Patient Safety team, the Medical Director and Chief Nurse lead on clinical risks. The Chief Operating Officer has accountability for the development, implementation and testing of the Trust's business continuity plan. King's has a ward to board approach to its systematic comprehensive approach to the identification and mitigation of risk. Each care group has its own Clinical Lead for clinical governance including quality, risk and patient experience. These care groups feed into the divisional senior management team and then up to the feeder clinical governance committees to the Board. The risk and quality framework is based on the CQC fundamental standards, and other NHS educational and research standards.

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. The Trust's policies and risk strategies are kept on a central policy database available to all staff. As part of their induction, staff are provided with guidance and training on the Trust's risk management policies and strategies, they are also provided with updates through regular staff briefings and the Trust's intranet.

The Trust recognises that it is important to be outward looking and to learn and improve from the experience of other organisations and experts and where possible to benchmark the quality and performance of the services we provide to our patients. We do this through a

variety of ways. We are members of external national groups and networks including but not limited to the Shelford Group which comprises leading NHS multi-specialty academic healthcare organisations, who are dedicated to excellence in clinical research, education and patient care.

The Trust uses the Healthcare Evaluation database which is set up to enable benchmarking internally and externally across a wide range of clinical effectiveness, patient experience and patient safety indicators. In addition, we seek both external and internal expertise such as the DHSC, King's Health Partners and our governors to provide an independent critical eye. The Trust is also working collaboratively with other external providers through OHSEL and the South East London Sustainability and Transformation Partnership (STP).

The Risk and Control Framework

Identifying, Evaluating and Controlling Risk

The Trust operates a cyclical mechanism for the identification, evaluation and control of risk, facilitated by means of a central risk register. This is a dynamic document which reflects corporate and local risks and their movement within the register. Divisional risk and governance committees 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. Trust-wide risks are considered for the Corporate Risk Register, with those rated as 'red' reviewed by the Board's Quality Assurance and Research Committee in line with the Trust's Risk Management Strategy. Each Corporate Director is responsible and accountable for the management of the risks in their designated area and capturing them on the corporate risk register also. The risk register is comprehensive and includes data security.

Corporate risks are those identified as potentially impacting on the Trust's ability to deliver its corporate objectives, which by nature have an impact on its ability to deliver its strategic objectives. The Board Assurance Framework (BAF) enables the Board to focus on the principle risks to delivering the Trust's strategic objectives and the robustness of internal controls in place to reduce or manage the risks to acceptable levels. The controls in place and sources of assurances are reviewed to determine a risk rating which gives an indication of the likelihood and severity of the risk. Identified gaps in control and assurance inform action plans in mitigation. The Trust Board's Quality, Assurance and Research Committee (QARC) and Audit Committee have delegated oversight to review the BAF and make recommendations to the Board in respect of the risks and associated controls in place.

Key Elements of Quality Governance Arrangements

The Trust's quality governance framework has at its centre the Quality Assurance and Research Committee with a membership comprising four non-executive directors, the majority of the executive directors and Commissioner representation from Southwark and Bromley CCGs. A Governor Representative also attends the scheduled Quality Assurance and Research Committee, providing a written report to the Council of Governors on the matters discussed. The quality assurance and research reporting committees include: executive quality committee, patient outcomes, patient safety, patient experience and occupational safety, all chaired by executive directors. Clinical directors are also accountable for reporting to the Quality Assurance and Research Committee on a rolling cycle. The reporting structures and processes are embedded across all sites down to divisional and specialty level.

This ensures that patient outcomes, patient and occupational safety and patient experience at all sites are integrated within existing and established quality governance monitoring framework and robust performance management infrastructure. Importantly, the relevant specialty and divisional clinical governance and associated committees operate across all

sites have been required to implement the terms of reference and reporting procedures that are in line with Governance principles already at King's.

Through a defined reporting programme the Quality Assurance and Research Committee, which is a committee of the Board, and its reporting committees: executive quality committee, patient safety, patient outcomes, patient experience and occupational safety, will receive progress reports and assurances from the various committees which feed into them. All of these committees are minuted and have in place action trackers which are updated after every meeting.

The Board receives a monthly Performance Report and performance scorecard which provides up to date information on key quality indicators drilling down to site-specific information – Infection Control updates, patient safety, patient experience and clinical effectiveness, highlighting current quality and safety issues and action being taken.

A suite of other reports are received by the Board of Directors on a rolling quarterly cycle on patient safety, patient outcomes and patient experience, which provide site-specific information. The Chief Nurse provides a monthly report to the Board of Directors on nursing numbers in comparison to an acuity-based evaluation of safe staffing levels. Nurse establishment levels are also regularly reviewed and reported to Board. Medical staffing levels have also been reviewed where particular concerns have been identified.

At the Quality Assurance and Research Committee, a quarterly report addressing the four dimension of quality, patient safety, patient outcomes, patient experience, are presented by the Medical Director and Chief Nurse/ Chief Operating Officer. The reports include updates on quality priorities, CQC key five domains and driving improvement across the quality dimensions:

- **Patient Outcomes:** mortality monitoring and review of mortality outliers, progress against NCEPODs and participation in National Audits, updates on public health priorities, NICE Quality standards
- **Patient Safety:** profile and analysis of adverse incidents and progress against related improvement work streams, serious incidents and improvement actions, adverse incident benchmarking data; ,
- **Patient Experience:** National Surveys, monthly internal How Are We Doing Survey, updates from patient opinion websites, complaints and PALS trends and analysis, service improvements, outcome of Ombudsman investigations, Local CQUIN, Friends and Family Test and
- **Occupational Safety:** analysis of health and safety incidents, inspection findings.

A quarterly report on Infection and Prevention Control is provided by the Chief Nurse who is also the Trust's DIPC.

The performance of divisions is formally reviewed at the monthly divisional performance review meetings led by the Chief Operating Officer in partnership with the Medical Director and Chief Nurse. These discussions inform the monthly Performance Report which is considered by the Board. The reports are structured so that the Board can drill down to site-specific performance and quality information.

Unresolved risks are passed to the Quality Assurance and Research Committee to review the adequacy of, and progress against action plans and to consider acceptance or further resolution. If additional resources are required to reduce the risk to an acceptable level, this is considered by the Investment Board and, if necessary by the Trust's Finance and Performance Committee. Risks that have an above average consequence and likelihood are given priority in the resource allocation process. It is the Trust's policy as defined within the Risk Management Strategy that its risk appetite is defined as all red risks are required to

be reviewed by the Board of Directors. The Board has decided that all risks assessed as having a greater than average likelihood of occurrence with a potential impact of more than moderate harm, are not acceptable and require mitigation. The Board reviews the nature and assessment of these risks and the potential impact on delivery of the Trust's Strategic priorities and careful consideration is given to whether the level of risk should be accepted or further treatment plans put in place. The Board will seek additional assurance or take direct action where it considers that risks are not being adequately controlled or accepted.

The Board Assurance Framework provides a high level management assessment process and record which enables the Trust to focus on the principal risks to delivering its strategic objectives and the robustness of internal controls to reduce or manage the risks to acceptable levels. In late 2018, the Board undertook a substantive review of the Board Assurance Framework to align it with the Trust's new strategic objectives, controls and assurances as well as national best practice. Where required, action plans were agreed to improve controls or assurances.

In the light of this review the following risks to strategic objectives were identified:

- Inability to meet key access targets due to delays to assessment and treatment in the emergency department caused by increased attendances and slow patient flow through the hospital
- Impact on the financial stability of the Trust as a result of a failure to achieve key financial targets including income projections.
- Risks to quality and safety as a result of an aging estate and a significant equipment maintenance and replacement backlog.

The risk register includes actions that the Trust will take and the outcomes it expects to see. These are reviewed and updated quarterly at QARC.

The Board Assurance Framework is updated by the Director of Quality Governance and reviewed by the Board periodically.

Assurance on compliance with relevant regulations, internal policies and procedures is undertaken through the Trust's committee structure for example CQC registration via QARC and fire regulations through the Health and Safety Committee. Compliance assessments are also undertaken by Internal Audit.

Care Quality Commission Registration

King's College Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is *Requires Improvement*.

In 2015 the Trust received a rating of **Requires Improvement** Trust-wide and for the Denmark Hill and Princess Royal University sites. Orpington Hospital received an overall rating of *Good*.

In September 2017 the Trust had a follow up inspection which noted significant improvement; however the Trust's rating remained the same as not all core areas were inspected on this occasion.

CQC Ratings

CQC's Overall Rating for King's College Hospital NHS Foundation Trust						
	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall Trust	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Key issues highlighted in the CQC report were:

- **Patient flow** in Outpatients and Emergency Departments as well as referral to treatment times at Denmark Hill and PRUH.
- **Documentation of care** completion and availability of paper records at PRUH.
- **Environment and Capacity** in Denmark Hill's Liver and Renal outpatients, Maternity, Critical Care wards and PRUH Surgical Admission Lounge.
- **Improving Skills, Knowledge and Processes to Improve Patient Safety** Mental Capacity Act 2005 and Deprivation of Liberty Safeguards policies were reviewed and targeted training is currently being implemented.

The Trust was inspected by the CQC in January and February 2019 and is expecting to receive its revised ratings in early June 2019. The Care Quality Commission did not take enforcement action against King's College Hospital NHS Foundation Trust during 2018/19. However, following the inspection in February, the CQC wrote to the Trust indicating they would take enforcement action if the Trust did not urgently address a number of issues they found when the inspectors visited the emergency department at the PRUH. The Trust has implemented a full action plan as a result of their findings.

Whilst the Trust continues to face challenges related to activity levels, it is generally meeting all the key milestones set out in its CQC Action Plan. These actions are being reviewed through the Planning and Delivery Board at executive meetings and at the Board of Directors.

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust has agreed a conflict of interest policy in line with NHS guidance but there is more to do in ensuring that all relevant staff have declared any relevant interests. The Trust has not yet published an up-to-date register of interest for all decision-making staff within the last 12 months as required by the 'managing conflicts of interest in the NHS' guidance.

The Trust has undertaken risk assessments and is in the process of developing a sustainable development management plan which takes account of UK climate projections 2018 (UKCPI1). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. The sustainable development management plan will be published in the summer of 2019.

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 into 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 Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Workforce safeguards

The nursing and midwifery workforce is reviewed twice a year in line with the NHS Improvement (2018) Developing Workforce Safeguards guidance. Safer staffing nursing levels are also monitored monthly by the Board.

The local policy for 'agreeing nursing and midwifery establishments' sets out a cycle to review wards, theatres, endoscopy, intensive care (including paediatrics and special care) and maternity. Where possible a recognised evidenced based tool, such as the Safer Nursing Care Tool is used to gather acuity and dependency data that in turn informs the nursing establishment.

Currently there are no evidenced based tools available to support the review of the emergency departments, outpatients and ambulatory services; these services are reviewed using benchmarking data, where available alongside professional judgement. The Trust is currently exploring the process to review the establishment of nurses and midwives in specialist roles, this will ensure that the nursing and midwifery workforce in totality can be reviewed twice a year, as recommended by the workforce safeguards guidance.

The Trust has less robust processes in place for monitoring workforce staffing levels in other areas, relying on vacancy and bank and agency data as a proxy. The Trust productivity programme, including GIRFT reviews staffing levels across all professions.

The Trust updates its workforce plan annually, and this includes a strategic assessment of the internal and external challenges facing the Trust.

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 robust governance structures and processes. Monthly finance and performance reports are considered in detail by the Finance and Performance Committee, a committee of the Board, chaired by a non-executive director, which met every month with the exception of August during 2018/19. The Audit Committee receives regular reports from the Trust's internal auditors, KPMG LLP and its external auditors, Deloitte LLP. The Board itself met on ten occasions during 2018/19.

On 11 December 2017 the Trust was placed in Financial Special Measures by NHSI due to the substantial variation off plan.

The Trust delivered savings in the 2018/19 financial year of £56m; split between one-off savings and recurrent savings. This missed the original plan to save £75m. The range of savings schemes include:

- a) significant reduction in the value of spend on agency staff
- b) workforce savings on administration and clerical staff
- c) success in a number of negotiations with major suppliers of services
- d) transformation efficiencies in theatres and outpatients
- e) pharmacy savings
- f) control of expenditure by clinical divisions and corporate directorates

All savings schemes were quality impact assessed to ensure they were not detrimental to patient care. The Chief Nurse and Medical Director were central to this assessment.

All Trust policies, procedures and business cases include an Equality Impact Assessment so that their implications can be considered by the Board of Directors. Major policy or strategic decisions are taken after consultation with the Council of Governors, Staff Side representatives and public and patient stakeholders. The Trust holds community events to receive the views of Trust Members and the Annual Public Meeting in early October 2018 was well attended.

Governance arrangements are kept under review and no significant changes were made to the governance structures in the Trust. The Financial Recovery Board, a sub-Committee of King's Executive continues to meet fortnightly. The purpose is to further strengthen the control and delivery of the Trust's financial recovery plans. Membership includes all Executive Directors, Divisional Directors and other relevant senior managers and meetings are chaired by the Interim Chief Financial Officer.

Specifically, the Financial Recovery Board's current purpose is to:

- a) provide assurance to the Trust Board that the Trust's CIP is on track to deliver against the overall financial target and quality goals that have been established;
- b) monitor progress of the totality of the CIP receiving exception reports and working collaboratively to resolve issues as appropriate.
- c) act as the primary decision-making body to address key blockers and define mitigating actions to support continuity of the work streams and programme's delivery objectives.
- d) hold executive sponsors and responsible officers to account for the delivery of their respective work streams.
- e) manage programme risks through a central risk register and ensure corrective and/or mitigating actions are in place.
- f) provide assurance that decisions taken support and enhance the quality and safety agenda of the Trust.
- g) receive monthly reports on CIP delivery and overall run-rate expenditure that support achievement of allowable expenditure limits.
- h) develop, assess and confirm new savings schemes to increase the savings delivered through the CIP.
- i) agree new policies that support restrictions or additional controls on Trust expenditure.
- j) ensure appropriate resource is in place to support the delivery of key workstreams and Programme Management Office function.
- k) approve accurate and timely reports for onward submission to the Trust's Finance and Performance Committee.

The Investment Board, also a committee of the King's Executive, was relaunched in quarter one of 2018/19. It has the overall purpose of ensuring that resource allocation is directed to the achievement of the Trust's objectives and in line with the current operating plan. It considers and either makes decisions on business cases or a recommendation to the King's Executive or Board, depending on the scale and nature of the investment. The Investment Board will also monitor the progress of agreed projects and the realisation of savings and other benefits. The Investment Board is chaired by the Chief Financial Officer and meets monthly.

Despite the level of savings delivered during the course of the year, the Trust reported a deficit in 2018/19, and has a planned deficit in 2019/20. The Trust required significant, unsecured, cash support during 2018/19 and will also require it for 2019/20. We have therefore concluded that the Trust does not currently have proper arrangements in place to secure economy, efficiency and effective use of its resources. The external auditors have reflected this in their modified audit opinion that they are not satisfied, in all significant respects, King's College Hospitals NHS Foundation Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Information on the Trust's going concern can be found in the annual accounts and in the performance section in this report.

Years of underinvestment in King's buildings, infrastructure and equipment has placed the Trust at considerable risk in a number of areas. The estates maintenance backlog figure for the Denmark Hill campus was assessed at £200m following an independent survey in 2016/17. Numerous items of equipment are beyond economic repair and are no longer supported by manufacturers. Solutions for equipment replacement are being developed in the areas of Radiology, proposals to introduce managed equipment services are currently being explored.

A concept Masterplan for the redevelopment of the Denmark Hill Campus was signed off by the Board in November 2018, to enable the Trust to focus investment in a structured and strategic manner. The Masterplan requires significant capital funding to progress.

Information Governance

The Trust is required to process information (personal and corporate) in line with current standards set out in statute (Data Protection Act 2018), regulation (EU General Data Protection Regulations 2016) and government guidance (NHS IG Assurance Framework). Information Governance (IG) at King's comprises identified responsibilities and strategy, policy and procedures that enable staff to handle personal information in line with these requirements.

Information Governance at King's is overseen by the Information Governance Steering Group (IGSG) which reports to the Quality Assurance and Research Committee, a committee of the Board.

The Chair of the IGSG is the Director of Improvement, Informatics and ICT acting as Trust Senior Information Risk Owner (SIRO) with membership including key roles such as the Caldicott Guardian, Data Protection Officer, Assistant Director of Performance and Contracts, Freedom of Information Lead/Deputy SIRO, Information Governance and Patient Records Service Managers.

In 2018 a series of major changes were introduced across the NHS covering the new Data Protection Legislation (EU General Data Protection Regulations 2016 and the UK Data Protection Act in May 2018) and the implementation of the National Data Guardian's 10 Data Security Standards.

These new areas have been encompassed into an annual assurance review measured by compliance with the new Data Security and Protection Toolkit (DSPT) standards introduced in April 2018.

Assurance of compliance with DSPT standards is demonstrated by achievement of requirements set out in ISB 1512 Information Governance Standards Framework. The standard NHS contract requires the Trust to achieve a status of all mandatory requirements met in year.

As this was the first year of the new standards, NHS Digital has agreed that improvement plans can be submitted where significant areas were not achieved. The Trust's 2018/19 DSPT submission achieved a Standards Not Met (Improvement Plan approved). The key area of focus was training which is set at 95% of all staff having completed the annual Data Security and Protection training.

IG Incidents

During the year 2018/19 in line with the NHS Improvement Serious Incident Framework (including amendments made by NHS Digital to reporting confidential breaches), the Trust reported four serious incidents relating to IG and breaches of confidentiality. These were reported to the Information Commissioner's Office (ICO) and other key regulatory bodies. Details of these incidents and the actions taken are summarised below.

Incident 1

- **Description:** May 2018: Full extract from internal Trust training system was circulated to a wider selection of employees
- **Action taken by Trust:** Review of system access controls and update of system user training
- **Action taken by ICO:** None (Closed)

Incident 2:

- **Description:** May 2018: Letter (including clinical diagnosis) was sent to incorrect location (individual's place of work)
- **Action taken by Trust:** Review of interoperability functionality of various systems and cross working
- **Action taken by ICO:** None (Closed)

Incident 3

- **Description:** June 2018: Lost USB memory stick during transfer between parties.
- **Action Taken by Trust:** Review of alternative mechanism for transfer of data and review of research process for data sharing.
- **Action Taken:** None (Closed)

Incident 4

- **Description:** September 2018: Data Quality issue raised between multiple systems preventing allocation of medication for home use
- **Action taken by Trust:** Review of interoperability of systems and process to reflect changes from one system to others effectively.
- **Action taken by ICO:** None (Closed)

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on 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.

Statement of Quality

King's continues to place quality, safety and the experience of patients, families and its staff at the forefront of everything that we do. During this year, we have experienced many challenges but have continued to report excellent clinical outcomes and ground-breaking research across the breadth of our clinical areas. Although we have experienced unprecedented demand on our services, 89% of patients across all our services would recommend us and our overall mortality has remained consistently below the national average.

The Foundations of quality (safety, experience and effectiveness) for the organisation are to listen to feedback from patients and families on the care we provide, to encourage an open culture where all staff are able to raise concerns and report incidents for investigation, to collect and review information on the outcomes of the treatment we provide and to ensure that we review all these and act on the findings through a robust improvement process.

During this year we have strengthened our senior leadership team with the appointment of new Board members and we have actively recruited a high number of clinical staff to ensure we have a stable workforce. This has resulted in the lowest nurse vacancy rate in the country. We have continued to develop our valuable volunteer workforce and engage with younger volunteers through partnership with the Prince's Trust. Our 'King's Way for Wards' accreditation scheme continues to develop and improve quality of care through regular auditing of systems and patient and staff feedback to identify areas for improvement for local teams to address.

We have developed our improvement methodology and continue to train staff in improvement skills, with local quality improvement projects being undertaken by clinical staff across the organisation. King's is leading the way with the development of 'value-based healthcare'; a model of delivering the outcomes that matter to patients for the best use of resources.

The initiative in which we perhaps take most pride is our new King's Stars award ceremony, which celebrates our many staff that go the extra mile for our patients.

All this work and more is being brought together into a new strategy which is currently out for consultation and feedback from our staff. The strategy will set our future direction, with quality of care at its very heart.

In December 2018 we held an engagement event for patients, the public, the voluntary sector and Trust members to showcase our progress on the 2018/19 quality priorities and to ask for suggestions for quality priorities for 2019/20. The group gave their continued support for the three quality priorities which we proposed to carry forward: mental health, cancer and outpatients. An additional improvement area was identified: improving communication and information for patients leaving hospital.

These four quality priorities were all supported and approved by our Executive Quality Board, the Quality Assurance and Research Committee and the Trust Board, the Board of Governors and by commissioner-led Clinical Quality Review Group (CQRG).

Priority 1: Improving the care of people with mental, as well as physical, health needs

Priority 2: Improving patients' experience of outpatient services

Priority 3: Improving cancer services for patients and their families

Priority 4: Improving our processes for patients leaving hospital

Data Quality

There are a number of inherent limitations in the preparation of Quality Accounts which may affect the reliability or accuracy of the data reported. These include:

- Data are derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audit's programme of work each year.
- Data are collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might reasonably have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

The Trust and its Board have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above.

The External Auditors have completed their data testing as part of the Quality Accounts review process. However, they have identified a number of errors in the A&E data and the cancer data that has been tested. The External Auditor will be working with the Trust to review prior year recommendations and agree management actions following the results of this year's audit. The Trust acknowledges weaknesses in the quality of internal data produced and will work with the auditors to update an action plan to identify areas of improvement.

Review of Effectiveness of the System of Internal Controls

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, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to the Annual Report and other performance information available to me.

My review is also informed by 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, the Quality Assurance and Research Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The processes that have been applied in maintaining and reviewing the effectiveness of the system of internal control are described in this Annual Governance Statement and throughout the report.

The control framework in place within the Trust continues to require improvement during 2018/19. The Trust was placed into financial special measures in December 2017 for failing to comply with its licence conditions because of a failure to deliver its forecasted budget, continued financial decline and a lack of financial control. The enforcement undertakings issued by NHSI includes requirements to deliver financial recovery and to improve performance against the national Emergency Care Standard and the Referral to Treatment target.

During 2018/19, the Trust has focused addressing the key issues which contributed to deterioration of the Trust's financial position. There has been particular emphasis on regaining financial control and internal efficiency and productivity in order to stabilise the Trust position. This has included addressing the following weaknesses:

- **Poor budgeting assumptions:** a more realistic view was taken on key assumptions underpinning the budget. The Trust is now more able to explain variances to the financial position and to track the underlying position. Forecasting has improved and Q4 financial forecasts were delivered.
- **Gaps between the HR electronic record system (ESR) and the financial ledger:** detailed reconciliation work has taken place and additional controls have been put in place to ensure that ESR and the General Ledger are reconciled on a monthly basis.
- **Weak workforce planning and pay control:** the Trust has implemented a central pay control panel and robust controls have been put into place to ensure appropriate governance around substantive and temporary staffing. Monthly reporting of all staffing including costs is now in place, and there is weekly analysis of bank and agency expenditure. A full review of nursing and midwifery establishments has been undertaken and reported to the Board.
- **Governance failings in the approach to signing off business cases:** there has been a retrospective review of all material business cases that have been approved in the last 18 months which focused on benefits realisation. The Trust has also strengthened the governance around business case approval through the Investment Board. Internal Audit reviewed the new approach and found that only minor improvements were required.
- **Lack of real time accessible management information:** work was progressed to improve the availability of data as well as the reconciliation of data on activity, finance and workforce. In turn this has resulted in better information to support financial oversight meetings.

- **Poor income data and weak data capture of activity and coding:** the Trust has worked with an external provider to ensure the systems and processes in place in the Trust address missed opportunities in coding and capturing income. This has led to improvements in activity capture, addressing historical contractual issues, refreshing local pricing and business rules as well as implementing corrections to technical errors. The work laid the groundwork to a significant local tariff increase in 2019/20. It also put in motion the corrective actions necessary to address the causes of recording issues. The Trust has also transformed the approach to contracting with our Commissioners which included better oversight by the Board.
- **Underperformance on key access targets (RTT and ECS):** the Trust has put in place the building blocks for significant productivity savings in 2019/20 (e.g. GIRFT, theatres and outpatients). There is early evidence that programmes will deliver productivity gains in the next 12 months.
- **Fragile financial recovery infrastructure:** more robust infrastructure is now in place which includes the recruitment of a substantive team and a Director of Financial Recovery. Governance of the programme is stronger with a greater focus on the delivery responsibilities of the divisions and corporate areas.
- **Weak governance of the Trust's subsidiaries:** the Trust has undertaken an independent review of KFM. New leadership is in place in both the Trust's wholly owned subsidiaries and new governance arrangements have improved Trust oversight of the subsidiaries. There is now a monthly financial reconciliation and consolidation which is reported to the Trust Board. The Trust has also reviewed the KFM contract value and the management arrangements in place to resolve disputes.
- **Poor estate and backlog maintenance of equipment and buildings:** the Trust has not been able to address the lack of capital, but there is now a clearly prioritised capital programme to support applications for Department of Health and Social Care funding. An innovative estate strategy is in development and commercial options for accessing modern equipment are being considered. However, there have been significant delays to the Critical Care Unit build while significant remedial work is completed.
- **The absence of a contracts database:** KFM has worked with the Trust to ensure that a contracts database is developed so that there can be proactive management of contracts and further procurement activity.
- **Interim leadership in key positions:** the Trust has appointed permanent a Chief Executive and a Chief Finance Officer as well as restructuring and strengthening a number of functions including finance, estates, commercial services and operational leadership.

It has been noted elsewhere in the 2018/19 annual report that the Trust is not meeting key access targets including the Emergency Care Standard and Referral to Treatment targets. Weaknesses were found in the management of the Emergency Department at the PRUH and diagnostic performance has also been weak.

- The Trust has reviewed emergency care and has detailed improvement plans in place on both of the sites that provide emergency care. A trajectory for improvement has been agreed as part of the 2019/20 annual plan.
- In developing an understanding of why the Trust is struggling to deliver the 18-week RTT target, it has become clear that the Trust is not managing its waiting lists as effectively as it should be. A significant programme of work is now in place to address this, including a review of capacity and demand to ensure that services are aligned to the needs of our patients.
- The Trust has implemented a 'serious incident' response to addressing the endoscopy backlog at the PRUH.

The Trust's internal and external auditors have raised a number of concerns during the year including but not limited to the robustness of financial planning processes, core financial

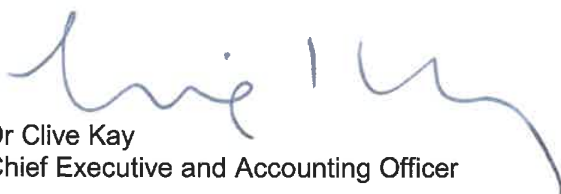
systems, the management of capital expenditure, information governance, the quality of performance reporting, financial recovery plans and the management of capital schemes. divisional risk management concerns were also raised. Action plans are in place to deliver improvements in all these areas in 2019/20. Internal Audit found good systems in place for the management of the agency cap. They also found that the Trust had improved its systems for managing standing financial instruction waivers and clinical handover processes. A number of areas were found to have 'significant assurance with minor improvement opportunities'. These included the reconciliation of HR systems, payroll analytics and the approach to business cases.

The Trust accepts that **the internal control environment requires improvement**. Whilst progress has been made during 2018/19, there is much more to do, including ensuring all the improvements outlined above are fully embedded as business as usual. Priorities for 2019/20 include:

- **Refreshing Board and Executive governance structures** so the Board can properly exercise its strategic leadership and decision making role as well as being assured that effective controls are in place to deliver the Trust objectives safely and efficiently and to meet the targets and trajectories laid out in the annual plan.
- **Strengthening the senior operational leadership capacity and capability to provide stability to staff and improvement engagement**, so that there is ownership and accountability at every level for delivering the Trust's recovery programmes.
- **Improving the quality and availability of financial and operational data** so that managers at every level have the information they need to make informed decisions about their services.
- **Improving the monitoring and governance of major programmes and complex contracts** including any actions arising from any regulatory oversight as well as developing more robust programme delivery and contract management approaches.
- **Continuing to improve and embed financial control** within the Trust by ensuring the improvements that have been made during 2018/19 are fully embedded and by applying the learning from more robust grip and control to income and non-pay expenditure, so that the Trust meets its 2019/20 control target.
- **Improving demand and capacity planning** at a service, site and Trust level to better inform operational performance management, capacity planning and a systematic approach to the deployment of all clinical staff.
- **Delivering and embedding the new risk strategy** and Board Assurance Framework so that the management of risk in the Trust is genuinely 'Ward to Board'.
- **Addressing the equipment maintenance and estates compliance** regime so that limited capital funding is appropriately targeted and prioritised.
- **Strengthening the Trust's policy framework** ensuring that Trust policies are being properly refreshed and implemented.

Conclusion

As set out above, significant internal control weaknesses have been identified during 2018/19. This annual governance statement, accountability report and specifically the paragraphs above identify what they are and how they are being addressed.

Annual Governance Statement Signed by:

Dr Clive Kay
Chief Executive and Accounting Officer

Date: 11/6/2019

Accountability Report Signed by:

Dr Clive Kay
Chief Executive and Accounting Officer

Date: 11/6/2019

Quality Account 2018/19



**Understanding You, Inspiring Confidence in our Care, Working Together,
Always Aiming Higher, Making a Difference in our Community**

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Introduction

King's College Hospital NHS Foundation Trust (King's) is one of London's largest and busiest teaching hospitals and is a founding partner of the Academic Health Science Centre with Guys and St. Thomas NHS Foundation Trust, South London and Maudsley NHS Foundation Trust and King's College London University. King's works with many partners across South East London importantly including the two mental health providers: South London and Maudsley NHS Foundation Trust and Oxleas NHS Foundation Trust. King's has strong relationships delivering local services with its borough partners across Lambeth, Southwark, Lewisham and Bromley. King's provides many services across five sites including the following:

Local services such as:

- Two Emergency Departments - one at King's College Hospital and one at the Princess Royal University Hospital
- An elective Orthopaedic Centre at Orpington Hospital
- Acute dental care at King's College Hospital
- Sexual Health Clinics at Beckenham Beacon and King's College Hospital
- Two Maternity Units - one at King's College Hospital and one at the Princess Royal University Hospital.

Community Services such as:

- A number of satellite renal dialysis units, community dental services, and a Breast Screening service for South East London
- The Haven sexual assault referral centres at King's College Hospital and also at the Royal London and St Mary's Hospitals.

Specialist services such as:

- Specialist care for the most seriously injured people via our Major Trauma Centre, our two Hyper Acute Stroke Units, our Heart Attack Centre and our new 60-bed Critical Care Unit on the King's College Hospital site
- Europe's largest liver centre
- Internationally renowned specialist care for people with blood cancers and sickle cell disease
- World leading Neurosciences Institute providing research, education and care for patients who have suffered major head trauma and brain haemorrhages as well as brain and spinal tumours
- A centre of excellence for primary angioplasty, thrombosis and Parkinson's disease
- The Variety Children's Hospital based at King's College Hospital.

Research and Innovation

King's is a major research centre hosting the Collaborations for Leadership in Applied Health Research and Care (CLAHRC) and currently chairing the National Institute for Health Research (NIHR) Clinical Research Network for South London.

King's works closely with King's College London and the Institute of Psychiatry, Psychology and Neurosciences to ensure patients benefit from new advances in care across a range of specialties.

We have over 12,500 staff across five main sites King's College Hospital, Princess Royal University Hospital, Orpington Hospital, Queen Mary's Hospital Sidcup and Beckenham Beacon as well as several satellite units.

Challenges in 2018/19

King's has faced significant financial and operational challenges over the last 12 months. Teams have worked hard to address the financial deficit, and through a range of cost controls and operational productivity programmes, the Trust has reduced its expenditure in staffing and particularly high cost agency spend.

King's has also been supported by various national programmes to improve its clinical productivity with a particular focus on the Getting it Right First Time (GIRFT) programme in Trauma and Orthopaedics, Ophthalmology and Neurosurgery.

Operationally, King's has faced particular challenges in meeting the national access targets, for example, meeting the four hour urgent and emergency care standards (UEC) at both King's College Hospital and the Princess Royal University Hospital sites, and in managing its elective waiting lists for patients waiting for outpatient appointments and/or surgery.

There is a recovery programme focused on all areas of emergency care across the hospitals to improve the waiting times for patients coming through our Emergency Departments. These programmes encompass the whole hospital but also our system partners, as key to success is reducing the large number of patients who come to either ED. In February when the CQC inspected both EDs they found issues at the PRUH that required immediate attention with the doubling up of patients in resuscitation areas and the use of non-clinical areas for patient care. The management of patients was rectified immediately and the team are progressing plans to use any capital resource to improve the environment in the PRUH ED. There was also an issue with one of the rooms in the DH ED and its suitability to assess children with mental health issues. This room is now used for an alternative purpose.

King's has also faced many challenges in delivering elective surgical care in line with the 18 week target. Over this year, the recovery programme ensured that the number of patients waiting for more than 52 weeks for elective surgery reduced from over 700 patients to just below 200. The aim during 2019 is that there will be no more 52 week waiters and that there will be a systematic trust wide approach to substantially reducing the waiting times for patients. During 2018 there was a period where the documentation of patients removed from the waiting list other than for treatment reasons was found to be missing or lacking in clinical sign off. An external audit was conducted by NHS Improvement and internally by the Trust which recommended education and training for managers and booking teams to ensure improved awareness, understanding and application of the national and Trust access policy.

There were also challenges over the year in some cancer pathways, although many pathways have improved in the last few months of the year, much attention is focused on the administration of the 2 week wait pathway and ensuring diagnostic tests are performed in a timely way. King's migrated on to "Somerset" one of the nationally recommended cancer ICT management systems this year in line with many London Trusts. During the migration there were issues with tracking patients from the Trust PIMs system onto Somerset, however there was no patient harm and all rectified by the 17th January 2019.

Finally, the Trust has not been able to meet the diagnostic target across the year. By the end of March 2019, all imaging targets were met with echocardiography across both sites expected to be

compliant by July 2019. The critical outstanding waiting time delays are for endoscopy at the Princess Royal University Hospital. As a result of the increased demand, challenges with capacity and prioritising the two week wait, the large backlog has increased over 2018/19. There is a new recovery programme in place to reduce the waiting times for endoscopy across 2019, using capacity at Denmark Hill, and other providers, with the aim of ensuring that in the future, capacity can meet the increasing national demand for endoscopy. A harm review is being led by the Executive Medical Director to ensure any patients who have waited longer than recommended have increased clinical scrutiny, and this is being augmented by an external medical review.

Achievements in 2018/19

Below are some of our patient outcomes and trust achievements during 2018/19:

Patient outcomes

- Risk-adjusted mortality (death rates) and risk-adjusted readmissions continue to be in top quartile nationally.
- We have lower than expected mortality in high-risk specialties, including liver, critical care, paediatric intensive care, renal replacement therapy and stroke, and around half the national average mortality for our emergency laparotomy surgery.
- Major trauma outcomes are the best nationally for the trauma network of which King's is part
- King's has the highest risk-adjusted 5-year survival rates nationally for adult elective and super-urgent liver transplantation.
- Over 10,000 patients have been recruited to participate in research studies in the current financial year, with King's leading the recruitment table in South London and in the top eight recruiting trusts in the UK. The areas with the highest recruitment are fetal medicine and HIV research.
- King's was rated as the best of 195 hospitals nationally for discharge planning for patients with dementia.
- King's College Hospital performed better than national average for the three key treatment targets for Type 1 diabetes and significantly more patients receive insulin pump therapy than average (32%; national 15%). We also performed better than national average for the number of patients with diabetes seen by the foot care service having major amputation.
- King's performed better than London and national average for key outcomes indicators relating to the care of women with diabetes who are pregnant, including large babies, pre-term deliveries and pre-pregnancy care.
- 98.7% of patients referred to our Fracture Liaison Service are assessed within 90 days, exceeding national average of 80%.
- The Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) perinatal mortality report demonstrated that King's stillbirth and neonatal death rates were 10% lower than peer Trusts.
- Survival following in-hospital cardiac arrest is better than national average for all patient age groups, and 21% survive to hospital discharge compared to 11% nationally.
- King's received 'exceptional' ratings for its organ donation service in the national Organ Donation Audit.
- Leading up to NHS70 we followed the national '*End PJ Paralysis*' campaign, enabling 10,885 patients at King's College Hospital and the Princess Royal University Hospital to 'get up, get dressed and get moving'.

King's staff

- We have improved the way we recognise our excellent staff with the launch of the King's Stars recognition scheme, with support from the King's College Hospital Charity. The scheme includes an annual awards ceremony, a quarterly awards ceremony and instant recognition pin badges and thank you cards designed to be given from line managers to staff.

- 2018/19s flu campaign was the most successful in our history, with 69.8% of staff having the vaccination. We also won the NHS Employers' Flu Fighter Award in the Most Improved Trust category.
- King's Able – Our Disability Network was formed to help build a better future for disabled staff at King's.
- We launched our new approach to appraisals and had the highest percentage of staff complete an appraisal on record: 89% of staff had an appraisal between April-June 2018.
- Our new anti-harassment campaign 'Not a Target' launched across site. Patient-facing posters are displayed in all hospitals, and a staff leaflet has been distributed with more information and details of the anti-bullying helpline.
- The new on-line staff learning, education and appraisal platform (LEAP) was introduced and an Advanced Leadership Programme launched in March 2019.
- We launched two new development programmes to develop, support and retain our staff and prepare them for future nursing leadership roles in the organisation: the Aspiring Matrons programme and the Aspiring Ward Managers programme.
- Over 2500 of our staff have been trained in supporting patients' mental health needs and new mental health staff have been recruited in renal, cancer and haematology teams. In addition, we are running a 'twinning' project, which links the staff on King's wards with those on wards at South London and Maudsley NHS Foundation Trust, so that they can get to know each other and communicate regularly to share skills and experiences in order to improve patient care.
- In July the Trust held two diversity events. The first was the 46th annual pride march that took place on Saturday 7 July. The event was organised by the LGBT+ staff Network in King's and over 30 staff attended the celebrations. The second event was the annual Black Asian and Minority Ethnic (BAME) conference which was attended by 100 staff at King's. The event was organised by the BAME Steering Group and the theme of the event was 'Involve to Evolve'.

King's infrastructure – information technology and environment

- King's is in the process of building a new state-of-the-art 60-bed Critical Care Centre which, when added to the existing Critical Care wards at King's, will be the largest and most progressive in the UK. Feedback from patients who have been treated in critical care has been incorporated into the design. We anticipate stage 1 to open in 2019.
- IT achievements included the roll-out of electronic prescribing and our Electronic Patient Record system at the Princess Royal University Hospital.
- A new entrance was completed for King's College Hospital Emergency Department.
- King's helipad has become the first Major Trauma Centre in London to be granted permission for air ambulances to land at night as well as during daylight hours. This will save up to 90 minutes in transfer time for patients on the Kent coast.
- A new Dialysis Unit opened in Thamesmead in October 2018.



King's volunteers

- Volunteering support continues to expand, with examples including:
 - The Home Hamper Service where we have provided patients with 278 donated food parcels during 2018/19 and 1000 donated food parcels since 2014.
 - The Hairdressing Service - we have two volunteers who provide hairdressing services to patients and have seen 92 patients since August 2018.
 - The End of Life Companion service was launched at the beginning of October 2018. Volunteers support and provide companionship to patients who are actively dying. Support ranges from many tasks such as sitting and talking, singing, listening to hymns, reading and taking patients outside.

Part One: Statement on quality from the Chief Executive

King's continues to place quality, safety and the experience of patients, families and its staff at the forefront of everything that we do. During this year, we have experienced many challenges but have continued to report excellent clinical outcomes and ground-breaking research across the breadth of our clinical areas. Although we have experienced unprecedented demand on our services, 89% of patients across all our services would recommend us and our overall mortality has remained consistently below the national average.

King's has faced significant financial and operational challenges over the last 12 months. Teams have worked hard to address the financial deficit and, through a range of cost controls and operational productivity programmes, the Trust has reduced its expenditure in staffing particularly high cost agency spend.

There were also challenges over the year in some cancer pathways, although many of these have improved in the last few months of the year, with many patients being able to see their diagnostic team within two weeks and then to receive their first definitive treatment within 62 days.

The Trust has not been able to meet the diagnostic target across the year. By the end of March 2019, all imaging targets were met with echocardiography improving across both sites. The critical waiting time delays are for endoscopy at the Princess Royal University Hospital. As a result of the increased demand, challenges with capacity and administrative issues with booking, the large backlog has increased over 2018/19. There is a new recovery programme in place to reduce the waiting times for endoscopy across 2019 using capacity at Denmark Hill, and other providers, with the aim of ensuring that in the future, capacity can meet the increasing national demand for endoscopy. A harm review is being led by the Executive Medical to ensure any patients who have waited longer than recommended have increased clinical scrutiny and this is being augmented by an external medical review.

King's current registration status with the Care Quality Commission (CQC) is 'Requires Improvement' following the inspection in September and October 2017 (report published 31st January 2018). King's was inspected between 30 January and 21 February 2019 for all five domains and we are currently waiting for the report detailing the findings and the overall rating. Some immediate areas requiring improvement were identified particularly concerning the PRUH Emergency Department (ED) and a possible enforcement action section 31 letter this was responded to within 48 hours and immediate actions taken and prospective audits commenced to address the concerns. Both EDs were also required to purchase and install digital locking fridges and this has been achieved. Both EDs were also required to improve the environment for the care of children and young people with mental ill health needs.

The foundations of quality (safety, experience and effectiveness) for the organisation are to listen to feedback from patients and families on the care we provide, to encourage an open culture where all staff are able to raise concerns and report incidents for investigation, to collect and review information on the outcomes of the treatment we provide and to ensure that we review all these and act on the findings through a robust improvement process.

During this year we have strengthened our senior leadership team with the appointment of new Board members and we have actively recruited a high number of clinical staff to ensure we have a stable workforce. This has resulted in the lowest nurse vacancy rate in the country. We have continued to develop our valuable volunteer workforce and engage with younger volunteers through partnership with the Prince's Trust. Our 'King's Way for Wards' accreditation scheme continues to develop and improve quality of care through regular auditing of systems and patient and staff feedback to identify areas for improvement for local teams to address.

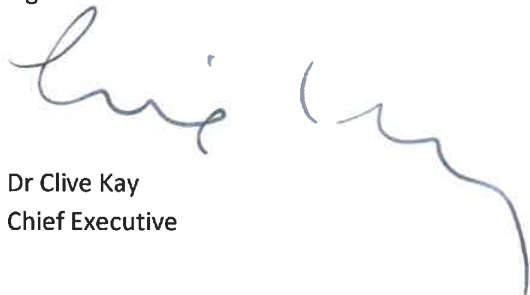
We have developed our improvement methodology and continue to train staff in improvement skills, with local quality improvement projects being undertaken by clinical staff across the organisation. King's is leading the way with the development of 'value-based healthcare' – a model of delivering the outcomes that matter to patients for the best use of resources.

The initiative in which we perhaps take most pride is our new King's Stars award ceremony, which celebrates our many staff who go the extra mile for our patients.

All this work and more is being brought together into a new strategy which is currently out for consultation and feedback from our staff. The strategy will set our future direction, with quality of care at its very heart.

There are a number of inherent limitations which may affect the reliability or accuracy of the data reported in this Quality Account. These include data being derived from a large number of different systems; local interpretations of national data and evolving data collection practices and data definitions. The Trust and its Board have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to these inherent limitations. The Trust acknowledges weaknesses in the quality of internal data produced with respect to the 4 Hour Accident and Emergency Waiting Times and cancer treatment within 62 days indicators and will work with the auditors to update an action plan to identify areas of improvement. Auditors' found a low error rate in relation to the Summary Hospital-level Mortality Indicator (SHMI) and no pervasive issues. Having had due regard for the contents of this statement and to the limitations as described above including the A&E 4 hour standard, to the best of my knowledge, the information contained in the following Quality Account is accurate.

Signed:

A handwritten signature in blue ink, appearing to read 'Clive Kay', followed by a long, sweeping horizontal line.

Dr Clive Kay
Chief Executive

Part Two: Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

Results and achievements for the 2018/19 Quality Account priorities

Summary of results and achievements for the 2018/19 Quality Account priorities		
Patient Outcomes		Achieved/Not achieved
Priority 1	Improving the care of people with mental, as well as physical, health needs	Achieved Year 2 of a 3 year priority
Priority 2	Improve outcomes for people having primary hip replacement	Achieved
Priority 3	Improving outcomes for people with heart failure	Achieved
Patient Experience		
Priority 4	Improve outpatient experience	Not achieved – Year 2 of a 3 year priority
Priority 5	Improving the experience of patients with cancer and their families	Partially achieved – Year 2 of a 3 year priority
Patient Safety		
Priority 6	Improve identification and treatment of sepsis	Partially achieved
Priority 7	Reducing harms to patients due to falls in hospital	Partially achieved

Priority 1: Improving the care of people with mental, as well as physical, health needs

Why was this a priority?

This has been an improvement priority for King's College Hospital NHS Foundation Trust since April 2017 and we identified from the outset that it would be a 3-year priority because:

- Nearly a third of people with long-term medical conditions have a mental health condition, and nearly half of people with mental illness have at least one long-term medical condition
- Joining-up the care of both mind and body leads to better patient outcomes
- It is also cost-effective - £1 in every £8 spent on caring for people with long-term medical conditions is linked to poor mental health
- National studies show that there is much that hospitals like King's and Princess Royal University Hospital can do to improve mental health care.

This work has been undertaken as part of King's Health Partners' (KHP) Mind and Body Programme. KHP is a collaboration between King's College Hospital NHS Foundation Trust, Guy's & St Thomas' NHS Foundation Trust, South London and Maudsley NHS Foundation Trust and King's College London University.



Aims and progress made in 2018-19

Achieved: Aim 1 - Increase number of outpatient clinics screening for mental health:

- In March 2018 we had 28 outpatient clinics where screening patients for mental health problems had been implemented and 23,426 screens had taken place.
- By March 2019, we had 29 clinics screening where screening had been implemented and 30,363 screens had taken place. Whilst this is just a small increase this year, a lot of preparation work has been undertaken and we have a further 20 clinics in the pipeline.

Achieved: Aim 2 - Provide self-help resources for our patients and help patients to refer themselves to psychology services:

- An extensive collection of patient-facing resources (30+) has been co-produced with patients and clinicians for a wide range of conditions in areas including rheumatology, neurology and gastroenterology. These are freely available on the IMPARTS website.
- A new online cognitive behaviour programme tailored for long-term conditions has been developed to help patients to self-manage their physical health conditions and associated distress or other psychological needs. Following extensive user-testing, it is currently being piloted (January 2019).

Achieved: Aim 3 - Work in partnership with South London & Maudsley NHS Trust, general practitioners and other local hospitals to develop new ways to join up physical and mental health care to improve the outcomes, experience and safety of our patients:

We have worked in partnership with South London & Maudsley NHS Trust, local GPs and other local hospitals and have improved the joining-up of mental and physical health services. For example:

- We have established a new psychology service for patients with cancer.
- A new steering group is currently clarifying objectives and agreeing the details of a work programme for eating disorders in patients with Type 1 diabetes.
- Building on the success of work in diabetes, mental health screening has been integrated into clinics for patients with heart failure, chronic obstructive pulmonary disease and hypertension, resulting in 750 referrals to the mental health team.
- A new integrated Mind and Body group has been established to increase awareness of all relevant Children's and Young People's services across King's Health Partners (KHP), and provide targeted education and training.
- Work to scope the current evidence base around men's cancers (prostate and testicular) and our understanding of the impact of mental health and psychological factors on cancer progression has been completed.
- A psychiatrist and psychologist have been recruited into the Haematology Institute and a mental health screening and education event is planned.
- A mental health nurse has been recruited to work in King's kidney care services to improve the mental health care and outcomes for patients with moderate to severe mental illness.
- King's medicine and pharmacy teams are working to improve the physical health of South London & Maudsley (SLAM) patients through the provision of advice, guidance and treatment across all four SLAM sites.
- A team twinning project has been established between King's Acute Medicine and SLAM's Acute Inpatient teams, to build a collaborative relationship between the teams and improve multi-disciplinary team working and the quality of patient care.
- A psychology-led review of King's palliative care services has been completed, aiming to improve

"I was referred from the mental health hospital and the staff here still treated me with respect without discrimination."

KAOS (King's Adolescent Outreach Service)

KAOS is a new, unique project to improve the care of adolescents, aged between 16-19 years, in hospital. Ten to twelve patients in this group are spread across many different adult wards at King's College Hospital at any one time. KAOS identifies and supports these young people by liaising with their medical and surgical teams to ensure that their needs are being met not only physically, but also mentally and socially. The service is led by a youth worker who meets with the young person and helps support the medical team in providing more holistic care to this vulnerable group of patients and is supported by over 40 multi-disciplinary team members working in different specialties.



screening, education and training and links with mental health services.

- An in-reach clinic has been established in gastroenterology from the local primary care mental health service.
- A new cross-KHP learning disabilities strategy group was established in November 2018 with the aim of improving the care of this vulnerable population.
- A new collaboration between the adult cystic fibrosis service and the SLAM eating disorders service has been established.

Achieved - Aim 4: Support staff to provide better mental health care through training and supervision:

- In 2018 more than 2,500 KCH staff received training and education on Mind and Body through a range of initiatives including induction, e-learning and face-to-face training.
- A Massive Open Online Course (MOOC) *'Integrating care: depression, anxiety and physical illness'* ran in September 2018 and January 2019 with more than 11,000 people registered.
- Delivery of a 1-day Mind and Body clinical skills course for adult mental health and new courses developed for child mental health, a 2-day Mind and Body simulation course, *'Healthy Lives, Healthy Mind, Healthy Bodies'*. In addition, funded places were offered to all staff for the specialist 5-day *'Mental Health Skills for non-Mental Health Professionals'*.
- A successful Health Education England bid in 2018/19 will enable the development of simulation training on de-escalation, communication and inter-professional working skills for KCH Emergency Department, acute medicine and trauma staff for delivery in 2019/20.



Priority 2: Improving outcomes for people having primary hip replacement

Why was this a priority?

Approximately 750 hip replacements are undertaken a year at King’s College Hospital NHS Foundation Trust, with most undertaken on our Orpington Hospital site. Following surgery, patients’ rehabilitation is provided either at Queen Mary’s Sidcup (QMS) Hospital or at our King’s College Hospital (Denmark Hill, DH) site.

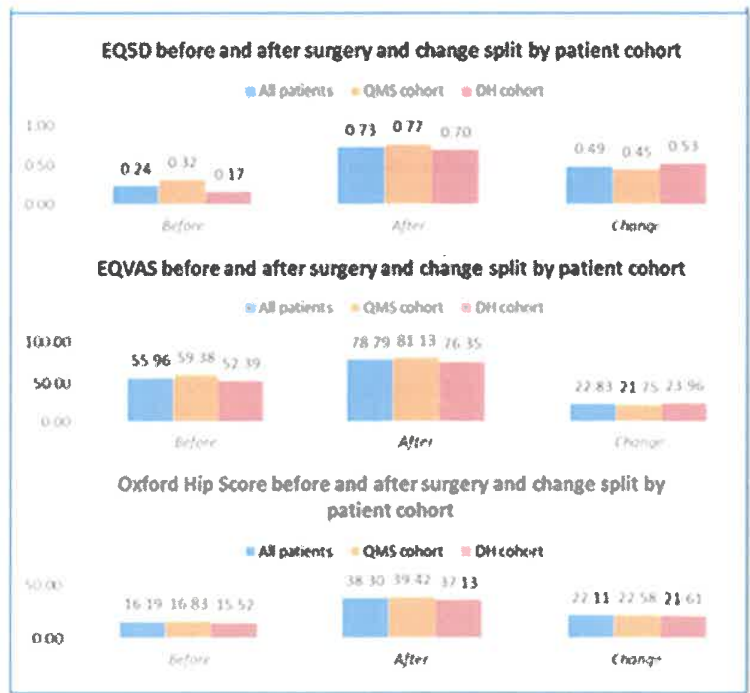
We planned to measure the patient-reported outcomes (PROMS) as mandated by the NHS as well as those outcomes that are important to patients and their carers, such as a return to normal activities and improved quality of life after surgery. The findings will inform service delivery and help us to develop the best approach for all our patients.

Aims and progress made 2018-19

Achieved: Aim 1 - Look at national information already gathered on patients’ outcomes after surgery and compare the two services (QMS and DH) in detail

- Patient-reported outcome measures were measured using three internationally validated scoring tools (the EQVAS, EQ5D and the Oxford Hip Score). Patient-reported outcomes improved following hip surgery for both QMS and DH services (see Figure 1).

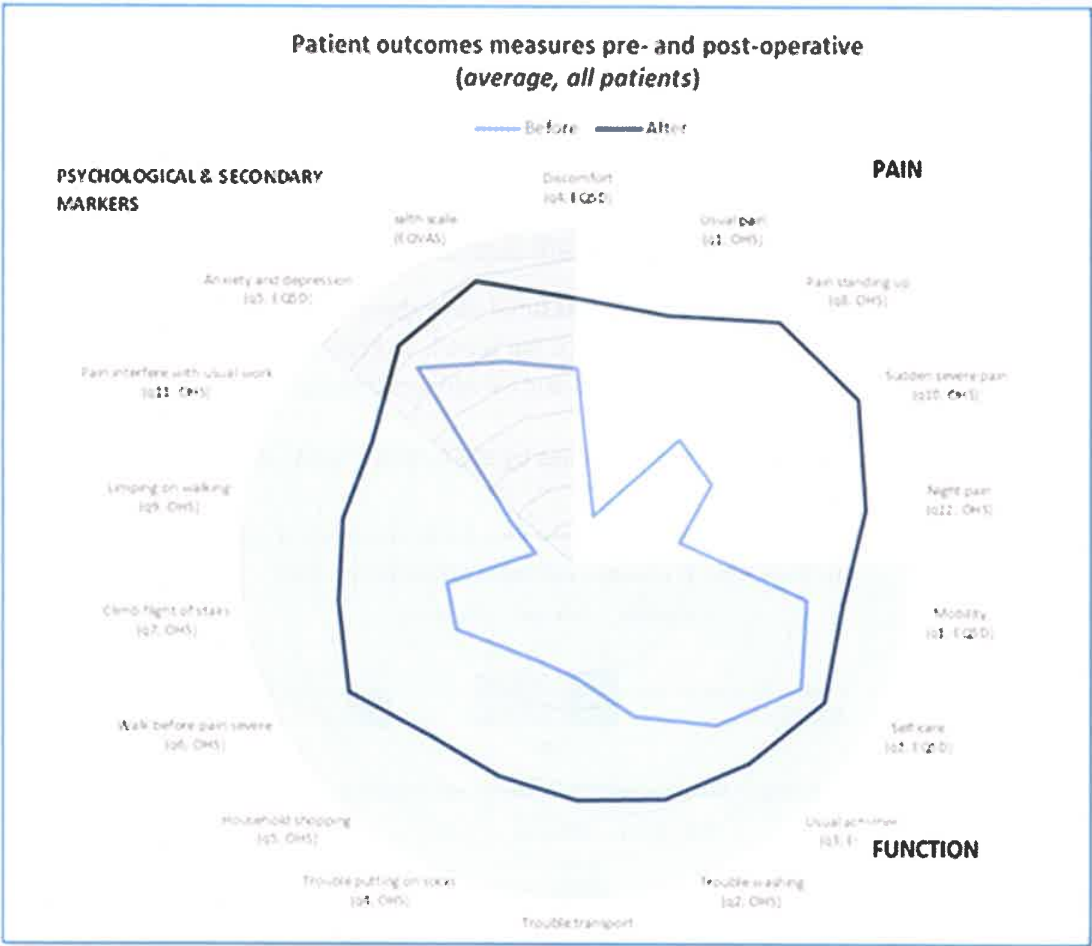
Figure 1: Patient-reported outcomes by EQ5D, EQVAS and Oxford Hip Score



Achieved: Aim 2 - Use this information to develop services that lead to the best possible patient outcomes at both hospital sites

- A method for identifying and using data to measure patient outcomes following hip replacement has been established. Figure 2 shows that, when measuring both physical and psychological outcomes that matter to patients, hip replacement surgery produces excellent results. Additional information is currently being obtained from patients, including addressing those aspects of recovery that are not included in existing measures, such as capacity to return to work.
- An approach for establishing the costs of providing this pathway of care has been developed.
- Work to embed the optimal pathway into routine care is in progress.

Figure 2: Outcomes that matter to patients - understanding what improves and by how much



Achieved: Aim 3 - Share this information with other local hospitals, improve the patient discharge process and information provided after a hospital stay

- This work has been shared with the King's Health Partners Chief Executive Officers' Action Group and Joint Boards, representing the most senior managers from King's College Hospital, Guys' and St Thomas', South London and Maudsley and King's College London University.
- Based on our new knowledge of outcomes that matter to patients and the optimal care pathway, information for patients is being redeveloped.
- This work has been shared nationally and internationally, including with the Institute for Healthcare Improvement National Forum, the International Forum on Quality and Safety in Healthcare, Arthritis UK, Aneurin Bevan University Health Board, the South East London Orthopaedic Network and the European University Hospital Alliance. A paper has been accepted for publication by BMJ Quality.

Priority 3: Improving outcomes for people with heart failure

Why was this a priority?

Heart failure (HF) is the most common reason for admission to hospital for patients over 65 years of age and, without appropriate treatment, is associated with high morbidity and mortality. UK audit data demonstrates that 30–40% of patients admitted to hospital with heart failure die within a year.



Despite this high cost to both the patient and NHS services, recognition of heart failure in community settings is challenging, with many patients remaining undiagnosed. It is estimated that 9,000 people are living with heart failure in Southwark and Lambeth and less than 3,000 are known to services, and the situation will be similar in Bromley. The Heart Failure Service aims to promote the benefits of timely, accurate diagnosis with diagnostic pathways and help people with heart failure live longer, with a better quality of life and in their own homes.

Aims and progress made in 2018-19

Achieved: Aim 1 - Ensure more patients are diagnosed and receive the treatment they need as soon as possible, and to keep people at home wherever possible:

- The Heart Failure Team worked with local GPs to roll out information on using the correct test to detect heart failure (NTproBNP test and echocardiogram). For January to April 2018, this had risen significantly, to 129 GP referrals, 85 having NTproBNP (66%) and 19 (14.7%) others having already had an echocardiogram (2019 data is currently being collected).

Table 1 Heart failure referrals

Period	Number of direct GP referrals to the Heart Failure team	% (Number) referrals having NTproBNP Results	% (Number) referrals having had an ECG
1/4/17 to 30/4/17	54	55% (30)	14.8% (8)
1/4/18 to 30/4/18	129	66% (85)	14.7% (19)

- Between January and April 2017 there were 238 new heart failure patient appointments (GP and other referrals). Between January and April 2018 there were 315 new patient appointments, representing a 32% increase (2019 data is currently being collected).
- KCH has been working with the @home service to provide care for HF patients in their home environment wherever possible. Nationally, there has been a 4.6% increase in hospital admissions for heart failure (National Heart Failure Audit, 2016-17). At KCH, our hospital admissions increased by 3.6% between 2017 and 2018 (April to November 2017 there were 249 patients discharged with a primary diagnosis of heart failure, between April and November 2018

there were 258 patients), indicating that more patients are able to stay out of hospital than national average. We are awaiting publication of the next annual audit results.

Achieved: Aim 2 - Work with local GP practices to ensure that it is easy for GPs to refer the right patients to specialist heart failure clinics

- To speed up the referral process, GPs are now able to refer patients to a single point of access to a Heart Failure Referral Assessment Service (RAS).
- We have worked with Clinical Effectiveness Southwark to provide evidence-based guidelines for the management of Heart Failure in primary care.
- Diagnostic referral pathways have been developed and educational events delivered.
- Two dedicated local GP champions have been identified to work with us and with local GP practices and ensure continuous improvement.

Achieved: Aim 3 - Provide a 'one stop shop' service for patients to ensure they get everything they need in one place, and to ensure they receive treatment quickly

- Protected slots for echocardiography have been secured for new referrals as part of patients' Heart Failure clinic visit, meaning that, wherever possible, patients only have to attend one appointment. An audit of new patient appointments demonstrated that 20% of patients received an echocardiogram on the same day as their review appointment between January and April 2017. This had risen to 36% between January and April 2018 and we expect to see a further increase for 2019 once data is available.

Achieved: Aim 4 - Ensure every patient receives information to help them live with their condition

- A series of patient information leaflets have been developed in collaboration with Guy's & St Thomas', including Medicines for Heart Failure, the Heart Failure Team, Self-Management Tool and Managing Fluid Balance.
- KCH and GSTT produced a series of films to give patients practical advice on how to cope with heart failure. 108 patients used the films between January and March 2018. 2018-19 data is currently being analysed.

Achieved: Aim 5 - Ensure that care continues after the patient leaves hospital

- Referrals to the community team following discharge has doubled. In 2015, 5.2% of discharges were referred, compared with 11.3% in 2017. 2018-19 data is currently being analysed.
- A monthly community HF nurse specialist multi-disciplinary team meeting is held at KCH to ensure effective coordination of patients' care after discharge, including the use of the @home care service to provide care for HF patients in their home environment where possible.

Priority 4: Improving outpatient experience

Why was this a priority?

We continued to focus on improving patients' outpatient experience as part of a three year programme of work, reflecting the scale of the challenge to make real and sustainable improvement. Feedback continues to show that King's falls short on the experience it delivers to outpatients. Despite a strong focus and good progress, scores from the Friends and Family Test have not shown improvement and the number of Patient Advocacy and Liaison Service (PALS) contacts and complaints relating to outpatients continue to be significant.

Aims and progress made in 2018-19

Although a lot of work has been undertaken to improve patient experience, the data shows that we have not yet achieved this. This was only year 1 of the quality priority, however, and we have taken a lot of improvement actions. We are continuing this quality priority for another two years and we aim to be able to report a positive change in patient experience in next year's Quality Account.

Progress we have made to date includes:

Developing outpatient standards

- During the year, we held a number of development and testing workshops with our staff, patients, Members, Governors and Volunteers. New Outpatient Standards were launched in October 2018 for all front line outpatient reception trust across all sites. The standards are comprehensive and include protocols from meeting and greeting patients, informing patients of waiting times to addressing the needs of patients with learning and communication difficulties to support compliance with the NHS Accessible Information Standards. A new working group has been launched to address how we can enhance the support given to patients and their families who have additional communication needs and ensure that we meet these national Standards.
- Alongside the new Standards, a new outpatient receptionist uniform was adopted.
- The bright yellow #hellomynameis badges and a staff pledge were also launched. The badges were initially brought in for patient facing staff and we are continuing to roll them out trust wide as a means of easily assisting patients to identify staff names.



Launching and embedding digital outpatients

- In 2018, we completed our pilot for digital patient letters in our musculoskeletal skeletal (MSK) service at Queen Mary's Hospital Sidcup. The aim of the pilot was to offer patients the opportunity to receive their outpatient appointment letters and other information digitally via a mobile phone or other mobile device. Patients were offered the opportunity, via text message, to opt into receiving the letters digitally. If they consented, their letter was sent to them on their device. This also enabled them to access maps and to translate information into other languages. Success was measured through patient uptake of the service, which at 40% was higher than many other digital interventions, which average 25% uptake. Patient feedback, as well as staff feedback, was positive. It proved difficult to assess potential impact on Did Not Attend (DNA) rates and, over the pilot, DNA rates fluctuated. This could be partly due to seasonality, insufficient data and the length of time in advance that MSK appointments are booked.
- We piloted a new electronic system for updating waiting times in some clinics, called 'InTouch'. This was introduced and tested in key outpatient areas including Suite 3 and the Venetian Building at King's College Hospital and in the Chartwell Unit at the Princess Royal University Hospital. The pilot has received positive feedback from patients and staff who appreciated more information about waiting times in clinic.
- In December 2018, the King's College Hospital Charity provided a generous grant to extend the InTouch system to a further six outpatient areas, including some of our largest specialties where patient feedback about a lack of information on waiting times is poorest. These include:
 - DH: Suite 9, Liver, Suite 7, General Surgery and Urology, Paediatrics, Haematology.
 - Princess Royal University Hospital: Outpatients C which sees patients from Colorectal, Urology, Gastroenterology, Neurology and General Surgery.
 - Orpington: Main Reception with multiple specialties.
- The extension of In Touch will include more detailed waiting times information and identify the consultant's clinic waiting time. There will also be new functionality for mobile check-in and information on waiting times including alerts to let patients know when their appointment slot is imminent. This will allow patients the freedom to leave clinic to get refreshments without affecting their appointment. The project is currently in planning and is scheduled to commence roll-out in 2019-20.
- We will be conducting a large-scale patient survey in the early summer of 2019 to assess the success of this exciting initiative and to see if it improves the experience of patients where the new system has been introduced. The survey will be part of our year three objectives.



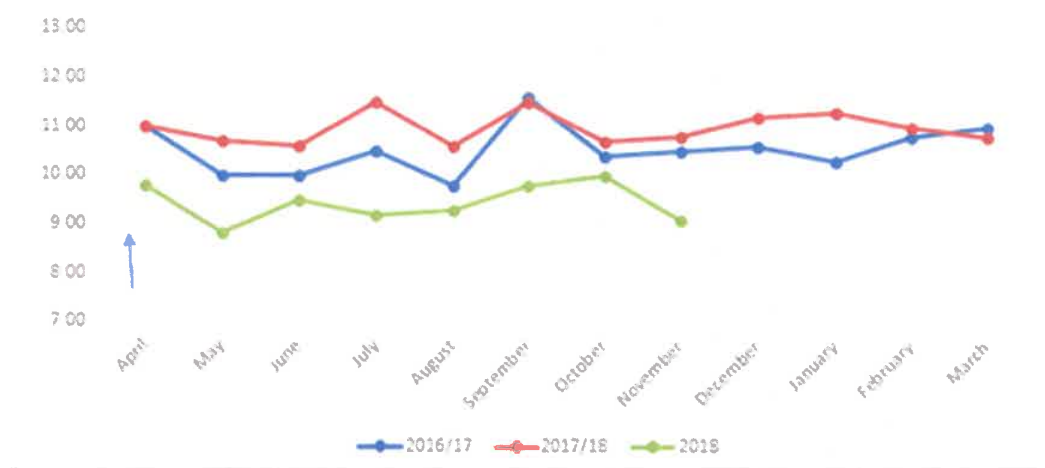
Focusing improvement work in specific specialties

Our plan was to carry out focussed improvement work in three specialties: Neurology, Cardiology, and Dermatology, and we completed the following work in these specialties:

Neurology:

- Clinic room availability was mapped and space freed up to schedule additional outpatient clinics to cope with capacity.
- Additional 'results clinics' provided advice to GPs to enhance the quality of referrals and avoid inappropriate referrals.
 - A pilot to help reduce 'Did Not Attends' (DNAs) was introduced with King's volunteers telephoning patients most likely to DNA to remind them about their appointment. This, along with other measures, has proved very successful and Figure 3 below demonstrates a clear reduction in DNAs in 2018.

Figure 3: Percentage 'Did not attend (DNA)' rate in Neurosciences at King's College Hospital 2016-18



The pilot has now been extended to additional specialties including Haematology, Nuclear Medicine, Radiology and to our therapy services and Ophthalmology (Glaucoma).

Dermatology:

- We reviewed our model of delivery and employed two GPs who are being trained to see patients referred via the cancer 2 week wait pathway. The GPs start by seeing a small number of patients and, as their skills and confidence increase, see a full clinic of patients, under the continued supervision of a consultant dermatologist. The model releases consultants to see more complex patients, whilst up-skilling GPs who become equipped to advise their GP colleagues about the appropriateness of referrals.
- The model started in December 2018 and is being seen as a prototype which, if successful, may be extended.

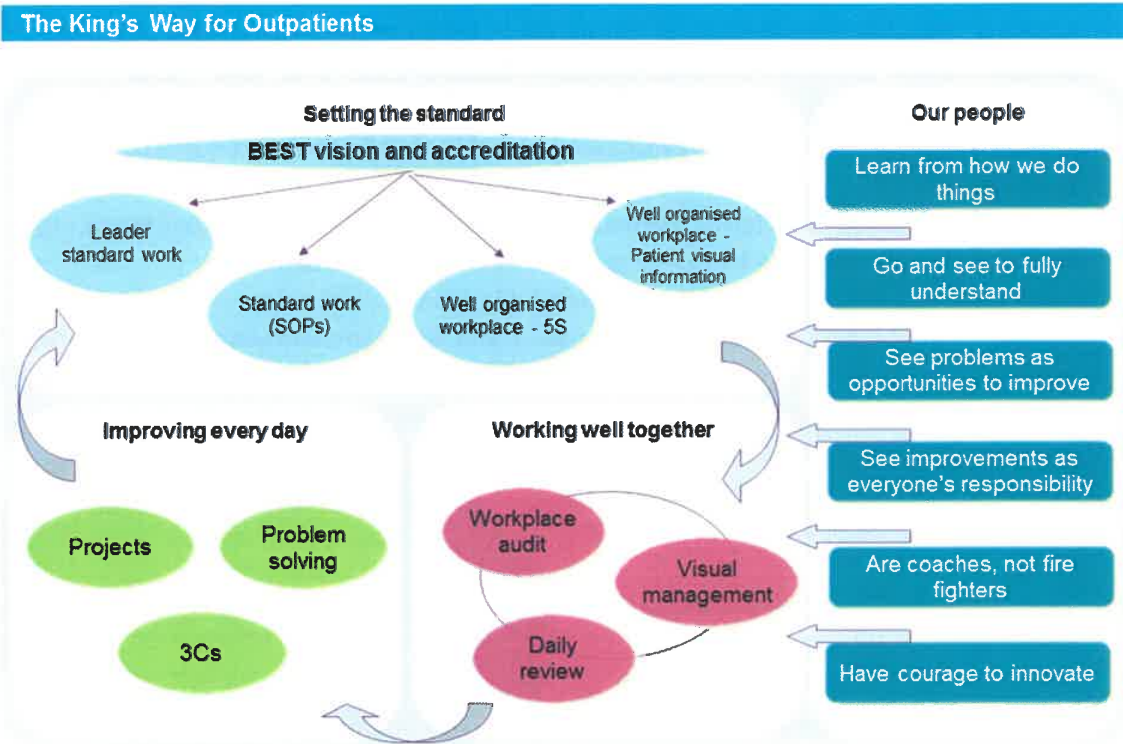
Cardiology:

- Our work in Cardiology focused on the development and pilot of King's Way for Outpatients.

Piloting King’s Way for Outpatients

- King’s Way for Outpatients aims to bring in standardised ways of working and accreditation of outpatient areas in the same way that the trust has already successfully done on its inpatient wards through King’s Way for Wards. This involves taking a close look at outpatient departments across our sites to make sure that they: all follow the same processes; are a pleasant place for patients to be seen and/or treated and for staff to work; and have the skills needed to be able to solve problems or issues that arise.
- Over this year, we successfully piloted King’s Way for Outpatients in Suite 6 Cardiology Outpatients at Princess Royal University Hospital. This system will allow us to measure many aspects of our outpatient service and environment and enable us to track how our outpatient areas are performing on a regular basis in order to be more responsive to issues such as waiting times in clinic, cleanliness and organisation of the clinic. As part of this, we have extended the Perfect Ward digital application to outpatients so that we can regularly track how we are achieving our targets.

Figure 4: The King’s Way for Outpatients



Delivering coaching and mentoring workshops for outpatient administration staff

As part of our work to improve the experience of our outpatients, alongside the introduction of the outpatient standards, we ran twelve (against target of 24) coaching and mentoring workshops for outpatient administration staff across all sites to improve skills and staff morale. Unfortunately the Trust’s financial position has meant that we have not had staff available to provide our target number of workshops. We know that staff who are satisfied with their job are more likely to give a better patient experience so was a key part of our priority. Research clearly shows that when staff have a good experience this extends to our patients.

Priority 5: Improving cancer services for patients and their families

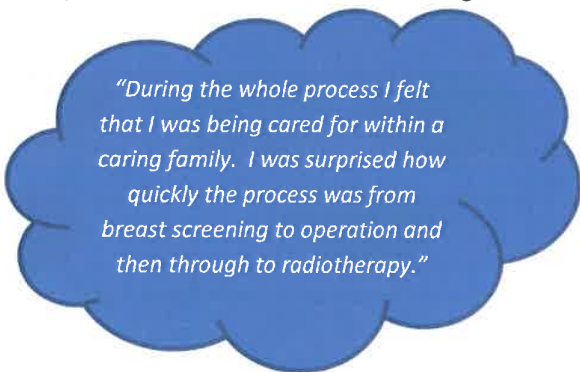
Why was this a priority?

We focused on improving the experience of our cancer patients and their families as we aim to make sustainable changes in how our cancer services are delivered and enhanced. The National Cancer Patient Experience Survey continues to highlight and direct our areas for improvement and will continue to be our marker of success.

Aims and progress made in 2018-19

Partially achieved: Aim 1 – Workforce Development, to give patients better access to specialist staff and to improve communication

- Over the past year we have offered the multi-disciplinary team advanced communication training and level 2 psychology training for relevant staff, which will continue into 2019. Schwartz Rounds have commenced at DH and will be started at the Princess Royal University Hospital in 2019. Schwartz Rounds are a group reflective practice forum which provide an opportunity for staff from all disciplines to reflect on the emotional aspects of their work. They were first introduced in the USA in cancer services and the programme in the UK is being led by the King's Fund.
- Many posts have been adopted by Macmillan to improve access to training as well as Macmillan providing clinical supervision for Level 2 practitioners (since August 2018).
- King's staff have attended the South East London Accountable Cancer Network tumour working groups, biannual cancer away days and team away days, to support and enhance collaborative working.
- We held our first Clinical Nurse Specialist Community of Practice event, to share learning and good practice amongst our Clinical Nurse Specialists who cover a wide range of cancer tumour groups. These will continue twice a year.
- To ensure learning from patient feedback, clinical teams have reviewed complaints, held four patient listening events, and established a pool of interested King's members, volunteers, governors and patients to take part in regular feedback events, working groups and training and interview panels for 2019-20.
- Patient experience, including detailed analysis from the National Cancer Patient Experience Survey, has been embedded into the work plan for each speciality to inform improvement actions.
- Cancer Nurse Specialist (CNS) provision has been reviewed to ensure effective cross cover and we have made two new CNS appointments through Macmillan.



"During the whole process I felt that I was being cared for within a caring family. I was surprised how quickly the process was from breast screening to operation and then through to radiotherapy."

- Further roles to support and develop chemotherapy, psychological input and the recovery package have been agreed, along with increased access to benefit services at Princess Royal University Hospital and DH.

Partially achieved - Aim 2: Accessible information for patients

- Work to optimise the usage and accessibility of the Macmillan Information and Support Centre (MISC) at DH resulted in a 40% increase in usage. In addition we ensured that information is readily accessible to patients at the PRUH and undertook preparation work for the opening of a MISC unit in Orpington by summer 2019.
- A review of current information for patients has resulted in the planning for new cancer information pack, which will include information about different treatments, the role of the multi-disciplinary team and practical information such as financial advice, benefits and free prescriptions.
- A directory of services for Bromley, Southwark and Lambeth has been produced to increase awareness for staff and patients into the services available and how to refer to or contact them. Volunteers have been recruited and trained to be able to signpost patients to information and support.

Work will continue to open the Macmillan Information and Support Centre at PRUH, develop the new cancer information pack for patients and embed our volunteer-led information service.

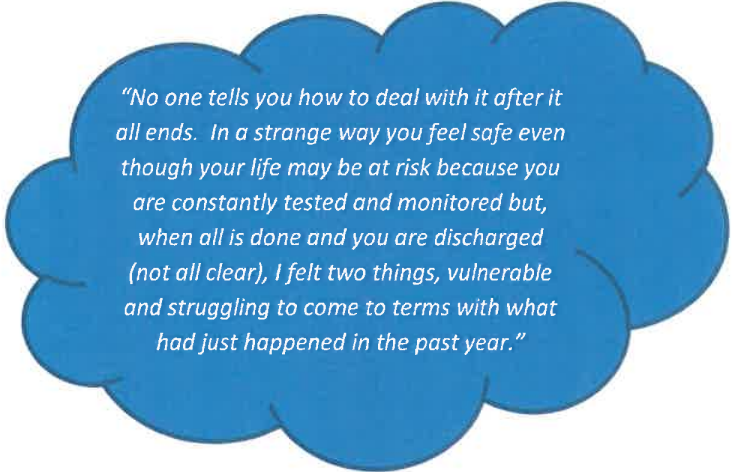
Achieved - Aim 3: Improving administration of care, including outpatients and care at home

- Listening events to capture feedback from patients and subsequent actions to develop alternative models for follow-up clinics, such as telephone or Skype clinics, have been adopted by some teams.
- The listening events have also given us insight into some of the negative comments from the National Cancer Patient Experience Survey and how to address the issues going forward.

Partially achieved - Aim 4:
Implementation of the Macmillan
Recovery Package

King's is committed to implementing the Macmillan Recovery Package which forms part of an overall support and self-management package for people affected by cancer, including physical activity as part of a healthy lifestyle, managing consequences of treatment, and information, financial and work support. Over the past year our focus has been on completion of the holistic needs assessment (HNA). We have:

- Appointed a project manager to deliver the Recovery Package
- Trained 85% of cancer staff in the delivery of electronic HNA, and this process is ongoing



"No one tells you how to deal with it after it all ends. In a strange way you feel safe even though your life may be at risk because you are constantly tested and monitored but, when all is done and you are discharged (not all clear), I felt two things, vulnerable and struggling to come to terms with what had just happened in the past year."

- Increased the use of the HNA for patients within Haematology, from 11% to 50%
- Taken steps to get Nurse-led clinics on PIMS in order to capture data, workload and provide allocated time for completion as well as ensuring electronic completion of the HNA.

Work will continue to train all cancer staff, further increase the use of the HNA, capture data and ensure electronic completion of the HNA.

Priority 6: Improve the identification and treatment of sepsis

Why was this a priority?

Sepsis is a rare but serious complication of an infection. It is vital that sepsis is identified and treated quickly and appropriately. Without quick treatment, sepsis can lead to multiple organ failure and death.

Aims and progress made in 2018-19

Our aim was to extend the quality improvement programme across a third year to improve our identification and treatment of sepsis in our emergency department and for inpatients.

Partially achieved – Aim 1: Extend and modify the Electronic Patient Record (EPR) toolkits on screening, and treatment bundle adherence, into paediatrics and cross-site

- The quality improvement project has worked with the electronic patient record (EPR) staff to ensure that these toolkits are available across site and across the majority of patient groups.
- A further update is currently being implemented with a view to roll-out in 2019-20, which includes a pilot version for paediatrics.

Achieved – Aim 2: Ensure that diagnostic information on sepsis is readily available to clinicians and coders alike to ensure that the hospital accurately records sepsis to support both timely antibiotic review and accurate coding

- The identification of sepsis in hospital coding has improved dramatically across the quality improvement programme and this is now much more representative of the caseload. Sepsis codes are now recorded for around 3,500 patients per year (see Table 2).

Table 2: Numbers of patients coded as having sepsis (Source: KCH Business Intelligence Unit) coding database

Financial year	Coded for sepsis
2014/15	500
2015/16	1781
2016/17	1898
2017/18	3596
2018/19 Q3 YTD	2558
Grand Total	10333

Achieved – Aim 3: Work towards automated flagging of patients who are qSOFA (see below) positive to the iMobile critical care outreach service, alongside the automated National Early Warning Score (NEWS) alerts, to ensure timely review of patients most at risk from sepsis

- The qSOFA (quick Sequential Organ Failure Assessment) score assists clinicians to estimate the extent of organ function and the risk of serious illness and death due to sepsis. It uses three criteria, assigning one point for low blood pressure (SBP≤100 mmHg), high respiratory rate (≥22 breaths per min), or altered mentation (Glasgow coma scale<15).
- During the sepsis quality improvement programme, data have been gathered on 2625 patients screened for sepsis. All patients had their qSOFA score identified and were flagged if qSOFA positive. The data (see Table 3) confirms that qSOFA is an effective marker of the high risk patient in the inpatient population ($p < 0.0001$). All patients flagged as qSOFA positive were under review by the iMobile critical care outreach service.

Table 3: Numbers of patients with the quick Sequential Organ Failure Assessment (qSOFA) completed (Source: KCH Business Intelligence Unit sepsis screening database)

Sepsis screening: qSOFA +ve patient outcomes	Patients with sepsis	% of Patients
No	1367	52.08%
1 Med Advice	9	0.66%
2 Self/relat	1160	84.86%
4 Death	21	1.54%
Not Yet Discharged	152	11.12%
Yes	1258	47.92%
1 Med Advice	11	0.87%
2 Self/relat	865	68.76%
4 Death	13	1.03%
Not Yet Discharged	345	27.42%
Grand Total	2625	100.00%

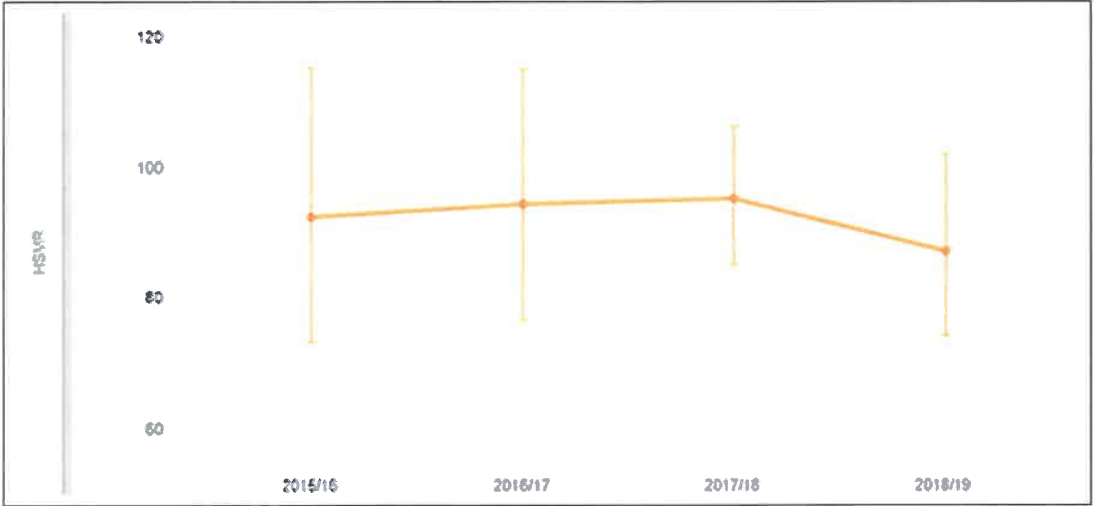
- Roll out of the National Early Warning Score (NEWS) 2 and e-observations within the electronic patient record will assist with the automated flagging of such patients.
- Clinical review, including antibiotic review, of patients has demonstrated compliance with the national Commissioning for Quality and Innovation (CQUIN) requirements.
- We aimed to reduce mortality and absolute mortality in patients with sepsis and we have seen a decrease in these patients across the trust ($p=0.0424$) (see Table 4).

Table 4: Absolute mortality from sepsis (Source: Business Intelligence Unit sepsis coding database)

Financial year	Death		Alive		Total Coded for sepsis
	Coded for sepsis	%	Coded for sepsis	%	
2015/16	321	18.15%	1460	81.85%	1781
2018/19 Q3 YTD	401	15.86%	2157	84.14%	2558
Grand Total	722	16.80%	9617	83.20%	4899

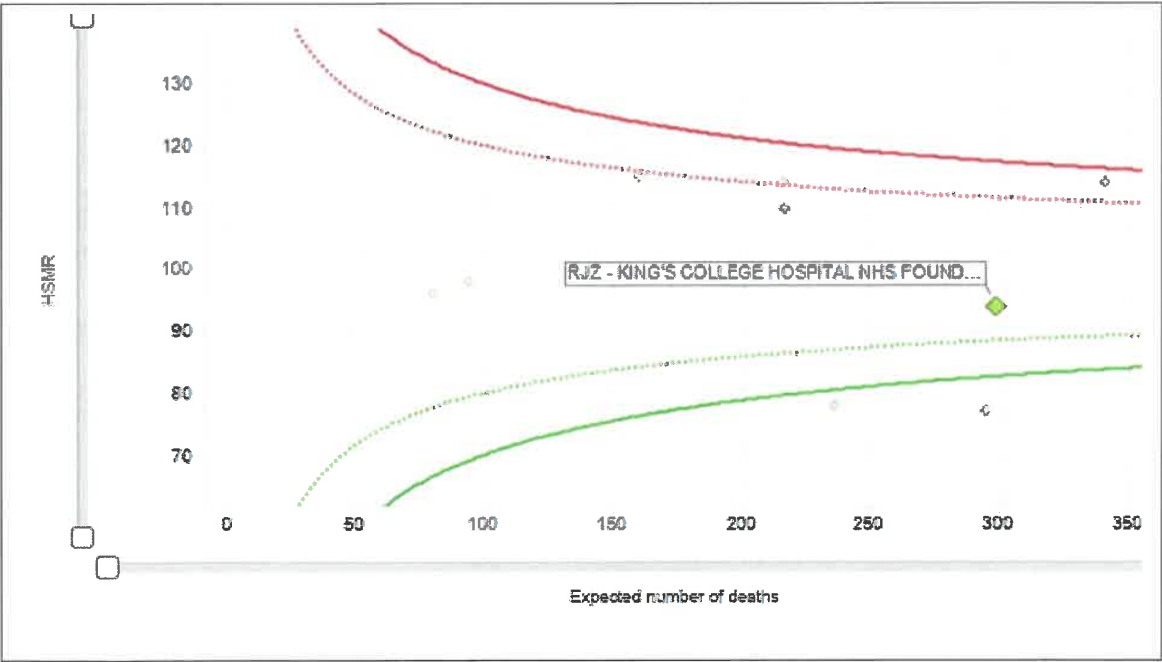
- Risk adjusted mortality from sepsis remains largely unchanged. This accords with the recent published data¹ that shows that co-morbidities are greater determinants of outcomes than sepsis in itself (Figure 5).

Figure 5: Hospital Standardised Mortality Ratio (HSMR): Septicaemia (except in labour) April 2015 to November 2018 (source: Hospital Episode Statistics via HED)



- Risk-adjusted mortality from sepsis at King’s College Hospital is within expected national range and amongst the best performing in our peer group of NHS Trusts (the Shelford Group) (see Figure 6).

Figure 6: Hospital Standardised Mortality Ratio (HSMR): Septicaemia (except in labour) December 2017 to November 2018 – Shelford Group (source: Hospital Episode Statistics via HED)



¹ <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2724768>

Priority 7: Reducing harms to patients due to falls in the hospital

Why was this a priority?

Patients are at risk of falling when in hospital because their underlying illness can predispose them to being weak, unsteady or disorientated. Patients may be on medication which affects their balance and the environment is unfamiliar.

While King's has been below the national average in the number of falls reported there are still falls occurring which can lead to serious harm, namely hip fractures or head injuries. Our patient demographic is vulnerable to such injuries as a high proportion are frail and elderly or are on anti-coagulants which may increase the risk of bleeding after a fall.

The Royal College of Physician's 2017 audit of inpatient falls showed that the Trust performed well in a number of areas. It also highlighted some areas of improvement such as assessing lying and standing Blood Pressure observations, medication review and assessment of a patient's vision.

Aims and progress made in 2018-19

Achieved: Aim 1 – Develop and standardise cross-site care plans and risk assessments (consider having an electronic assessment tool that can be audited)

- Standardised documents used across all sites with 90% compliance using the screening tool and 70% compliance using the risk assessment with continued improvement to 95% in (2019/2020) as per roll out.
 - We have developed and agreed an improved risk assessment and care plan based on the Fallsafe principles as outlined by the Royal College of Physicians (RCP), which has been positively received by staff.
 - In DH the introduction of the improved risk assessment has been staggered, starting initially in surgery and liver and is to be launched in medicine. Launch requires in-depth teaching to appropriate ward representatives.
 - At PRUH the assessment tool is being used on Darwin 2, with a plan to migrate the hard copy risk assessment into the Electronic Patient Record as part of the National Early Warning Score (NEWS) 2 project roll out. An electronic version will assist with completion, compliance and audit of this tool.
 - The post-falls care plan has been adapted and improved to include patients on anticoagulation to help clearly guide staff following a falls related head injury.
 - Current compliance with the new risk assessment is 100%.
 - At DH and Churchill Ward (Orpington Hospital) the health care support workers (HCSW) in the Health and Aging Units have been taught how to complete the bedside visual assessments.
 - All nursing staff have a 'preventing falls' session at induction and all HCSWs now receive additional session on visual screening at their induction.

Partially achieved : Aim 2 – Improve on Lying & Standing blood pressure (BP) measurement compliance in line with NICE guidelines by promotion, training and aid memoirs

- We aimed to achieve 95% compliance with Lying & Standing BP measurement assessments where required but we have not achieved our aim to date.

There is a challenge nationally in improving compliance with Lying and Standing blood pressure (L&SBP). The clinical importance of L&SBP is promoted by the Royal College of Physicians as an important assessment in minimising the risk of falls. This is a relatively recent addition in nursing assessment and requires a culture change. In addition, it is not an easy measure to record in our electronic vital signs observation system.

A poster and card campaign promoting the L&SBP was launched in Spring 2018, and instruction on 'how to do' L&SBP were disseminated. Screensavers were utilised to raise awareness and a Falls Focus mobile teaching board is planned which can move from ward to ward.

We continue to emphasise the importance of L&SBP in all falls awareness teaching and at other strategic meetings such as the Safer Care Forum, Clinical Governance meetings, ward managers meeting and the Falls Steering Group, and we will continue to develop our information technology to assist.

Achieved: Aim 3 – Improve adherence to standardised post-falls protocol, in particular where there was an unwitnessed fall

- An audit of all falls with moderate and major injuries occurring in 2018 was carried out across both sites and we found that the post-falls protocol was completed 95% of the time.
- There appeared to be some challenges related to medical staff adjusting the frequency of neurological observations following a head injury in accordance with NICE guidance. This meant that some neurological observations were completed less frequently than recommended (with no harms noted). As a result, we revised the post-falls algorithm and this is now included in all junior doctor induction packs. We will re-audit in Spring 2019.

We are also working to:

- Prevent readmission of frail and elderly people due to falls and ensure referral to falls clinics. A 6-monthly report on all patients attending ED due to a fall is being shared with the Bromley Falls Service (PRUH) and the Falls Clinic at DH. This will assist the falls clinics to identify priority patients who require assessment or review. We will analyse the data to ascertain whether this has resulted in a reduction in the re-attendance rate in ED.
- Promote early mobilisation and consider non-therapies assessments, through our falls awareness teaching. At PRUH the lead physiotherapist in medicine has developed a manual handling/mobilisation competency document which has been rolled out on 3 wards and which aims to improve the confidence and competence of nursing staff to mobilise patients as early as possible during their admission. Promotion of mobilisation is a core element of the Fallsafe principles.

- Increase collaboration with the Dementia and Delirium team, build this service at the PRUH and develop joint training. The Dementia Team is now established at PRUH and there has been joint working to promote best practice on the wards.

Choosing Priorities for 2019/20

In December 2018 we held an engagement event for patients, the public, the voluntary sector and Trust members to showcase our progress on the 2018-19 quality priorities and to ask for suggestions for quality priorities for 2019/20. The group gave their continued support for the three quality priorities which we proposed to carry forward – mental health, cancer and outpatients. An additional improvement area was identified – improving communication and information for patients leaving hospital.

These four quality priorities were all supported and approved by our Executive Quality Board, the Quality Assurance and Research Committee and the Trust Board, the Board of Governors and by commissioner-led Clinical Quality Review Group (CQRG).

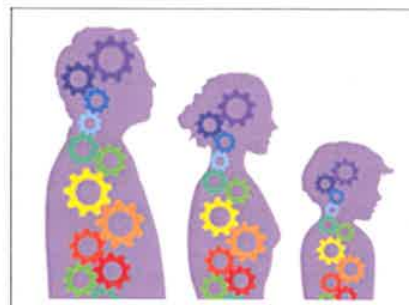
Our aims for each are set out below.

2019-20 Quality Priority 1: Improving the care of people with mental, as well as physical, health needs

Why is this continuing as a priority?

In 2017 we made a 3 year commitment to focus on mental health care. 2019-20 will be year 3 and mental health continues to be a quality priority because:

- Nearly a third of people with long-term medical conditions have a mental illness, and nearly half of people with mental illness have at least one long-term medical condition
- Joining-up the care of both mind and body leads to better patient outcomes
- It is cost-effective - £1 in every £8 spent on caring for people with long-term medical conditions is linked to poor mental health
- National studies show that there is much that hospitals like King's can do to improve mental health care.



What are our aims for the coming year?

In 2019-20 we will continue to:

- Increase the number of outpatient clinics undertaking screening for mental health and develop new models of screening in inpatient settings, as well as a screening platform that patients can access from home. Begin screening at PRUH and Orpington Hospital.
- Provide self-help resources for our patients on all our sites to help them manage their health and wellbeing.
- Improve links between physical and mental health services in our local system, for example, helping patients to refer themselves to psychology services or improving the care of those with severe mental illness within King's.
- Work in partnership with South London and Maudsley NHS Trust, Oxleas NHS Trust, general practitioners and other local hospitals to develop new ways to join up physical and mental health care to improve the outcomes, experience and safety of our patients.
- Support staff to provide better mental health care through training and supervision.
- Undertake an in-reach pilot with mental health and advocacy groups. Working with Healthwatch Lambeth we will develop and pilot a project to involve local mental health groups in providing signposting and support to staff and patients on some inpatient wards at King's College Hospital.

How will we monitor and measure our progress?

- Progress against these aims will be reported to the Trust's Mental Health Board and Executive Quality Board and included in the Trust's Quarterly Quality Priorities Report
- Measures of success will include:
 - o A 10% increase in the number of mental health screens, from 30,363 to 33,399
 - o An additional 5 clinics screening for mental health
 - o Self-help resources available in 2 new clinical areas
 - o A further 500 members of KCH staff receiving training and education in Mind and Body.
 - o In-reach project with local advocacy groups piloted on three wards and positively evaluated by patients and staff.

2019-20 Quality Priority 2: Improving patients' experience of outpatient services

Why is this continuing as a priority?

Improving outpatient experience is part of a three year programme of work, reflecting the scale of the challenge to make real and sustainable improvement to our outpatient services.

What are our aims for the coming year?

In 2019-20 we aim to:

- Improve our written communication to patients, by:
 - o Improving performance against national target for turnaround time of clinic outcome letters for patients.
 - o Reviewing King's '*Copying Letters to Patients*' policy, introduced in 2018, to ensure that the style, language and content of letters to patients is accessible and useful for both patients and GPs. We will undertake workshops with patients to obtain their views and then use this information to help us design new standardised letter templates.
- Improve outpatients check-in processes for patients and information on waiting times in clinics, by:
 - o Successfully rolling-out the InTouch system in six further clinics at King's College Hospital and Princess Royal University Hospital.
 - o Piloting and evaluating new waiting times information modules.
 - o Piloting and evaluating a new mobile application for check-in and information on waits.
 - o Increasing volunteer support in outpatient areas to support patients waiting in clinic.
 - o Adding questions to the Trust's '*How are we doing?*' survey relating to communication in clinic and then measuring improvement over a six-month period. We will deliver a more detailed outpatient survey, via text message, to all outpatients who have a mobile phone listed on their record. This will ensure a robust number of responses across our specialties.
- Optimise the use of outpatient appointment slots to reduce waiting times, by:
 - o Working with key clinical areas at King's College Hospital, Princess Royal University Hospital and Orpington Hospital, to reduce Did Not Attend (DNA) rates. This will ensure that as many appointment slots as possible are filled and aid the reduction in waiting times for appointments.
 - o Increasing support from volunteers to telephone patients and remind them of their appointments, to reduce the numbers of missed appointments.
 - o Rolling-out the 'Drumbeat' programme which allows clinical teams to plan clinic use in advance and ensure vacant appointment slots are filled.

How will we monitor and measure our progress?

- Progress against these aims will be reported to the Executive Quality Board and included in the Trust's Quarterly Quality Priorities Report.
- Measures of success will include:
 - o A 5% improvement in the overall patient experience score between the baseline patient survey and the first repeat survey.
 - o 85% compliance with national target of 7 day turnaround for clinic letters.
 - o New clinic outcome letter templates agreed by September 2019, for piloting and roll out commencing Q1 2020.
 - o Template for appointment and other administration letters agreed by December 2019, for piloting from March 2020 and roll-out in key specialties during 2020.
 - o 5% reduction in DNA rates in pilot specialties.
 - o 5% reduction in unfilled appointment slots.

2019-20 Quality Priority 3: Improving cancer services for patients and their families

Why is this continuing as a priority?

In the National Cancer Patient Experience Survey (NCPES) King's was ranked 136th out of 209 cancer care providers. Improving the experience of cancer patients was identified as a three year quality priority in 2017, to ensure that we achieve a sustainable step change in patient and family experience. This is the second year of the three year improvement work and it will continue to be informed by listening to patients with cancer and their families.

What are our aims for the coming year?

In 2019-20 we aim to:

- Develop our workforce, by:
 - Ensuring continued commissioning of Advanced Communication Skills Training.
 - Providing Psychology level 2 training and Sage and Thyme, a model to enable health and social care professionals to listen and respond to concerned or distressed people in a way that empowers the distressed person, for all staff.
 - Increasing opportunities to access specialist training and uptake of specialist cancer courses by highly specialist Clinical Nurse Specialists (CNSs).
 - Enhancing knowledge of the Macmillan Information and Support Centres and community services to support staff with meeting patients' needs.
- Improve access to and the service provided to patients and their families by cancer CNSs, by:
 - Completing a Cancer CNS review to ensure better service coverage to improve patient access to CNSs.
 - Evaluating the potential of the support worker role to help coordinate care and improve data collection, including submission of business cases for support workers to free CNSs for complex clinical or psychological consultations.
 - Reviewing patient pathways to ensure coordination of care and access to CNSs at any stage of the pathway from diagnosis to Living With and Beyond Cancer (LWBC).
- Improve information and support for cancer patients and their families, by:
 - Reviewing and revising current cancer information and utilisation and provision of the Macmillan Information and Support Centres to ensure timely provision and effective support to patients and their families, including:
 - Raising the profile of the DH Macmillan Information and Support Centre with staff, patients and community.
 - Working with Bromley Clinical Commissioning Group to develop an Information Centre for the Bromley catchment area.
 - Establishing and sustaining a group of patient representatives who can assist with improving cancer care across King's College Hospital and Princess Royal University Hospital.

- Ensuring defined processes and procedures for recruiting and utilising patient representatives.
- Improve access to wider support for patients and their families, by:
 - Increasing the availability of cancer psychological support across all King's College Hospital sites, including:
 - Launching our Cancer Psychological Support Project Team with three Cancer Psychological Support Staff planned to develop and deliver services at both King's College Hospital and the Princess Royal University Hospital.
 - Exploring options for provision of specialist cancer Allied Health Professional services focusing on Physiotherapy, Dietetics and Occupational Therapy across both sites.
 - Ensuring delivery of Holistic Needs Assessments to identify needs and increase access and uptake of well-being events and support.
 - Working with local CCGs to ensure coordination of care, communication and provision of services.
- Implement the Recovery Package, by:
 - Embedding Holistic Needs Assessment and Health and Well-Being Events (HWBE) as mandated practice for King's as part of the standard pathway of care, including:
 - Setting up working groups to improve compliance with Holistic Needs Assessments offered to patients around wider issues of cancer, social, emotional and practical support.
 - Standardising use of the electronic Holistic Needs Assessments in order to set up reporting validation processes.
 - Provision of generic Health and Well-Being Events at King's College Hospital and Beckenham Beacon, Bromley.
 - Achieving open access follow up in breast, colorectal and urology (the national priorities) by setting up the Somerset remote monitoring system.

How will we monitor and measure our progress?

- Progress against these aims will be reported to the Executive Quality Board and included in the Trust's Quarterly Quality Priorities Report.
- Measures of success will include:
 - Improvement in the 2019/20 National Cancer Patient Experience Survey (NCPES) results, from our last position of 136, to be within the top 100 trusts.
 - To increase King's overall score in the NCPES to at least national average (KCH most recent score 8.6, national average 8.7).
 - To achieve upper range for Clinical Nurse Specialist (CNS) targets in the NCPES questions relating to patients' contact with CNSs (current target >90%).
 - To implement real time feedback questionnaires (based on the NCPES) for each tumour group, linked to the Friends and Family Test, and improve responses in line with the NCPES outcomes.

- o To achieve:
 - >95% of CNS workforce trained in advanced communication skills
 - >95% of CNS workforce trained in level 2 psychology
 - 80% of CNS posts adopted by Macmillan to enhance access to continuing professional development
 - Training of 100 staff members, targeting bands 2-6 in Sage and Thyme Communication Training
 - >95% of CNS workforce with access and trained to use my care plan (electronic HNA).
- o To be successful in a bid to Macmillan to secure 4 support workers posts.
- o To offer pre-chemotherapy consultations to >95% of patients starting new cycles of chemotherapy.
- o To increase the availability of cancer psychological support across King's College Hospital sites, including:
 - Establishing Key Performance Indicators, referral criteria and pathway and collating service activity and outcomes data.
 - Setting set up a Project group to evaluate and monitor progress.
 - Submitting a business case for specialist cancer Allied Health Professionals.
- o To ensure that 70% of patients from decision to referral will have been offered an Holistic Needs Assessment within 31 days of diagnosis.
- o To increase by 50% the number of individuals receiving treatment summaries.

2019-20 Quality Priority 4: Improving our processes for patients leaving hospital

Why is this a quality priority?

Effective patient discharge commences on, or even before, admission and is a smooth transition to ensure that the patient is safe at home or in the community after leaving the hospital. There are many factors and elements of planning and communication that must be put in place to achieve this.

Across King's we have learned of incidents and received complaints where the discharge process has been sub-optimal. The CQC National Inpatient Survey reports disappointing results for King's in relation to lack of information and communication with patients about leaving hospital and this is supported by our own patient surveys. Information provided to patients was raised as an issue during feedback from an engagement event held with the public, commissioners, members and trust governors in December 2018, and improving the whole process of ensuring an effective discharge has been raised as a quality priority by our senior management team, Governors and Board.

What are our aims for the coming year?

We aim to:

- Undertake quality improvement work, led by our most senior nurses and therapists and involving all members of the multi-disciplinary team, to improve communication and information and hospital processes to ensure a caring and effective discharge process.
- In 2019-20 we will:
 - o For patients who return to their own home, call them the day after they are discharged from hospital to ensure that arrangements are working well.
 - o For patients who return to a care home, we will call the care home staff the day after discharge to ensure that discharge arrangements have worked well and to provide the opportunity for improved patient-centred communication between hospital and care home.
 - o Fully embed the national 'Hospital Transfer Pathway', also known as the 'Red Bag' scheme, across the organisation. This approach provides a prompt, safe and efficient transfer of clinical care when patients move between hospital and care home or other clinical setting. The Red Bag contains all a patient's essential paperwork, personal belongings and medication, and it travels with the patient as they move between care settings.
 - o Roll out these new approaches on surgical, medical, elderly care, maternity and paediatric wards as appropriate.
 - o Provide coaching and support for ward staff to implement these new initiatives.
 - o Set up this process within the King's Way for Wards Accreditation Programme, so that we can track how well wards are performing.
 - o Align this work with other initiatives to improve discharge planning, both internally and with our external partners, adapting processes and identifying resources as appropriate.



- o Scope additional pieces of work, identifying management leads and initiating projects as required, to improve:
 - The complex needs of elderly patients, in particular those with dementia where we will work with the NHS London improvement lead to improve our care.
 - Information to patients and families and carers.
 - Clinical documentation.
 - Communication with GPs.

How will we monitor and measure our progress?

- Progress against these aims will be reported to the Executive Quality Board and included in the Trust's Quarterly Quality Priorities Report.
- Measures of success will include:
 - o Improved scores (+5 points) for the two of the worst scoring questions from the CQC National Inpatient Survey on the pilot wards. These will be measured through the Trust's inpatient survey questions:
 - Did you feel you were involved in decisions about your discharge from hospital?
 - Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
 - o A structured programme of continuous quality improvement work, with identified senior nursing/therapy and operational leads, clear reporting structure and schedule of actions.
 - o Reduction in number of complaints, adverse incidents and quality alerts.
 - o The results of an audit of the new approach of calling patients and care homes on the day after discharge. We will then adjust the process to reflect feedback from patients, carers and care homes staff as appropriate.
 - o Feedback from care homes on the effectiveness of the Red Bag scheme.

2.2 Statements of Assurance from the Board

1. During 2018/19 King's College Hospital NHS Foundation Trust provided eight regulated activities across 10 registered locations with no conditions attached to the registration.
 - Assessment or medical treatment for persons detained under the 1983 Act
 - Diagnostic and screening procedures
 - Family planning services
 - Management of supply of blood and blood derived products
 - Maternity and midwifery services
 - Surgical procedures
 - Termination of pregnancies
 - Treatment of disease, disorder or injury.
- 1.1 The trust has reviewed all data available to it on the quality of care in these services.
- 1.2 The income generated by the relevant health services reviewed in 2018-19 represents 90% of the total income generated from the provision of health services by King's College Hospital NHS Foundation Trust for 2018-19.

Clinical Audits and National Confidential Enquiries

2. During the 2018/19 financial year, 61 national clinical audits and 12 national confidential enquiries covered relevant health services that King's College London NHS Foundation Trust provides.
 - 2.1 During that period King's College Hospital NHS Foundation Trust participated in 98% of the national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate.
 - 2.2 The national clinical audits and national confidential enquiries in which King's College Hospital NHS Foundation Trust was eligible to participate during 2018/19 are as follows (see Table 5).
 - 2.3 The national clinical audits and national confidential enquiries that King's College Hospital NHS Foundation Trust participated in during 2018/19 are as follows (see Table 5).
 - 2.4 The national clinical audits and national confidential enquiries that King's College Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2018-19 (or on the required Quality Account list published by HQIP), 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 the audit or enquiry (see Table 5).

Table 5: Participation in national clinical audits and confidential enquiries

Participation in national clinical audits and confidential enquiries		
In which KCH was eligible to participate	Participation	% submitted
BAUS Urology Audits: Nephrectomy	Yes	Awaiting publication
Intensive Care National Audit and Research Centre Case Mix Programme	Yes	Data collection in progress
Child Health Clinical Outcome Review Programme (NCEPOD) - Chronic Neurodisability	Yes	Not available
Child Health Clinical Outcome Review Programme (NCEPOD) - Young People's Mental Health	Yes	Awaiting publication
Child Health Clinical Outcome Review Programme (NCEPOD) - Long-term ventilation in children, young people and young adults	Yes	Data collection in progress
Elective Surgery (National PROMs Programme) – Hip replacement	Yes	Data collection in progress
Elective Surgery (National PROMs Programme) – Knee replacement	Yes	Data collection in progress
Falls and Fragility Audit Programme (FFAP) - Fracture Liaison Database	Yes	Data collection in progress
Falls and Fragility Audit Programme (FFAP) - National Audit of Inpatient Falls	Yes	Awaiting publication
Falls and Fragility Audit Programme (FFAP) - National Hip Fracture Database	Yes	Data collection in progress
Inflammatory Bowel Disease (IBD) programme	Yes	Data collection in progress
Learning Disability Mortality Review Programme (LeDeR)	Yes	Awaiting publication
Major Trauma Audit	Yes	Awaiting publication
Mandatory Surveillance of bloodstream infection and clostridium difficile infection	Yes	Data collection not started
Maternal, Newborn and Infant Clinical Outcome Review Programme – Perinatal Mortality Surveillance	Yes	Data collection in progress
Maternal, Newborn and Infant Clinical Outcome Review Programme – Perinatal Mortality & Morbidity	Yes	Data collection in progress
Maternal, Newborn and Infant Clinical Outcome Review Programme – Maternal Mortality & Morbidity	Yes	Data collection in progress
Maternal, Newborn and Infant Clinical Outcome Review Programme – Maternal Mortality & Morbidity	Yes	Data collection in progress
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – Acute Heart Failure	Yes	57%
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – Cancer in Children, Teens and Young Adults	Yes	Not available
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – Perioperative diabetes	Yes	83%
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – Pulmonary Embolism	Yes	Data collection in progress
Medical and Surgical Clinical Outcomes Review Programme (NCEPOD) – Acute Bowel Obstruction	Yes	Data collection in progress
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – Paediatric Asthma Secondary Care	Yes	Data collection not yet started
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – Adult Asthma Secondary Care	Yes	Awaiting publication
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – COPD Secondary Care	Yes	Awaiting publication
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – Pulmonary Rehabilitation	Yes	Awaiting publication
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Data collection in progress
National Audit of Cardiac Rehabilitation	Yes	Awaiting publication
National Audit of Care at the End of Life (NACEL)	Yes	Data collection not yet started
National Audit of Dementia	Yes	Awaiting publication
National Audit of Seizures and Epilepsies in Children and Young People	Yes	Not available
National Bariatric Surgery Registry (NBSR)	Yes	Data collection in progress
National Cardiac Arrest Audit (NCAA)	Yes	Data collection in progress
National Cardiac Audit Programme – National audit of cardiac rhythm management (CRM)	Yes	Data collection in progress
National Cardiac Audit Programme – Myocardial Ischaemia National Audit Project (MINAP)	Yes	Data collection in progress

Participation in national clinical audits and confidential enquiries		
In which KCH was eligible to participate	Participation	% submitted
National Cardiac Audit Programme – National Adult Cardiac Surgery Audit	No	Not applicable
National Cardiac Audit Programme – National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Data collection in progress
National Cardiac Audit Programme – National Heart Failure Audit	Yes	Awaiting publication
National Cardiac Audit Programme – National Congenital Heart Disease (CHD)	Yes	Data collection in progress
National Child Mortality Database	Yes	Data collection not yet started
National Clinical Audit of Specialist Rehabilitation for patients with complex needs following major injury (NCASRI)	Yes	Awaiting publication
National Comparative Audit of Blood Transfusion programme – Use of fresh frozen plasma and Cryoprecipitate in neonates and children	Yes	Awaiting publication
National Diabetes Audit – National diabetes foot care audit	Yes	Data collection in progress
National Diabetes Audit – National Diabetes Inpatient Audit (NaDIA)	Yes	Awaiting report
National Diabetes Audit – National Core Diabetes Audit	Yes	Data collection in progress
National Diabetes Audit – National Diabetes Transition Audit	Yes	Data collection in progress
National Diabetes Audit – National pregnancy in diabetes audit	Yes	Data collection in progress
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Data collection not yet started
National Emergency Laparotomy Audit (NELA)	Yes	Awaiting publication
National Gastrointestinal Cancer Programme- National Bowel Cancer Audit (NBOCA)	Yes	Data collection in progress
National Gastrointestinal Cancer Programme- National Oesophago-gastric Cancer (NOGCA)	Yes	Data collection in progress
National Joint Registry (NJR)	Yes	Data collection in progress
National Lung Cancer Audit (NLCA)	Yes	Data collection in progress
National Maternity and Perinatal Audit	Yes	Awaiting publication
National Mortality Case Record Review Programme	Yes	Awaiting publication
National Neonatal Audit Programme (NNAP)	Yes	Awaiting publication
National Ophthalmology Audit- Adult Cataract Surgery	Yes	Awaiting publication
National Paediatric Diabetes Audit (NPDA)	Yes	Awaiting publication
National Prostate Cancer Audit	Yes	Data collection in progress
National Vascular Registry	Yes	Awaiting publication
Neurosurgical National Audit Programme	Yes	Data collection in progress
Non-invasive Ventilation- Adults	Yes	Data collection not yet started
Paediatric Intensive Care (PICANet)	Yes	Awaiting publication
Perinatal Mortality Review Tool	Yes	Awaiting publication
Royal College of Emergency Medicine (RCEM) – Feverish Child	Yes	Data collection in progress
Sentinel Stroke National Audit programme (SSNAP)	Yes	Data collection in progress
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance scheme	Yes	Awaiting publication
Seven Day Hospital Services Self-assessment Survey	Yes	Awaiting publication
Surgical Site Infection Surveillance Service	Yes	Awaiting publication
UK Cystic Fibrosis Registry	Yes	Awaiting publication
UK Parkinson's Audit	Yes	Awaiting publication
UK Renal Registry	Yes	Awaiting publication
UK Registry of Endocrine and Thyroid Surgery (UKRETS)	Yes	Awaiting publication
Vital Signs in Adults	Yes	Awaiting publication

2.5 The reports of 37 national clinical audits were reviewed by the Trust in 2018/19.

2.6 King's College Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Table 6).

Table 6: Reports of national clinical audits reviewed

Reports of national clinical audits reviewed	
Title	Improvement actions
National Diabetes Inpatient Audit England and Wales, 2017	Patients at PRUH visited by a member of the Diabetes Team and received foot risk assessment during stay is lower than national figures and there are comprehensive improvement actions in place, including establishment of a specialist diabetes foot service in March 2018, the introduction of consultant-led ward rounds and sweeps by the diabetes nurse specialists on the Acute Medical Unit, with the majority of patients seen within 24 hours of admission. The introduction of EPR has enabled the diabetes specialist team to receive alerts for patients with abnormal glucose levels. Foot risk assessments are now included in the medical clerking proforma and increased education for non-diabetes specialists, and possibly an EPR prompt, are under consideration.
National Maternity and Perinatal Audit, Clinical Report 2017 – revised version 2018. Annual Report.	The audit reported that DH 3 rd /4 th degree tears (4.7%) are higher than expected range (3.7%) and DH instrumental birth (16.7%) is higher than the expected range (13.0%). Improvements in 3 rd /4 th degree tears were made in 2016 (prior to the report publication) and the rate had fallen to 2.9% by 2016-17. Instrumental birth rate, particularly the use of forceps, is under close internal monitoring and is showing improvement. Improvement actions include teaching of trainees, a ROBUST course, consultant presence at trials of instrumentals and improved consultant support for juniors. PRUH did not submit data for the reported time period so improvement actions relate to ensuring data submission.
Trauma Audit and Research Network (TARN) – Major Trauma Dashboard Q4	Rapid access to specialist MTC care in DH is lower than national figures, driven by KCH capacity issues. Senior trust planning is in progress to address this issue and performance for this indicator has improved since previous Quarter. DH performed lower than national figures in delivering definitive cover of open fractures within BOAST 4 guidelines, driven by the lack of plastic surgeon availability at DH. The issue has been escalated and is being addressed by the senior management team. DH performed lower than national figures in administering Tranexamic Acid within 3 hours of incident to patients that receive blood products within 6 hours of incident. This is a data interpretation issue - first dose given at scene/ ambulance. Second dose is often not required.
National Cardiac Arrest Audit Published March 2018	At PRUH there are some results that are lower than national and the case mix of the aging population at PRUH is a major factor, coupled with lack of capacity in the resuscitation team at PRUH which impacted on data collection. Steps have been taken to address the issues with data capture and improve resuscitation team resource at PRUH.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme : Pulmonary rehabilitation audit 2017	Proportion of patients reporting Medical Research Council dyspnoea score of Grade 5 at discharge assessment is lower than national result. Improvement actions focus on ensuring timely referral for rehabilitation.
National COPD Audit Programme : Secondary care audit 2017	Whilst inpatient mortality rate at DH is lower than national results, time of arrival to admissions at DH is higher than national results, due to Trust capacity issues. The proportion of patients at DH receiving acute treatment with NIV (Non-Invasive Ventilation) within three hours of arrival is lower than national results. The Trust NIV lead is leading an improvement project looking at the whole NIV pathway. The proportion of patients at DH prescribed Oxygen is lower than national results. This is an ongoing issue, senior leadership aware, improvement expected because of the new oxygen service, oxygen prescription will be added to COPD order sets
National Oesophago-gastric Cancer Audit (NOGCA) Annual Report	DH and PRUH patients are referred to GSTT for surgical procedures and, whilst GSTT adjusted 30-day and 90-day mortality rate is below the national average the adjusted rate of emergency admissions (21.3%) is higher than the national average (13.7%), suggesting an issue with late presentation amongst the local population, as found with other cancer audits. Information passed Cancer Network for public health and primary care to agree local action.

Reports of national clinical audits reviewed	
Title	Improvement actions
Royal College of Emergency Medicine - Procedural sedation in adults	Improvement action focuses on improved participation. For 2018/19 RCEM audits, leads for each audit have been identified prior to data collection period. RCEM audit timeline will be monitored through the governance tracker and reviewed in monthly governance meeting.
Royal College of Emergency Medicine - Fractured neck of femur, 2017/18	Improvement action focuses on ensuring recording of pain score. Local audit in progress to ensure improvement.
Royal College of Emergency Medicine - Pain in children	Mixed results indicate issues relating to recording of analgesia given. Improvement actions relate to improved recording.
Sentinel Stroke National Audit Programme (SSNAP) Hyper Acute Stroke Unit (HASU) and Stroke Unit (SU) data	Overall improvement in SSNAP score and much better than expected for risk-adjusted mortality following stroke. Team-centred SSNAP score is influenced by indicators relating to therapies provision. This is a data issue, known to the national audit team, whereby the denominator used is 'all patients' when it should be 'all patients for whom 45 mins of therapy is appropriate'.
National Paediatric Diabetes Audit Annual Report 2016-17	Improvement actions include the recruitment of a third nurse to complete annual review clinics to make sure the care processes are all completed and entered onto the sunrise system by the nurses.
National Diabetes Insulin Pump Audit	The data was fully prepared and submitted for this audit but was not included in the report due to technical system issues at the national diabetes audit team. No feedback/alerts were sent to KCH regarding the insufficient data submission and therefore the team assumed that the data had been submitted correctly. The national diabetes audit team have been contacted regarding the issues and the data collection process at national level has been amended. Subsequent period data was submitted by 29/06/2018 and King's has checked to ensure all data was received fully by the national diabetes audit team.
Intensive Care National Audit and Research Centre (ICNARC): Case Mix Programme. Medical and Surgical Critical Care Unit Report 2017-18	Most results within expected range including the ICNARC mortality ratio. DH achieved worse than national/similar units for 'High-risk admissions from the ward' (rated red), Improvement actions focus on monitoring of deteriorating patients and escalation to critical care outreach team, and this is being taken forward through the Deteriorating Patients Committee.
Intensive Care National Audit and Research Centre (ICNARC): Case Mix Programme: Liver Intensive Therapy Unit Report 2017-18	Most results were within expected range including the ICNARC mortality ratio. DH achieved worse than national/similar units for 'High-risk admissions from the ward' (rated red) but investigation demonstrated that this is due to the casemix of patients within Liver ITU. The national audit team accept this finding and are revising the national definitions for use in future reports.
National Audit of Percutaneous Coronary interventions (PCI) - Consultant Outcomes	Improvement actions focus on ensuring data completeness.
National Bowel Cancer Audit (NBOCA) Annual Report	Improvement actions focus on ensuring data completeness for patients undergoing major surgery.
National Joint Registry (NJR) Consultant Outcomes Publication Report	Improvement actions focus on ensuring data completeness across all sites. New computers and barcode scanner are being purchased to enable data entry in theatres in Orpington site. If successful, this approach will be rolled out to DH and PRUH sites.

2.7 The reports of approximately 200 local clinical audits were reviewed by the Trust in 2018-19. The Trust has a comprehensive programme of clinical audits known as King's Way for Wards, providing a standardised regular audit of the ward environment (physical, material, clinical and process) and a ward accreditation scheme. In addition, King's has just re-started its participation in the national Safety Thermometer.

A key focus for King's is the measurement of patient outcomes and a comprehensive approach to identification and monitoring of outcomes indicators is in place throughout the Trust.

2.8 King's College Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Continue the provision of comprehensive quality improvement (Lean) training programme rolled out across organisation, which has so far seen 2,336 staff trained (at 12/2/19).
- Continue the roll out of the King's Way for Wards Quality Improvement Accreditation Programme, so far completed by 38 of 78 wards and 1 outpatient area across the Trust (24 of the 49 wards at King's College Hospital (47%) and 14 of the 29 at PRUH (45%)), and demonstrating significant improvement.
- Four-monthly cycles of inspection audits across KCH wards has demonstrated good evidence of learning from incidents, staff feeling empowered to improve patient care and patients feeling that they are treated with care and compassion. We intend to continue this programme and identified improvement areas currently include early-warning score observations, fridge temperatures and adherence to uniform policy.
- Fully embed the use of the recently rolled-out Electronic Patient Record (EPR) on the PRUH site, and re-develop the trust-wide audit of electronic record keeping, discharge documentation, consent and hand-over documentation.
- Continued improvements in relation to the completion and communication of Do Not Attempt Cardio-Pulmonary Resuscitation (DNA CPR) forms, reinforcing the importance of reviewing the CPR status by the receiving team when patients are transferred between teams within the trust.
- Use of Dose Track in Radiology to improve patient pathway for inlet/outlet views. Sending post-operative patients for a low dose CT scan, following concern about multiple repeat of scans due to difficulty in patient positioning and discomfort.
- Improved optimisation lateral digital chest radiography following an initial audit which indicated that default kV for lateral chest X-rays was relatively low.
- The introduction of the National Safety Standards for Invasive Procedures and changed procedure sheet to ensure changes of staff are documented.
- Reduce the risk of retained swabs after vaginal birth and perineal suturing by sending out a safety briefing via email and providing paper copies in communal areas. Swab count to continue to be highlighted during Matron ward rounds. Issue will be re-audited monthly until 100%.
- Following publication of Safer Practice Notice in relation to the standardisation and use of wristbands for in-patients, SafetyNet newsletter will highlight the learning points and risks identified in relation to duplicate wrist bands. There will be a discussion at Nursing Board and information disseminated. Blood track compliance will continue to be encouraged.
- To reduce the risk of nasogastric tube misplacement, orders will be placed on EPR and learning points communicated to senior nurses. A safety briefing will be circulated to all staff and further education provided to teams.
- To reduce treatment dose errors with low molecular weight heparins, and to reduce the risk of low molecular weight heparins being used when contraindicated, the EPR clinical analytics suite will be adapted for use by the venous thromboembolism clinical nurse specialists so that they can identify currently admitted patients who are on the incorrect thromboprophylaxis prescription and take prompt action.

Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by the Trust for 2018/19 that were recruited to participate in research and approved by a research ethics committee was 19,712.

Commissioning for Quality and Innovation (CQUIN) framework

A proportion (2.5% of CCG and 2.8% of NHSE) of King's College Hospital NHS Foundation Trust's income in 2018-19 was conditional on achieving quality improvement and innovation goals agreed between King's and both NHS South East Commissioning leads and NHE England through the Commissioning for Quality and Innovation (CQUIN) payment framework. The monetary total for this income in 2018-19 was £20.09m.

For 2017-18 the Trust received £17.36m CQUIN related income and £0.92m related to other contracts (London Secondary Dental Care, London Breast Screening and NCAs) totalling £18.28m. For 2018-19 the Trust received £17.41m CQUIN related income and £0.82m related to other contracts (London Secondary Dental Care, London Breast Screening and NCAs) totalling £18.23m.

National CQUINS

National CQUINS have been published and the following schemes apply to King's College Hospital Foundation Trust (1.25% = £5,916,000) in 2018/19 (see Table 7):

Table 7: National CQUINS that apply to King's

National CQUINS	Description	Annual Financial Value
Improving Staff Health and Wellbeing (Continuation from 16/17)	Improvement in staff Health and Wellbeing. Healthy food for staff, patients and visitors. Improving the Flu uptake.	£1,183,200
Reducing the impact of serious infections (Antimicrobial resistance and Sepsis) (Continuation from 17/18)	Timely identification of sepsis in ED and Acute Inpatient areas. Timely treatment of sepsis in ED and Acute Inpatient areas. Antibiotic review. Reduction in antibiotic consumption.	£1,183,200
Mental Health in A&E	Improving services for people with mental health needs who present at A&E.	£1,183,200
Offering Advice and Guidance (New)	Increase areas offering Advice and Guidance.	£1,183,200
Preventing ill health by risky behaviours – alcohol and smoking (New 18/19 only)	Tobacco screening. Tobacco brief advice. Tobacco referral medication. Alcohol screening. Alcohol brief advice.	£1,183,200

Local CQUINS

Southwark CCG Contract (1.25% = £5,916,000) in 2018-19 (see Table 8):

Table 8: Local CCG CQUINS

Local CCG CQUINS	Description	Annual Financial Value
Vital 5	Launching routine recording and reporting of five key metrics for our entire population, across primary, secondary, tertiary and community care. It will offer the capacity to track health gain and benefits, to slow the progression to long-term conditions.	£2,958,000
Care Co-ordination – Lambeth and Southwark (Continuation from 16/17)	Develop and implement proactive and person-centred care coordination for people with complex needs and with long term conditions.	£2,958,000

NHS England CQUINS

NHS England contract (2.8% - £7,477,000) in 2018-19 (see Table 9):

Table 9: NHS England CQUINS 2018-19

NHS England CQUINS	Description	Annual Financial Value
Hepatitis C	Improving pathways through Operational Delivery Networks (ODNs) - continuation from 16/17.	£4,539,607
Haemoglobinopathy	Improving pathways through ODNs.	£133,518
Sickle Cell	Automated exchange transfusion for Sickle Cell patients (Continuation from 16/17).	£400,554
Clinical Utilisation Review	Implementation, application and use of system to which will assist in reduction of inappropriate hospital utilisation (continuation from 16/17) – PRUH to be rolled out in 19/20.	£1,388,506
Cancer Dose Banding IV SACT	Standardising chemo dosages (continuation from 16/17).	£267,036
Paediatric Networked Care	To reduce recourse to critical care distant from home.	£240,332
Spinal surgery	Networks, data and MDT oversight.	£240,332

NHS England CQUINS	Description	Annual Financial Value
Cystic Fibrosis Patient Adherence	This scheme employs an electronic Cystic Fibrosis (CF) adherence indicator captured by an IT platform (CFHealthHub) to deliver a complex behavioural intervention that increases patient activation and adherence, thus delivering better patient outcomes and avoidance of costly escalations. Objective adherence is measured for high cost inhaled therapies collected via chipped nebulisers and displayed in CFHealthHub.	£186,925
Neuro Rehabilitation	NHS England has reviewed neuro-rehabilitation services in London and recognised that the service does not run as part of properly co-ordinated network, instead there are delays in assessment, multiple referrals for assessment, a high level of rejected referrals and poor sign-posting early in the pathway. This results in delay for patients accessing the right service at the right time. Additionally NHS England London found that patient experience data was not available in a routine format within units.	£80,111
Difficult to deal with Asthma	The CQUIN scheme aims to ensure assessment and investigation of children with difficult to control asthma within twelve weeks of referral, so to ensure that all eligible children have appropriate and timely assessment and investigation in order to improve asthma control, reduce hospital admissions and avoid inappropriate escalation of therapy including the initiation of expensive monoclonal antibodies.	0
Dental	Activity reporting by Referral to Treatment for each dental specialty. Acute Dental Systems Resilience Group and acute dental portal.	£619,235

Full details on the contracts for 2017-2019 are available on request.

NHS England contract (1.55% - £4,308,820) in 2019-20 (see Table 10):

Table 10: NHS England CQUINS 2019-20

NHS England CQUINS	Description	Annual Financial Value (estimate value)
Medicines Optimisation and Stewardship	Optimising the use and management of medicines through a series of procedural and cultural changes	£691,484
Towards Hepatitis C Virus (HCV) Elimination	Improving pathways through Operational Delivery Networks (ODNs)	£2,308,145

NHS England CQUINS	Description	Annual Financial Value (estimate value)
Towards Hepatitis C Virus (HCV) Elimination Governance		£225,000
Clinical Utilisation Review: Avoiding Inappropriate Hospital Stays	Implementation, application and use of system to which will assist in reduction of inappropriate hospital utilisation (continuation from 16/17) – PRUH to be rolled out in 19/20.	£750,000
Networked Delivery of Cirrhosis Care Bundle	Improved patient care and reduced care costs through a network model to ensure adoption of nationally developed clinical guidelines and policies regarding management of patients with decompensated cirrhosis.	£334,190

Care Quality Commission (CQC)

King's College Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'Requires Improvement' following the inspection in September and October 2017 (report published 31st January 2018). King's College NHS Foundation Trust does not have any conditions on registration. The Care Quality Commission has not taken enforcement action against King's College Hospital NHS Foundation Trust during 2018-19.

The tables 11 and 12 below show the overall ratings by site.

Table 11: Overall CQC rating, King's College Hospital, published Jan-18

Ratings for King's College Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good Sept 2015	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015
Medical care (including older people's care)	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2016	Good Sept 2017	Good Sept 2017
Surgery	Good Sept 2017	Requires improvement Sept 2017	Good Sept 2017	Requires improvement Sept 2017	Good Sept 2017	Requires improvement Sept 2017
Critical care	Requires improvement Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017
Maternity	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015
Services for children and young people	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2017	Good Sept 2015	Good Sept 2015	Good Sept 2015
End of life care	Requires improvement Sept 2015	Requires improvement Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015
Outpatients	Good Sept 2015	Not rated	Good Sept 2015	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015
Diagnostic imaging	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall*	Requires improvement Sept 2017	Good Sept 2017	Good Sept 2017	Requires improvement Sept 2017	Requires improvement Sept 2017	Requires improvement Sept 2017

Table 12: Overall CQC rating, Princess Royal University Hospital, published Jan-18

Ratings for Princess Royal University Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017	Requires improvement Sept 2017	Requires improvement Sept 2017
Medical care (including older people's care)	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017	Requires improvement Sept 2017	Good Sept 2017
Surgery	Requires improvement Sept 2017	Good Sept 2017	Good Sept 2017	Requires improvement Sept 2017	Good Sept 2017	Requires improvement Sept 2017
Critical care	Good Sept 2017	Good Sept 2017	Good Sept 2017	Requires improvement Sept 2017	Good Sept 2017	Good Sept 2017
Maternity	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Services for children and young people	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Outstanding Sept 2015	Good Sept 2015	Good Sept 2015
End of life care	Requires improvement Sept 2015	Requires improvement Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015
Outpatients	Requires improvement Sept 2017	Not rated	Good Sept 2017	Requires improvement Sept 2017	Requires improvement Sept 2017	Requires improvement Sept 2017
Overall*	Requires improvement Sept 2017	Good Sept 2017	Good Sept 2017	Requires improvement Sept 2017	Requires improvement Sept 2017	Requires improvement Sept 2017

The Trust was inspected between 30 January 2019 and 21 February 2019 for all five domains. We are currently waiting on the report detailing the findings and the overall rating however some immediate areas requiring improvement were identified and have been actioned to address the concerns.

Special reviews or investigations by CQC

King's College Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Records Submission

King's College Hospital NHS Foundation Trust submitted 2,215,708 records during 2018/19 M1-11 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data April 2018 – February 2019 which included the patient's valid NHS number was:

- 98.5% for admitted patient care;
- 99.1% for outpatient (non-admitted) patient care; and
- 91.3% for accident and emergency care.

The percentage of records in the published data April 2018 – February 2019 which included the patient's valid General Medical Practice Code was:

- 100.0% for admitted patient care;
- 99.9% for outpatient (non-admitted) patient care; and
- 99.8% for accident and emergency care.

Information Governance Assessment

In April 2018, NHS Digital replaced the NHS Information Governance Toolkit with the Data Security and Protection Toolkit (DSPT). King's College Hospital NHS Foundation Trust's 2018-19 submission of the Data Security and Protection Toolkit reports an overall assessment of Standards Not Met (Approved Improvement Plan in place). The key area not met was information governance training.

Payments by Results (PbR)

The Trust was not identified as necessary for a Payment by Results (PbR) clinical coding audit in 2018-19.

Data Quality

There are a number of inherent limitations in the preparation of Quality Accounts which may affect the reliability or accuracy of the data reported. These include:

- Data are derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audit's programme of work each year.
- Data are collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflect clinical judgement about individual cases, where another clinician might reasonably have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

The Trust and its Board have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above.

The External Auditors have completed their data testing as part of the Quality Accounts review process, which included A&E waiting times, 62-day cancer pathway and Summary Hospital Mortality Index (SHMI) data. They have identified a number of errors in the A&E data that has been tested, and have made recommendations to improve the 62-day cancer pathway data quality. The External Auditor will be working with the Trust to review prior year recommendations and agree management actions following the results of this year's audit. The Trust acknowledges weaknesses in the quality of internal data produced with respect to the 4 Hour Accident and Emergency Waiting Times and the 62-day cancer pathway and will work with the auditors to update an action plan to identify areas of improvement.

Learning from Deaths

During 2018/19, 2296 (April 2018 to Jan 2019) patients died at King's College Hospital NHS Foundation Trust. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 552 in the first quarter (April to June 2018);
- 547 in the second quarter (July to September 2018);
- 595 in the third quarter (October to December 2018);
- 602 in the fourth quarter (January to March 2019).

By 31 March 2019, 336 case record reviews and 60 investigations have been carried out in relation to 396 of the 2296 deaths included above.

In 17 cases a death was subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 131 in the first quarter;
- 161 in the second quarter;
- 90 in the third quarter;
- 35 in the fourth quarter.

2 representing 0.54% of the patient deaths reviewed during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter this consisted of:

- 1 representing 0.8% for the first quarter;
- 1 representing 0.9% for the second quarter;
- 0 representing 0% for the third quarter;
- 0 representing 0% for the fourth quarter.

These numbers have been estimated using the locally-adapted version of the structured judgment review method of case record review.

Summary of learning from case record reviews and investigations

Case record review indicated probable contributions to death from issues relating to inadequate arrangements for care after discharge for a patient who was an 'outlier' on a ward not directly managed by the specialty responsible for their care.

Through review and multi-disciplinary discussion at the Morbidity and Mortality Meeting and through the adverse incident process, the medical, nursing and ward teams involved in the care of this patient have learned about potential weaknesses in the discharge process where a patient is outlying on a ward not directly managed by the specialty responsible for their care. These weaknesses included the formal communication and escalation of abnormal results received after the patient had been discharged and communications with GP and patient about further management necessary.

Serious incident reviews where patients have died have resulted in learning in relation to venous thromboembolism (VTE), insulin dosage and aortic dissection.

A description of the actions which King's College Hospital NHS Foundation Trust has taken in the reporting period, and proposes to take in the next period, in relation to Learning from Deaths

Based on the Learning from Deaths review described above, the medical, nursing and ward teams have clarified and confirmed arrangements for the discharge process, including for patients who are outliers on wards outside of the specialty, and including formal communication and escalation of results received following patient discharge, and communications with patient and GP. Discharge communications has been identified as a Trust Quality Priority for 2019-20.

Based on the Serious Incident reviews, action has included:

- Dissemination of information in relation to VTE prevention, a study day attended by more than 50 nurses and midwives, a 'Safer Care Day' attended by over 160 clinical staff, VTE prevention performance circulated trust-wide and reviewed in governance meetings.
- Insulin training updated at one of King's College Hospital's sites, insulin training added to the staff training and development portal, a SafetyNet message sent out trust-wide.
- A revised aortic dissection pathway agreed with Guy's and St Thomas's NHS Foundation Trust.

At King's we aim to ensure that learning from deaths and other safety incidents is shared widely and becomes embedded in clinical practice through a variety of internal communication mechanisms, including team meetings, accreditation boards, Quality and Safety feedback boards, newsletters, Grand Rounds and many other events. The SafetyNet Programme has been devised specifically for the purpose of sharing lessons learned and includes sharing of summaries of individual incidents and the themes identified from their analysis.

An assessment of the impact of the actions described

No further incidents have been reported similar to the cases identified above and it therefore appears that these were isolated cases and/or actions taken have been effective.

The effectiveness of the SafetyNet Programme has been surveyed and staff report that there is increased learning from incidents, including death reviews.

Previous reporting period

- 112 case record reviews and 25 investigations were completed after March 2018 which related to deaths which took place before the start of the latest reporting period.
- Zero representing 0% of the patient deaths before the latest reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been estimated using the locally-adapted version of the structured judgment review method of case record review.

Four representing 0.2% of the patient deaths during 2017-18 were judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Reporting Against Core Indicators

Table 13: Reporting against core indicators

Indicator	Measure	Current Period	Value ¹	Previous Period	Value	Highest Value Comparable ² Foundation Trust	Lowest Value Comparable ^{1,3} Foundation Trust	National Average	Data Source	Regulatory Statement
Summary Hospital-level Mortality Indicator (SHMI)	Ratio of observed mortality as a proportion of expected mortality	01/10/2017 to 31/09/2018	0.9589 (95% Confidence Interval 0.8926, 1.1203)	1/01/2017 to 31/12/2017	0.9287 (95% Confidence Interval 0.8948, 1.1176)	0.9847 (95% Confidence Interval 0.8914, 1.1218) – better than expected	0.7017 (95% Confidence Interval 0.8898, 1.1239) – better than expected	1.0	NHS Digital	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons: it is based on data submitted to NHS Digital and the Trust takes all reasonable steps and exercises appropriate due diligence to ensure the accuracy of data reported.
	Percentage of patient deaths with palliative care coded	01/10/2017 to 31/09/2018	2.4%	1/01/2017 to 31/12/2017	48.5%	2.6%	1.2%	1.8%	NHS Digital	King's College Hospital NHS Foundation Trust intends to take/has taken the following actions to improve the SHMI, and so the quality of its services, by continuing to invest in routine monitoring of mortality and detailed investigation of any issues identified, including data quality as well as quality of care.

² Shelford Group

³ Displayed by NHS Digital

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable ¹ Foundation Trust	Lowest Value Comparable ¹ Foundation Trust	National Average	Data Source	Regulatory Statement
Patient Reported Outcomes Measures - hip replacement surgery	EQ-5D Index: 136 modelled records	Apr 17 - Mar 18	Adjusted average health gain: 0.459	Apr 16 - Mar 17	Adjusted average health gain: 0.445	0.484	0.441	0.46	NHS Digital	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons - our performance is in line with Shelford Group peers. King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by continuing to provide excellent elective orthopaedic services.
	EQ VAS: 133 modelled records		Adjusted average health gain: 12.79		Adjusted average health gain: 15.006	19.588	10.441	13.53		
	Oxford Hip Score: 146 modelled records		Adjusted average health gain: 21.30		Adjusted average health gain: 22.002	23.401	19.950	22.14		
Patient Reported Outcomes Measures - knee replacement surgery	EQ-5D Index: 189 modelled records	Apr 17 - Mar 18	Adjusted average health gain: 0.333	Apr 16 - Mar 17	Adjusted average health gain: 0.294	0.370	0.216	0.338		
	EQ VAS: 201 modelled records		Adjusted average health gain: 7.204		Adjusted average health gain: 5.823	9.963	2.862	7.938		
	Oxford Knee Score: 209 modelled records		Adjusted average health gain: 16.516		Adjusted average health gain: 14.641	18.008	13.228	16.971		

NB: In line with NHS England letter (3/10/17), KCH ceased participation in PROMs for Groin Hernia and Varicose Veins from 1/10/17.

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory Statement
Percentage of patients readmitted within 28 days of being discharged	Patients aged 0-15 - %	Apr-18 to Mar-19	1.01%	Apr-17 to Mar-18	1.25%	Data not comparable due to differences in local reporting.	Data not comparable due to differences in local reporting.	N/A	To be added	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons – readmissions data forms part of the divisional Best Quality of Care scorecard reports which are produced and reviewed by divisional management teams, and forms part of the monthly integrated performance review with the executive team.
	Patients aged 16+ - %		7.03%		6.97%	Data not comparable due to differences in local reporting.	Data not comparable due to differences in local reporting.	N/A		
Trust's responsiveness to the personal needs of its patients:	Score out of 10 trust-wide	2017 National Inpatient Survey	7.3	2016 National Inpatient Survey	7.1	8.5	6.6		CQC	King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by rolling out a 7 day occupational therapy and physiotherapy service across medicine to support early identification, acute treatment and onward referral to for rehab and discharge planning needs; proactive referrals to community health, social care and voluntary sector services for those who need support to enable seamless transfer and delivery of onward care on discharge.
• Were you involved as much as you wanted to be in decisions										King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons as CQC national patient surveys are a validated tool for assessing patient experience and in line with local survey results.
										King's College Hospital NHS Foundation Trust intends to take the following actions

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory Statement
about your care and treatment?										to improve this score, and so the quality of its services, by launching regular Care Group patient experience reviews with key actions for improvement. National Inpatient Action Plan in place.
• Did you find someone on the hospital staff to talk to about your worries and fears?	Score out of 10 trust-wide	2017 National Inpatient Survey	5.2	2016 National Inpatient Survey	5.5	7.7	4.3		CQC	King's College Hospital NHS Foundation Trust considers that this data is as described as CQC national patient surveys are a validated tool for assessing patient experience.
• Were you given enough privacy when discussing your condition or treatment?	Score out of 10 trust-wide	2017 National Inpatient Survey	8.6	2016 National Inpatient Survey	8.7	9.4	8.00			King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by launching regular Care Group patient experience reviews with key actions for improvement. National Inpatient Action Plan in place.
• Did a member of staff tell you about medication side effects to watch for when you went home?	Score out of 10 trust-wide	2017 National Inpatient Survey	4.9	2016 National Inpatient Survey	4.2	7.7	3.7			

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory Statement
Did hospital tell you who to contact if you were worried about your condition or treatment after you left hospital?	Score out of 10	2016 National Inpatient Survey	7.2	2015 National Inpatient Survey	6.9	9.8	6.5		CQC	King's College Hospital NHS Foundation Trust considers that this data is as described as CQC national patient surveys are a validated tool for assessing patient experience King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by launching regular Care Group patient experience reviews with key actions for improvement. National Inpatient Action Plan in place
Staff employed by, or under contract to the trust who would recommend the Trust as a provider of care to their family or friends.	%	2018/19 Q2	79.6%	2018/19 Q1	80%	Royal Brompton & Harefield NHS Foundation Trust – 100% (Q2 data)	The Hillingdon hospitals NHS Foundation Trust – 39% (Q2 data)	81%	NHS England staff family and friends test data	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons – This is taken from NHS England national staff family and friends test website. King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by: Improving staff moral and engagement through specific engagement work streams

Please note:

Q4 Family and Friends data not available until after Quality Account publication date.

Q3 data is sourced through Trust staff survey the fore national comparators are not available.

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory Statement
The percentage of patients who were admitted to hospital and who were risk-assessed for venous thromboembolism during the reporting period	%	April 2018-December 2018	97.1%	April 2017-March 2018	96.7%	Norfolk and Norwich University Hospitals NHS Foundation Trust 98.9%	East Kent Hospitals University NHS Foundation Trust 92.5%	95.59%	NHS Improvement	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons: This data was collected electronically. Regular ward audits are completed every month and they reflect similar compliance score. The VTE CNSs also manually check a small proportion of the data to check accuracy. King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by: The Thrombosis team is currently working with ICT on additional strategies to prompt completion of the VTE risk assessments and to highlight patients assessed as high risk of VTE low risk bleeding without appropriate thromboprophylaxis prescribed. A newsletter is circulated regularly to recognise wards with high VTE risk assessment compliance. Ward and specialty VTE risk assessment scores are also circulated every month. The VTE CNSs continue to provide staff teaching on VTE prevention across sites.

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Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory Statement
The rate per 100,000 bed days of cases of <i>C. difficile</i> infection reported within the trust among patients aged 2 or over during the reporting period	rate/100,000 bed days	April 2018-March 2019	79 cases	April 2017-March 2018	88 cases	Shelford group highest 2018/19 = 153 cases	Shelford group lowest 2018/19 = 21 cases	Shelford group average 2018/19 = 76 cases	https://www.gov.uk/government/statistics/clostridium-difficile-infection-monthly-data-by-nhs-acute-trust	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons – 25% cases were colonisations; 35% were on laxatives; all had complex case histories. King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by: Ensuring appropriate testing in place. Undertaking root cause analysis and shared learning for every hospital-acquired infection. Implementation of effective antimicrobial and preventions stewardship, including routine audits and staff training.
The number and, where available, rate of patient safety incidents reported within the trust during the reporting period	Number (rate per 1,000 bed days)	April 2018 – March 2019	25,573 total and 49.85 per 100 bed days	2017/18	25,565	12 month Data not available from NRLS yet. In 6 month NRLS data KCH reported 12787 incidents. Birmingham reported 23692 incidents in 6 months. King's was 4th highest in reporting number of incidents.	12 month Data not available from NRLS yet. In 6 month NRLS data KCH reported 12787 incidents. Weston Health Foundation Trust reported 565 incidents in 6 months. King's was 4th highest in reporting number of incidents.	12 month Data not available from NRLS yet. In 6 month NRLS total average was 5582	NRLS reporting system	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons – 12 month national data is not yet available for bench-marking. Source is NRLS (National Reporting and Learning System) King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by: Continue positive feedback from incident reporting, continue supporting open and transparent culture, allow for anonymous reporting, automatic feedback installed on incident reporting system.

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory Statement
The number and percentage of such safety incidents that resulted in severe harm or death	Number (rate per 1,000 bed days)	April 2018 – March 2019	Death: 15 (0.059 %) Serious Harm 123 Serious Harm (0.059%)	2017/18	Death: 18 (0.07) Serious harm: 96 (0.38)	12 month Data not available from NRLS yet. In 6 month NRLS data KCH reported 8 death incidents. Guy's and St Thomas reported 22 death incidents in 6 months. KCH reported 52 serious harm incidents. Birmingham reported 72 serious harm incidents in 6 months	12 month Data not available from NRLS yet. In 6 month NRLS data KCH reported 8 death incidents. Multiple Trusts reported 0 death incidents in 6 months. KCH reported 52 serious harm incidents. Three Trusts reported 0 serious harm incidents in 6 months	12 month Data not available from NRLS yet. In 6 month NRLS data based on figures only was 5.4 average for deaths and 13.5 average for major harm	NRLS reporting system	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons – 12 month national data is not yet available for bench-marking. Source is NRLS (National Reporting and Learning System). To note that Trusts vary in size and incident numbers. King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by: Most of the serious harm incidents relate to pressure ulcers or falls for which the Trust has steady work-streams to reduce the number of such events. After a successful pilot in 2018 seeing a reduction of such incidents in specific areas the learning is being used across the Trust. As ever the Trust encourages reporting and has a positive culture which allows the organisation to learn from such serious events collaboratively with staff and patients/relatives. Any themes identified have specific work-streams to address them and reduce the likelihood of reoccurrence. The Trust also has a very robust Serious Incident

Part Three: Other information

Overview of the quality of care offered by the King's College Hospital NHS Foundation Trust

Table 14: Overview of the quality of care offered by King's

Indicators	Reason for selection	Trust Performance 2018-19	Trust Performance 2017-18	Peer Performance (Shelford Group Trusts) 2018-19	Data source
Patient Safety Indicators					
Duty of Candour	Duty of Candour was chosen as high performance is a key objective for the Trust as it demonstrates its positive and transparent culture. The Trust changed its reporting mechanism in April 2017 making it more robust, measuring full compliance rather than spot check audits. The higher the compliance % the better.	>92%	>90%	Not available	Datix
WHO Surgical Safety compliance	Even though the Trust has not listed Surgical Safety as a quality priority for 18/19 it remains a key objective and workstream at the Trust. Since the beginning of 2017 the Trust has been able to electronically monitor compliance with the WHO checklist. The higher the compliance % the better.	94%	93%	Not available	Local audit of data on Galaxy surgical system
Total number of never events	Outside of Surgical Safety, the Trust has a number of workstreams that aim to reduce the number of Never Events.	10	8	Information available at: https://improvement.nhs.uk/resources/never-events-data/	Transfer of Strategic Executive Information System (StEIS), NHS Improvement

Indicators	Reason for selection	Trust Performance 2018-19	Trust Performance 2017-18	Peer Performance (Shelford Group Trusts) 2018-19	Data source
Clinical effectiveness indicators					
SHMI Elective admissions	Summary Hospital-level Mortality Indicator (SHMI) is a key patient outcomes performance indicator, addressing Trust objective ‘to deliver excellent patient outcomes’.	0.7842 (95% CI 0.643 , 0.948) – Better than expected*	0.7960 (95% CI 0.654 , 0.964) – Better than expected	0.6797 (95% CI 0.641, 0.720) – Better than expected*	Hospital Episode Statistics via HED, period: January 18 to December 18
SHMI Non-elective admissions		0.9535 (95% CI 0.920 , 0.988) – Better than expected*	95.75 (95% CI 92.4 , 99.2) – Better than expected	0.8991 (95% CI 0.888 , 0.910) – Better than expected*	
SHMI Weekend admissions		0.9994 (95% CI 0.933 , 1.069) – As expected*	1.290 (95% CI 0.937 , 1.0730) – As expected	0.9818 (95% CI 0.958 , 1.060) – Better than expected*	
Patient experience indicators					
Friends & Family – A&E	Patients discharged from Accident & Emergency (types 1/2) who would recommend the Trust as a provider of care to their family or friends	78%	81%		NHS England national statistics
Friends & Family – inpatients	Inpatients who would recommend the Trust as a provider of care to their family or friends	94%	94%		NHS England national statistics
Friends & Family - outpatients	Outpatients who would recommend the Trust as a provider of care to their family or friends	88%	88%		NHS England national statistics

Performance against relevant indicators

Table 15: Performance against relevant indicators

Indicators	Trust Performance 2018-19	Trust Performance 2017-18	National average	Target
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	79.4%	78.2%	87.3%	92.0%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	76.0%	84.2%	88.0%	95.0%
All cancers: 62-day wait for first treatment from Urgent GP referral for suspected cancer	79.1%	83.8%	79.0%	85.0%
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	87.4%	98.3%	97.2%	>99%
<i>C. difficile</i> : variance from plan	80 cases	88 cases	n/a	71
Maximum 6-week wait for diagnostic procedures	92.2%	98.3%	97.2%	>99%
Venous thromboembolism risk assessment	97.3%	96.7%	95.6%	95.0%

Access to services

King's College Hospital NHS Foundation Trust continues to have one of the highest levels of acute bed occupancy on its acute sites at King's College Hospital and PRUH throughout 2018/19, which restricts our ability to be able to respond to peaks in demand above expected levels. This year, 2018/19, has been challenging in our ability to maintain and improve on patient access standards for emergency, elective and diagnostic care. We continue to see more elderly patients attending our emergency department (ED) on both acute sites, and an increase in the number of elderly patients who require subsequent admission to the hospital. This places additional pressure on wider capacity within the Trust across beds (including step-down beds at Orpington Hospital that we provide), outpatient clinics and diagnostic services.

The Trust's ED type 1 and 3 attendances performance based on monthly ED Sitrep return submissions is 76.0% for 2018/19 overall, and includes type 3 Urgent Care Centre (UCC) activity provided at Princess Royal University Hospital. To support the external audit into our ED performance compliance, the auditors were provided with a patient-level attendance dataset based on the latest ED system data available as this level of data is not available from month-end snapshot data. This also excludes UCC type 3 activity at PRUH which is provided by Greenbrook Healthcare. Performance compliance for 2018/19 based on the datasets provided for audit is lower at 69.8%.

Cancer referral demand into the Trust continues to increase with an 11% referral increase during 2018/19 which puts pressure on our ability to deliver the two week waiting time and 62-day time to first treatment cancer standards.

Referral to Treatment (18 Weeks)

Achievement of the Referral to Treatment (18 Weeks) performance standard continues to be a challenge for the Trust. We continue to work closely with our regulator, local and national commissioners to develop and invest in plans to improve our overall RTT compliance and elimination of 52+ week breaches. These plans link with outpatient and theatre productivity improvement programmes to maximise the use of our day case theatres and outpatient clinics in-week, as well as use day case theatres and main theatres on the Orpington site at the weekend. We have also continued to use an insourcing provider to deliver additional weekend capacity in outpatients and day case theatres, specifically in Ophthalmology and Dermatology specialties, as well as endoscopy provision.

We are working with other NHS and independent sector providers to provide additional capacity in bariatric surgery and elective Orthopaedics to reduce the number of over-52 week breach patients which was increasing during the first half of the year. The number of breaches has been reducing since September 2018. Based on our year-end position reported for 2018/19, we had 37 bariatric breach patients in 2018/19.

RTT data quality and validation has been a key area of focus for the year, and we have published a number of data quality reports within our Operational PTL (patient tracker lists) system which can be accessed by our central validation team as well as divisional PTL users. We have been recruiting additional staff to the central validation team in the latter part of the year to focus on validation of 'lost to follow-up' pathways and the closure of these pathway referrals on our Patient Administration System.

Cancer Treatment within 62 Days

Referral demand for cancer services has continued to increase in recent years including 2018/19. As a result we have not been compliant with the two week wait GP referral standard since May 2018. Performance has gradually improved in the second half of the year, driven in part by the reduction in appointment polling ranges across all tumour groups at PRUH, with service areas in Gynaecology, Head & Neck and Urology all down to 8 days.

There are a number of high impact actions which the Trust has delivered throughout the year to improve performance and data quality, not only for the two week standard but also for the 62-day time to first definitive treatment standards. These form part of a comprehensive action plan which is reviewed weekly on both acute sites.

Urology at the PRUH have moved to delivering local anaesthetic template biopsies in an outpatient setting which enables for template biopsy capacity and removes the constraints of running the service in theatres. Pathology turnaround times have been another constraint in the prostate pathway and this has been resolved by bringing reporting back in-house from the outsourcing provider.

Additional virtual clinic capacity has been put into place on the King's College Hospital site for colorectal pathways which has resulted in a circa 300 patient reduction in the patient tracker list (PTL) size.

Diagnostic Test within 6 Weeks

The Trust has not been compliant against the 99% target since December 2017, with performance worsening throughout 2018/19 due to capacity constraints and demand exceeding available capacity in a couple of diagnostic test areas.

Endoscopy demand at PRUH for both surveillance and diagnostic patients has outstripped capacity by circa 80%, as during periods where emergency demand exceeds the available acute beds within our wards, we have been forced to admit patients to planned escalation areas such as our Endoscopy Suite overnight. This has a significant impact on our ability provide our endoscopy services as planned on the PRUH site. The South East London Cancer Alliance have supported the Trust and all local partners by funding operational management at PRUH as well as additional capacity in the Endoscopy Unit at Croydon University Hospital.

Radiology continues to utilise additional capacity including the use of independent sector providers, mobile imaging scanners and by providing additional sessions in-house. PRUH and South sites have also seen an increase in non-obstetric ultrasound breaches linked to the termination of a community scanning service.

Emergency Department four-hour standard

Achievement of the Emergency Department four-hour performance standard continues to be a significant challenge among London Trusts as well as at King's, on both its King's College Hospital and PRUH sites. An overall lack of patient flow within both of our acute sites is preventing any positive impact on performance improvement.

The Trust has recognised that a culture change that achieves site-wide engagement is a key enabler for both sites with targeted actions to deliver the recovery plan that has been agreed with NHS Improvement. There are at least weekly reviews of actions through working groups on each site, with increased Board and King's Executive (KE) oversight provided through monthly Board reporting and fortnightly KE reporting on progress against our recovery plan.

In the latter half of the year, the Trust has been working with Hunter Consulting to provide additional support to the Emergency Care Recovery Programme. The focus of this work is to improve end-to-end flow and achieve sustainable results. The team from Hunter are based across both of our acute sites with dedicated support to the challenges that are faced on each site. Hunter have also reviewed the Trust's governance framework structure and recommended a new Governance Structure which has been signed off by the executive sponsor, and these arrangements have been implemented in the last quarter of 2018/19.

On the King's College Hospital site the key areas of focus for flow improvement include ED flow and escalation processes, Ambulatory Care and Front End assessment, improving site function and Operational control, and a refresh of the Ward Board round standard.

On the PRUH site the key areas of focus include ED Flow and escalation, and rollout of Board Round Standards and Content.

7-day Service Provision

NHS England's Seven Day Hospital Services aim is for patients to be able to access hospital services which meet four priority clinical standards (PCS) every day of the week:

- **PCS2 Consultant Review:** initial consultant review within 14 hours of admission
- **PCS5 Diagnostics:** Patients have access to specific diagnostic tests
- **PCS6 Interventions/Key Services:** Specific consultant directed interventions are available to patients
- **PCS8 Ongoing Review:** Patients receive ongoing daily consultant reviews.

Since April 2016 six-monthly audit of a sample of patient case notes has been undertaken to enable measurement of performance against these standards. NHS England confirms that King's is compliant with seven day services (7DS) standards in relation to Diagnostics, Interventions/Key Services and Ongoing Review.

The standard relating to time to consultant review (PCS2) has shown progressive improvement since the audit programme began in April 2016. At that survey, 64% of acute patients were reviewed by a consultant within 14 hours of admission, a figure rising to 89% in the survey conducted in April 2018, and at January 2019 is 1% off achieving the standard (unreleased data, 7DS Programme, NHS England).

Other standard and non-standard metrics relating to Trust performance of 7 day operations are regularly reviewed. There is no difference between weekday and weekend admissions in respect of mortality metrics of HMSR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-level Mortality Indicator), or risk of readmission after discharge (Standardised Readmission ratio).

The Trust is a lead participant in the national High-Intensity Specialist-Led Acute Care (HISLAC) study, an academic research project funded by the National Institute of Health Research evaluating a key component of NHS England's policy drive for 7-day services: the intensity of specialist-led care of emergency medical admissions, with a particular focus on weekend provision.

Freedom to Speak Up

The Mid Staffordshire Inquiry and subsequent Freedom to Speak Up review by Sir Robert Francis highlighted the tragic consequences for patients and their families when health staff felt unable to speak up, are victimised for doing so, or their concerns were ignored.

The Trust's Freedom to Speak up Guardians are Jen Watson (DH) and Stefan Karwatowski (PRUH) working alongside a team of nineteen ambassadors.

The Freedom to Speak Up Committee (FTSU), chaired by non-executive director Sue Slipman, meets regularly to review activity as well as strategize and drive the service. The FTSU committee includes a further three board members: Dawn Broderick, Faith Boardman and Shelley Dolan.

The National Guardian's Office published annual data in May 2018. Since inception, 7,037 concerns have been raised nationally, equating to 0.6% of the NHS workforce. Nationally, 45% of concerns were related to bullying and harassment and 32% to patient safety. At King's College Hospital NHS Foundation Trust 49% of concerns were related to bullying and harassment and 16% related to patient safety.

The Guardians are contacted directly by individuals usually via email; increasingly the ambassadors are now also being contacted. There is a specific Freedom to Speak email address and mobile number. Occasionally staff will contact the guardians and ambassadors in person.

Staff are also able to speak up/whistle-blow through the Trust line management or Human Resource structure, or staff can raise concerns externally direct with the Care Quality Commission or other organisation. King's College NHS Foundation Trust's approach is outlined in its policy.

Annex 1 - Statements from commissioners, local HealthWatch organisations and Overview and Scrutiny Committees

Commissioners' feedback:

Dear colleagues

Thank you for sending over the draft KCH Quality Account for 2018/19. I am pleased to provide a response on behalf of the commissioners.

It is apparent from reading the Quality Account that King's College Hospital NHS Foundation Trust have achieved a lot in 2018/19 which is great to see and for this to be recognised in a public document. The developments with King's Volunteers are particularly notable and the excellent participation in national clinical audits.

The commissioners agree with the priorities chosen and recognise that these cannot always be achieved in one year. The mental health priority is a good example of something which needed to run for long enough that achievements were stretching and credible. We particularly welcome the new priority regarding improving process for patients leaving hospital as this is an area which is often a cause of negative feedback from patients and clinicians alike.

It is good to see that KCH have added tangible metrics to the priorities for 2019/20 with 'SMART' measures of success. The commissioners fed back that this was not the case in 2018/19 and it has meant it was difficult to track progress – and it would also have been difficult for KCH to be aware of and acknowledge where priorities were off target needing re-direction, so the addition of metrics is welcomed.

In lieu of SMART metrics for 2018/19 a little more information about what has changed and the impact, rather than descriptions of what has been done would be useful. It would also be useful for readers to have more information about the priorities which were partly-achieved - regarding what elements were not achieved - particularly the impact of that and any learning that can be gleaned to avoid this happening in the future. It would also be helpful for readers to understand if each priority and metric is Trust-wide or site specific as sometimes the narrative from 2018/19 is not very clear.

The Commissioners would like to note the productive discussions which take place at the monthly CQRG (clinical quality review group) and expect to track progress of these priorities at those meetings. The regular, senior level attendance of KCH directors contributes to the culture of open and honest discussion at CQRG.

In summary the commissioners are pleased to support KCH in working to maintain quality and congratulate the Trust on maintaining quality and safety in very challenging times.

Dr Noel Baxter
Chair of KCH CQRG
On behalf of commissioners

Healthwatch Southwark's response to King's College Hospital NHS Foundation Trust's 2018/19 Quality Accounts

Healthwatch Southwark thanks the Trust for the opportunity to comment on these Quality Accounts.

Especially given the current CQC 'Requires Improvement' rating in place and the considerable financial pressure under which the Trust is operating, we are pleased to note the progress made on a broad range of patient centric quality improvement initiatives.

Healthwatch Southwark participated in a well-attended public engagement event held prior to finalising the new quality priorities. We are pleased to see that the priorities now set were all championed by attendees at this event.

Priorities which have not been carried into 2019/20

It is commendable that Priority 2 (improved outcomes in **hip replacements**) and Priority 3 (improved outcomes in **heart failure**) have both been achieved. It would be informative to outline the changes to the hip replacement pathway now in progress.

The partially achieved status on Priority 6 (**sepsis**) and Priority 7 (**falls in hospital**) is noted.

Priorities carried into 2019/20

Whilst still work in progress, the focus on improving the **experience of patients with cancer** and their families (Priority 5), and partnership with Macmillan, are welcomed. The attention to patient engagement and the goal of increasing holistic needs assessments are particularly positive.

We are impressed by many developments under Priority 1 to **join up physical and mental health care**, particularly in training over 2,500 staff, increasing mental health screening activities, increasing specialist mental health support in a variety of services, and strengthening partnership working. This priority fits well with Healthwatch Southwark's ongoing priority work around mental health.

We also note the progress made on Priority 4, **improving outpatient experience**. These initiatives may well help to mitigate issues that have been reported to us by local residents. Efforts to reduce DNAs may also help to ease fundamental pressures on the system.

New priorities in 2019/20

We look forward to seeing improvements in **discharge planning and follow-up**, where better communication, patient involvement in decision making, and keeping patients well once home, have the potential to dramatically improve outcomes. This has been an area of focus for local Healthwatch for several years, through our work with older people seen in the Emergency Department, looking at discharge to a step-down unit, and work on reablement services.

Other activities

Prioritising the Freedom to Speak Up, training and education opportunities, equality and retention initiatives, notably the introduction of the 'King's Stars' awards for outstanding achievement, are all valuable investments in developing a workforce that will sustain the Trust in future.

We are delighted by the growth of the King's Volunteers programme. This represents an important way to engage local residents from diverse backgrounds (and particularly younger volunteers) in the Trust's services, as well as provide more personal support to patients.

Fundamental challenges for the Trust

We acknowledge that the Trust is under strain from many external factors, such as large numbers of elderly emergency department and inpatient admissions, and an increase in demand on cancer services. Nonetheless, we register significant concern at the lack of material improvement in meeting important performance standards for accessing treatment services, including referral to treatment (RTT) within 18 weeks, cancer treatment within 62 days, diagnostic tests within 6 weeks and the emergency department four-hour standard. We also note further capacity concerns raised in audits listed on p38.

We hope that the extensive suite of process improvements in progress will have a positive impact on waiting times. We will launch our own 'Referral to Treatment Times' priority work in Southwark later this year.

Data presentation

We found this year's report clearer than last year's. It is difficult to comment in full on some metrics before national data is available. In several places it would be helpful to include baseline/current figures in order to assess progress and ambition. In order to improve accessibility to the lay reader, we suggest colour coding some tables to indicate performance, and clarity on whether high or low scores are positive.

Patient engagement

Healthwatch Southwark appreciates the Trust's efforts to include us in their public engagement activities and we value our quarterly meetings with the KCH Engagement Team. We look forward to seeing the Trust progress in all its quality priorities this year.

Healthwatch Southwark

17 April, 2019

Healthwatch Lambeth response to King's College Hospital NHS Foundation Trust's 2018/19 Quality Accounts

We welcome the opportunity to give a statement on the 2018/19 Quality Accounts and acknowledge our good working relationship with KCH Trust in engaging patients and using their views to improve services.

We congratulate the Trust on its rating as the best nationally for discharge planning for patients with dementia and welcome the Trust's decision to make discharge information one of its quality improvement priorities for 19/20. We are keen to work with the Trust on this agenda, building on intelligence from our previous transfer of care work and our current audit of sample discharge information from King's and GSTT (at April 19). We welcome the inclusion of the Red Bag initiative for care home residents in the work programme for this priority area, and would be keen for the opportunity to take another look at it with the Trust, following the apparent low take up of the scheme when we assisted the Health Innovation Network with an early programme evaluation in summer 2018.

We welcome the emphasis placed on patient-oriented outcomes to measure improvements in hip replacements over the past year, and that intelligence from this project will be used to improve patient information.

We are pleased to hear that the Trust has been working with local GPs on improving testing for heart failure and that collaboration with the @home service is enabling some patients to avoid hospital admission. We hope to see the falls awareness teaching approach at the PRUH rolled out to the DH site. (p17)

However, we were disappointed that the Local Care Network partners involved in the local care coordination programme (local CCG CQUIN) were unable to develop an effective support offer to people with several long-term conditions in Southwark and Lambeth to enable them to better manage their own wellbeing and experience more joined up care. However, we support the decision to halt the scheme in its current form and to explore alternative models for tackling the fragmentation of care through the new Primary Care Networks. (p49).

We also acknowledge that KCH Trust provided platform for us to discuss and consider patients' feedback, such as the following:

- Enter and View at the Paediatric A and E by 15 young people. The Trust has welcomed the report and responded to the recommendations from that visit. The Trust also showed commitment by way of a forward plan to address the recommendations and more importantly, continue to involve young people in on how to best make the hospital more youth-friendly.
- Accessible Information Policy. We acknowledge that KCH Trust is improving on making information accessible to its patients. We are particularly enthused with our participation in the Accessible Information Working Group and the opportunity to speak to some of the staff on its current practice on information accessibility.
- Information and signposting. The Trust received a report from us on patients views of its services. We were pleased that the report was discussed at the patient engagement committee and how much they welcomed the feedback. This showed their commitment in making changes to ensure that the patients have better experience of care.

We are supportive of the ambitions of the King's Health Partners' Mind and Body programme to improve the holistic care and support individuals receive. We welcome the continued priority being given to improving the care of people with mental, as well as physical, health needs and the initiatives being undertaken to identify people with mental health needs. However, so far this has not always been reflected in improved patient

experience. For example there has been a decline in patient experience (reference: National In Patient Scores 2017) particularly patients' needs for help and support to cope.

In this context, we are pleased that KCH wishes to partner with us on a new project aimed at better meeting the needs of inpatients with mental health needs and staff, on a sample of adult inpatient wards. The project will make links to the programme of developing a coordinated 'training offer' to ward staff on mental health, working closely with the Mind and Body programme and the new KCH mental health lead nurse. We will identify the information and advice patients/carers would benefit from while in hospital and during discharge; help staff to better identify in-patients with emotional or mental health needs; build stronger links between local voluntary sector mental health groups and in patient wards; test options for in-reach support onto the wards; and better signpost and connect people who also have mental health needs to the right support and help for them in the community.

We continue to commit to the same principles for better experience of patient care that KCH espouses and look forward to working with them in 2019/20.

Catherine Pearson

Chief Executive

Healthwatch Lambeth

Healthwatch Bromley response to King's College Hospital NHS Foundation Trust's 2018/19 Quality Accounts

Firstly we are pleased to note the achievements for 2018/19 for the Trust that have included lower than expected mortality in high-risk specialties, including liver, critical care, paediatric intensive care, renal replacement therapy and stroke, and around half the national average mortality for our emergency laparotomy surgery and that major trauma outcomes are the best nationally for the trauma network.

We note that King's was rated as the best of 195 hospitals nationally for discharge planning for patients with dementia and that the Trust performed better than London and national average for key outcomes indicators relating to the care of women with diabetes who are pregnant, including large babies, pre-term deliveries & pre-pregnancy care.

Quality priorities for 2018/19

We are pleased to note that the priority outcomes of people with mental, as well as physical health needs, outcomes for people having primary hip replacement and improving outcomes for people with heart failure have all been achieved.

We are pleased to see that progress is being made and that the priority outcomes of outpatient experience and improving the experience of patients with cancer and their families have been partially achieved and that work is still on-going in these areas. We note that the two priority outcomes of implementation of sepsis bundles and reducing harms to patients due to falls in hospital have been partially achieved and look forward to further progress in these areas, falls particularly is a challenge nationally and we would welcome feedback on this.

Quality priorities for 2019/20

Whereas it is pleasing to see the Trust held an engagement event for patients, the public, the voluntary sector and Trust members to showcase progress on their 2018-19 quality priorities and to ask for suggestions for quality priorities for 2019/20, greater feedback and more involvement would be most welcome. Furthermore it is important to note some key themes identified from Healthwatch Bromley Patient Experience feedback which highlights some areas of positive reviews on the PRUH quality of treatment and staff attitude. However some areas of improvements are required around waiting times for assessment and treatment and on staff communication and appointments.

It is very positive to note the Trusts continuing commitment to mental health, cancer and outpatients and additional commitment to improving communication and information for patients leaving hospital as effective discharge is key to prevention and better wellbeing.

Overview and Scrutiny Committee, London Borough of Lambeth, feedback:

Lambeth Council's Overview and Scrutiny Committee would like to thank King's College Hospital NHS Foundation Trust for the invitation to submit a statement on the Trust's draft Quality Account 2018/19. It has not been possible to formally consider the draft QA within the timeline requested and the Committee is not therefore submitting a response. However the Committee would wish to acknowledge that a positive working relationship exists between OSC and the Foundation Trust.

Overview and Scrutiny Committee, London Borough of Southwark, feedback:

No reply received.

Overview and Scrutiny Committee, London Borough of Bromley, feedback:

No reply received.

Lambeth, Southwark and Bromley Overview and Scrutiny Committees were sent the draft Quality Account on 29/03/2019 and asked to feedback by 23/04/2019 in order to meet the external Quality Accounts deadline. Comments were accepted until 09/05/2019.

Trust Governors, feedback:

The Trust Governors provided detailed feedback. This has been collated, acted upon, incorporated within the Quality Account as appropriate and a record held for reference.

Annex 2 - Statement of Directors' Responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

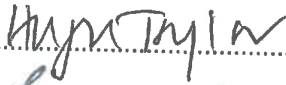
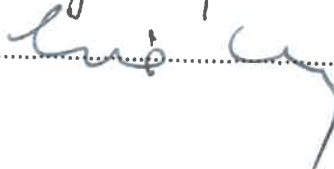
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance, detailed requirements for quality reports 2018/19.
- the content of the Quality Report is consistent with internal and external sources of information including:
 - board minutes and papers for the period April 2018 to 31 May 2019
 - papers relating to quality reported to the board over the period April 2018 to 31 May 2019
 - feedback from commissioners dated 25/04/2019
 - feedback from governors dated 11/04/2019
 - feedback from local Healthwatch organisations dated 25/04/2019 (Southwark), 30/04/2019 (Bromley) and 02/05/2019 (Lambeth)
 - feedback from Overview and Scrutiny Committee dated 23/04/2019 (Lambeth), feedback not received from Southwark and Bromley
 - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 21/05/2019
 - the national patient survey May 2018
 - the national staff survey February 2019
 - the Head of Internal Audit's annual opinion of the trust's control environment dated 30/05/2019
 - CQC inspection report dated 31/01/2018.
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered.
- the performance information reported in the Quality Report is reliable and accurate.
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

30.5.19 Date..........Chairman
16/6/19 Date..........Chief Executive

Independent auditor's report to the council of governors of King's College Hospital NHS Foundation Trust on the quality report

We have been engaged by the council of governors of King's College Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of King's College Hospital NHS Foundation Trust's quality report for the year ended 31 March 2019 (the 'quality report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of King's College Hospital NHS Foundation Trust as a body, to assist the council of governors in reporting King's College Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and King's College Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers, reported in accordance with official performance statistics based on 50:50 breach allocation rules.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in the detailed guidance; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the specified documents in the detailed guidance.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by King's College Hospital NHS Foundation Trust.

Basis for qualified conclusion***Percentage of patients with total time in A&E of four hours or less from arrival to admission, transfer or discharge***

The "percentage of patients with total time in A&E of four hours or less from arrival to admission, transfer or discharge" indicator requires that the NHS Foundation Trust accurately records the start and end times of each patient's wait in A&E, in accordance with detailed requirements set out in the national guidance. This is calculated as a percentage of the total number of unplanned attendances at A&E for which patients' total time in A&E from arrival is four hours or less until admission, transfer or discharge as an inpatient.

Our procedures included testing a risk based sample of 22 items, and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

We identified the following errors:

- In 2 cases of our sample of patients' records tested, the start or end time of treatment was not accurately recorded affecting the calculation of the published indicator; and
- In 8 cases of our sample of patients' records tested, the start or end time of treatment was not accurately recorded, but did not affect the calculation of the published indicator;

As a result of the issues identified, we have concluded that there are errors in the calculation of the "percentage of patients with total time in A&E of four hours or less from arrival to admission, transfer or discharge" indicator for the year ended 31 March 2019. We are unable to quantify the effect of these errors on the reported indicator.

In addition, we identified:

- In 7 cases of our sample of patients' records tested, we were unable to obtain sufficient supporting evidence to confirm the details necessary to test the calculation of the published indicator.

As a result there is a limitation in the scope of our procedures which means we are unable to complete our testing and are unable to determine whether the indicator has been prepared in accordance with the criteria for reporting "percentage of patients with total time in A&E of four hours or less from arrival to admission, transfer or discharge" indicator for the year ended 31 March 2019.

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers, reported in accordance with official performance statistics based on 50:50 breach allocation rules

The "Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers, reported in accordance with official performance statistics based on 50:50 breach allocation rules" indicator requires that the NHS Foundation Trust accurately record the start and end dates of each patient's treatment pathway, in accordance with detailed requirements set out in the national guidance. This is calculated as a percentage of the total number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers.

Our procedures included testing a risk based sample of 22 items, and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

We identified the following errors:

- In 1 case of our sample of patients' records tested, the duration of a clock pause was not accurately recorded affecting the calculation of the published indicator; and
- In 2 cases of our sample of patients' records tested, the end date of the pathway was not accurately recorded, but did not affect the calculation of the published indicator.

As a result of the issues identified, we have concluded that there are errors in the calculation of the "Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers, reported in accordance with official performance statistics based on 50:50 breach allocation rules" indicator for the year ended 31 March 2019. We are unable to quantify the effect of these errors on the reported indicator.

In addition, we identified:

- In 4 cases of our sample of patients' records tested, we were unable to obtain sufficient supporting evidence to confirm the details necessary to test the calculation of the published indicator.

As a result there is a limitation in the scope of our procedures which means we are unable to complete our testing and are unable to determine whether the indicator has been prepared in accordance with the criteria for reporting "Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers, reported in accordance with official performance statistics based on 50:50 breach allocation rules" indicator for the year ended 31 March 2019.

Qualified Conclusion

Based on the results of our procedures, except for the matters set out in the basis for qualified conclusion section of our report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in the detailed guidance; and

- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.

A handwritten signature in black ink, appearing to read 'Deloitte LLP', is positioned above the printed text.

Deloitte LLP
St Albans
11 June 2019

ANNUAL ACCOUNTS 2018/19

*INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND
BOARD OF DIRECTORS OF KING'S COLLEGE HOSPITAL NHS FOUNDATION
TRUST*

Report on the audit of the financial statements



INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of King's College Hospital NHS Foundation Trust (the 'foundation trust') and its subsidiaries (the 'group'):

- **give a true and fair view of the state of the group's and foundation trust's affairs as at 31 March 2019 and of the group's and foundation trust's income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

We have audited the financial statements which comprise:

- the consolidated statement of comprehensive income;
- the group and foundation trust statements of financial position;
- the group and foundation trust statements of changes in taxpayers' equity;
- the group and foundation trust statements of cash flow; and
- the related notes 1 to 29.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Material uncertainty relating to going concern

We draw attention to note 1.27 in the financial statements, which indicates that the Group:

- Has a planned deficit before impairments and capital grants and donations of approximately £133m for 2019/20;
- Has a cost improvement plan of £60m for 2019/20;
- Has accepted its control total and has been allocated provider sustainability and financial recovery funding totaling £35m;
- Has prepared cash flow forecasts that show a minimum level of headroom of £3 million throughout 2019/20;
- Has assumed it will receive additional loans of £133 million, which have not yet been committed by the lender, to meet a revenue funding gap in 2018/19;
- Is working with NHSI to secure additional distressed capital resource of £26m; and
- Has significant existing loan arrangements falling due within the next 12 months including a term loan of £99m which falls due in November 2019 and revolving credit facility of £90m which matures in April 2020.

The foundation trust has identified that additional funding is required before the end of 2019/20 to support the foundation trust in meeting its liabilities which is yet to be formally agreed. Without additional funding, the Group will have insufficient working capital to meet its liabilities as they fall due.

In response to this, we:

- reviewed the Group's financial performance in 2018/19 including its achievement of planned cost improvements in the year;
- held discussions with management to understand the funding arrangements that have been agreed, confirming to signed loan agreements, and regarding management's expectation around further funding requirements;
- reviewed the Group's cash flow forecasts and the Group's financial plan submitted to NHS Improvement;
- challenged the key assumptions used in the cash flow forecasts by reference to NHS Improvement guidance; and
- considered the consistency and historical accuracy of the budgeting process used by the Group.

As stated in note 1.27, these events or conditions indicate that a material uncertainty exists that may cast significant doubt on the Group's and the foundation trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Summary of our audit approach

Key audit matters	The key audit matters that we identified in the current year were: • Recognition of NHS revenue; • Property valuations; • Going concern (see 'material uncertainty relating to going concern' section); • Management override of controls; and • Arrangements to secure value for money (see matters on which we are required to report by exception – use of resources section). Within this report, any new key audit matters are identified with  and any key audit matters which are the same as the prior year identified with .
Materiality	The materiality that we used for the group financial statements was £11.6m which was determined on the basis of 1% of revenue.
Scoping	Our group audit was scoped by obtaining an understanding of the group and its environment, including internal controls, and assessing the risks of material misstatement at the group level. Audit work was performed at the group's head offices in Denmark Hill directly by the audit engagement team, led by the engagement lead. We performed a fully substantive audit on the foundation trust and one of the foundation trust's subsidiaries, KCH Interventional Facilities Management LLP, which together account for over 99% of the revenue of the group.
Significant changes in our approach	We identified appropriate capitalisation of expenditure as a key audit matter for 2017/18. Due to the reduction in the size of the foundation trust's capital program which was £35m in 2018/19 compared to £55m in 2017/18, we did not identify capital expenditure as a key audit matter for 2018/19.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit

strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to the matters described in the 'material uncertainty relating to going concern' section and the 'matters on which we are required to report by exception – use of resources' section, we have determined the matters described below to be the key audit matters to be communicated in our report.

Recognition of NHS revenue

Key audit matter description



As described in note 1.7 and note 1.28, there are significant judgements in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to the judgemental nature of provisions for disputes, including in respect of outstanding overperformance and non-contracted income for quarters 3 and 4.

Details of the Group's income, including £983m of Commissioner Requested Services, are shown in note 2 to the financial statements. NHS debtors are shown in note 13 to the financial statements.

The Group earns revenue from a wide range of commissioners, increasing the complexity of agreeing a final year-end position. The settlement of income with Clinical Commissioning Groups continues to present challenges, leading to disputes and delays in the agreement of year end positions.

How the scope of our audit responded to the key audit matter



We evaluated the design and implementation of controls over recognition of NHS income.

We performed detailed substantive testing on a sample basis of the recoverability of unsettled revenue amounts, and evaluated the results of the agreement of balances exercise.

We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners.

Key observations



We concluded that NHS revenue and provisions were within an acceptable range.

Our evaluation of the design and implementation of controls identified weaknesses.

Property valuations

Key audit matter description



The Group holds property assets within Property, Plant and Equipment at a modern equivalent use valuation of £467m. The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value.

The net valuation movement on the Group's estate shown in note 10 is a

	net gain on revaluation of £16m and notes 1.12 and note 7 provide more information about the valuation basis.
How the scope of our audit responded to the key audit matter 	We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the foundation trust to the valuer. We used Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Group's properties. We challenged the Group's assumption that an alternative, lower value, site could be used in calculating a Modern Equivalent Asset value by critically evaluating whether the alternatives considered would be viable given the nature of the foundation trust's activities. We have reviewed the disclosures in notes 1.12 and 7 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation. We considered the impact of uncertainties relating to the UK's exit from the EU upon property valuations in evaluating the property valuations and related disclosures. We assessed whether the valuation and the accounting treatment of the impairment were compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.
Key observations 	We have concluded the Group's valuation assumptions fall within the expected range highlighted by Deloitte internal valuation specialists. Our evaluation of the design and implementation of controls identified weaknesses.
Management override of controls 	
Key audit matter description 	We consider that in the current year there continues to be a heightened risk across the NHS that management may override controls to fraudulently manipulate the financial statements or accounting judgements or estimates. This is due to the increasingly challenging financial circumstances of the NHS and close scrutiny of the reported financial performance of individual organisations. The areas of judgement which are more susceptible to management override include accruals, deferred income, accrued income, provisions, impairment allowances, property valuations, and useful economic lives of assets. Details of critical accounting judgements and key sources of estimation uncertainty are included in note 1.28.
How the scope of our audit responded to the key audit matter 	Manipulation of accounting estimates Our work on accounting estimates included considering areas of judgement including deferred income, partially completed patient spells, bad debt provisions, property valuations, and useful economic lives of assets. We have considered both the individual judgements and their impact individually and in aggregate upon the financial statements. In testing each of the relevant accounting estimates, engagement team members were directed to consider their findings in the context of the identified fraud risk. Where relevant, the recognition and valuation criteria used were compared to the specific requirements of IFRS.

We tested accounting estimates (including in respect of NHS revenue and provisions and property valuations discussed above), focusing on the areas of greatest judgement and value. Our procedures included comparing amounts recorded or inputs to estimates to relevant supporting information from third party sources.

We evaluated the rationale for recognising or not recognising balances in the financial statements and the estimation techniques used in calculations, and considered whether these were in accordance with accounting requirements and were appropriate in the circumstances of the Group.

Manipulation of journal entries

We used data analytic techniques to select journals for testing with characteristics indicative of potential manipulation of reporting focusing in particular upon manual journals.

We traced the journals to supporting documentation, considered whether they had been appropriately approved and evaluated the accounting rationale for the posting. We evaluated individually and in aggregate whether the journals tested were indicative of fraud or bias.

We tested the year-end adjustments made outside of the accounting system between the general ledger and the financial statements and consolidation adjustments and journals.

Accounting for significant or unusual transactions

We considered whether any transactions identified in the year required specific consideration and did not identify any requiring additional procedures to address this key audit matter.

Key observations



We agreed with management that the treatment of the accounting estimates, journal entries and significant or unusual transactions is appropriate.

Our evaluation of the design and implementation of controls identified weaknesses.

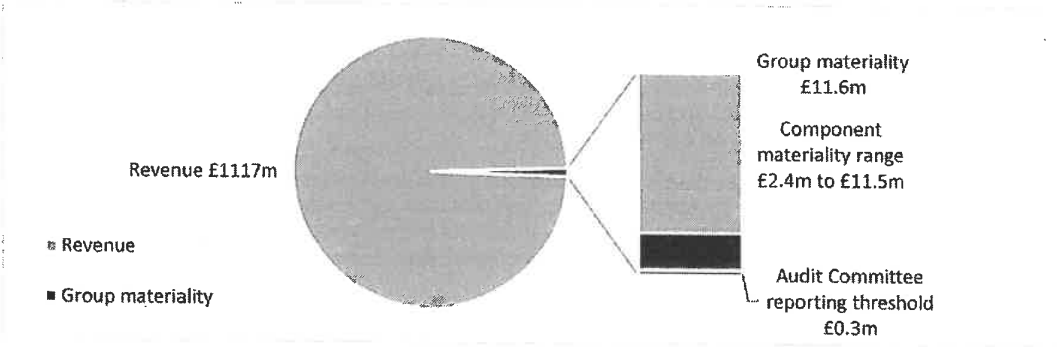
Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

	Group financial statements	Foundation trust financial statements
Materiality	£11.6 million (2018: £11.2 million)	£11.5 million (2018: £11.1 million)
Basis for determining materiality	1% of revenue (2018: 1% of revenue)	1% of revenue (2018: 1% of revenue)

Rationale for the benchmark applied	Revenue was chosen as a benchmark as the foundation trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.	Revenue was chosen as a benchmark as the foundation trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.
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We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £300,000 (2018: £223,000), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our group audit was scoped by obtaining an understanding of the group and its environment, including internal controls, and assessing the risks of material misstatement at the group level. Audit work was performed at the group's head offices in Denmark Hill directly by the audit engagement team, led by the engagement lead.

We performed full scope audit procedures on the foundation trust and one of the foundation trust's subsidiaries, KCH Interventional Facilities Management LLP, which together account for over 99% of the revenue of the group.

Our audit work was executed at the level of materiality determined on an entity by entity basis, all of which were lower than group materiality.

At the group level we also tested the consolidation process and carried out analytical procedures to confirm our conclusion that there were no significant risks of material misstatement of the aggregated financial information of the remaining components not subject to audit or audit of specified account balances.

The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and information technology systems.

Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon.

We have nothing to report in respect of these matters.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

Responsibilities of accounting officer

As explained more fully in the accounting officer's responsibilities statement, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the foundation trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the group or the foundation trust or to cease operations, or has no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources

We are required to report to you if, in our opinion the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Basis for adverse conclusion

- There are weaknesses in the Trust's arrangements for agreeing, monitoring and recording of contracts with third parties. The Annual Governance Statement describes the action which the Trust has taken during the year to prepare a comprehensive contract register as a basis for improving management of its contracts and procurement activity. These improvements to arrangements did not operate throughout the financial year.

This issue is evidence of weaknesses in proper arrangements for commissioning services and procuring supplies effectively to support the delivery of strategic priorities.

- NHSI accepted updated enforcement undertakings from the Trust in September 2018 as it stated it had reasonable grounds for suspecting that the Trust was providing healthcare services for the purpose of the NHS in breach of its license conditions, in particular because of:
 - the Trust's financial position and performance;
 - the governance issues identified by the Care Quality Commission (CQC) in their January 2018 report and others;
 - and the Trust's performance against access standards for A&E 4 hour waits and Referral to Treatment 18 week and number of patients who had waited more than 52 weeks.

The Trust was inspected by the CQC with its report being issued in January 2018. The report concludes that overall the Trust 'Requires improvement' and identifies weaknesses in governance arrangements.

These issues are evidence of weaknesses in proper arrangements for acting in the public interest, through demonstrating and applying the principles and values of sound governance.

- A number of significant financial reporting control weaknesses were identified through our audit of the 2018/19 financial statements of the Trust relating to the ability of the Trust to produce reliable financial reporting securely within the timetable set by NHSI.

This issue is evidence of weaknesses in the Trust's arrangements in respect of producing reliable and timely financial reporting that supports the delivery of strategic priorities.

- In our "Limited assurance report on the content of the quality report and mandated performance indicators", we issued a qualified conclusion because of errors identified in the calculation of the 62 day cancer and Accident and Emergency 4 hour wait performance indicators.
- Internal audit identified improvement requirements in relation to performance information; in particular, the Trust has not established minimum requirements which apply to all Trust systems and the quality of data within them.
- Weaknesses identified in 2017/18 in the capture, analysis and reporting of activity data used for contracting and billing purposes and in the evaluation of local pricing decisions and other contract terms have impacted on the amount of income earned by the Trust in 2018/19.

These issues are evidence of weaknesses in proper arrangements for understanding and using appropriate and reliable financial and performance information to support informed decision making and performance management.

- The Trust incurred a deficit of £178m for the year ended 31 March 2019. The Trust's deficit before impairments, capital donations and grants and provider sustainability funding was £190m. This is £44m higher than the Trust's 2018/19 plan.

-
- The Trust's Annual Governance Statement describes weaknesses in financial planning, budgetary control and financial recovery governance and control arrangements identified through the work of the Trust's internal auditor.
 - The foundation trust's 2019/20 plan submission in March 2019 shows a forecast deficit before impairments, capital donations and grants and provider sustainability funding of £170m for 2019/20.
 - In order to fund the deficit in 2018/19, the Trust received additional financial support in 2018/19 from the Department of Health and Social Care of £146m and is seeking additional revenue financial support in 2019/20 of £133m and capital financial support of £26m from the same source, as well as seeking the extension of a term loan of £99m which is due for repayment in November 2019 and revolving credit facility of £90m which matures in April 2020. There were weaknesses in financial planning and budgetary control identified through the work of the Trust's internal auditor.
 - In 2016/17, an independent report was provided to the Trust that estimated the Trust's backlog maintenance costs to be approximately £200m, excluding costs in respect of equipment. The Trust now estimates this cost to be well in excess of £200m. The Trust does not have an up-to-date estates strategy and is substantially reliant on additional loan funding, agreed annually, to meet the cost of capital works. These matters expose the Trust to significant risks related to the age and condition of the estate that could impact levels of service provision.

These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

- Internal audit and other reports issued in 2017/18 and 2018/19 identified weaknesses in governance, financial control and contracting arrangements in relation to commercial activities carried out by subsidiary entities. Issues included weaknesses in arrangements for membership of the KCH Interventional Facilities Management LLP ("KIFM") Management Board, failure to update contract documentation to reflect activities carried out by KIFM and performance of regular reconciliations of all intercompany balances. Actions taken to address these weaknesses were not in place for some or all of the year.
- The Annual Governance Statement reports on the changes the Trust has made to address weaknesses in its controls over the development and scrutiny of business cases. These improvements were not in place for the full financial year.
- The opinion of the Trust's Head of Internal Audit is that only 'partial assurance with improvements required' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control and the Annual Governance Statement describes the weaknesses in control identified from his 2018/19 audit plan which have contributed to this opinion, including financial planning and budget monitoring processes, capital expenditure management, agency cap compliance, responding to GDPR, information governance self assessment, quality of performance reporting, governance and controls over financial recovery, management of capital projects and divisional risk management.

These issues provide evidence of weaknesses in proper arrangements for managing risks effectively and maintaining a sound system of internal control.

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in December 2017, we are not satisfied that, in all significant respects, King's College Hospital NHS Foundation Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Annual Governance Statement and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of King's College Hospital NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the foundation trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.



Jonathan Gooding, FCA (Senior statutory auditor)
for and on behalf of Deloitte LLP
Statutory Auditor
St Albans, United Kingdom
11 June 2019

Trust Accounts Consolidation (TAC) Summarisation Schedules for King's College Hospital NHS Foundation Trust

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2018/19 are attached.

Finance Director Certificate

1. I certify that the attached TAC schedules have been compiled and are in accordance with:
 - the financial records maintained by the NHS Foundation Trust
 - accounting standards and policies which comply with the Group Accounting Manual issued by the Department of Health and Social Care and
 - the template accounting policies for NHS Foundation Trusts issued by NHS Improvement, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.
2. I certify that the TAC schedules are internally consistent and that there are no validation errors.
3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Foundation Trust.

Lorcan Woods

Lorcan Woods
Chief Finance Officer
Date *10/6/19*

Chief Executive Certificate

1. I acknowledge the attached TAC schedules, which have been prepared and certified by the Finance Director, as the TAC schedules which the Foundation Trust is required to submit to NHS Improvement.
2. I have reviewed the schedules and agree the statements made by the Chief Finance Officer above.

Clive Kay

Dr Clive Kay
Chief Executive
Date *11/6/19*



Annual Accounts
for the year ended 31 March 2019

King's College Hospital NHS Foundation Trust

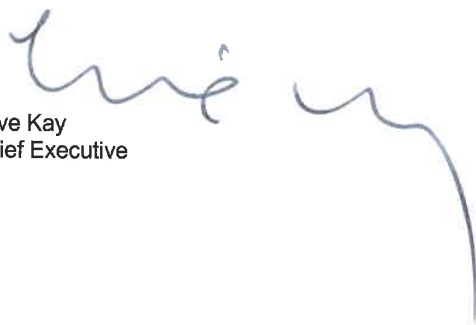
FOREWORD TO THE ACCOUNTS

King's College Hospital NHS Foundation Trust

These accounts, for the year ending 31 March 2019, 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 and comply with the guidance for NHS Foundation Trusts within the Department of Health Group Accounting Manual.

Signed:

Clive Kay
Chief Executive

A handwritten signature in blue ink, appearing to read 'Clive Kay', with a long, sweeping underline that extends to the right.

Date: **11 June 2019**

King's College Hospital NHS Foundation Trust

Statement of the 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 the 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 *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require King's College Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. 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.

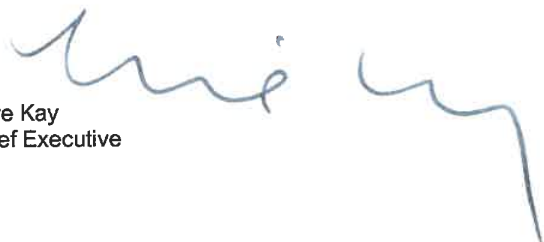
In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, 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 (and the Department of Health Group Accounting Manual)* have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy 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 the NHS Foundation Trust Accounting Officer Memorandum.

Signed:



Clive Kay
Chief Executive

Date: 11 June 2019

King's College Hospital NHS Foundation Trust

Consolidated Statement of Comprehensive Income for year ended 31 March 2019

	Note	Group	
		2018-19	2017-18
		£000	£000
Operating income from patient care activities	2	1,005,197	1,004,454
Other operating income	2	111,863	111,345
Total operating income from continuing operations		1,117,060	1,115,799
Operating expenses	3	(1,253,576)	(1,222,151)
Operating deficit from continuing operations		(136,516)	(106,352)
Finance income and costs			
Finance income	5	442	164
Finance expenses	6	(42,851)	(34,982)
Public Dividend Capital dividends payable		-	-
Net finance costs		(42,409)	(34,818)
Other gains	8	185	187
Share of profit of associates and joint ventures	8	1,126	(1,268)
Corporation tax expense		-	-
Deficit from continuing operations		(177,614)	(142,251)
Surplus of discontinued operations and the gain on disposal of discontinued operations		-	-
Deficit for the year		(177,614)	(142,251)
Other comprehensive income/(expense), that will not be reclassified subsequently to income and expenditure			
Impairments	7	(1,121)	(10,464)
Revaluations	22	17,442	4,102
Fair value gains/(losses) on equity instruments designated at FV through OCI		1,344	-
Other reserve movements		-	(435)
Total other comprehensive income/(expenditure)		17,665	(6,797)
Total comprehensive expense for the year		(159,949)	(149,048)
Allocation of losses for the year			
Deficit for the year attributable to:			
(i) non-controlling interest; and		-	-
(ii) owners of the parent		(177,614)	(142,251)
Total		(177,614)	(142,251)
Total comprehensive expense for the year attributable to:			
(i) non-controlling interest; and		-	-
(ii) owners of the parent		(159,949)	(149,048)
Total		(159,949)	(149,048)

King's College Hospital NHS Foundation Trust

**Consolidated Statement of Comprehensive Income for year ended 31 March 2019
(continued)**

		Group	
	Note	2018-19	2017-18
		£000	£000
Note to Statement of Comprehensive Income			
Total comprehensive expense for the year		(159,949)	(149,048)
Plus other comprehensive (expense)/income		(17,665)	6,797
Deficit for the year		(177,614)	(142,251)
Add back impairments and reversal of impairments *	3	(198)	4,617
Remove capital donations / grants I&E impact		(2,274)	(1,318)
Adjusted financial performance including PSF		(180,086)	(138,952)
Less provider sustainability fund (PSF)		(9,677)	0
Adjusted financial performance excluding PSF		(189,763)	(138,952)

The Adjusted financial performance excluding PSF is the primary view which is used by the Board of Directors to monitor the Trust's financial performance and is in line with NHSI's financial performance control total.

** This is the total impairments and impairment reversals charged to the Consolidated Statement of Comprehensive Income in the year as disclosed in note 3.1 and note 7.*

The Group's deficit for the year was £177.6m and this figure includes the reversal of asset impairments of £0.198m. This charge relates to impairments that arise from a clear consumption of economic benefits or service potential in the asset. The NHS Improvement (NHSI) financial performance control total measures the surplus/(deficit) before impairments and transfers. The Group's consolidated adjusted financial performance deficit for the year was £180.1m.

The Trust has taken advantage of the exception afforded by the Companies Act to omit the unconsolidated Foundation Trust Statement of Comprehensive Income. The unconsolidated deficit relating to the Foundation Trust for the year ended 31 March 2019 is £175.0m (2018: £139.614m) and total operating income for the year is £1,156,994m (2018: £1,115.954m).

King's College Hospital NHS Foundation Trust

Statements of Financial Position as at 31 March 2019

	Note	Group		Trust	
		31 March 2019	31 March 2018	31 March 2019	31 March 2018
		£000	£000	£000	£000
Non-current assets					
Intangible assets	9	8,578	8,400	8,365	8,123
Property, plant and equipment	10	603,630	577,008	603,630	569,369
Investment in associates and joint ventures	11	4,175	3,049	250	250
Other investments	11	2,025	335	335	335
Receivables	13	11,605	13,011	46,063	18,590
Total non-current assets		630,013	601,803	658,643	596,667
Current assets					
Inventories	12	18,302	16,053	6,987	7,713
Receivables	13	111,736	134,639	148,762	162,827
Non-current assets for sale and assets in disposal groups	11	387	600	387	600
Cash and cash equivalents	14	45,771	54,386	39,217	50,525
Total current assets		176,196	205,678	195,353	221,665
Total assets		806,209	807,481	853,996	818,332
Current liabilities					
Trade and other payables	15	(162,053)	(148,858)	(194,066)	(161,365)
Borrowings	17	(195,375)	(112,779)	(199,041)	(112,581)
Provisions	19	(2,640)	(2,336)	(2,624)	(2,266)
Other liabilities	16	(13,541)	(9,627)	(13,541)	(9,627)
Total current liabilities		(373,609)	(273,600)	(409,272)	(285,839)
Net current liabilities		(197,413)	(67,922)	(213,919)	(64,174)
Total assets less current liabilities		432,600	533,881	444,724	532,493
Non-current liabilities					
Borrowings	17	(607,766)	(552,104)	(619,068)	(551,149)
Provisions	19	(4,233)	(5,171)	(4,233)	(5,171)
Total non-current liabilities		(611,999)	(557,275)	(623,301)	(556,320)
Total liabilities employed		(179,400)	(23,394)	(178,578)	(23,827)
Financed by:					
Taxpayers' equity					
Public Dividend Capital		230,136	226,194	230,136	226,194
Revaluation reserve	22	109,168	92,847	109,168	92,847
Financial assets at FV through Other Comprehensive Income reserve		1,344	-	-	-
Income and expenditure reserve		(520,048)	(342,435)	(517,882)	(342,868)
Total taxpayers' equity		(179,400)	(23,394)	(178,578)	(23,827)

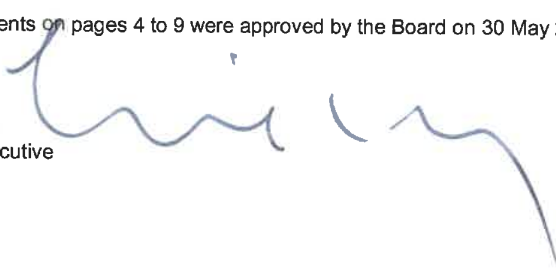
The notes on pages 10 to 56 form part of these accounts.

The financial statements on pages 4 to 9 were approved by the Board on 30 May 2019 and signed on its behalf by

Signed:

Date: 11 June 2019

Clive Kay
Chief Executive



King's College Hospital NHS Foundation Trust

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2019

Group	Note	Public Dividend Capital £000	Revaluation reserve £000	Financial assets at FV through Other Comprehensive Income reserve £000	Income and expenditure reserve £000	Total reserves £000
Taxpayers' and others' equity at 1 April 2018 - brought forward		226,194	92,847	-	(342,435)	(23,394)
Impact of implementing IFRS 15 on 1 April 2018		-	-	-	-	-
Impact of implementing IFRS 9 on 1 April 2018		-	-	-	-	-
Deficit for the year		-	-	-	(177,614)	(177,614)
Impairments	22	-	(1,121)	-	-	(1,121)
Revaluations - property, plant and equipment	22	-	17,442	-	-	17,442
Transfer to retained earnings on disposal of assets	22	-	-	-	-	-
Fair value gains/(losses) on equity instruments designated at FV through OCI		-	-	1,344	-	1,344
Other recognised gains and losses		-	-	-	-	-
Public Dividend Capital received		3,942	-	-	-	3,942
Other reserve movements		-	-	-	-	-
Taxpayers' and others' equity at 31 March 2019		230,136	109,168	1,344	(520,048)	(179,400)
Taxpayers' and others' equity at 1 April 2017 - brought forward		224,929	99,716	-	(200,256)	124,389
Deficit for the year		-	-	-	(142,251)	(142,251)
Impairments	22	-	(10,464)	-	-	(10,464)
Revaluations - property, plant and equipment	22	-	4,102	-	-	4,102
Transfer to retained earnings on disposal of assets	22	-	(507)	-	507	-
Public Dividend Capital received		1,265	-	-	-	1,265
Other reserve movements		-	-	-	(435)	(435)
Taxpayers' and others' equity at 31 March 2018		226,194	92,847	-	(342,435)	(23,394)
Trust	Note	Public Dividend Capital £000	Revaluation reserve £000	Financial assets at FV through Other Comprehensive Income reserve £000	Income and expenditure reserve £000	Total reserves £000
Taxpayers' and others' equity at 1 April 2018 - brought forward		226,194	92,847	-	(342,868)	(23,827)
Impact of implementing IFRS 15 on 1 April 2018		-	-	-	-	-
Impact of implementing IFRS 9 on 1 April 2018		-	-	-	-	-
Deficit for the year		-	-	-	(175,014)	(175,014)
Transfers by normal absorption: transfers between reserves		-	-	-	-	-
Impairments	22	-	(1,121)	-	-	(1,121)
Revaluations - property, plant and equipment	22	-	17,442	-	-	17,442
Public Dividend Capital received		3,942	-	-	-	3,942
Other reserve movements		-	-	-	-	-
Taxpayers' and others' equity at 31 March 2019		230,136	109,168	-	(517,882)	(178,578)
Taxpayers' and others' equity at 1 April 2017 - brought forward		224,929	99,716	-	(203,761)	120,884
Deficit for the year		-	-	-	(139,614)	(139,614)
Transfers by normal absorption: transfers between reserves		-	-	-	-	-
Impairments	22	-	(10,464)	-	-	(10,464)
Revaluations - property, plant and equipment	22	-	4,102	-	-	4,102
Transfer to retained earnings on disposal of assets	22	-	(507)	-	507	-
Public Dividend Capital received		1,265	-	-	-	1,265
Taxpayers' and others' equity at 31 March 2018		226,194	92,847	-	(342,868)	(23,827)

King's College Hospital NHS Foundation Trust

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2019 (continued)**Public dividend capital**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

King's College Hospital NHS Foundation Trust

Statement of Cash Flows for the year ended 31 March 2019

	Note	Group		Trust	
		2018-19	2017-18	2018-19	2017-18
		£000	£000	£000	£000
Cash flows from operating activities					
Operating deficit from continuing operations		(136,516)	(106,352)	(132,701)	(102,710)
Non-cash income and expense					
Depreciation and amortisation	3	25,058	24,580	24,992	23,118
Net Impairments	3	(198)	4,617	(198)	4,617
Income recognised in respect of capital donations		(3,004)	(2,033)	(3,004)	(2,033)
Decrease in trade and other receivables		24,146	21,642	(13,217)	24,283
(Increase)/Decrease in inventories		(2,249)	68	726	1,375
Increase/(Decrease) in trade and other payables		15,942	(42,514)	35,448	(51,039)
Increase/(Decrease) in other liabilities		3,914	(4,033)	3,914	(4,033)
(Decrease)/Increase in provisions		(644)	418	(590)	348
Net cash used in operations		<u>(73,551)</u>	<u>(103,607)</u>	<u>(84,630)</u>	<u>(106,074)</u>
Cash flows used in investing activities					
Interest received		442	170	908	486
Purchase of intangible assets	9	(1,599)	(3,989)	(1,598)	(3,663)
Purchase of property, plant and equipment	10	(31,251)	(45,981)	(23,622)	(45,581)
Sales of property, plant and equipment		398	1,128	3,496	1,128
Receipt of cash donation to purchase asset		2,281	2,033	2,282	2,033
Net cash used in investing activities		<u>(29,729)</u>	<u>(46,639)</u>	<u>(18,534)</u>	<u>(45,597)</u>
Cash flows from financing activities					
Public Dividend Capital received		3,942	1,265	3,942	1,265
Movement in loans from the Department of Health and Social Care		136,122	206,901	136,122	206,901
Movement in other loans		(138)	(153)	-	-
Capital element of finance lease repayments		(529)	-	(3,330)	-
Capital element of PFI and other service concession	23	(4,213)	(3,918)	(4,213)	(3,918)
Interest on loans		(16,478)	(8,886)	(16,416)	(8,794)
Interest element of finance lease		(5)	-	(211)	-
Interest element of PFI and other service concession obligations		(25,037)	(24,261)	(25,037)	(24,261)
Public Dividend Capital dividend received/(paid)		1,000	(210)	1,000	(210)
Net cash from financing activities		<u>94,664</u>	<u>170,738</u>	<u>91,857</u>	<u>170,983</u>
(Decrease)/Increase in cash and cash equivalents		<u>(8,616)</u>	<u>20,492</u>	<u>(11,307)</u>	<u>19,312</u>
Cash and cash equivalents at 1 April		<u>54,386</u>	<u>33,894</u>	<u>50,525</u>	<u>31,213</u>
Cash and cash equivalents at 31 March		<u>45,771</u>	<u>54,386</u>	<u>39,217</u>	<u>50,525</u>

King's College Hospital NHS Foundation Trust

Notes to the accounts**1. Accounting policies**

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 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.

1.2 Charitable funds

The King's College Hospital Charity and Friends of King's are independent charities and are not under the control of the Foundation Trust. Therefore, these charities have not been consolidated within these accounts.

1.3 Subsidiaries

Subsidiary entities are those over which the Foundation Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

The amounts consolidated are drawn from the draft financial statements of the subsidiaries for the year. Where subsidiaries' accounting policies are not aligned with those of the Foundation Trust then the amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

The Foundation Trust has a wholly owned subsidiary company, KCH Commercial Services Ltd, which wholly owns Agnensis Ltd and KCH Management Ltd. The accounts for these companies have been consolidated into the Trust's annual accounts.

In 2016/17, the Foundation Trust formed King's Interventional Facilities Management LLP in partnership with Kings Commercial Services Ltd. The accounts for this partnership have been consolidated into the Trust's annual accounts.

The primary statements and notes to the accounts have been presented with separate 'Group' and 'Trust' columns. Where the difference between the 'Group' and 'Trust' figures is considered immaterial, the 'Trust' version of the note has been omitted.

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's deficit for the period was (£175.0m) (2017/18: (£139.6m)).

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1. Accounting Policies (continued)**1.4 Associates**

Associate entities are those over which the Foundation Trust has power to exercise a significant influence. Associate entities are recognised in the Foundation Trust's financial statements using the equity method of accounting. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Foundation Trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant or equipment) following acquisition. It is also reduced when any distribution (e.g. share dividends) are received by the Foundation Trust from the associate.

1.5 Joint ventures

Joint ventures are arrangements in which the Foundation Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

1.6 Joint operations

Joint operations are arrangements in which the Foundation Trust has joint control with one or more other parties, and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Foundation Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

1.7 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

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1. Accounting Policies (continued)**Revenue from research contracts**

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

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, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.8 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.9 Other income

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.

In respect to the Operating plan framework, NHSI allocate Provider Sustainability Funds (PSF) to Trusts if they agree to a financial control total. The Trust agreed to a deficit control total of £124.498m for 2018/2019 including £21.532m PSF. The funding is non-recurrent and subject to financial and operational performance criteria. The Trust achieved £2.261m in 18/19 as a result of delivering against its financial quarterly target in the first quarter. An additional £7.416m was received in quarter 4 in relation to a general distribution of PSF.

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1. Accounting policies (continued)**1.10 Expenditure on employee benefits****Short-term employee benefits**

Salaries, wages and employment-related payments, such as social security costs and the apprenticeship levy, 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.

Pension Costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. 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. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

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 operating expenses at the time the foundation trust commits itself to the retirement, regardless of the method of payment.

1.11 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.

1.12 Property, plant and equipment**Recognition**

Property, plant and equipment is capitalised if:

- 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 will be supplied to the foundation trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items 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
- items 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, the components are treated as separate assets and depreciated over their own useful economic lives.

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1. Accounting policies (continued)**Measurement****Valuation**

All property, plant and equipment is measured initially at cost, representing the cost 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 assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation – Professional Standards UK January 2014 (revised April 2015). Valuations are based on the IFRS 13 definition of Fair Value and the definition adopted by the International Accounting Standards Board (IASB), being the price that would be received to sell an asset, or paid to transfer a liability, in an orderly transaction between market participants at the measurement date. All land and buildings are restated to fair value every five years, with a three year interim revaluation. The last asset valuations were undertaken as at 31 March 2019 by Avison Young.

Depreciated Replacement Cost (DRC) is recognised under IAS 16 as a method of valuation for financial reporting purposes. DRC assessments were undertaken for those assets considered to be specialised properties (e.g. NHS patient treatment facilities). The Department of Health has adopted the Modern Equivalent Asset approach (MEA) in carrying out the DRC assessment method.

Depreciated Replacement Cost has been adopted because of the asset classification as specialist properties which are rarely sold in the open market. The MEA approach is based on valuing 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.

For properties where Fair Value has been arrived at based on a comparable basis (Market Value), an assumption has been made that there would be a ready demand without major works required for alternative uses. The comparable methodology has been adopted to arrive at the values reported, allowing for reasonable costs relating to adaptations for current use or for non-operational properties, i.e. costs to make these properties marketable for alternative uses.

Only that plant and machinery forming part of the building services installations has been included. Total external works for each site which have been allocated to each building based upon a percentage of replacement build costs adopted.

The valuation included the Foundation Trust's PFI schemes.

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. 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.

1. Accounting policies (continued)

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. 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. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

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.

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 foundation trust, respectively.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the 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.

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The major categories and their useful economic lives are:

- 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; and
- mainframe-type IT installations - 8 years.

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that had previously been recognised in operating expenses, in which case they are recognised as operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter 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'.

1. Accounting policies (continued)

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

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; and
- 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. 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.

Donated, government grant or other grant-funded assets

Donated and grant-funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor. In which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

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. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment at their fair value, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate. The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

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1. Accounting policies (continued)

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income. Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Foundation 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 predetermined 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, and 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 Foundation Trust for use in the scheme continue to be recognised as items of property, plant and equipment in the foundation trust's Statement of Financial Position.

1.13 Intangible assets**Recognition**

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

Software

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

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: it is recognised as an operating expense in the period in which it is incurred.

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.

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 current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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1. Accounting policies (continued)**Amortisation**

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The Trust amortise intangibles over the following useful lives range:

- software license, 3 - 10 years;
- development cost, 5 - 10 years.

1.14 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 method. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks.

1.15 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 Foundation Trust's bank account belonging to patients. 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.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Foundation Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.16 Financial assets and financial liabilities**Recognition**

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes 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 and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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 below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

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1. Accounting policies (continued)***Financial assets and financial liabilities at amortised cost***

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

The carrying amount of the trade receivable is reduced when the outstanding debt is greater than one year and payment has not been agreed with the respective debtor. Overseas visitor's debts less than one year are provided for based on historical recoverability. Private Patient debts and salary overpayments are provided for based on management estimation of the percentage of recoverability. The Foundation Trust applies the percentage provided by the Department of Health to gross debts for injury costs recovery (RTA).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

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

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1. Accounting policies (continued)**1.17 Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Foundation Trust as lessee***Finance leases***

Where substantially all risks and rewards of ownership of a leased asset are borne by the 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 asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

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.

The Foundation Trust as lessor***Finance leases***

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.18 Provisions

The Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Foundation Trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the Foundation Trust is disclosed in note 19 but is not recognised in the Foundation Trust's accounts.

King's College Hospital NHS Foundation Trust

1. Accounting policies (continued)**Non-clinical risk pooling**

The Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the foundation trust pays an annual contribution to the NHS Resolution 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.

1.19 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 20 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 20, 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.

1.20 Public dividend capital

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

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the 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:

- donated assets (including lottery funded assets);
- average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility and;
- any PDC dividend balance receivable or payable;
- any incentive or bonus Sustainability and Transformation Funding.

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 in the '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.

1.21 Value added tax

Most of the activities of the 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.

King's College Hospital NHS Foundation Trust

1. Accounting policies (continued)**1.22 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 did not incur Corporation Tax in 2018/19 as the Foundation Trust did not generate any taxable income.

1.23 Foreign exchange

The functional and presentational currency of the Foundation Trust 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. The Foundation Trust does not have material foreign currency transactions. 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.

1.24 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 25 to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

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

1.26 Segmental analysis

The Foundation Trust has a number of business divisions which are aggregated under one reportable segment being the provision of healthcare. The Foundation Trust provides Private Patient, Research and Development and Training and Education services within this healthcare sector, but as they do not have a material impact they are aggregated under this one reportable segment. Note 2 entitled "Operating Income" includes the relevant income figures for these services.

The subsidiary figures have not been disclosed separately in this note as separate Group and Trust only accounts have been provided. The subsidiaries support the Trust in the overall provision of healthcare.

1.27 Going concern

These accounts have been prepared on a going concern basis.

IAS 1 requires management to undertake an assessment of the NHS Foundation Trust's ability to continue as a going concern. Due to the size of the financial deficit, the Board has carefully considered whether the accounts should be prepared on the basis of being a 'Going Concern' and whether there are uncertainties which may impact on the entity's ability to continue as a going concern.

King's College Hospital NHS Foundation Trust

1. Accounting policies (continued)

The Board considered the advice in the Department of Health and Social Care (DHSC) Group Accounting Manual 2018/19 that: "the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern; and that "DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity".

In this respect the Trust has signed contracts for the continued provision and funding of services with both local commissioners and NHS England Specialised Commissioning to cover the 2019/20 financial year.

Accordingly these accounts have been prepared on a going concern basis.

These signed contracts are reflected in the income assumptions of the Financial Plan with an agreed deficit control total of £132.6m for 2019/20. The Financial plan deficit is in line with the control total letter expectations communicated to the Board by NHS Improvement for 2019/20. The Board has reviewed and approved the 2019/20 Financial Plan.

This plan includes central non-recurrent funding support in the form of the Provider Sustainability Fund (£20.4m) and the Financial Recovery Fund (£14.8m); which are dependent on delivering a deficit of £167.9m. The 2019/20 savings plan consists of new schemes with a current target value of £60m, 6% of turnover, compared to the national efficiency factor of 1.1%. A number of contingency reserves have been established to cover recognised financial risks within the 2019/20 plan.

The Trust has agreed block contract values with the key South East London (SEL) CCGs for 2019/20 to a value of £463m. The NHSE contract for 2019/20 has been agreed at a value of £389m and is a cost and volume based contract. The Trust believes the 2019/20 plan can be delivered in terms of activity demand and capacity and the challenging cost improvement programme.

The Trust has assumed it will receive cash support in line with the agreed control total and the remaining cash issues are still to be resolved:

- The Trust has prepared a cash flow forecast which shows a minimum level of headroom of £3m. The Trust has developed its financial plans to include interim funding as indicated by the Department of Health and Social Care (DHSC) and thus continue on a going concern basis. The Trust has included a revenue funding requirement from DHSC of £132.6m in its 2019/20 annual plan at this point in time.
- The Trust is working with NHSI to secure additional distressed capital resource, to meet significant backlog maintenance and other requirements, with a Capital funding requirement included in its 2019/20 annual plan of £25.9m.
- A term loan from the DHSC of £98.9m was extended for one year and will fall due in November 2019. The Revolving Working Capital facility provided by DHSC of £89.6m will fall due in April 2020. DHSC is aware that the Trust will need to secure further extensions of these loans.

The planned mitigations to these key risks are:

- Savings Plan of £60m - identifying robust schemes that will deliver savings in year including the SEL CCG System Improvement plan. The theatre efficiency and GIRFT projects are covered by the RTT and growth % included in the SEL CCG Block contract which mitigates the in year income CIP risk.
- The Trust income operating plan has been signed off by all the Clinical Divisions and should be deliverable through the demand and capacity planning. A winter pressure contingency fund has been established to increase capacity and to ensure elective activity is not disrupted through the winter period.
- The Trust has established contingency reserves for cost pressures such as the national pay award including medical pay awards and distinction awards. The Trust has set pay budgets using a realistic vacancy factor and is also reducing the agency costs to ensure the pay costs remain within budget.

1. Accounting policies (continued)

The level of planned deficit, the reliance on interim funding for 2019/20 and 2020/21 which has not yet been confirmed, the reliance on DHSC agreement to the rollover of loans and facilities which are due for repayment or which mature in November 2019 and April 2020 which has not yet been confirmed, and the risks in relation to variability in the Trust's cash flows outlined above represent material uncertainties that may cast significant doubt as to the Trust's ability to continue as a going concern and therefore it may be unable to realise its assets and discharge its liabilities in the normal course of business. The financial statements do not include any adjustments that would result if the going concern basis were not appropriate.

After making enquiries, the directors have concluded that there is sufficient evidence that services will continue to be provided and that there is financial provision within the forward plans of commissioners. This provision will also be dependent on both acceptance and delivery of the financial recovery plans and continuation of support from the Department of Health and Social Care. The Directors have a reasonable expectation that this will be the case and have therefore prepared these financial statements on a going concern basis

1.28 Critical judgements in applying accounting policies

In the application of the Foundation Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are reviewed on an on-going basis.

Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the NHS foundation trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- In recognising provisions and in addition to widely used estimation techniques, judgement is required when determining the probable outflow of economic benefits relating to early voluntary retirement pension and injury benefit liabilities; and
- Management will use their judgement to decide when to write-off revenue or to provide against the probability of not being able to collect debt.
- The Trust is required to review property, plant and equipment for impairment. In between formal valuations by qualified surveyors, management make judgements about the condition of assets and review their estimated lives. Land and buildings have been valued on a Depreciated Replacement Cost (DRC) basis as at 31st March 2018 by an independent professionally qualified valuer (see Note 1.12). In between formal valuations, management make judgements about the condition of assets and review their estimated lives;

1.29 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- Clinical Income from activities includes an estimate in respect of income relating to patient care spells that are part-completed at the year end which include consideration of Commissioner data challenges. The Trust regularly reviews contract income alignment with local CCGs and NHSE (London Office) during the financial year as part of the SEL STP (see note 1.7);
- Estimations as to the recoverability of receivables have been made in determining the carrying amounts of these assets.
- The use of estimated asset lives in calculating depreciation (see note 1.12 and 1.13); and
- Provisions for early voluntary retirement pension contributions and injury benefit obligations are estimated using expected life tables and discounted at the pensions rate of 0.29% (2017/18: 0.1%).
- Provisions have been made for legal and constructive obligations of uncertain timing or amount as at the reporting date. These are based on estimates using relevant and reliable information as is available at the time the financial statements are prepared. These provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made.

King's College Hospital NHS Foundation Trust

1. Accounting policies (continued)

1.30 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

1.31 Standards, amendments and interpretations in issue but not yet effective or adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2018/19. These recently issued IFRS standards and amendments are still subject to HM Treasury FReM adoption.

- IFRS 14 Regulatory Deferral Accounts - Not yet EU-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

Following the release of the 2019/20 Department of Health and Social Care Group Accounting Manual, the Trust is assessing the likely impact of IFRS 16 (and adaptations included in the GAM).

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2. Operating income**2.1 Income from activities by classification**

	Group	
	2018-19	2017-18
	£000	£000
Elective income	171,768	160,433
Non-elective income	207,520	198,063
First outpatient income	88,231	87,371
Follow up outpatient income	53,873	55,806
Accident and emergency income	34,358	32,950
High cost drugs income from commissioners (excluding pass-through costs)	115,204	119,479
Other NHS clinical income*	293,053	321,517
Additional income for delivery of healthcare services		
Private Patient income	20,579	20,367
Agenda for Change pay award central funding	8,857	-
Other clinical income	11,754	8,468
Total income from activities	1,005,197	1,004,454
Less: Income related to discontinued operations	-	-
Total income from continuing operations	1,005,197	1,004,454
Other operating income	111,863	111,345
Total operating income	1,117,060	1,115,799

* Other NHS clinical income includes HIV/AIDS funding, NSCG funding for liver services, bone marrow transplant funding, critical care funding from CCGs, CQUIN funding, off-tariff drugs and devices, renal dialysis, direct access, community midwifery, community dental services, national screening programmes, RTA funding and IVF services.

Other operating income includes the following:

	Group	
	2018-19	2017-18
	£000	£000
Research and development	14,658	16,237
Education and training	42,391	43,220
Receipt of capital grants and donations	3,004	2,033
Charitable and other contributions to expenditure **	184	7,000
Non-patient care services to other bodies	13,864	13,500
Provider sustainability fund / Sustainability and transformation fund income	9,677	-
Education and training - notional income from apprenticeship fund	273	-
Income in respect of employee benefits accounted on a gross basis	7,416	7,374
Rental revenue from operating leases	1,165	1,311
Other***	19,231	20,670
Total other operating income	111,863	111,345

** Charitable donation received in 2017-18 from The Fetal Medicine Foundation for investment in the Trust's Fetal Medicine services as a key stakeholder in the clinical service and is acknowledged as non-recurrent financial support.

*** Other income includes PFI transitional support, clinical excellence awards, staff nursery, car parking, accommodation and commercial rents.

2.2 Income from activities by type

	Group	
	2018-19	2017-18
	£000	£000
NHS Foundation Trusts	927	740
NHS Trusts	1,497	1,518
Clinical Commissioning Groups and NHS England	956,755	960,739
Department of Health and Social Care ***	8,857	-
NHS Other (including Public Health England and Prop Co)	2,256	2,131
Non-NHS		
Local Authorities	4,247	4,657
Private patients	20,579	20,367
Overseas patients (non-reciprocal)	4,886	6,043
Injury costs recovery*	2,330	3,671
Other**	2,865	4,588
Total income from activities	1,005,197	1,004,454

* NHS Injury Scheme income is subject to a provision for doubtful debts of 21.89% (2017/18: 22.84%) to reflect expected rates of collection. The total outstanding claims against this scheme at 31 March 2019 were £12.271m (31 March 2018: £13.142m), and a provision of £2.686m (31 March 2018: £3.002m) 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.

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2.3 Overseas visitors

	Group	
	2018-19	2017-18
	£000	£000
Income recognised this year	4,886	6,043
Cash payments received in-year	1,317	1,006
Provision for impairment of receivables	1,346	3,425
Amounts written off in-year	4,263	3,937

2.4 Additional information on contract revenue (IFRS 15) recognised in the period

	2018-19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	7,902
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0

2.5 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2019
	£000
within one year	6,867
after one year, not later than five years	0
after five years	0
Total revenue allocated to remaining performance obligations	<u>6,867</u>

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

2.6 Income from activities arising from commissioner requested and non-commissioner requested services

Under the terms of its Provider License, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Group	
	2018-19	2017-18
	£000	£000
Commissioner requested services	983,065	993,605
Non-commissioner requested services	134,012	122,194
Total	<u>1,117,076</u>	<u>1,115,799</u>

2.7 Fees and charges - aggregate of all schemes that, individually, have a cost exceeding £1m

	Group	
	2018-19	2017-18
	£000	£000
Income	20,579	20,367
Full cost	(21,218)	(18,305)
(Deficit)/Surplus	<u>(639)</u>	<u>2,062</u>

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2.8 Operating lease income

	Group	
	2018-19	2017-18
	£000	£000
Rental revenue from operating leases	1,165	1,311
	31 March	31 March
	2018	2018
	£000	£000
Future minimum lease payments due on leases of buildings expiring		
- not later than one year	1,149	1,311
- between one and five years	-	345
Total	1,149	1,656

The above note discloses income generated in operating lease agreements where King's College Hospital NHS FT is the lessor. The operating leases relate to the lease of space and buildings owned by the Trust.

3. Operating expenses**3.1 Operating expenses by type**

	Group	
	2018-19	2017-18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	13,048	13,817
Purchase of healthcare from non-NHS and non-DHSC bodies	53,647	49,011
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	139,381	145,936
Supplies and services - clinical (excluding drugs costs)	101,105	92,469
Supplies and services - general	7,047	15,594
Staff and executive directors costs	703,429	682,686
Remuneration of non-executive directors	175	191
Establishment	6,956	4,902
Transport (including patient travel)	10,435	9,743
Premises	33,925	31,734
Rentals under operating leases - minimum lease payments	10,348	7,907
PFI service costs	61,249	57,884
Clinical negligence	38,582	32,558
Depreciation on property, plant and equipment	23,637	23,372
Amortisation on intangible assets	1,421	1,208
Net impairments	(198)	4,617
Movement in credit loss allowance: contract receivables / contract assets	9,466	14,337
Consultancy costs	7,082	3,401
Audit fees payable to the external auditor		
Statutory audit	283	183
Other audit-related assurance services	16	15
Internal audit costs	167	144
Other *	32,375	30,442
Total operating expenses	1,253,576	1,222,151

* Other operating expenses include expenditure relating to training, legal fees, storage costs, work permits and infection control costs.

Audit fees are inclusive of VAT. The amount charged in 2018/19 for statutory audit includes £103k in respect of the 2017/18 audit.

Research and development expenditure is included in other operating expenditure, clinical and general supplies and services, premises and establishment expenses as well as in staff costs.

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3.2 Operating leases

Rentals under operating leases include the following:

	Group	
	2018-19	2017-18
	£000	£000
Operating lease expense		
Minimum lease payments	10,348	7,907
Total	10,348	7,907

Future minimum lease payments fall due as follows:

	2018-19	2017-18
	£000	£000
Hire of plant and machinery		
- not later than one year	4,866	5,268
- between one and five years	10,916	12,113
- later than five years	889	2,995
Total hire of plant and machinery	16,671	20,376
Rental of buildings		
- not later than one year	4,445	2,144
- between one and five years	1,091	1,166
- later than five years	1,217	1,539
Total rental of buildings	6,753	4,849
Total	23,424	25,225

This note discloses costs and commitments incurred under cancellable operating lease arrangements where King's College Hospital NHS FT is the lessee. The Trust does not have any non-cancellable operating leases.

3.3 Better Payment Practice Code - measure of compliance

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 the earlier. The target is to pay 95% of invoices, in terms of value and volume, within 30 days.

The Foundation Trust's performance against this target was as follows:

	Group		Group	
	2018-19		2017-18	
	Number	£000	Number	£000
Non-NHS trade invoices:				
Paid in the year	138,757	638,422	157,340	691,415
Paid within target	132,863	586,893	143,587	652,585
Percentage paid within target	96%	92%	91%	94%
NHS trade invoices				
Paid in the year	4,976	112,007	5,382	160,538
Paid within target	4,663	110,478	3,504	147,279
Percentage paid within target	94%	99%	65%	92%
Total trade invoices				
Paid in the year	143,733	750,429	162,722	851,953
Paid within target	137,526	697,371	147,091	799,864
Percentage paid within target	96%	93%	90%	94%

3.4 Late Payment of Commercial Debts (Interest) Act 1998

	2018-19	2017-18
	£000	£000
Compensation paid to cover debt recovery costs under this legislation	3	7

3.5 Audit fees (external auditors)

There was no limitation on auditor's liability in 2018/19 or in 2017/18.

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4 Employee benefits**4.1 Employee benefits**

	Group	
	2018-19	2017-18
	Total	Total
	£000	£000
Salaries and wages	524,627	486,182
Social security costs	53,262	49,107
Apprenticeship levy	2,489	2,318
Employer contributions to NHS Pensions	60,238	56,783
Temporary staff (including bank and agency)	63,563	89,915
Total gross employee benefits	704,179	684,305
Recoveries from other bodies in respect of staff cost netted off expenditure	-	-
Total employee benefits	704,179	684,305
Of which		
Costs capitalised as part of assets	(750)	(1,619)
Total employee benefits excluding capitalised costs	703,429	682,686

4.2 Staff sickness absence

	2018-19	2017-18
	Number	Number
Total days lost	87,795	78,229
Total staff years	11,529	10,953
Average working days lost	7.6	7.1

Average sickness absence days are provided by the Department of Health, and are calculated using calendar years, rather than financial years.

4.3 Early retirements due to ill health

	2018-19	2017-18
	Number	Number
Early retirements on the grounds of ill-health	5	3
	£000	£000
Early retirements on the grounds of ill-health	165	317

The cost of ill-health retirements is borne by NHS Pensions.

4.4 Termination benefits**4.4a By number of cases:**

	2018-19	2017-18
	Total	Total
Exit package cost band (including any special payment element)		
Less than £10,000	26	15
£10,000-£25,000	4	3
£25,001-£50,000	-	1
£50,001-£100,000	2	2
£100,001 - £150,000	1	-
£150,001 - £200,000	-	-
Greater than £200,000	1	-
Total	34	21

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4.4b By value of payments:

	2018-19	2017-18
Exit package cost band (including any special payment element)	Total	Total
	£000	£000
Less than £10,000	95	46
£10,000-£25,000	76	42
£25,001-£50,000	-	30
£50,001-£100,000	161	181
£100,001 - £150,000	117	-
£150,001 - £200,000	-	-
Greater than £200,000	930	-
Total	1,379	299

Two (2017/18: 0) of the above exit packages relate to compulsory redundancies totalling £26k (2017/18: £0k). All other termination benefits related to other agreed departures.

4.4c Other departures agreed are as follows:

	2018-19		2017-18	
	Number	£000	Number	£000
Mutually agreed resignations (MARS) contractual costs	9	38		
Contractual payments in lieu of notice	19	204	21	299
Exit payments following Employment Tribunal or court orders				
(This figure includes the £930k exit package referred to in table 4.4b above)	4	1,111	-	-
Total	32	1,353	21	299
Of which:				
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

4.5 Salary and pension entitlements of senior managers**4.5a Median salary disclosures**

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/member in their organisation and the median remuneration of the organisation's workforce.

	2018-19 (bands of £5,000)	2017-18 (bands of £5,000)
Band of highest paid director/member's total remuneration	265 - 270	255 - 260
Median total remuneration (£)	25,675	26,002
Ratio	10.4	9.9

In 2018/19, 0 (2017/18: 4) employees received remuneration in excess of the highest-paid director/member.

Remuneration ranged from £44 to £292k (2017/18: £14 to £329k).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

4.5b Business related travel and subsistence expenses

Two Executive Directors received travel and subsistence expenses totalling £3,190 in 2018-19 (2017-18: one, £27).

0 Non-Executive Director received travel and subsistence expenses in 2018-19 (2017-18: one, £1,187).

0 Governors received travel and subsistence in 2018-19 (2017-18: two, £604).

4.5 Salary and pension entitlements of senior managers**4.6c Remuneration**

Name	Title	2018-19 Salary & Fees (bands of £5,000)	2018-19 Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)	2017-18 Salary & Fees (bands of £5,000)	2017-18 Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Chairman and Non-Executive Directors							
Lord Kerslake	Chair	-	-	-	40 - 45	-	40 - 45
Ian Smith	Chair	55 - 60	-	55 - 60	15 - 20	-	15 - 20
Sir Hugh Taylor	Interim Chair	0 - 5	-	0 - 5	-	-	-
Faith Boardman	Non-Executive Director	10 - 15	-	10 - 15	10 - 15	-	10 - 15
Professor Gulam J Mufti	Non-Executive Director	15 - 20	-	15 - 20	15 - 20	-	15 - 20
Sue Slipman	Non-Executive Director	10 - 15	-	10 - 15	15 - 20	-	15 - 20
Chris Stooke	Non-Executive Director	10 - 15	-	10 - 15	10 - 15	-	10 - 15
Professor Jonathan Cohen	Non-Executive Director	10 - 15	-	10 - 15	10 - 15	-	10 - 15
Dr Alix Pryde	Non-Executive Director	10 - 15	-	10 - 15	10 - 15	-	10 - 15
Erik Nordkamp	Non-Executive Director	0 - 5	-	0 - 5	10 - 15	-	10 - 15
Professor Richard Trembath	Non-Executive Director	10 - 15	-	10 - 15	10 - 15	-	10 - 15
Executive Directors							
Nicholas Moberly	Chief Executive	130 - 135	-	130 - 135	255 - 260	7.5 - 10	260 - 265
Peter Herring	Chief Executive	265 - 270	-	265 - 270	-	-	-
Colin Gentile	Chief Financial Officer	-	-	-	185 - 190	-	185 - 190
Alan Goldsman	Interim Chief Financial Officer/Director of Financial Recovery/Interim Director of Strategy	15 - 20	-	15 - 20	175 - 180	72.5 - 75	320 - 325
Iain Alexander	Interim Chief Financial Officer	120 - 125	-	120 - 125	-	-	-
Lorcan Woods	Chief Financial Officer	145 - 150	32.5 - 35	180 - 185	-	-	-
Professor Julia Wendon	Executive Medical Director	225 - 230	-	225 - 230	225 - 230	-	225 - 230
Dr Michelle (Shelley) Dolan	Acting Deputy Chief Executive	190 - 195	260 - 262.5	450 - 455	170 - 175	105 - 107.5	275 - 280
Dawn Brodick	Executive Director of Workforce Development	150 - 155	-	150 - 155	150 - 155	-	150 - 155
Trudi Kamp	Director of Strategy	-	-	-	30 - 35	360 - 362.5	390 - 395
Abigail Stapleton	Director of Strategy	120 - 125	27.5 - 30	150 - 155	10 - 12.5	10 - 12.5	60 - 65
Amanda (Jane) Farrell	Chief Operating Officer	-	-	-	205 - 210	-	220 - 225
Bernadette Bluhm	Interim Chief Operating Officer	25 - 30	-	25 - 30	-	-	-
Lisa Hollins	Director of Improvement, Informatics and ICT	140 - 145	15 - 17.5	155 - 160	140 - 145	67.5 - 70	205 - 210
Jane Bond	Director of Capital and Estates	55 - 60	12.5 - 15.0	65 - 70	150 - 155	32.5 - 35	185 - 190
Steven Bannister	Interim Director of Capital, Estates & Facilities	170 - 175	-	170 - 175	-	-	-
Peter Pentecost	Financial Recovery Director	105 - 110	-	105 - 110	-	-	-
Fiona Wheeler	Acting Executive Managing Director PRUH & South Sites	20 - 25	-	20 - 25	-	-	-
Andrew Lockwood	Managing Director Kings Facilities Management	145 - 150	-	145 - 150	-	-	-

The remuneration of the interim directors include agency fees and VAT

*Salary relating to non-managerial role

Professor Julia Wendon	180 - 185	180 - 185	180 - 185
Abigail Stapleton	70 - 75	70 - 75	180 - 185
Alan Goldsman held three roles in the Trust during 2017/18			
Alan Goldsman	Interim Chief Financial Officer	80 - 85	
Alan Goldsman	Director of Financial Recovery	65 - 70	
Alan Goldsman	Interim Director of Strategy	25 - 30	

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4.5 Salary and pension entitlements of senior managers**4.5c Remuneration (Cont'd)**

Ian Smith	Chair	1 April 2018 - 28 February 2019
Sir Hugh Taylor	Interim Chair	1 March 2019 - 31 March 2019
Faith Boardman	Non-Executive Director	1 April 2018 - 31 March 2019
Professor Gulam J Muffi	Non-Executive Director	1 April 2018 - 31 March 2019
Sue Slipman	Non-Executive Director	1 April 2018 - 31 March 2019
Chris Stooke	Non-Executive Director	1 April 2018 - 31 March 2019
Professor Jonathan Cohen	Non-Executive Director	1 April 2018 - 31 March 2019
Dr Alix Pryde	Non-Executive Director	1 April 2018 - 31 March 2019
Erik Nordkamp	Non-Executive Director	1 April 2018 - 31 July 2018
Prof Richard Trembath	Non-Executive Director	1 April 2018 - 31 March 2019
Nicholas Moberly	Chief Executive	1 April 2018 - 22 April 2018
Peter Herring	Chief Executive	9 May 2018 - 31 March 2019
Alan Goldsman	Interim Chief Financial Officer	1 April 2018 - 30 April 2018
Iain Alexander	Interim Chief Financial Officer	1 April 2018 - 30 June 2018
Lorcan Woods	Chief Financial Officer	2 July 2018 - 31 March 2019
Professor Julia Wendon	Executive Medical Director	1 April 2018 - 31 March 2019
Dr Michelle (Shelley) Dolan	Acting Deputy Chief Executive	1 April 2018 - 31 March 2019
Dawn Brodrick	Executive Director of Workforce Development	1 April 2018 - 31 March 2019
Abigail Stapleton	Director of Strategy	1 April 2018 - 31 March 2019
Bernadette Bluhm	Interim Chief Operating Officer	11 February 2019 - 31 March 2019
Lisa Hollins	Director of Improvement, Informatics and ICT	1 April 2018 - 31 March 2019
Jane Bond	Director of Capital and Estates	1 April 2018 - 12 August 2018
Steven Bannister	Interim Director of Capital, Estates & Facilities	20 August 2018 - 31 March 2019
Peter Pentecost	Financial Recovery Director	1 October 2018 - 31 March 2019
Fiona Wheeler	Acting Executive Managing Director PRUH & South Sites	1 February 2019 - 31 March 2019
Andrew Lockwood	Managing Director Kings Facilities Management	11 May 2018 - 31 March 2019

None of the Non-Executive or Executive Directors received benefits in kinds in 2018-19 or 2017-18

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4.5 Salary and pension entitlements of senior managers**4.5d Pension entitlements at 31 March 2019**

Name	Title	Real increase in pension at pension age £000 (bands of £2,500)	Real increase in pension lump sum at pension age £000 (bands of £2,500)	Total accrued pension at pension age £000 (bands of £5,000)	Lump sum at pension age £000 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2019 £000	Employer's Contribution to stakeholder pension £000
Non-Executive Directors									
Non-Executive Directors do not receive pensionable remuneration.									
Executive Directors									
Nicholas Moberly	Chief Executive	(0 - 2.5)	(0 - 2.5)	65 - 70	205 - 210	1,390	-	1,541	55
Alan Goldsman	Interim Chief Financial Officer	(0 - 2.5)	(0 - 2.5)	45 - 50	135 - 140	1,180	-	1,140	2
Dr Michelle (Shelley) Dolan	Acting Deputy Chief Executive	12.5 - 15.0	37.5 - 40.0	75 - 80	235 - 240	-	-	-	28
Abigail Stapleton	Director of Strategy	0 - 2.5	-	0 - 5	-	6	4	28	18
Lisa Hollins	Director of Transformation & ICT	0 - 2.5	(0 - 2.5)	45 - 50	115 - 120	722	102	866	21
Jane Bond	Director of Capital, Estates and Facilities	0 - 2.5	-	0 - 5	-	46	-	69	8
Lorcan Woods	Chief Financial Officer	0 - 2.5	-	0 - 5	-	-	4	34	21

During the 2018/19 the total value of employer contributions to the pension scheme in respect of Board member directors was £153k (2017/18: £156k).

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 and other disclosures are provided by NHS Pensions, and 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.

Michelle Dolan's CETV Real Increase is not shown here as the guidance states that Senior Managers over NPA will not be applicable.

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4.6 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

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5 Finance income

	Group	
	2018-19	2017-18
	£000	£000
Interest on bank accounts	368	99
Interest on other investments/financial assets	74	65
Total	442	164

6 Finance expenses

	Group	
	2018-19	2017-18
	£000	£000
Loans from the Department of Health and Social Care		
Capital loans	3,537	2,989
Revenue support / working capital loans	11,134	4,328
Revolving working capital facilities	2,978	3,294
Finance leases	5	-
Other Loans	150	-
Finance costs on PFI and other service concession arrangements		
Main finance cost	16,596	16,813
Contingent finance cost	8,441	7,448
Total interest expense	42,841	34,872
Unwinding of discount on provisions	10	16
Other finance costs	-	94
Total finance costs	42,851	34,982

Finance expenditure represents interest and other charges involved in the borrowing of money.

7 Impairments

	Group	
	2018-19	2017-18
	£000	£000
Changes in market price - charged to operating expenses	(198)	4,617
Changes in market price - charged to the revaluation reserve	1,121	10,464
Total	923	15,081

Asset valuations were undertaken in 2019 as at the prospective valuation date of 31 March 2019. This was based on alternative site which included a review of the Trust's patient base, through an analysis of postcode information allocated between outpatients and inpatients.

The revaluation resulted in an overall increase of £6.665m in the value of land owned by the Trust and an overall increase of £9.864m in the net book value of buildings and dwellings.

A reversal of impairment amount of £0.198m has been taken to the Statement of Comprehensive Income and a revaluation surplus of £17.442m transferred to revaluation reserve. An impairment of £1.121m has been charged to the revaluation reserve.

The buildings with material decrease in value include the ED Olympic Entrance (£0.546m), Diabetic Foot Clinic & Haematology (£0.678m), Theatre Block (£0.519m), Cooling Structure (£0.551m) and other buildings (£2.044m).

8 Other gains / (losses)

	Group	
	2018-19	2017-18
	£000	£000
Gains on disposal of assets	185	227
Losses on disposal of assets	-	(40)
Total gains / (losses) on disposal of assets	185	187

8.1 Share of operating profit / (loss) in associates and joint ventures

	Group	
	2018-19	2017-18
	£000	£000
Viapath Group LLP	1,126	(1,268)
	1,126	(1,268)

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9 Intangible non-current assets**9.1 Intangible non-current assets - current year**

Group	Group		
	Software licences £000	Development expenditure £000	Total £000
Cost or valuation			
At 1 April 2018	16,569	707	17,276
Additions purchased	1,599	-	1,599
Additions leased	-	-	-
At 31 March 2019	18,168	707	18,875
Amortisation			
At 1 April 2018	8,169	707	8,876
Charged during the year	1,421	-	1,421
At 31 March 2019	9,590	707	10,297
Net book value			
Purchased	7,289	-	7,289
Leased	1,289	-	1,289
Total at 31 March 2019	8,578	-	8,578
Revaluation reserve balance			
At 1 April 2018	37	-	37
At 31 March 2019	37	-	37

Development expenditure represents the implementation cost of the Activity Based Costing project, which was completed in 2006-07, and is still in use.

9.2 Intangible non-current assets - current year

Trust	Trust		
	Software licences £000	Development expenditure £000	Total £000
Cost or valuation			
At 1 April 2018	16,244	707	16,951
Additions purchased	1,598	-	1,598
Additions leased	-	-	-
At 31 March 2019	17,842	707	18,549
Amortisation			
At 1 April 2018	8,121	707	8,828
Charged during the year	1,356	-	1,356
At 31 March 2019	9,477	707	10,184
Net book value			
Purchased	7,076	-	7,076
Leased	1,289	-	1,289
Total at 31 March 2019	8,365	-	8,365
Revaluation reserve balance			
At 1 April 2018	37	-	37
At 31 March 2019	37	-	37

The range of useful economic lives over which intangible assets are amortised is included in note 1.13.

For all categories of intangible assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

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9 Intangible non-current assets**9.3 Intangible non-current assets - prior year**

	Group		
Group	Software licences £000	Development expenditure £000	Total £000
Cost or valuation			
At 1 April 2017	11,291	707	11,998
Additions purchased	3,989	-	3,989
Additions leased	1,289	-	1,289
At 31 March 2018	16,569	707	17,276
Amortisation			
At 1 April 2017	6,961	707	7,668
Charged during the year	1,208	-	1,208
At 31 March 2018	8,169	707	8,876
Net book value			
Purchased	7,111	-	7,111
Leased	1,289	-	1,289
Total at 31 March 2018	8,400	-	8,400
Revaluation reserve balance			
At 1 April 2017	37	-	37
At 31 March 2018	37	-	37

Development expenditure represents the implementation cost of the Activity Based Costing project, which was completed in 2006-07, and is still in use.

9.4 Intangible non-current assets - prior year

	Trust		
Trust	Software licences £000	Development expenditure £000	Total £000
Cost or valuation			
At 1 April 2017	11,568	707	12,275
Additions purchased	3,387	-	3,387
Additions leased	1,289	-	-
At 31 March 2018	16,244	707	15,662
Amortisation			
At 1 April 2017	6,961	707	7,668
Charged during the year	1,160	-	1,160
At 31 March 2018	8,121	707	8,828
Net book value			
Purchased	6,834	-	6,834
Leased	1,289	-	1,289
Total at 31 March 2018	8,123	-	8,123
Revaluation reserve balance			
At 1 April 2017	37	-	37
At 31 March 2018	37	-	37

The range of useful economic lives over which intangible assets are amortised is included in note 1.13.

For all categories of intangible assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

10 Property, plant and equipment**10.1 Property, plant and equipment - current year**

	Group						
	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000
Group							
Cost or valuation							
At 1 April 2018	59,995	394,046	1,545	81,523	70,685	29,334	2,184
Additions purchased	-	574	-	15,343	9,709	3,434	146
Additions leased	-	16	-	-	2,237	-	-
Additions donated	-	-	-	992	972	317	-
Impairments charged to operating expenses	-	(3,845)	-	-	-	-	-
Impairments charged to the revaluation reserve	-	(1,649)	-	-	-	-	-
Reversal of impairments credited to operating expenses	140	1,292	-	-	-	-	-
Reversal of impairments credited to the revaluation reserve	-	-	-	-	-	-	-
Revaluations	6,515	(332)	5	-	-	-	-
Reclassifications	-	9,149	-	(9,149)	-	-	-
Transfers to/from assets held for sale and assets in disposal groups	-	-	-	-	-	-	-
Disposals	-	-	-	-	-	-	-
At 31 March 2019	66,650	399,251	1,550	88,709	83,603	33,085	2,330
Depreciation							
At 1 April 2018	-	126	-	-	47,495	13,302	1,381
Charged during the year	-	14,373	70	-	5,055	3,961	178
Impairments charged to operating expenses	-	(626)	-	-	-	-	-
Impairments charged to the revaluation reserve	-	(528)	-	-	-	-	-
Reversal of impairments credited to operating expenses	-	(1,985)	-	-	-	-	-
Reversal of impairments credited to the revaluation reserve	-	-	-	-	-	-	-
Revaluations	-	(11,184)	(70)	-	-	-	-
Disposals	-	-	-	-	-	-	-
At 31 March 2019	-	176	-	-	52,550	17,263	1,559
Net book value							
Owned - purchased	44,166	198,007	1,304	87,389	24,652	15,764	630
Owned - donated	1,956	12,798	246	550	1,542	58	141
On balance sheet PFI	20,528	188,270	-	770	4,859	-	-
Total at 31 March 2019	66,650	399,075	1,550	88,709	31,053	15,822	771
Revaluation reserve balance							
At 1 April 2018	24,798	61,993	1,161	-	4,601	-	257
Revaluation and indexation in year	6,431	9,755	135	-	-	-	-
At 31 March 2019	31,229	71,748	1,296	-	4,601	-	257

The effective date of land and building revaluation was 31 March 2019 and the valuation was carried out by an independent valuer.

The range of useful economic lives over which property plant and equipment are depreciated are included in note 1.12.

For all categories of non-property assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

10 Property, plant and equipment - continued**10.2 Property, plant and equipment - current year**

	Trust						
Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation							
At 1 April 2018	59,995	394,046	1,545	81,523	46,949	29,334	2,184
Additions purchased	-	574	-	15,343	2,080	3,434	146
Additions leased	-	16	-	-	17,508	-	-
Additions donated	-	-	-	992	972	317	-
Impairments charged to operating expenses	-	(3,845)	-	-	-	-	-
Impairments charged to the revaluation reserve	-	(1,649)	-	-	-	-	-
Reversal of impairments credited to operating expenses	140	1,292	-	-	-	-	-
Reversal of impairments credited to the revaluation reserve	-	-	-	-	-	-	-
Revaluations	6,515	(332)	5	-	-	-	-
Reclassifications	-	9,149	-	(9,149)	-	-	-
Transfers to/from assets held for sale and assets in disposal groups	-	-	-	-	-	-	-
Disposals	-	-	-	-	-	-	-
At 31 March 2019	66,650	395,251	1,550	88,709	67,509	33,085	2,330
Depreciation							
At 1 April 2018	-	126	-	-	31,398	13,302	1,381
Charged during the year	-	14,373	70	-	5,054	3,961	178
Impairments charged to operating expenses	-	(626)	-	-	-	-	-
Impairments charged to the revaluation reserve	-	(528)	-	-	-	-	-
Reversal of impairments credited to operating expenses	-	(2,272)	-	-	-	-	-
Reversal of impairments credited to the revaluation reserve	-	-	-	-	-	-	-
Revaluations	-	(10,897)	(70)	-	-	-	-
Disposals	-	-	-	-	-	-	-
At 31 March 2019	-	176	-	-	36,452	17,263	1,559
Net book value							
Owned - purchased	44,166	198,007	1,304	87,389	7,436	15,764	630
Owned - donated	1,956	12,798	246	550	1,826	58	141
On balance sheet PFI & Finance Lease	20,528	188,270	-	770	21,791	-	-
Total at 31 March 2019	66,650	399,075	1,550	88,709	31,053	15,822	771
Revaluation reserve balance							
At 1 April 2018	24,798	61,993	1,161	-	4,601	-	257
Revaluation and indexation in year	6,431	9,755	135	-	-	-	-
At 31 March 2019	31,229	71,748	1,296	-	4,601	-	257

The effective date of land and building revaluation was 31 March 2018 and the valuation was carried out by independent valuer.

The range of useful economic lives over which property plant and equipment are depreciated are included in note 1.12.

For all categories of non-property assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

10 Property, plant and equipment**10.3 Property, plant and equipment - prior year**

Group	Group							Total
	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation								
At 1 April 2017	58,496	418,527	2,875	45,411	69,619	21,787	2,142	618,857
Additions purchased	-	57	-	37,978	2,093	7,527	42	47,697
Additions leased	-	-	-	-	-	-	-	-
Additions donated	-	12	-	1,736	265	20	-	2,033
Impairments charged to operating expenses	(35)	(8,262)	-	-	-	-	-	(8,297)
Impairments charged to the revaluation reserve	(659)	(18,614)	(219)	-	-	-	-	(19,492)
Reversal of impairments credited to operating expenses	37	460	-	-	-	-	-	497
Reversal of impairments credited to the revaluation reserve	-	-	-	-	-	-	-	-
Revaluations	2,602	(1,736)	-	-	-	-	-	866
Reclassifications	-	3,602	-	(3,602)	-	-	-	-
Transfers to/from assets held for sale and assets in disposal groups	(175)	-	(425)	-	-	-	-	(600)
Disposals	(271)	-	(686)	-	(1,292)	-	-	(2,249)
At 31 March 2018	59,995	394,046	1,545	81,523	70,685	29,334	2,184	639,312
Depreciation								
At 1 April 2017	-	334	-	-	43,798	10,349	1,206	55,687
Charged during the year	-	15,150	112	-	4,982	2,953	175	23,372
Impairments charged to operating expenses	-	(2,601)	-	-	-	-	-	(2,601)
Impairments charged to the revaluation reserve	-	(8,939)	(89)	-	-	-	-	(9,028)
Reversal of impairments credited to operating expenses	-	(582)	-	-	-	-	-	(582)
Reversal of impairments credited to the revaluation reserve	-	-	-	-	-	-	-	-
Revaluations	-	(3,236)	-	-	-	-	-	(3,236)
Disposals	-	-	(23)	-	(1,285)	-	-	(1,308)
At 31 March 2018	-	126	-	-	47,495	13,302	1,381	62,304
Net book value								
Owned - purchased	42,627	192,281	1,274	80,901	18,399	15,954	795	352,231
Owned - donated	1,843	12,837	271	39	1,329	78	8	16,405
On balance sheet PFI	15,525	188,802	-	583	3,462	-	-	208,372
Total at 31 March 2018	59,995	393,920	1,545	81,523	23,190	16,032	803	577,008
Revaluation reserve balance								
At 1 April 2017	22,855	70,169	1,798	-	4,601	-	257	99,680
Revaluation and indexation in year	1,943	(8,176)	(637)	-	-	-	-	(6,870)
At 31 March 2018	24,798	61,993	1,161	-	4,601	-	257	92,810

The effective date of land and building revaluation was 31 March 2018 and the valuation was carried out by an independent valuer.

The range of useful economic lives over which property plant and equipment are depreciated are included in note 1.12.

For all categories of non-property assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

10 Property, plant and equipment - continued**10.4 Property, plant and equipment - prior year**

Property, plant and equipment - prior year								
Trust	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 2017	58,496	418,527	2,875	45,411	46,360	21,787	2,142	595,598
Additions purchased	-	57	-	37,978	1,616	7,527	42	47,220
Additions leased	-	-	-	-	-	-	-	-
Additions donated	-	12	-	1,736	265	20	-	2,033
Impairments charged to operating expenses	(35)	(8,262)	-	-	-	-	-	(8,297)
Impairments charged to the revaluation reserve	(659)	(18,614)	(219)	-	-	-	-	(19,492)
Reversal of impairments credited to operating expenses	37	460	-	-	-	-	-	497
Reversal of impairments credited to the revaluation reserve	-	-	-	-	-	-	-	-
Revaluations	2,602	(1,736)	-	-	-	-	-	866
Reclassifications	-	3,602	-	(3,602)	-	-	-	-
Transfers to/from assets held for sale and assets in disposal groups	(175)	-	(425)	-	-	-	-	(600)
Disposals	(271)	-	(686)	-	(1,292)	-	-	(2,249)
At 31 March 2018	59,995	394,046	1,545	81,523	46,949	29,334	2,184	615,576
Depreciation								
At 1 April 2017	-	334	-	-	29,191	10,349	1,206	41,080
Charged during the year	-	15,150	112	-	3,492	2,953	175	21,882
Impairments charged to operating expenses	-	-	-	-	-	-	-	-
Impairments charged to the revaluation reserve	-	(8,939)	(89)	-	-	-	-	(9,028)
Reversal of impairments credited to operating expenses	-	(582)	-	-	-	-	-	(582)
Reversal of impairments credited to the revaluation reserve	-	-	-	-	-	-	-	-
Revaluations	-	(3,236)	-	-	-	-	-	(3,236)
Disposals	-	-	(23)	-	(1,285)	-	-	(1,308)
At 31 March 2018	-	126	-	-	31,398	13,302	1,381	46,207
Net book value								
Owned - purchased	42,627	192,281	1,274	80,901	10,760	15,954	795	344,592
Owned - donated	1,843	12,837	271	39	1,329	78	8	16,405
On balance sheet PFI	15,525	188,802	-	583	3,462	-	-	208,372
Total at 31 March 2018	59,995	393,920	1,545	81,523	15,551	16,032	803	569,369
Revaluation reserve balance								
At 1 April 2017	22,855	70,169	1,798	-	4,601	-	257	99,680
Revaluation and indexation in year	1,943	(8,176)	(637)	-	-	-	-	(6,870)
At 31 March 2018	24,798	61,993	1,161	-	4,601	-	257	92,810

The effective date of land and building revaluation was 31 March 2018 and the valuation was carried out by independent valuer.

The range of useful economic lives over which property plant and equipment are depreciated are included in note 1.12.

For all categories of non-property assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

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11 Investments**11.1 Subsidiary undertakings, associates and joint ventures held**

The Foundation Trust's principal subsidiary undertakings, associates and joint ventures as included in its consolidated accounts are set out below.
The accounting date of the financial statements for the subsidiaries is 31 March 2019, and for the associate, 31 December 2018.
For the associate undertaking that has a different accounting year end date, draft accounts for year ending 31 December 2018, have been consolidated.
The Trust holds a £250k investment in KCH Commercial Services Ltd.

	Country of Incorporation	Beneficial interest	Principal activity
Directly owned subsidiary undertakings			
KCH Commercial Services Ltd	UK	100%	Holding company
KCH Interventional Facilities Management LLP *	UK	100%	Interventional Facilities Management
Indirectly owned subsidiary undertakings			
KCH Management Ltd	UK	100%	Healthcare services
Agnentis Ltd	UK	100%	Software consultancy and supply
Associates			
Viapath Group LLP (Viapath)	UK	33.3%	Healthcare services
Joint operations			
NIHR/Wellcome Trust Clinical Research Facility (CRF) **	UK		
Equity		35%	Research
Constructions		54%	Research
Other investments			
King's Fertility Limited	UK	10%	Healthcare services

* KCH Interventional Facilities Management LLP (KIFM) is a limited liability partnership between King's College Hospital NHS Foundation Trust (99%) and KCH Commercial Services Ltd (1%). KIFM started trading on 1 July 2016 and was set up to provide an efficient transformation and procurement service to the Trust. The income, expenses, assets, liabilities, equity and reserves of KIFM have been consolidated in full into the appropriate financial statement lines.

** The Foundation Trust entered into a joint operation with King's College London and South London and Maudsley NHS Foundation Trust for the construction and use of premises known as the NIHR/Wellcome Trust Clinical Research Facility, which opened in November 2012.

The Foundation Trust has capitalised 54% of the cost of the building, and equipment assets therein based on the construction proportion. The Foundation Trust recognises 35% of revenue and expenditure generated by the facility, based on the equity proportion as stipulated in the Collaboration Agreement.

11.2 Carrying value of associates

	2018-19 Viapath £000	2017-18 Viapath £000
Group		
Balance at 1 April	3,049	4,317
Share of profit	1,126	(1,268)
Balance at 31 March	4,175	3,049

11.3 Fair value of associates

	2018-19 Viapath £000	2017-18 Viapath £000
Total gross assets of the entity as at 31 March	47,355	47,686
Total gross liabilities of the entity as at 31 March	(37,507)	(41,217)
Total revenues for the year ending 31 March	122,028	116,656
Profit for the year ending 31 March	3,379	1,196

The above figures are estimates based on the Viapath annual accounts for the year ended 31 December 2018.

11.4 Carrying value of other investments

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
King's Fertility Limited	335	335	335	335
Other financial assets	1,690	-	-	-
	2,025	335	335	335

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11.5 Non-current assets held for sale and assets in disposal groups

	Group and Trust	
	31 March	31 March
	2019	2018
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	600	-
Assets classified as available for sale in the year	-	600
Less assets sold in year	(213)	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	387	600

Non-current assets classified as available for sale consisted of the long leasehold interest in two residential flats. These units were surplus to requirements and one unit was disposed of in 2018/19. The Trust expects to dispose of the remaining flat in 2019/20 through auction or sale on the open market.

12 Inventories**12.1 Inventories - current year**

	Group			
	Drugs	Consumables	Energy	Total
	£000	£000	£000	£000
At 1 April 2018	6,080	9,973	-	16,053
Additions	139,870	32,200	-	172,070
Inventories consumed and expensed	(139,381)	(30,440)	-	(169,821)
At 31 March 2019	6,569	11,733	-	18,302

Inventories - current year

	Trust			
	Drugs	Consumables	Energy	Total
	£000	£000	£000	£000
At 1 April 2018	6,080	1,633	-	7,713
Additions	139,870	71	-	139,941
Inventories consumed and expensed	(139,381)	-	-	(139,381)
Consumables sold to Subsidiary during year	-	(1,286)	-	(1,286)
At 31 March 2019	6,569	418	-	6,987

12.2 Inventories - prior year

	Group			
	Drugs	Consumables	Energy	Total
	£000	£000	£000	£000
At 1 April 2017	6,062	10,041	18	16,121
Additions	145,954	42,131	501	188,586
Inventories consumed and expensed	(145,936)	(42,199)	(519)	(188,654)
At 31 March 2018	6,080	9,973	-	16,053

Inventories - prior year

	Trust			
	Drugs	Consumables	Energy	Total
	£000	£000	£000	£000
At 1 April 2017	6,062	3,008	18	9,088
Additions	145,954	9,923	501	156,378
Inventories consumed and expensed	(145,936)	(8,952)	(519)	(155,407)
Consumables sold to Subsidiary during year	-	(2,346)	-	(2,346)
At 31 March 2018	6,080	1,633	-	7,713

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13 Trade and other receivables**13.1 Trade and other receivables**

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Current				
Contract receivables*	106,986	-	106,026	-
Trade receivables*	-	78,058	-	78,058
Accrued income*	-	20,025	-	21,598
Allowance for impaired contract receivables / assets*	(19,546)	-	(19,546)	-
Allowance for other impaired receivables	-	(15,866)	-	(15,866)
Deposits and advances	1,723	1,878	1,712	1,874
Prepayments (non-PFI)	5,164	6,153	3,844	5,330
PDC dividend receivable	-	1,000	-	1,000
VAT receivable	15,401	12,564	14,880	6,875
Other receivables due from subsidiaries	-	-	39,838	33,785
Other receivables	2,008	30,827	2,008	30,173
Total current receivables	111,736	134,639	148,762	162,827
Non-current				
Contract receivables*	4,860	-	2,265	-
Allowance for other impaired receivables	-	(2,682)	(1,183)	(14,622)
Other receivables due from subsidiaries	-	-	38,235	22,797
Other Receivables	6,745	15,693	6,746	10,415
Total non-current receivables	11,605	13,011	46,063	18,590
Total	123,341	147,650	194,825	181,417
Of which are receivable from NHS and DHSC group bodies:				
Current	60,902	77,746	60,902	77,746
Non-current	-	-	-	-
	60,902	77,746	60,902	77,746

The majority of trade is with NHS England and Clinical Commissioning Groups. As these bodies are funded by the UK Government to buy NHS patient care services, no credit scoring of them is considered necessary.

The largest outstanding debtor at 31 March 2019 was NHS England totalling £24.960m (2018: £36.694m).

* Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

13.2 Allowances for credit losses - 2018/2019

	Group		Trust	
	Contract receivables and contract assets £000	All other receivables £000	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 Apr 2018 - brought forward	-	18,548	-	30,488
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	18,548	(18,548)	30,488	(30,488)
New allowances arising	16,140	-	16,140	-
Reversals of allowances	(6,674)	-	(7,267)	-
Utilisation of allowances (write offs)	(8,468)	-	(18,632)	-
Allowances as at 31 Mar 2019	19,546	-	20,729	-

Allowances for credit losses - 2017/2018

	Group 31 March 2018 £000	Trust 31 March 2018 £000
Balance at 1 April	9,150	9,150
Amount written off during the year	(4,939)	(4,939)
Amount recovered during the year	(776)	(776)
Increase in receivables impaired	15,113	27,053
Balance at 31 March	18,548	30,488

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14 Cash and cash equivalents

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Opening balance	54,386	33,894	50,525	31,213
Net change in year	(8,615)	20,492	(11,308)	19,312
Closing balance	45,771	54,386	39,217	50,525
Made up of				
Cash with Government Banking Service	36,625	44,324	30,795	41,085
Commercial banks and cash in hand	9,146	10,062	8,422	9,440
Cash and cash equivalents as in statement of financial position	45,771	54,386	39,217	50,525
Patients' money held by the Foundation Trust, not included above	13	14	13	14

15 Trade and other payables

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Current				
Trade payables	22,201	23,978	53,853	21,739
Capital payables	7,929	7,693	7,929	7,693
Accruals	106,667	89,153	107,153	104,193
Receipts in advance	1,948	2,031	1,948	2,031
Social security costs	7,881	7,349	7,695	7,349
Other taxes payable	6,747	6,950	6,698	6,693
Accrued interest on loans*	-	2,983	-	2,983
Other payables	8,680	8,721	8,790	8,684
Total	162,053	148,858	194,066	161,365
Of which are receivable from NHS and DHSC group bodies:				
Current	17,408	18,062	17,408	18,062
Non-current	-	-	-	-

All trade and other payables are current; there are no non-current balances.

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 17. IFRS 9 is applied without restatement therefore comparatives have not been restated.

16 Other liabilities - Deferred income

	Group and Trust	
	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income	13,541	9,627
Total	13,541	9,627

All deferred income is current; there are no non-current balances.

The increase in Deferred Income from 2017/18 to 2018/19 is due largely to the deferral of Research Grants received (£1.645m).

King's College Hospital NHS Foundation Trust

17 Borrowings

	Group		Trust	
	31 March	31 March	31 March	31 March
	2019	2018	2019	2018
	£000	£000	£000	£000
Current				
Loans from DHSC				
Capital loans	11,120	9,038	11,120	9,038
Revenue support / working capital loans	179,163	98,900	179,163	98,900
Other loans	304	197	-	-
Obligations under finance leases	590	430	4,560	430
Obligations under PFI contracts	4,198	4,214	4,198	4,213
Total current borrowings	195,375	112,779	199,041	112,581
Non-current				
Loans from DHSC				
Capital loans	128,432	128,162	128,432	128,162
Revenue support / working capital loans	245,399	187,677	245,399	187,677
Revolving working capital facilities	89,600	89,600	89,600	89,600
Other loans	799	955	-	-
Obligations under finance leases	591	859	12,692	859
Obligations under PFI contracts	142,945	144,851	142,945	144,851
Total non-current borrowings	607,766	552,104	619,068	551,149
Total	803,142	664,883	818,110	663,730

The Trust has secured additional revenue support / interim working capital loans of £134.8m from the Department of Health in 2018/19 (2017/18: £131.8m). These are repayable between March 2021 to March 2022. The Trust also received Capital loans of £11m in 2018/19 (2017/18: £79.9m).

17.1 Reconciliation of liabilities arising from financing activities

Group	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2018	513,377	1,152	1,289	149,065	664,883
Cash movements:					
Financing cash flows - payments and receipts of principal	136,122	(138)	(529)	(4,213)	131,242
Financing cash flows - payments of interest	(16,259)	(219)	(5)	(16,596)	(33,079)
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	2,825	158	-	-	2,983
Additions	-	-	421	2,292	2,713
Application of effective interest rate	17,649	150	5	16,596	34,400
Carrying value at 31 March 2019	653,714	1,103	1,181	147,144	803,142

Trust	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2018	513,377	-	1,289	149,065	663,731
Cash movements:					
Financing cash flows - payments and receipts of principal	136,122	-	(3,330)	(4,213)	128,579
Financing cash flows - payments of interest	(16,259)	-	(211)	(16,596)	(33,066)
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	2,825	-	-	-	2,825
Additions	-	-	19,294	2,292	21,586
Application of effective interest rate	17,649	-	210	16,596	34,455
Carrying value at 31 March 2019	653,714	-	17,252	147,144	818,110

18 Finance lease obligations

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	1,195	1,335	18,455	1,335
Of which liabilities are due:				
- not later than one year	597	445	4,845	445
- later than one year and not later than five years	598	890	13,610	890
- later than five years	-	-	-	-
Total	1,195	1,335	18,455	1,335
Finance charges allocated to future periods	(14)	(46)	(1,203)	(46)
Net lease liabilities	1,181	1,289	17,252	1,289
Of which liabilities are due:				
- not later than one year	590	430	4,560	430
- later than one year and not later than five years	591	430	12,692	430
- later than five years	-	429	-	429
Total	1,181	1,289	17,252	1,289

19 Provisions**19.1 Provisions - current year**

Group	Total £000	Pensions: Early Departure costs £000	Pensions: Injury benefits * £000	Legal claims £000	Other £000
At 1 April 2018	7,507	5,569	375	365	1,198
Arising during the year	1,698	-	-	113	1,585
Utilised during the year - cash	(1,762)	(538)	(43)	(56)	(1,125)
Utilised during the year - accruals	(193)	(178)	(15)	-	-
Reversed unused	(216)	-	-	(216)	-
Change in discount rate	(171)	(171)	-	-	-
Unwinding of discount	10	5	5	-	-
At 31 March 2019	6,873	4,687	322	206	1,658
Expected timing of cash flows:					
No later than one year	2,640	718	58	206	1,658
Later than one year and not later than five years	3,105	2,873	232	-	-
Later than five years	1,128	1,096	32	-	-
Total	6,873	4,687	322	206	1,658

KCH Managment Services Ltd has included a provision of £16k which is consolidated in the group provisions within "Other provisions". This is excluded from the Trust only provision figures on the Statement of Financial Position.

The timing of the provisions cash flow represents our best estimate of future liabilities based on available input from NHS professionals in the respective areas.

"Other provisions" relates to provisions raised against the cost of defending and settling claims against the Trust.

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within legal claims.

19.2 Provisions - prior year

Group	Total £000	Pensions: Early Departure £000	Pensions: Injury benefits* £000	Legal claims £000	Other £000
At 1 April 2017	7,073	6,165	375	505	28
Arising during the year	1,360	-	-	190	1,170
Utilised during the year - cash	(635)	(543)	-	(92)	-
Utilised during the year - accruals	(178)	(178)	-	-	-
Reversed unused	(263)	-	-	(263)	-
Change in discount rate	134	112	-	22	-
Unwinding of discount	16	13	-	3	-
At 31 March 2018	7,507	5,569	375	365	1,198
Expected timing of cash flows:					
No later than one year	2,336	721	52	365	1,198
Later than one year and not later than five years	3,108	2,883	323	-	-
Later than five years	2,063	1,965	-	-	-
Total	7,507	5,569	375	365	1,198

KCH Managment Services Ltd has included a provision of £70k which is consolidated in the group provisions within "Other provisions". This is excluded from the Trust only provision figures on the Statement of Financial Position.

The timing of the provisions cash flow represents our best estimate of future liabilities based on available input from NHS professionals in the respective areas.

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within legal claims.

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19.3 Provisions - further information**Clinical negligence**

£523.843m (31 March 2018: £519.117m) is included in the provisions of the NHS Resolution at 31 March 2019, in respect of the estimated clinical negligence liabilities and existing liabilities of the Foundation Trust. As such, no provision is included in the Trust's accounts. NHS Resolution took over responsibility for unsettled clinical negligence claims for 1 April 2000, financial responsibility for all other clinical negligence claims transferred on 1 April 2002.

Pensions

The measure of the Foundation Trust's pension liability for early retired staff was recalculated in 2012-13, using the Office for National Statistics life expectancy tables. Expected future cash flows have been discounted using the real discount rate of 0.29% (2017/18: 0.1%) (set by HM Treasury) to determine the full liability.

Legal claims

The provision is based upon information provided by the NHS Resolution and refers to non-clinical claims against the Foundation Trust (e.g. public and employer's liability cases).

Other

The Foundation Trust has provided £0.082m (31 March 2018: £0.056m) for outstanding Employment Tribunal cases and associated legal fees. A further provision has been provided for the costs of defending and settling legal claims.

20 Contingencies

	Group and Trust	
	31 March	31 March
	2019	2018
	£000	£000
Contingent liabilities		
Non-clinical legal claims	106	114

The above contingencies refer to non-clinical legal claims, dealt with by the NHS Resolution on behalf of the Foundation Trust. This represents our best estimate of future liabilities based on available input from NHS professionals in the respective areas. The Foundation Trust has no contingent assets.

21 Contracted capital commitments

	Group and Trust	
	31 March	31 March
	2019	2018
	£000	£000
Property, plant and equipment	22,593	17,610

These contracts include the Critical Care Unit (£21.08m), ED Entrance (£0.022m), Replacement Angio 1 & 2 (£0.364m), Replacement of CT Scanner (£0.066m) and Safer Room (£0.016m). It is anticipated that these projects will be completed in the next financial year.

22 Revaluation reserve

Group and Trust		31 March	31 March
		2019	2018
	Intangibles	Property, plant and equipment	Total
	£000	£000	£000
At 1 April	37	92,810	92,847
Net impairments	-	(1,121)	(1,121)
Revaluations	-	17,442	17,442
Transfer to I&E reserve upon asset disposal	-	-	-
Other recognised gains and losses	-	-	-
At 31 March	37	109,131	109,168
			92,847

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23 On-SoFP PFI arrangements**23.1 The following are obligations in respect of the finance lease element of on-Statement of Financial Position PFI schemes:**

	Group and Trust	
	31 March	31 March
	2019	2018
	£000	£000
Gross PFI liabilities	359,661	375,605
Of which liabilities are due:		
- not later than one year	20,782	20,709
- later than one year and not later than five years	81,616	81,370
- later than five years	257,263	273,526
Total	359,661	375,605
Finance charges allocated to future periods	(212,517)	(226,540)
Net PFI liabilities	147,144	149,065
Of which liabilities are due:		
- not later than one year	4,198	4,214
- later than one year and not later than five years	14,863	12,773
- later than five years	128,083	132,078
Total	147,144	149,065

23.2 Total on-SoFP PFI commitments**Total future obligations under these on-SoFP schemes are as follows:**

	Group and Trust	
	31 March	31 March
	2019	2018
	£000	£000
Total future payments committed of which will fall due:		
- not later than one year	77,387	74,109
- later than one year and not later than five years	325,595	315,384
- later than five years	1,325,071	1,464,426
Total	1,728,053	1,853,919

23.3 Analysis of amounts payable to service concession operator**This note provides an analysis of the unitary payments made to the service concession operator:**

	Group and Trust	
	31 March	31 March
	2019	2018
	£000	£000
Unitary payment payable to service concession operator (total of all schemes)	80,593	77,162
Consisting of:		
- Interest charge	16,596	16,813
- Repayment of finance lease liability	4,213	3,918
- Service element	48,050	45,752
- Revenue lifecycle maintenance	3,293	3,231
- Contingent rent	8,441	7,448
	80,593	77,162
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	9,906	8,901
Total	90,499	86,063

23.4 PFI Schemes**King's College Hospital**

The PFI consisted of two phases: phase 1 (construction of the new Golden Jubilee Clinical Wing) and phase 2 (refurbishment of the existing Ruskin Wing). The project enabled the centralisation of acute services on the Denmark Hill site following the transfer of services from Dulwich Hospital and Mapother House. As part of the scheme, HpC (King's College Hospital) plc also took responsibility for the provision of site-wide catering, domestic and portering services from April 2000. As a result recurrent revenue savings were achieved.

The project has been financed by a 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. The annual payments by the Trust are dependent on availability and service quality standards being met. The commitments above include an inflationary increase of 2.5% (2017/18: 3.28%).

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Princess Royal Hospital - building PFI

Under the building PFI, United Healthcare (Bromley) Ltd provided the land, building and site-wide hard and soft facilities management at the Princess Royal Hospital.

The capital funding is a combination of senior debt and equity finance. The senior debt financing was originally provided by way of loan from Commerzbank AG (and others). There was a refinancing process in 2004 which involved the issue of 3.018% index-linked guaranteed secure bonds, repayable in 66 six monthly instalments which commenced in 2004 and will end in 2036, and are subject to half yearly indexation in line with RPI.

Princess Royal Hospital - managed equipment services PFI

The MES PFI Scheme agreement dated 22 March 2002 is a 30 year PFI agreement and relates to the purchase of medical equipment, and the installation, maintenance and replacement of this and other clinical equipment. This agreement is between (1) The Trust, (2) United Healthcare (Bromley) Limited and (3) Healthsource (Bromley) Limited and commenced on the 1st of January 2003.

24 Financial instruments**24.1 Risk profile and management****Financial risk management**

Financial reporting standard 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. Because of the continuing service provider relationship that the Foundation Trust has with NHS England and clinical commissioning groups, and the way those commissioners are financed, the 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 the financial reporting standards mainly apply. The 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 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. This treasury activity is subject to review by the internal auditor.

Currency risk

The Foundation Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Foundation Trust has no overseas operations. The Foundation Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

70% of the Foundation Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. The Foundation Trust is not, therefore, exposed to significant interest-rate risk. The two tables below show the interest rate profiles of the Foundation Trust's financial assets and liabilities.

Credit risk

Because the majority of the Foundation Trust's revenue comes from contracts with other public sector bodies, the Foundation Trust has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in the trade and other receivables note (note 13). Trade and other receivables outstanding but not past due date are considered recoverable and are not impaired. Factors determining the of impairment of trade and other receivables past due is included in note 1.15.

Liquidity risk

The Foundation Trust's operating costs are incurred under contracts with clinical commissioning groups and NHS England, which are financed from resources voted annually by Parliament. The Foundation Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Foundation Trust is not, therefore, exposed to significant liquidity risks.

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24.2 Financial assets

	Total £000	Floating rate £000	Fixed rate £000	Non-interest bearing £000
Group				
Gross financial assets				
at 31 March 2019	148,338	45,771	-	102,567
at 31 March 2018	173,552	54,386	-	119,166
Trust				
Gross financial assets				
at 31 March 2019	214,578	39,217	-	175,361
at 31 March 2018	212,637	50,525	-	162,112
The weighted average interest rate for total financial assets was 0.22% (2017/18: 0.11%).				
The weighted average period for which fixed years was unlimited (2016-17: unlimited).				
The non-interest bearing weighted average term years was nil (2016-17: nil).				

24.3 Financial liabilities

	Total £000	Floating rate £000	Fixed rate £000	Non-interest bearing £000
Group				
Gross financial liabilities				
at 31 March 2019	955,492	1,103	808,912	145,477
at 31 March 2018	804,902	1,153	671,236	132,513
Trust				
Gross financial liabilities				
at 31 March 2019	1,002,693	-	824,967	177,726
at 31 March 2018	816,442	-	671,166	145,276
The weighted average interest rate for total financial liabilities was 4.49% (2017/18: 4.61%).				
The weighted average period for which fixed years was unlimited (2016-17: unlimited).				
The non-interest bearing weighted average term years was nil (2016-17: nil).				

24.4 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group					
	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000		Total book value £000
Carrying values of financial assets as at 31 March 2019 under IFRS 9					
Trade and other receivables excluding non financial assets	100,155	-	-		100,155
Other investments / financial assets	-	-	2,412		2,412
Cash and cash equivalents	45,771	-	-		45,771
Total at 31 March 2019	145,926	-	2,412		148,338
Group					
	Assets at fair value through the I&E £000	Held to maturity £000	Available-for- sale £000		Total book value £000
Carrying values of financial assets as at 31 March 2018 under IAS 39					
Trade and other receivables excluding non financial assets	115,782	-	-		115,782
Other investments / financial assets	-	3,384	-		3,384
Cash and cash equivalents	54,386	-	-		54,386
Total at 31 March 2018	170,168	3,384	-		173,552
Trust					
	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000		Total book value £000
Carrying values of financial assets as at 31 March 2019 under IFRS 9					
Trade and other receivables excluding non financial assets	174,389	-	-		174,389
Other investments / financial assets	-	-	972		972
Cash and cash equivalents	39,217	-	-		39,217
Total at 31 March 2019	213,606	-	972		214,578
Trust					
	Assets at fair value through the I&E £000	Held to maturity £000	Available-for- sale £000		Total book value £000
Carrying values of financial assets as at 31 March 2018 under IAS 39					
Trade and other receivables excluding non financial assets	161,527	-	-		161,527
Other investments / financial assets	-	585	-		585
Cash and cash equivalents	50,525	-	-		50,525
Total at 31 March 2018	212,052	585	-		212,637

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24.5 Carrying values of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Carrying values of financial liabilities as at 31 March 2019 under IFRS 9	Held at amortised cost £000	Group Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	653,714	-	653,714
Obligations under finance leases	1,181	-	1,181
Obligations under PFI, LIFT and other service concession contracts	147,144	-	147,144
Other borrowings	1,103	-	1,103
Trade and other payables excluding non financial liabilities	145,477	-	145,477
Other financial liabilities	-	-	-
Provisions under contract	6,873	-	6,873
Total at 31 March 2019	955,492	-	955,492

Carrying values of financial liabilities as at 31 March 2018 under IAS 39	Held at amortised cost £000	Group Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	514,529	-	514,529
Obligations under finance leases	1,289	-	1,289
Obligations under PFI, LIFT and other service concession contracts	149,065	-	149,065
Trade and other payables excluding non financial liabilities	132,513	-	132,513
Other financial liabilities	-	-	-
Provisions under contract	7,507	-	7,507
Total at 31 March 2018	804,902	-	804,902

Carrying values of financial liabilities as at 31 March 2019 under IFRS 9	Held at amortised cost £000	Trust Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	653,714	-	653,714
Obligations under finance leases	17,252	-	17,252
Obligations under PFI, LIFT and other service concession contracts	147,144	-	147,144
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	177,726	-	177,726
Other financial liabilities	-	-	-
Provisions under contract	6,857	-	6,857
Total at 31 March 2019	1,002,693	-	1,002,693

Carrying values of financial liabilities as at 31 March 2018 under IAS 39	Held at amortised cost £000	Trust Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	513,376	-	513,376
Obligations under finance leases	1,289	-	1,289
Obligations under PFI, LIFT and other service concession contracts	149,065	-	149,065
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	145,276	-	145,276
Other financial liabilities	-	-	-
Provisions under contract	7,437	-	7,437
Total at 31 March 2018	816,443	-	816,443

24.6 Fair values of financial assets and liabilities

The carrying value of financial assets and liabilities is considered a reasonable approximation of their fair values.

24.7 Maturity of financial liabilities

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
In one year or less	343,493	247,715	379,392	260,212
In more than one year but not more than two years	215,624	90,268	227,529	90,070
In more than two years but not more than five years	177,485	239,263	176,891	238,671
In more than five years	218,890	227,657	218,881	227,490
Total	955,492	804,902	1,002,693	816,443

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25 Third party assets

At 31 March 2019, the Foundation Trust held £13,070 (31 March 2018: £13,917) cash at bank and in hand that related to monies held by the Foundation Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

26 Events after the reporting period

There have been no material adjusting or non-adjusting events after 31 March 2019.

27 Related parties

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 and Social Care is the Trust's parent department and ultimate controlling party.

During the year, none of the Board members, the Foundation Trust's governors, members of the key management staff or parties related to them have undertaken any material transactions with the Foundation Trust.

The Department of Health and Social Care is regarded as a related party. During the year, the Foundation 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 entity, including CCGs, NHS Trusts and NHS England, as well as the NHS Resolution and the NHS Business Services Authority (including NHS Supply Chain).

The Foundation Trust received revenue and capital payments from charitable funds, principally the King's College Hospital Charitable Fund and these transactions have been disclosed below.

In addition, the Trust has significant transactions with King's College London in respect of education, training and research and development.

The Foundation Trust has entered into the following material related party transactions:

	Income £000	Expenditure £000	Receivables £000	Payables £000
Department of Health and Social Care	13,084	-	6	-
NHS England	453,044	-	24,960	926
NHS Bexley CCG	43,438	-	2,025	67
NHS Bromley CCG	178,867	-	1,988	1,329
NHS Croydon CCG	20,037	-	-	175
NHS Dartford, Gravesham And Swanley CCG	10,283	-	-	454
NHS Greenwich CCG	20,878	-	2,872	26
NHS Lambeth CCG	72,729	-	2,222	1,570
NHS Lewisham CCG	38,730	-	2,756	353
NHS Medway CCG	3,729	-	-	106
NHS Southwark CCG	87,964	-	5,474	1,888
NHS Wandsworth CCG	2,693	-	183	-
NHS West Kent CCG	9,575	-	-	834
Guys And St Thomas NHS Foundation Trust	9,012	3,378	3,943	4,014
South London and Maudsley NHS Foundation Trust	1,506	1,662	400	858
Lewisham and Greenwich NHS Trust	1,208	3,380	746	3,130
Oxleas NHS Foundation Trust	1,427	9,357	597	1,424
Health Education England	42,290	-	252	626
NHS Resolution	709	38,582	-	81
NHS Blood and Transplant	2,573	6,208	-	12
HM Revenue and Customs	-	55,751	15,401	15,028
NHS Pension Scheme	-	59,412	-	356
Viapath Group LLP	6,543	43,478	2,467	439
King's College Hospital Charitable Fund	2,115	-	51	9
Kings College London	6,345	6,493	5,979	4,088
King's College Hospital Clinics LLC	245	-	132	-

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28 Losses and special payments

Group and Trust	2018-19		2017-18	
	Number	Value £000	Number	Value £000
Losses of cash due to:				
- overpayment of salaries	400	247	134	50
Bad debts and claims abandoned in relation to:				
- private patients	118	776	97	291
- overseas visitors	1,003	4,263	890	3,937
- other	120	826	-	-
Damage to buildings, property etc. due to:				
- theft, fraud etc.	11	11	24	29
Total losses	1,652	6,123	1,145	4,307
Special payments due to:				
- Compensation under court order or legally binding arbitration award	4	1,111	-	-
Ex-gratia payments due to:				
- loss of personal effects	2	3	-	-
Total special payments	6	1,114	-	-
Total losses and special payments	1,658	7,237	1,145	4,307

In 2018-19 there was 1 case where the loss or special payment exceeded £300,000 (2017-18: nil cases).

Losses and special payments are disclosed on an accruals, rather than a cash basis, but exclude provision for future losses.

29.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £2.983m, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model did not result in a change to the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £13.142m.

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29.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

The application of IFRS 15 has had a trivial impact in the Trust's current reporting period.

