



Annual Report and Accounts
2015-2016

King's College Hospital NHS Foundation Trust

Annual Report and Accounts 2015/16

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

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Picture I: King's College Hospital - Princess Royal University Hospital Site



Picture II: King's College Hospital - Denmark Hill Site

GLOSSARY

ACRONYM/WORD	MEANING
A&E	Accident & Emergency
ACC	Accredited Clinical Coder
AHP	Allied Health Professionals i.e. Physiotherapists, Occupational Therapists, Speech & Language Therapists etc.
AHSC	Academic Health Science Centre
ANS	Association of Neurophysiological Scientists Standards
BAF	Board Assurance Framework
BCIS	Bone Cement Implantation Syndrome
BER	Beyond Economical Repair
BHRS	British Heart Rhythm Society
BIU	Business Intelligence Unit
BME	Black and Minority Ethnic
BMI	Body Mass Index
BREEAM	Building Research Establishment Environmental Assessment Method
BSCN	British Society for Clinical Neurophysiology
BSI	The British Standards Institution
BSS	Breathlessness Support Service
CC	Critical Care
CCG	Clinical Commissioning Groups (previously Primary Care Trusts)
CCS	Crown Commercial Service
CCTD	Critical Care Theatres and Diagnostics
CCUTB	Critical Care Unit over Theatre Block
CDG	Cultural Diversity Group
C-difficile	Clostridium Difficile
CDU	Clinical Decisions Unit
CEM	Royal College of Emergency Medicine
CEO	Chief Executive Officer
CHD	Congenital Heart Disease
CHKS	Comparative Health Knowledge System
CHP	Community Health Partnership
CHR – UK	Child Health Clinical Outcome Review Programme (UK)
CLAHRC	Collaboration for Leadership in Applied Research and Care
CLINIWEB	The Trust's internal web-based information resource for sharing clinical guidelines and statements.
CLL	Chronic Lymphocytic Leukaemia
CLRN	Comprehensive Local Research Network
CMUH	Central Manchester University Hospitals
CNS	Clinical Nurse Specialist
CO2	Carbon Dioxide
COO	Chief Operating Officer
COPD	Chronic Obstructive Pulmonary Disease

ACRONYM/WORD	MEANING
COSD	Cancer Outcomes and Services Dataset
COSHH	Control of Substances Hazardous to Health
CPD	Continuing Professional Development
CPPD	Continuing Professional and Personal Development
CQC	Care Quality Commission
CQRG	Clinical Quality Review Group (organised by local commissioners)
CQUIN	Commissioning for Quality and Innovation
CRF	Clinical Research Facility
CRISP	Community for Research Involvement and Support for People with Parkinson's
CSHC	Certified Health and Safety Consultant
CT	Computerised Tomography
CUH	Cambridge University Hospitals
DAHNO	National Head & Neck Cancer Audit
Deloitte LLP	King's External Auditor
DH/KCH DH	Denmark Hill. The Trust acute hospital based at Denmark Hill
DIN	Disability Inclusivity Network
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DNAR	Do Not Attempt Cardiopulmonary Resuscitation
DoH	Department of Health
DOLS	Deprivation of Liberty Safeguards
DTOC	Delayed Transfer of Care
DTR	Default Rollover Tariff
ED	Emergency Department
EDS2	Equality Delivery System
EMIS	Egton Medical Information Systems
EMS	Environmental Management System
EPC	Energy Performance Contract
EPMA	Electron Probe Micro-Analysis
EPR	Electronic Patient Record
ERAS	Enhanced Recovery after Surgery
ERR	Enhanced Rapid Response
ESCO	Energy Service Company
EUROPAR	European Network for Parkinson's Disease Research Organization
EWS	Early Warning Score
FAST	Fast Alcohol Screening Test
FFT	Friends & Family Test
FY	Financial Year
GC	Gonorrhoea
GCS	Glasgow Coma Scale
GMC	General Medical Council
GP	General Practitioner
GSTS Pathology	Venture between King's, Guy's and St Thomas' and Serco plc

ACRONYM/WORD	MEANING
GSTT	Guy's St Thomas' NHS Foundation Trust
H&S	Health & Safety
HASU	Hyper Acute Stroke Unit
HAT	Hospital Acquired Thrombosis
HAU	Health and Aging Units
HCAI	Healthcare Acquired Infections
HCAs	Health Care Assistants
HESL	Health Education South London
HF	Heart Failure
HIN	Health Innovation Network
HIV	Human Immunodeficiency Virus
HNA	Holistic Needs Assessment
HQIP	Healthcare Quality Improvement Partnership
HRWD	'How are we doing?' King's Patient/User Survey
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HTA	Human Tissue Authority
HWB	Health and Well Being
IAPT	Improving Access to Psychological Therapies
IBD	Inflammatory Bowel Disease
ICAEW	Institute of Chartered Accountants in England and Wales Code of Ethics
ICH	International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use
ICNARC	Intensive Care National Audit & Research Centre
ICO	Information Commissioner's Office
ICT	Information and Communications Technology
ICU	Intensive Care Unit
IG Toolkit	Information Governance Toolkit
IGSG	Information Governance Steering Group
IGT	Information Governance Toolkit
IHDT	Integrated Hospital Discharge Team
ILM	Institute of Leadership and Management
iMOBILE	Specialist critical care outreach team
IPC	Integrated Personal Commissioning
ISO	International Organization for Standardization
ISS	Injury Severity Score
JCC	Joint Consultation Committee
KAD	King's Appraisal & Development System
KCH, KING's, TRUST	King's College Hospital NHS Foundation Trust
KCL	King's College London – King's University Partner
KHP	King's Health Partners
KHP Online	King's Health Partners Online
KPIs	Key Performance Indicators

ACRONYM/WORD	MEANING
KPMG LLP	King's Internal Auditor
KPP	King's Performance and Potential
KWIKI	The Trust's internal web-based information resource. Used for sharing trust-wide polices, guidance and information. Accessible by all staff and authorised users.
LCA	London Cancer Alliance
LCN	Local Care Networks
LGBT	Lesbian, Gay, Bisexual and Transgender
LIPs	Local Incentive Premiums
LITU	Liver Intensive Therapy Unit
LOCSSIPs	Local Surgical Safety Interventional Procedure Standards
LPG	Liquefied Petroleum Gas
LRS	Liver, Renal and Surgery
LUCR	Local Unified Care Record
MACCE	Major Adverse Cardiac and Cerebrovascular Event
MBRRACE-UK	Maternal, Newborn and Infant Clinical Outcome Review Programme
MCA	Mental Capacity Act 2005
MDMs	Multidisciplinary Meeting
MDS	Myelodysplastic Syndromes
MDTs	Multidisciplinary Team
MEOWS	Modified Early Obstetric Warning Score
MHA	Mental Health Act
MHRA	Medicine Health Regulatory Authority
MINAP	The Myocardial Ischaemia National Audit Project
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant staphylococcus aureus
MSM	Men Who Have Sex with Men
MTC	Major Trauma Services
NAC	N-acetylcysteine
NADIA	National Diabetes Inpatient Audit
NAOGC	National Audit of Oesophageal & Gastric Cancers
NASH	National Audit of Seizure Management
NBOCAP	National Bowel Cancer Audit Programme
NCAA	National Cardiac Arrest Audit
NCEPOD	National Confidential Enquiry into Patient Outcome & Death Studies
NCISH	National Confidential Inquiry into Suicide & Homicide for People with Mental Illness
NCLA	National Lung Cancer Audit
NCPES	National Cancer Patient Experience Survey
NDA	National Diabetes Audit
NEDs	Non-Executive Directors
NELA	National Emergency Laparotomy Audit
NEST	National Employment Savings Trust
NEWS	National Early Warning System

ACRONYM/WORD	MEANING
NGT	Nasogastric Tube
NHFD	National Hip Fracture Database
NHS	National Health Service
NHS IC	National Health Service Information Centre
NHS Safety Thermometer	A NHS local system for measuring, monitoring, & analysing patient harms and 'harm-free' care
NHSBT	NHS Blood and Transplant
NICE	National Institute for Health & Excellence
NICU	Neonatal Intensive Care Unit
NIHR	National Institute for Health Research
NJR	National Joint Registry
NMC	Nursing and Midwifery Council
NNAP	National Neonatal Audit Programme
NPDA	National Paediatric Diabetes Audit
NPID	Pregnancy Care in Women with Diabetes
NPSA	National Patient Safety Agency
NRAD	National Review of Asthma Deaths
NRLS	National Reporting and Learning Service
NUTH	Newcastle upon Tyne Hospitals
OBDs	Occupied Bed Days
OH/ORPINGTON HOSPITAL	The Trust acquired services at this hospital site on 01 October 2013
OSC	King's Organizational Safety Committee
OUH	Oxford University Hospitals
PALS	Patient Advocacy & Liaison Service
PbR	Payment by Results
PCAs	Patient Controlled Analgesia
PCI	Percutaneous Coronary Intervention
PEACE	Proactive Elderly Advance CarE
PFI	Private Finance Initiative
PGMDE	Postgraduate Medical and Dental Education
PICANet	Paediatric Intensive Care Audit Network
PiMS	Patient Administration System
PLACE	Patient Led Assessments of the Care Environment
POEM	Peroral Endoscopic Myotomy
POMH	Prescribing Observatory for Mental Health
POTTS	Physiological Observation Track & Trigger System
PPI	Patient & Public Engagement and Experience
PROMs	Patient Reported Outcome Measures
PRUH/KCH PRUH	Princess Royal University Hospital. The Trust acquired this acute hospital site on 01 October 2013
PUCAI	Paediatric Ulcerative Colitis Activity Index
PwC	PricewaterhouseCoopers
QMH	Queen Mary's Hospital

ACRONYM/WORD	MEANING
QMS	Queen Mary's Hospital Sidcup
QUIPP	Quality, Innovation, Productivity and Prevention Programme
RAID	Rheumatoid Arthritis Impact of Disease
RCPCH	Royal College of Paediatric and Child Health
RIDDOR	Reporting of Injuries, Dangerous Diseases and Dangerous Occurrences Regulations
ROP	Retinopathy of Prematurity
RRT	Renal Replacement Therapy
RTT	Referral to Treatment
SASG	Staff and Associate Specialist Grade
SBAR	Situation, Background, Assessment & Recognition factors for prompt & effective communication amongst staff
SCG	Specialist Commissioning Group (NHS England)
SCLC/NSCLC	Small-cell Lung Cancer/Non-Small Lung Cancer
SCTS	Society for Cardiothoracic Surgery in Great Britain & Ireland
SDU	Sustainable Development Unit
SEL	South East London
SEQOHS	Safe Effective Quality Occupational Health Service
SHMI	Standardised Hospital Mortality Index. This measure all deaths of patients admitted to hospital and those that occur up to 30 days after discharge from hospital.
SIRO	Senior Information Risk Owner
SLAM	South London & Maudsley NHS Foundation Trust
SLHT	South London Health Care Trust. SLHT dissolved on 01 October 2013 having being entered into the administration process in July 2012.
SLIC	Southwark & Lambeth Integrated Care Programme
SOP	Standard Operating Procedure
SSC	Surgical Safety Checklist
SSIG	Surgical Safety Improvement Group
SSNAP	Sentinel Stroke National Audit Programme
SUS	Secondary Uses Service
SW	Social Worker
TARN	Trauma Audit & Research Network
TLC	Turn Off, Lights Out, Close Doors
TTAs	Tablets to take away
TUPE	Transfer of Undertakings (Protection of Employment) Regulations
UAE	United Arab Emirates
UCL	University College Hospital
UNE	Ulnar Neuropathy at Elbow
VTE	Venous-Thromboembolism
W&C	Women & Children's
WHO	World Health Organisation
WISE	Women in Science, Technology and Engineering
WTE	Whole Time Equivalent

Introduction





Picture III: The first King's College Hospital (c.1840) built from a converted workhouse in Portugal Street

King's College Hospital today is renowned for the international reputations of its specialty services. These include the tertiary services for liver disease and transplantation, neurosciences, cardiology, haematology, paediatric disease and foetal medicine. In addition there is a wide range of local services which includes a large accident and emergency department, orthopaedics, diabetes, ophthalmology, dermatology and many more. The historical vignettes presented throughout this report attempt to illustrate the foundations of KCH through short notes on the origin of the hospital building and some of the great people who brought fame to the institution in the early years.

Chair's Statement



I am delighted to be writing this statement for the Annual Report and Accounts, my first as Chairman.

I joined the Trust in April 2015, having spent the majority of my career in local Government, and latterly as Head of the Civil Service.

I have spent the past 12 months getting to know King's and the challenges we face – which are significant, although the Trust is not alone in this regard. The NHS is under pressure, both financially and operationally, and this is unlikely to change any time soon.

However, despite the challenges, I have been impressed with the attitude of staff up and down the organisation, and across the various sites King's now runs in south east London.

Patients rightly expect a first-class service when they visit our hospitals – and, in many cases, we are able to provide it. Unfortunately, this isn't always the case and, as our CQC inspection rating of 'requires improvement' shows, we need to do better in many areas. I am pleased to say we have an action plan to address areas for improvement, many of which have already been completed.

We have made a number of new appointments at both non-executive and executive level, in a year of major change for the organisation. We have also welcomed new non-executives from a range of different professions, which I am very excited about. I was particularly delighted to welcome Nick Moberly back

to the Trust, and he took over from Roland Sinker as Chief Executive in November 2015.

Nick Moberly re-joined the Trust from Royal Surrey County Hospital, having previously worked at King's as Director of Strategy. Since November, Nick has been busy building his executive team, as well as developing ambitious transformation plans for the organisation, which will ensure we are fit for purpose in the future, and better equipped to provide the care our patients deserve. Watch this space.

King's continues to be a major employer locally, and a significant part of the communities we serve. Since becoming Chair, I have encouraged more proactive engagement with local stakeholders, in particular those organisations also involved in delivering healthcare to the people of south east London.

We are one organisation and, however hard we try, we can't solve systemic problems – such as increased A&E attendances, delayed discharge of patients – on our own. By working more closely with our local health and social care partners, I am confident we will be in a better position to tackle these and other challenges facing the NHS.

Finally, I would like to say how much I've enjoyed my first year at King's. It has been as exciting and interesting as people told me it would be. I look forward to building on the progress we are making, to ensure that it is our patients who reap the benefit in the future.

A handwritten signature in black ink, appearing to read "R W Kerslake".

Lord Kerslake
Chair

Chief Executive's Statement



I have been Chief Executive at King's for six months now, and I am delighted to be back, having held the position of Director of Strategy here up until 2006.

The past year at King's has been extremely challenging, particularly from a financial perspective. We set ourselves the ambitious target at the start of the year of securing £65 million of savings from our annual budget.

I am pleased to say that we finished the in line with our financial recovery planned target, having delivered one of the biggest savings packages ever seen in the NHS.

The scale of the task the organisation faced shouldn't be underestimated, and the pressure on staff to deliver the savings required has been intense.

Every member of the Board acknowledges this, and I want to say how impressed I have been at the can-do attitude of staff, who have helped us identify savings whilst also continuing to deliver services day in, day out for patients.

Our focus at all times has been on securing the required savings, whilst also ensuring we protect frontline services – patients are the reason we are here, and we need to make sure they are getting the care and treatment they deserve at all times.

We have managed to achieve the required savings by streamlining processes and patient pathways; by reducing the amount

of money we spend on agency nurses and locum doctors; and by negotiating better terms for the purchase of drugs and medicines.

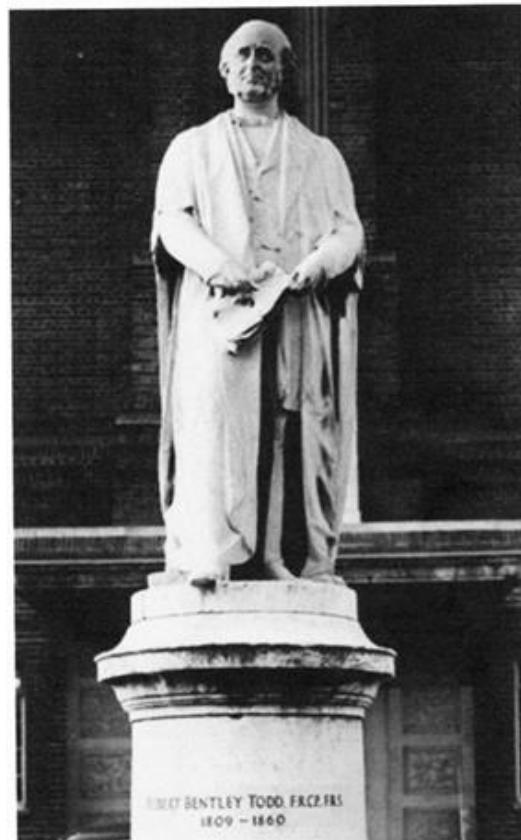
Of course, we have had to take some difficult decisions – however, the savings programme has also helped us identify ways of doing things better, and more efficiently. For example, we are now doing more and more procedures in day surgery, as opposed to main theatres; this is better for patients, who get to go home the same day after their operation, but also means we reduce the number of days patients spend in hospital, which is more cost-effective.

Our financial position has improved, but we need to make further savings in 2016/17. However, we are now much better positioned to identify the savings required, and how they can be delivered without impacting adversely on the patient services we provide.

The financial challenges aside, we are improving care for patients; although the CQC's rating of 'requires improvement' following their inspection in April 2015 is a reminder that we have a long way to go. But we are making progress, and over the coming 12 months we will continue to deliver on the action plan we presented to the CQC in November 2015.

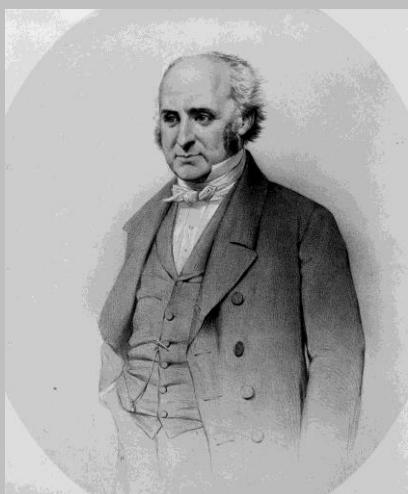
On a positive note, we are continuing to modernise our hospitals, with the helipad at Denmark Hill nearing completion, and the elective orthopaedic centre we created at Orpington Hospital now among the most highly rated centres in London by patients on the NHS Choices website. Our stroke services at both Denmark Hill and the PRUH sites are also rated as the best in the country, which is fantastic, and credit to the staff who work in them.

In conclusion, I would also like to thank our patients, who often write to me praising the care they've received. Staff also deserve huge credit for their efforts this year, and I am looking forward to shortly launching a clear strategy and transformation project for the organisation, which will give everyone a stronger sense of direction going forward, after a challenging 12 months.



Picture IV: Statue of Professor Robert Bentley Todd

Nick Moberly
Chief Executive Officer



Picture V: Professor Robert Bentley (1809-1860)

KCH rapidly gained a first class staff led by Robert Bentley Todd, (1809-1860), the professor of physiology and anatomy, who introduced an effective tutorial system of teaching which he had admired whilst a student at Oxford University. His neurological studies are remembered in the description of post epileptic transient paralysis known as 'Todd's paralysis.'



Performance Report





Picture VI: The second King's College Hospital c.1865

King's College London was founded in 1829 as a Christian institution with Royal patronage. Clinical teaching in the medical faculty was dependant on the Middlesex hospital until 1839 when KCL gained its own hospital in Portugal Street, a former workhouse. This was rebuilt in 1861. The site of the hospital is now occupied by the London School of Economics.

Sir William Bowman (1816-1892) was an internationally renowned histologist, surgeon, and close colleague of Bentley Todd. They worked together in raising the standard of medical education and with the help of Florence Nightingale, a close friend of Bowman, they designed the second KCH in Portugal Street on the foundations of the first.

Overview of Performance

Overview of Trust

King's College Hospital NHS Foundation Trust received foundation trust status on 01 December 2006. The Trust 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.

The regulator carried out an investigation at King's in March 2015 after the trust was unable to resolve long-standing problems at the Princess Royal University Hospital (PRUH), which it took over in October 2013.

As a result of the investigation the Trust was placed under enforcement action and as such successfully delivered the following to Monitor between April - October 2015:

- A one year financial recovery plan for 2015/16.
- A recovery plan for the two years, 2015/16 and 2016/17.
- A five-year Strategic Plan for the Trust's longer-term sustainability.

King's is required to make periodic submissions pertaining to its strategic plans, audit results and its financial and operational performance to Monitor.

These plans and submissions provide the framework for decision-making and performance tracking. As part of King's annual reporting to Monitor, the Board of Directors had to assess and forecast how the organisation would perform operationally and financially.

The Board also had to self-certify against three statements:

- General condition systems for compliance with Licence Conditions.
- Continuity of services condition 7 – availability of resources.
- How it will perform in relation to the corporate governance statements outlined in the licence.

On completing a review of its performance against licence conditions, schedule of assurance against corporate governance statements, board assurance framework and the risk registers, the Board identified and self-certified that there were risks to achievement of the following targets for 2015/16:

- RTT admitted-completed, non-admitted completed and Incomplete pathways.
- Total time in A&E under 4 hours.
- Cancer 62 day waits for first treatment.
- Clostridium-difficile.

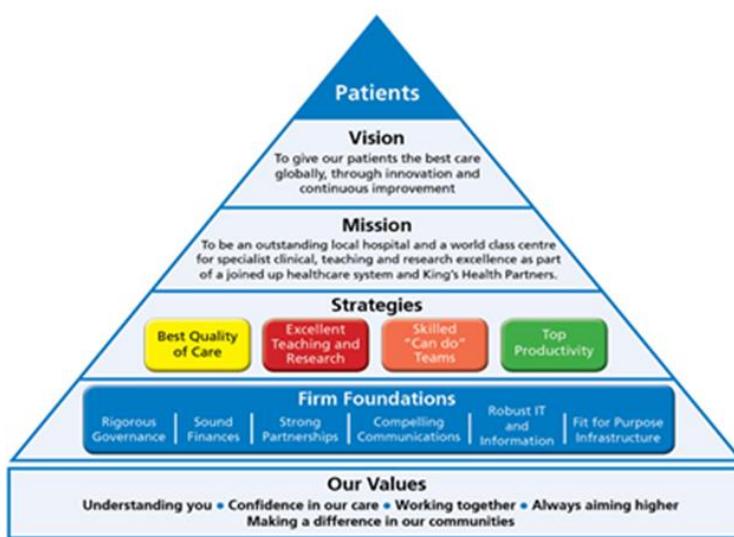
		2014/2015		2015/16	
		CoSRR	GRR	CoSRR /FSRR	GRR
Quarter	Q1	3	Under Review	1	Red - Enforcement Action
	Q2	3	Under Review	1	Red - Enforcement Action
	Q3	3	Under Review - investigation	1	Red - Enforcement Action
	Q4	3	Red - Enforcement Action	2	Red - Enforcement Action

Table 1: Summary of regulatory ratings (*Continuity of Risk Rating/Financial Sustainability Risk Rating/**Governance Risk Rating)**

Details of the financial and operational performance and risks can be found on pages 25-32.

Planning for the Future

The Trust has developed and codified its strategic vision, mission and objectives as detailed in diagram below.



The King's vision is to give our patients the best care globally, through innovation and continuous improvement.

King's provides services to local residents of Lambeth, Southwark, Bromley, Bexley and Lewisham. For people across south east London and Kent, King's is the designated major trauma centre, a heart attack centre and a regional hyper-acute stroke centre. King's is recognised across the UK and internationally for its work in liver disease and transplantation, neurosciences, diabetes, cardiac services, haematology and foetal medicine.

The local healthcare system faces a tremendous challenge - to transform care models to meet the needs of an ailing and ageing population and improve quality at a time when finances are very strained. The south east London health economy faces a net financial deficit over the next five

years, if action is not taken, of approximately £1 billion.

Performance for referral to treatment (RTT), clinical outcomes for key services, and discharge times need to improve, whilst at the same time there is demographic growth and increasing demand for services.

King's plan is to ensure the Trust rectifies its budget position, and remains efficient, highly productive and fosters innovation in all areas. In addition to a robust programme of cost improvement the Trust is developing a transformation plan to support lean service delivery in 2016/17. The plan will improve the quality of services offered, address some of the pressing needs of the local health system and support the financial recovery.

However, delivering better care for service users and King's long-term sustainability will require both more ambitious changes at King's and more joined-up system redesign across the south east London health and care economy. Together with our partners we will need to make, and implement, significant strategic choices with implications for services and funding across the whole health and care system.

Nationally, strong emphasis is being placed on broad geographical areas developing overarching Sustainability and Transformation Plans (STP). King's is working together with commissioners and providers on a south east London STP, and work has already begun under the auspices of the "Our Healthier South East London". We are scoping a number of important quality and efficiency initiatives – with early attention being given to the configuration of orthopaedic services across the sector.

In parallel, King's continues to work with our partners in King's Health Partners to develop a specialist service portfolio, focusing initially on plans to create powerful new KHP Institutes for Neurosciences, Haematology and Cardiovascular Services. The partners are also looking at how to collaborate in Child Health, and how to strengthen the academic profile in Liver and Transplantation.

The Trust is also developing an overarching clinical/site strategy which will lay out clearly what services the Trust intends to offer, on which sites, and the capacity which will be required to meet forecast levels of demand.

The development of this detailed strategic plan has already started. Because of its complexity and wide-ranging impact on people and organisations, King's is committed to involving and engaging staff, governors and local commissioners and stakeholders.

Quality priorities

King's Quality Account, on pages 107--178, sets out the priority areas for improving quality in the coming year, as well as evaluating performance against last year's priorities.

King's Health Partners Academic Health Sciences Centre

King's Health Partners (KHP) Academic Health Sciences Centre was set up in 2009. It brings together a world-leading research led university (King's College London) and three successful NHS foundation trusts (Guy's and St Thomas', King's College Hospital and South London and Maudsley).

KHP launched its five year plan in summer 2014, aimed at transforming health and wellbeing, locally and globally. Combining its focus on key underpinning themes of excellence in education, research translation and clinical practice, public health, integrated care, mind and body and value based healthcare. KHP also aims to achieve internationally competitive standards of practice in a number of key specialties.

A key part of the KHP's vision for excellence is the way in which it continues to align itself with its partners right across the south east London health and care economy. Colleagues from across KHP have been closely involved in developing the '*Our Healthier South East London*' strategy and KHP is committed to supporting and enabling its successful delivery.

Local services

KHP is aware that successful delivery of the six borough strategy in south east London requires the ongoing delivery of high quality services right across the three foundation trusts and wider partners. To this end, KHP is committed to seeking continuous improvement of its services, working closely with partners across the sector to deliver joined up and effective care for local people.

Provision of excellent local services remains the highest priority and KHP is taking significant strides towards the integration of care: working with local colleagues to develop and deliver Local Care Networks and GP federated structures which KHP fully support as an important step towards better integrated care.

Specialised Services

People in south east London should have access to the very best specialist care, as benchmarked against the best in the world.

KHP believe that a new type of clinical and academic model for south east London (and stretching across the south of England), working across sites and campuses to bring together the combined strength of the partners, will provide improved outcomes and experience for patients and service users whilst ensuring the delivery of its science and translational research ambitions. In scoping the feasibility of making further improvements to its services across KHP, KHP is considering:

- How the nature of differing specialties now and in the future will require bespoke and carefully calibrated models of delivery, particularly with regard to clinical pathways across out of hospital and in hospital care environments.
- That some specialties may require highly specialised tertiary diagnostic and treatment facilities in one place to enable translational practice. For others the model of care may require a new focus on localities, communities and acute hospital pathways.
- Improved informatics and data sharing to be crucial – the development of KHP Online and its planned evolution into the Local Unified Care Record (LUCR) is a major step in the right direction.
- The collective strength in KHP's partner organisations and leveraging the expertise of clinical services, research and education into a more joined up offer.

- Improving access to the very best specialist care with the best outcomes for patient and family experience.
- Providing networks of care across south east London/south east England that support acute, community and primary care.

As set out in the five year plan, KHP is focusing on achieving internationally competitive excellence in the seven key specialties of cancer, cardiovascular, child health, dental, diabetes, mental health & neurosciences and regenerative & transplantation medicine through the establishment of institutes that bring together clinical service, teaching and research.

Research

KHP is working hard to speed up how the outputs of research can be incorporated into clinical care, from basic science through to novel therapeutics, drug discovery, clinical trials and applied research so that the local population reap the benefits more quickly.

Education and training

KHP will continue to develop its educational and training programmes to support the emerging models of care recognising the increasing need for healthcare workers that can work across traditional boundaries and apply their skills in a range of settings.

Central to everything KHP does will be a focus on improving outcomes, experience and public health for patients, service users and local population. CCG, local government, stakeholder, locality and patient perspectives will drive KHP's thinking. To this end KHP look forward to hearing views and reflections from CCG colleagues and wider stakeholders about how it moves forward and makes the

changes needed for patients and service users. KHP is committed to working with local partners over the coming months to shape and design the collective vision for excellence.

Ensuring Financial Sustainability

2015/16 was essentially a year focusing on the turnaround of the Trust's finances, recognising the significant financial challenges faced. The Trust established a Turnaround programme and developed a Programme Management Office to ensure there was sufficient rigour in delivering the programme.

For 2015/16 the Trust agreed with Monitor (the regulator) that it would end the year with a deficit of £65 million. This was under-pinned by a £86 million savings programme being built into the financial plan. Against the ambitious target of £86 million to be saved in-year, the Trust delivered £56.5 million efficiencies during the 2015/16 financial year.

The Trust's final outturn was £65.4m deficit. This was achieved by taking mitigating actions. Many of these actions were one-off in nature.

Liquidity and capital

For 2015/16 the Trust utilised internal cash resources and a long term loan of £98.9m from the Department of Health to address the liquidity issue driven by the financial operating deficit of £65m. The Trust has a working capital facility of £89.4m in place for 2016/17. The Trust is working with NHSI in respect to further working capital support and capital funding to achieve operational targets. When the Trust agrees the 2016/17 control total with NHSI, non-recurrent Sustainability and Transformation funds at a value of £30m

will be provided. The Trust's five year strategic plan will identify further long term support in line with the Trust's underlying deficit in conjunction with the transformation programme and capital plan.

Total capital expenditure in 2015/16 was £28.6m – the major schemes being the ongoing project to expand critical care capacity and the new Helipad. For future years, the capital programme has been reviewed to include only schemes that are already in progress, are essential for health and safety reasons or directly contribute to the financial and operational recovery plans.

Going Concern

The Board has carefully considered whether the accounts should be prepared on the basis of being a 'Going Concern'. The Board considered the advice in the Government Reporting Manual 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." 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 NHS Improvement. The Directors have a reasonable expectation that this will be the case.

More information on going concern can be found on pages 179-243 in the Annual Accounts. Furthermore the Trust is working closely with partners to develop medium-term sustainability and transformation plans.

Value for money and improved efficiency

Divisions and corporate departments delivered £56.5m of cost improvement schemes representing 90.3% of the planned schemes (£62.5m) during 2015/16; noting the original CIP plan was £86.3m

Changes to accounting policies

There were no significant changes to accounting policies during the year.

Cost allocation requirements

King's has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

The Trust's deficit for the year was £87.103m and this figure includes the asset impairment cost of £21.708m. 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 Trust's consolidated operational deficit for the year was £65.4m which was in line with the Trust's financial recovery plan for 2015/16.

External audit services

Deloitte LLP is King's external auditor having been appointed by the Council of Governors the details of that can be found on pages 47-69 of the Directors Report.

King's incurred £125,000 in audit services fees in relation to the statutory audit for the year to 31 March 2016 and £20,000 in respect of audit-related assurance services.

Borrowing and capital plans

Due to the adoption of International Financial Reporting Standards, the majority of the Trust's reported borrowing represents 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.

Further borrowing has been undertaken to finance the construction of the new Critical Care Facility. At 31 March 2016, loans outstanding to the Department of Health totalled £165m.

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 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.

King's has low exposure to interest rate risk and credit risk material for the assessment of the assets, liabilities, financial position and results of the entity. Due to the Trust's investing 2.58% in King's College Hospital Clinics LLC (KCHC), operating in the United Arab Emirates, the Trust is exposed to limited currency risk in the form of currency rate fluctuations on interest and capital repayments of the loan denominated in Emirati Dirhams (AED).

The Trust is currently exposed to liquidity risk due to its requirement for working capital support. The Trust has secured £89m of Interim Revolving Working Capital Support Funding from Monitor/DoH but agreement is required from Monitor regarding the amount that may be drawn down on a monthly basis.

Details of Overseas Operations

King's Commercial is the company established to oversee 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 eight years.

During that time, the first of the operating companies, Agnentis 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 and Africa and latterly India. In November 2015, King's Commercial announced an agreement with Ashmore, Al Tayer and Dubai Investments to expand King's operation in Abu Dhabi, which opened in October 2014 with a further three Clinics and a hospital to be located in Dubai. In the same month, at a ceremony attended by both the UK and Indian Prime Ministers, the company also announced plans to open a series of hospitals in India as part of the Indian government's 'Smart Cities' initiative. The company also operates a successful international recruitment business both for King's and other healthcare organisations.

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 2015 financial year of £875k.

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 2015/16, it is estimated that the surplus reinvested was approximately £7m.

Further information about these risks can be found in the financial statements on pages 179-243.

Full details of financial performance in 2015/16, the responsibilities of the Accounting Officer and a statement from the auditors can be found in the Annual Accounts 2015/16 on pages 179-243.

The accounts have been prepared under a direction issued by Monitor under the National Health Service Act 2006.

Table 2: Key Financial Implications

Full Year (£'000)	2015-16	2014-15
Operating income and costs	1,067,006	1,083,782
Operating income from continuing operations	(1,119,308)	(1,099,712)
Operating expenses from continuing operations	(52,302)	(15,930)
Operating surplus/deficit	(35,405)	(36,642)
Net finance costs		
Share of profit of Associate/Joint Ventures accounted for using the equity method	652	757
Gain from transfer by absorption	-	-
Corporate tax expense	(47)	(250)
(Deficit)/surplus from continuing operations	(87,102)	(52,065)
Add back impairment and reversal of impairment	21,708	4,535
(Deficit)/surplus from continuing operations	(65,394)	(47,530)



Key operational and performance highlights

During 2015/16 King's continued to see high numbers of patients coming into its Emergency Departments (ED) at both the Denmark Hill (DH) and Princess Royal University Hospital (PRUH) sites, and an increase in the acuity level of patients requiring emergency admission.

Consequently, King's bed occupancy has remained high at over 97% which has put considerable pressure on delivering King's key performance targets, such as getting patients into hospital quickly enough and managing infection control trajectories across the acute sites. King's is not alone in these challenges as these pressures are mirrored across South East London.

Emergency department '4-hour wait' performance

During the period, King's continued to face significant challenges in meeting its 4-hour waiting time standard (95%) but has made significant investment with commissioner financial support on both its acute sites in the form of additional staff and extra capacity to enable improved delivery in the face of increasing demand. These developments will come on line in 2016/17

Innovative ideas to support improved flow and capacity include the establishment of Acute Care Hub models in the latter half of the year at the PRUH and at the DH site. In addition, repatriation bed day delays that have been a historic issue compounding capacity constraints, improved significantly in 2015/16 with the introduction of a Repatriation Project Manager across South East London and

implementation of the South London Repatriation Network.

Denmark Hill '4-hour wait' performance

The number of patients attending the ED during 2015/16 increased by 2.3% compared to the previous year, with a significant increase in attendances during March 2015 where we saw the highest number of patients in a month.

Bed flow and capacity remain the major challenge, and alongside the development of new and pathways and service models that will take time to embed and deliver the improvements required. As a result, the 4-hour target has not been achieved in any quarter during 2015/16, but is anticipated to be delivered by the end of 2016/17.

PRUH '4-hour wait' performance

The 4-hour target has also not been achieved in any quarter during 2015/16 at the PRUH site including the Urgent Care Centre (UCC) which sees 'type 3' attendances. Performance improvements were made for each quarter compared to 2014/15, with 91.2% achieved in quarter two, but has remained highly challenged since.

The number of patients attending the ED during 2015/16 has remained relatively stable with a 0.3% increase. However, there has been an 8.6% increase in the number of patients attending the UCC which has led to an increased number of type 3 breaches and late handovers to the ED, which impact on our reported performance for the PRUH site.

King's was actively involved with our local commissioners in a review of in-hospital and wider local health economy patient flow and pathways, led by McKinsey. The resulting 'One Version of the Truth'

recommendations and actions which were published by McKinsey were incorporated into the PRUH site ED recovery plan for 2015/16 and remain a feature of the improvement plans being developed for 2016/17.

Referral to Treatment (RTT) 18 Week Access targets

During 2014 King's migrated data from the legacy patient administration systems (Cerner at Queen Mary's Sidcup hospital and OASIS at PRUH) into its PiMS system. This resulted in a large number of patients having multiple hospital numbers and further complicated our ability to monitor and manage pathways for patients with admitted and non-admitted (outpatient) appointments. The Trust requested an RTT reporting break which was supported by Monitor, NHS England and local commissioners, originally from April 2015 for six months and later extended to February 2016. This enabled the Trust to address the data and reporting issues and achieve a stronger confidence in our RTT reporting.

An RTT recovery programme of work was developed to ensure firm foundational policies and processes were established, alongside the development of informatics and operational capabilities to support the delivery of sustainable RTT performance. Workstreams were set up to focus on systems and reporting, policies and processes pathway validation, RTT education and training, backlog clearance and demand and capacity.

Since the last submission of its RTT position for March 2015 to the Department of Health's UNIFY system, the Trust has commenced reporting of its RTT position for March 2016, following two reviews by the national Intensive Support Team (IST).

The Trust Board and our commissioners have endorsed the IST recommendation which supports the Trust's return to national reporting of RTT. As predicted, performance was significantly below the national 92% target for open/incomplete pathways at 80.4% for March 2016; and we reported 165 patients waiting over 52 weeks of which 80 patients are waiting in neuro-specialties.

Cancer Waiting Time Access targets

Cancer waiting time targets were achieved with the exception of the 62-day wait for first treatment target which was not achieved in Q1, although consistent with our risk assessment submitted to Monitor. This target had been achieved for each month from November 2015 to March 2016 which has been one of our strongest performance against this cancer standard. However the 2-week wait for symptomatic breast referrals was not achieved in Q4. Plans are in place to both recover and sustain performance from the end of Q1 2016/17

Denmark Hill access target highlights:

National waiting time targets for cancer patients were achieved on the DH site with the exception of the 62-day wait for first treatment target for each quarter during the year. The 2-week wait for symptomatic breast referrals target was also not achieved in Q4, in part due to a number of staffing issues which impacted on the booking processes towards the end of the quarter.

PRUH access target highlight

All cancer waiting time targets were achieved on the PRUH site throughout 2015/16, with the exception of the 31-day treatment standard for second/subsequent surgery which was not achieved in Q2.

Diagnostic Waiting Time Access targets

King's has not achieved the national target of less than 1% of patients waiting 6 weeks or less for diagnostic tests. Our performance has worsened during Q4 and by March 2016, there were 632 patients waiting over 6 weeks which represents 5.8% of the total number of patients waiting. A significant mismatch in capacity versus demand has been the key issue, and improvement plans to address the shortfall and deliver sustained performance from Q2 2016/17 are under development.

Denmark Hill access target highlights

The number of patients waiting over 6 weeks for diagnostic tests reduced in year to our lowest level with 54 patients breaching the standard in November 2016, which meant the DH site achieved the national standard for this month. However, performance has worsened during Q4 with just over 400 breaches reported in March. Over 250 of these breaches are for patients waiting for an MRI, and mainly for neuro scans. Over 40 breaches are for non-obstetric ultrasound scans.

PRUH access target highlights

The number of breaches reported at the PRUH site had reduced significantly to 45 in October, however, the position has worsened over the last 5 months of the year. Staffing issues have been a key factor, in particular for permanent and temporary sonographers, resulting in nearly 200 of the 230 breaches reported in March due to long waits for non-obstetric ultrasound tests.

Infection prevention and control

There were 82 C-difficile cases that were attributed to the Trust in 2015/16, an increase compared to the 77 cases that

were reported during 2014/15. This is also higher than the target of 72 cases set by the Department of Health for the Trust.

Denmark Hill infection control highlights

The number of cases of C-difficile increased during 2015/16 with a total of 60 cases which was above the site quota of 53 cases, and higher than the 57 cases in 2014/15. Although no longer a reporting requirement, there were four cases of *Methicillin-resistant Staphylococcus aureus* (MRSA) attributed to King's during the year.

PRUH infection control highlights

There were 22 cases of C-difficile attributed to the PRUH during 2015/16, higher than the quota of 19 cases, and slightly higher than the 20 cases reported in the previous year.

There were no cases of MRSA attributed to PRUH during the year. King's continues to monitor other instances of healthcare acquired infections (HCAI) and this remains a priority area.

Mortality indicators

In line with guidance from the Department of Health, King's has continued to review mortality based on the Summary Hospital-level Mortality Indicator (SHMI). The SHMI for publicly-published period July-2014 to June-2015 is 89, and is better than the expected index of 100. This also represents an improvement on the SHMI rating of 91 which was reported for the prior 12-month period July-2013 to June-2014.

Improving outcomes following hip fracture

When we began work three years ago to achieve best practice criteria for patients admitted with hip fracture, we met the criteria in just 4% of cases on our DH site. We now meet all the criteria for 70% of patients, exceeding the national target of 60%, and meaning that King's is now one of the best performing Trusts in this area. We are also achieving these criteria for all our patients above the national target level since August.

Sustainability & Environmental Performance

King's undertakes sustainability reporting in line with the HM Treasury 2013/14 guidance *Public Sector Annual Reports: Sustainability Reporting in the Public Sector*. Sustainability reporting is an important element of King's performance and the need to minimise impact on the environment and to operate as a sustainable and efficient organisation is recognised.

On 1 October 2013, King's took over responsibility for the Princess Royal University Hospital (PRUH) in Bromley, as well as Orpington Hospital and other satellite sites. This dramatic increase in the size of King's estate has naturally resulted in an increase in gas, electricity, water and waste costs and volumes.

Summary of performance

2015/16 was a very positive year for the Trust in terms of environmental

performance as total energy consumption decreased by 1.3 %, carbon emissions by 3.6%. However, water consumption increased by 9% for reasons explained later. The total waste generated increased by 22% in 2015/16; compared to a 29% increase in 2014/15.

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

- Improving the patient experience;
- Designing and maintaining the built environment;
- Waste management, including minimisation and waste diversion strategy;
- Pollution prevention;
- Energy and CO₂ management;
- Water;
- Sustainable procurement;
- Low carbon transport and travel;
- Staff engagement and ownership;
- Working with our stakeholders; and
- Governance and finance.

Area	Performance 2015 – 16	
Greenhouse Gas Emissions (Scope 1, 2, 3)	Emissions (000, tonnes)	35.3
Business Travel (excluding air and rail travel)		
Estate Energy	Consumption (kWh)	152,274,624
	Expenditure (£)	£5,583,040
Estate Waste	Amount (tonnes)	6,217
	Expenditure (£)	£1,790,817.80
Estate Water	Consumption (m ³)	313,000
	Expenditure (£)	£589,000

Table 3: Summary of energy performance

A copy of King's Environmental Strategy document can be obtained from: kch-tr.foi@nhs.net.

Greenhouse gas emissions

Recalculation of Carbon and energy baseline.

The annual energy costs and consumption reduced this year by 1.3% and 3.6% respectively.

As a result of the acquisition of the PRUH and Orpington Hospitals this year carbon emissions and energy consumption base-year details have been recalculated to enable King's College Hospital (KCH) to report progress of the new organisation against both energy and carbon reduction targets. The Sustainable Development Unit (SDU) has identified the NHS as needing to achieve a 10% reduction in its energy use and associated carbon dioxide (CO_2) emissions by 2015,

compared to the CO_2 emissions produced in 2007. This is 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.

The Trust is one of London's largest teaching hospitals and now provides services to the boroughs of Bromley and Bexley as well as Lambeth, Southwark and Lewisham. As a consequence KCH is a large consumer of energy; meaning reducing KCH's energy use and CO_2 emissions is a huge challenge.

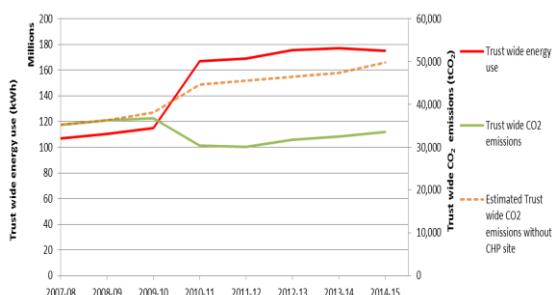


Figure 1:CO2 Emissions/Energy Use

Progress against reduction targets

In 2014-15, the Trust has made progress towards its 10% reduction target with a 4.9% reduction in CO_2 emissions compared to 2007-08, and a cumulative reduction of 6.5% in CO_2 emissions for the period 2008/2015.

Year	Target Energy Use (kWh)	Actual Energy Use (kWh)	Target CO ₂ Emissions (tCO ₂)	Actual CO ₂ Emissions (tCO ₂)	% Change
2007/08	-	106,637,428	-	35,182	-
2014/15		150,357,228	31,664	33,544	-4.9
2020/21		-	23,220	-	-34

Table 4: Energy & carbon reduction targets compared to actual performance

The bulk of these emission reductions have been achieved by the installation of an on-site Combined Heat and Power plant. After the installation of the CHP in 2010-11, while energy use increased the resulting CO_2 emissions decreased beyond the 10% reduction target to 16%.

On average the CHP has allowed King's to avoid the emission of 13,000 t CO_2 per year to the atmosphere. Without the CHP installation, CO_2 emissions would have continued to grow in-line with energy use, as shown in the figure below, resulting in increased CO_2 emissions of 25%, increased costs due to carbon taxation e.g. the CCL and CRC, and network upgrades to enable the site to draw this additional power from the networks.

Since 2010-11 the Trust has experienced a period of growth, with the GIA of King's increasing by circa 10% with energy use increasing by 5.9% over the same period.

A portion of this increase in energy use and CO₂ emissions has been offset by savings offered from the CHP site, but the net effect has been to move King's performance above the 2014-15 reduction target of 10%.

To date King's has achieved a reduction of 4.9% in CO₂ emissions compared to the 2007-08 base-year, and a cumulative reduction of 6.5% in CO₂ emissions between 2008-2015.

It is increasingly challenging to reduce energy consumption on site because King's is a successful and growing Trust that will increase its energy consumption as it increases in size and activity. Work is well underway on the design and build of a critical care unit and helicopter pad at the Denmark Hill site.

Further new buildings will be added to King's estate in 2016/17, all of which 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.

Waste management

Overall, the total waste generated by King's has increased by 1,127 tonnes in 2015 – 2016 compared to 2014 – 2015.

General non-hazardous waste including bulky waste and furniture items continue to be diverted to materials recycling facilities. This has continued improving the recovery of materials for recycling with high yield recovery percentages.

There are currently ongoing schemes to increase the recycling and recoverable materials at the satellite sites which has overall increased recycling figures for this period and led to a positive outcome.

The provision of waste management services is a fixed annual cost to King's at the Denmark Hill site. Any increase in costs associated with waste quantities, HM taxes or gate fees at the Denmark Hill site are at the risk of contractor. The total cost of waste disposed was £1,790,819 in 2015/16 compared to £1,798,537 in 2014/15.

It is worth noting that, even though there is a higher tonnage of waste volume reported this year (2015/16) than in the previous year (2014/15); the cost of waste disposal is less due to increase in waste diversion and recycling strategies, etc. The scheme is anticipated to further increase in 2016/17 with the addition of new projects.

The Trust is currently in the process of tendering the waste contract which would then test the market for a competitive pricing, quality, effective and enhanced service provision overall.

Environmental management system

King's has successfully operated an Environmental Management system that complies with the requirements of ISO 14001 since October 2012. This covers the activities and responsibilities of the Capital, Estates and Facilities Department on the Denmark site. The EMS has been very effective in providing the architecture to enable effective environmental risk management by our staff and contractors and drives continual improvement. Continued commitment to the maintenance of this accreditation provides a system of assurance that the department is compliant with all waste and environmental legislation.

King's has undergone a number of successful BSI surveillance audits which raised no non-conformities and showed

the Trust was making continual improvement. The BSI three-year audit plan was successfully completed and a re-certification audit took place on 2nd October 2015 after which King's was reaccredited for a further three years.

The Orpington and Princess Royal University Hospitals are currently outside the scope of the EMS. It is the intention to bring these sites within the remit of the EMS by 2017 and 2019 respectively.

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

Energy and CO₂ management

King's Environmental Strategy has superseded the Carbon Management Plan. King's, for the time being, continues to work towards a target to reduce CO₂ emissions by 34% by 2020.

With the acquisition of the PRUH and Orpington hospitals, however, the historic absolute targets are no longer appropriate to the larger hospital estate. It will be necessary for King's to move away from absolute carbon reduction targets to relative targets. The new target should be in place for the new reporting year. In the interim King's plans to reduce its carbon emissions by a further 1% in 2016-2017 compared to this year.

Energy cost inflation

Gas and Electricity is procured by the Trust 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.

Since October 2014, there has been a volatile but generally downward trend in gas and electricity prices assisted by milder weather than in previous years. It is hoped that as CCS has purchased a large % of gas and electricity in advance this will lock in some of the cost reduction benefits over the 2016-2017 financial year.

Total energy costs now total £5,838,040, a reduction on the previous year. However, the recent trend of a reduction in energy costs is short term and will be offset by higher non-energy costs further increasing the need for energy efficiency measures.

Water minimisation

The Trust is developing a water reduction strategy. 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 will provide the detailed water consumption data required to carry out leak detection analysis later in the project.

Water processing charges are set to rise significantly over the coming years with the building of the Thames Tideway Tunnel resulting in increases of approximately 25% for all Londoners and London based businesses.

King's reported increased water consumption by 9%. This was mainly the result of the consumption for a large water meter at Orpington Hospital being billed and reported for the first time.

Energy Efficiency Projects

The Trust has continued to invest in energy efficiency projects and in 2016-2017 a major project will be progressed to

update the condensate return system. In addition a feasibility study is being carried out to investigate the possibility of supplying cooling from the absorption chillers within the Trust's energy centre to the its new critical care unit. Further details of the project are given below:

Normanby and Camberwell Heating Boiler Projects

The Normanby Building was heated by old and inefficient boilers originally designed to run on coal and since converted to run on gas. These have been replaced with new high efficiency boilers which will greatly improve the resilience to the site, reduce the risk of loss of heating and improve energy efficiency of the heating system.

The Camberwell Boiler was heated by an all electric heating system which was both very expensive and did not provide adequate heating to the public areas on the ground floor of the building or to the clinical rooms. The heating system on the ground floor was replaced with a new gas fired boiler and wet system which also provided domestic hot water. The system is capable of heating the first floor of the building if required at a later date. This new system will greatly improve the comfort of staff and patients in the communal areas and will reduce energy costs.

Pipework Insulation Project

A large area of steam, low temperature hot water, domestic hot water and condensate pipework has been insulated this year. The benefits of this £1m investment include: reducing heat loss, saving energy, reducing Health and Safety risks of burns and improving the patient staff environment by reducing overheating.

Spirax Sarco Steam Trap Audit

A site wide steam trap survey was completed this year, the results of which will be used to develop a programme of works to upgrade steam traps across the site. As a first phase, fifty five STS17.2 steam traps have been purchased and will be installed during the summer of 2016.

Condensate System Upgrade

The condensate return to the boiler house is between 55-65% as a result of pipework leaks and an ageing condensate return system. The Trust is currently finalising a design to relocate the main condensate system route and upgrade condensate recovery vessels in order to improve the condensate return rate to approximately 80%. This will reduce water, gas and chemical costs and reduce health and safety risks in plantrooms. This project will require a substantial investment and will be implemented in phases over two to three years.

Improving the patient experience through behavioural change

King's engaged Global Action Plan to deliver Operation TLC on 20 wards of the Denmark Hill Campus. Operation TLC is a behavioural change programme focused on creating better environments for patients and delivering financial and carbon savings. The programme engaged staff at all levels of the organisation including nurses, doctors, facilities, security and cleaning staff in order to deliver financial savings and environmental improvements. This project focused on three actions: implementing a mid-day quiet time, turning off equipment when not in use and switching off lights where possible.

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.

The key sustainability measures in both the Centenary Wing and the Critical Care Unit over the existing Theatre Block (CCUTB) project are:

- 25% improvement in water consumption compared with the notional building.
- Five credits under Ene01 with 25% improvements of BER over TER.
- Best practice construction site management.
- Best practice construction site waste management.
- Measures are specified to minimise noise and light pollutions.

- Resource efficiency and use of materials with low environmental impacts over the lifecycle of the building.



Image 1: showing staff on Annie Zunz ward with the Operation TLC prizes



Image 2: NHS Sustainability Day 24th March 2016 Lambeth GP Food Group event - Golden Jubilee Wing

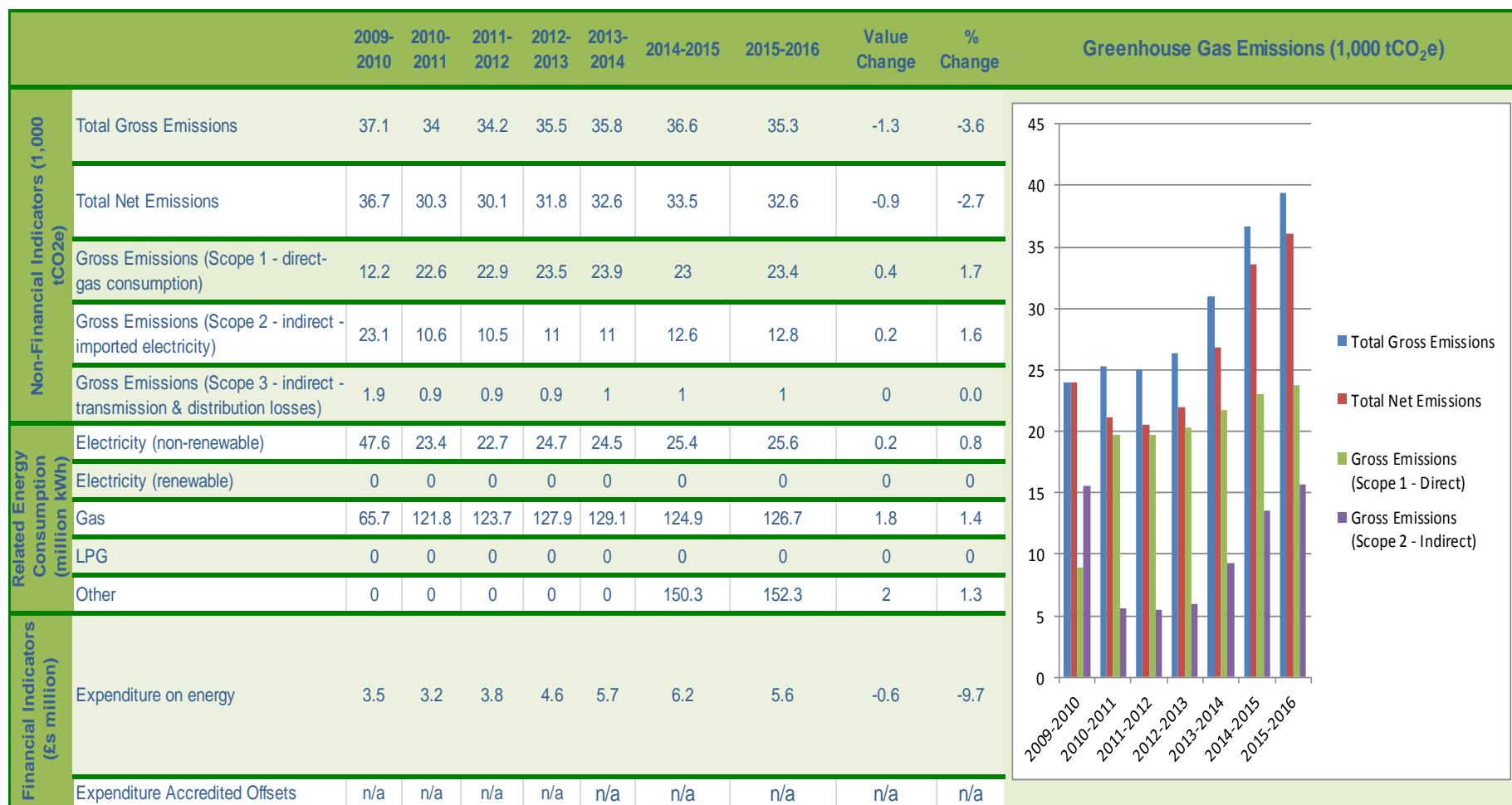


Figure 2: Greenhouse gas omissions

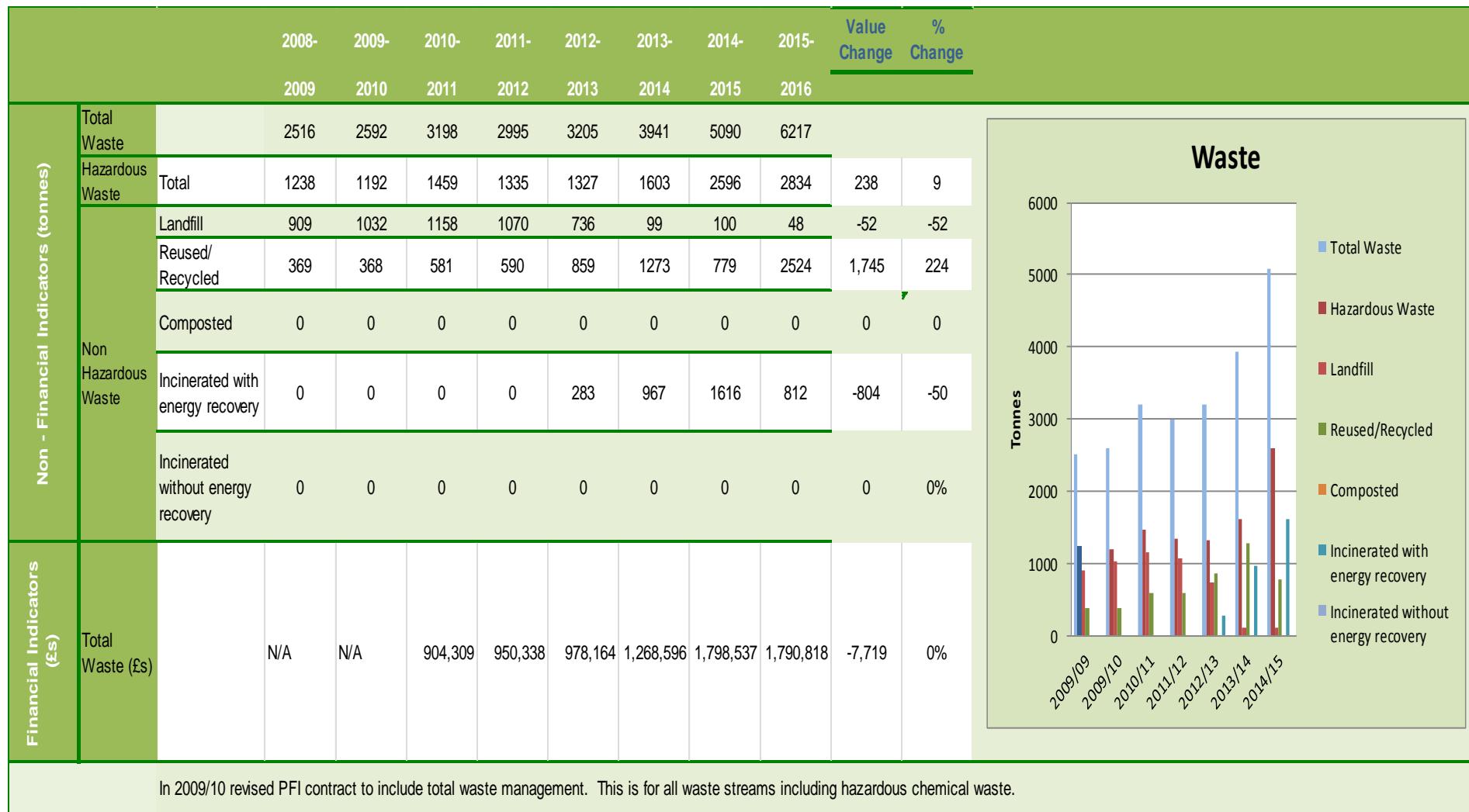
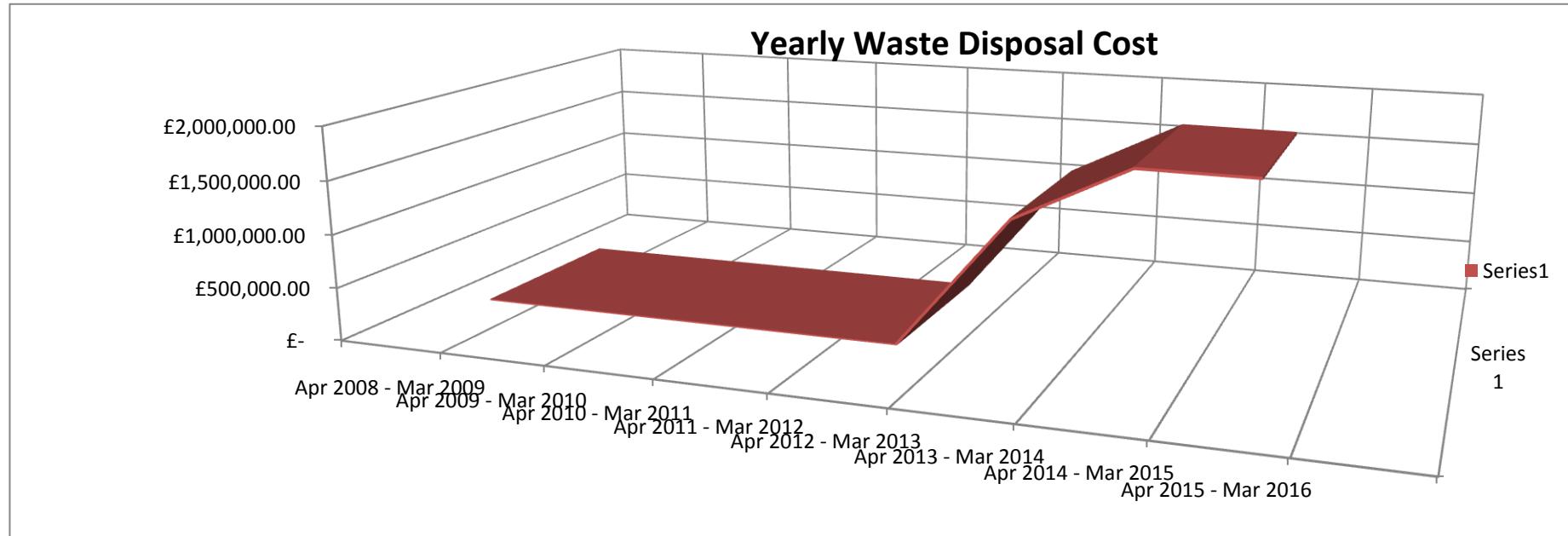
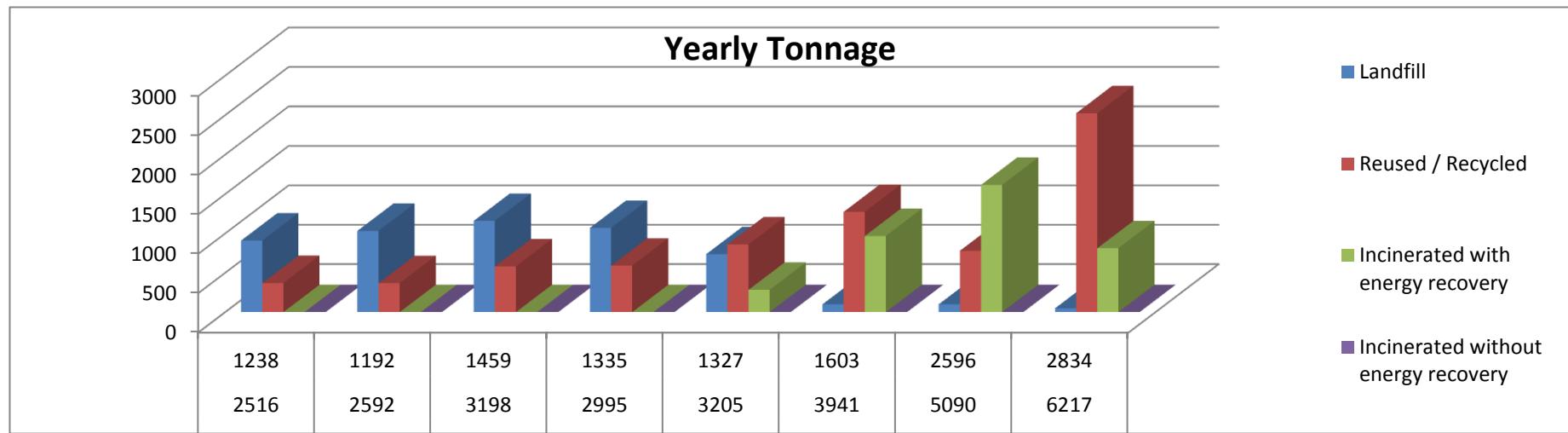


Figure 3: Waste



Critical Care Unit over Theatre Block

The new Critical Care Unit over the existing Theatre Block (CCUTB) has been designed to support world class care and to achieve BREEAM rating of excellent 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, low air leakage rates, high efficiency lighting solutions and energy efficient building services. Energy for heating and domestic hot water will be provided by connecting to the combined heat and power plant heating and cooling network. A feasibility study is being carried out to investigate the possibility of supplying cooling from the absorption chillers within the trust's energy centre.

The south facing aspect of the CCUTB building has been designed to maximise the use of natural daylight. A fully glazed curtain wall is proposed for the south facing rooms which will maximise natural daylight in these spaces. A good level of natural daylight reduces the demand for electric lighting, saving carbon and energy but also creates and enhancing the environment for patients, visitors and staff.

Low carbon transport and travel

King's will be producing a new travel plan in 2015/16 in order to refresh its 2009 strategy.

Work has continued to promote activity and wellbeing to staff. A staff bicycle user group remains continues to support and promote cycling to work as an alternative low carbon means of transport.

In November 2012, King's was fully registered for the Transport for London Cycle Superhighway Workplace Offering

and was awarded credits to exchange for cycle parking, training or cycle safety checks.

King's has purchased a tracking system for internal transport staff vehicles. This allows us to monitor driving techniques in relation to fuel use, hours worked and whether further training would be required. This may be extended to all King's lease cars so that departments can monitor fuel and driving behaviour.

King's has replaced the previous transport fleet with Toyota hybrid cars used for GP collections. The hybrid Toyota is still the vehicle of choice, with any remaining vans that we lease being EURO 5/6 to reduce emissions and save on fuel with stop start technology.

Climate change adaption and mitigation

King's has a target in place to assess how climate change may impact the site and to devise an action plan outlining adaption measures.

Biodiversity and the natural environment

King's has a target in place to assess how the implementation of promoting biodiversity on site can assist the healing process. King's has continued to work with the Lambeth GP Food Co-op to deliver a patient-led gardening project. It seeks to involve patients with chronic conditions from nine 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. Eight large planters for growing vegetables, containing two tons of soil each, have been located in the garden of Jennie Lee House at King's. These are

being attended by groups of patients led by experienced group leaders. The Lambeth GP Food Co-op is a co-operative of patients, doctors, nurses, and Lambeth residents.

Lambeth is the eighth most deprived borough in London. Just over 12% of its 318,000 population have a long-term health condition. Hunger is also a growing problem: according to the Trussell Trust, nearly 105,000 people used food banks in London in the year to April 2015, up just over 10,000 from the previous year. One of the attractions of the co-op is that its members get to eat the food they produce.

The project will be going a step further in 2016. To mark NHS sustainability day on 24th March 2016, the co-op has launched a new venture: selling its produce in King's College hospital. Members of the co-op will run a fruit and vegetable stall in the hospital's restaurant, with any profits reinvested in the co-op.

Lisa Hunter, Medirest's catering dietitian, says a key element of the government's new hospital food standards is that "trusts need to make the food served to patients healthier and more sustainable". We hope that our collaboration with Lambeth GP Food Co-op will allow us to do this by increasing the availability of locally grown fruit and vegetables to staff, visitors and patients.

Governance

King's Environmental Strategy places an emphasis on the improvement of staff engagement and ownership, working with our stakeholders and governance systems to ensure that King's continues to evolve to become a more sustainable and efficient organisation.

The strategic report was approved by the Board of Directors on 26 May 2016 and signed on its behalf by:



Signed:

Nick Moberly
Chief Executive Officer

King's Workforce and Values

The King's workforce is key to the delivery of the Trust's emerging BEST Strategy, developed by the CEO and Executive team.

In order to ensure we have skilled "can do" teams we need to ensure that we:

- Recruit and promote the best and ensure everyone has the chance to fulfil their potential
- Devolve accountability and decision making to local level
- Ensure that everyone is clear about the expectations of them, the offer in return and where they fit in
- Invest in quality education and learning which enable us to learn and improve
- Build high performing leaders and teams who are proud to work for King's recognised when we achieve excellence; confident to speak up if things aren't right; all pulling our weight and working across teams and professions

King's is committed to improving the working lives of its staff and central to this are the "my promise values".

King's Values

Since they were introduced in 2009, our King's Values have resonated with staff, carers and patients. They are the core principles which underpin and guide everything we do.

Each value is underpinned by four or five defining statements that set out King's approach. King's has taken its values to the next step by introducing 'My Promise'.

We expect 'My Promise' to really become part of everyone's working life at King's. It is here to support and guide staff as they interact with patients and colleagues.

Understanding you		Working together
	Always aiming higher	
Making a difference in our community		Inspiring confidence in our care

Figure 4: King's Values

'My Promise' has been developed in response to feedback from staff, who told King's they wanted to promote positive behaviours and performance. 'My Promise' supports and develops the King's Values placing the emphasis on individual responsibility and provides examples of the My Promise standards as they relate to each value. My Promise was launched in June 2015.

Implicit in King's Values and significant factors in King's strategic thinking are social, community and human rights issues. Tackling the health inequalities prevalent amongst sections of the local

population is an area of focus for both King's and KHP.

More information about how King's works with its members and governors to ensure that hospital services meet the needs of its diverse community can be found on pages 72-83.

Ensuring that the human rights of patients are protected is an important part of King's practice. King's policies uphold protocols of the European Convention on Human Rights, and recognise the importance of human rights such as privacy, dignity, liberty and right to life.

Workforce statistics

King's is a significant employer in the local area and is committed to the training and development of its staff.

In the table on page 91 there is a breakdown of staff according to age, ethnicity, gender, recorded disability, sexual orientation and religion covering the past three years.

During the period there have been many changes to the membership of the Board of Directors. As at 31 March 2016 the Board of directors consisted of nine male directors and nine female directors.

More information about King's workforce and in particular its approach to equality and diversity can be found in the Directors' report on pages 83-93.





Accountability Report



Lord Joseph Lister (1827-1912)

At the time of the death of the surgeon Sir William Fergusson in 1877, KCH was in decline with falling student numbers. With great foresight William Bowman invited Lister, (1827-1912), then Edinburgh Professor of Surgery, on to the KCH staff. Lister already had an international reputation as physiologist, microbiologist and surgeon and was engaged in the investigations of the causes and treatment of wound infection. He had introduced carbolic sprays in the operating theatres and carbolic dressings on the wards. However, many surgeons in London remained sceptical even though the techniques quickly reduced the post-operative infection rate at King's from 9 percent to 2 percent. Elective surgery on body cavities had been forbidden because of the risk of serious post-operative infection but Lister courageously repaired a fractured patella successfully by open operation on the knee joint and without infection, thus changing the course of surgery forever.



Picture VII: Statue of Lord Lister and Lord Lister on ward round at 2nd King's College Hospital

Directors' Report

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

Statutory framework

King's College 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, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

King's meets all the main principles of the code especially those relating to the development and management of patient services, information provision and accountability for the use of public resources.

The Trust has agreed to take steps to reduce waiting times for patients and improve its financial position, following an investigation by Monitor.

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 can be found on pages 72-83.

The Council of Governors is elected by the membership or appointed by various organisations 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 the 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 pages 63-69.

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 on pages 95-104.

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 table 6/7 on page 59-62.

The Board considers that all of its non-executive directors (NEDs) are independent in character and judgement, including Professor Ghulam Mufti, who was the representative from the Medical School at King's College London throughout the reporting period. NEDs bring a breadth of expertise to the Board and provide objective and balanced opinions on matters relating to King's business. The independence of NEDs 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 other matters to the executive directors and other senior managers.

The Board of Directors and the Council of Governors meet together periodically 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 resolution 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 sub-committees, the Annual Members Meeting and community events.

Management framework

The Board of Directors is responsible for the management and governance of King's. It is responsible for ensuring compliance with the Trust's provider license, constitution, mandatory guidance issued by the independent regulator, Monitor, and with relevant statutory requirements and contractual obligations.

Commercial opportunities and activities are subject to scrutiny by the Board of Directors as are the minutes of commercial companies Board of Directors meetings, 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 27.

Information, development and evaluation

Directors and governors are supplied with information in a timely manner in an appropriate form and quality to enable them to discharge their duties. The information needs of the Board of Directors and Council of Governors are subject to periodic review.

The performance of the Board of Directors, its committees and individual directors are subject to regular review, as outlined on page 56.

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

Board members and governors are asked to declare any interests and to self-certify that he/she meets the eligibility criteria set out in the Trust's Constitution. In addition, governors and directors are subject to a disclosure and barring service investigation (formerly the criminal records bureau).

Accountability and audit

Deloitte remained external auditors during the period and following a robust tender and procurement process, the Council of Governors, on the recommendation of a panel made up of Audit Committee members and governors, reappointed Deloitte LLP as the Trust's external auditor on 17 March 2016. Deloitte was appointed for a three year term starting in July 2016 with the option to extend a further two

years. In addition, the Board of Directors maintained a sound system of evaluating and continually improving effectiveness of risk management and internal control processes. The Trust also appointed KPMG following a procurement and tender process, as its internal auditors in March 2016. During the period, KPMG continued to provide comprehensive internal audit function, the plan for which 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 regular reporting to the Board by presenting a balanced and understandable assessment of King's position 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.

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

Further all the Board of Directors have made enquires 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.

Within this annual report, information about King's future plans and likely future developments, for example, the development of King's Health Partners' is

recorded in the 'Planning for the Future' section.

Information about the financial risk management policies, use of financial instruments and plans for capital projects can also be found in the Overview of Performance section.

Information about greenhouse gas emissions can be found in the 'Sustainability and Environment section.

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 also 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 members of the Board boast a wide range of skills and bring experience gained from NHS organisations, other public bodies and private sector organisations.

The skills portfolio of the directors, both executive and non-executive, is wide-ranging and 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.

There have been changes to the Board in the period which are illustrated in the following pages.

The Board said goodbye to a number of long-serving executive directors during the period including, Tim Smart, Simon Taylor, Roland Sinker, Jane Walters, Mike Marrinan and Angela Huxham.

The Trust was delighted to welcome Lord Kerslake who took on the role of chair in April 2015. The following appointments were also made:

- Nick Moberly, Chief Executive Officer (November 2015).
- Julia Wendon, Medical Director (October 2015).
- Dawn Brodrick, Director of Workforce & Development (October 2015).
- Colin Gentile, Chief Financial Officer (January 2016).
- Jane Farrell, Chief Operating Officer (April 2016)
- Prof Jonathan Cohen, Non-Executive Director (September 2015).
- Dr Alix Pryde, Non-Executive Director (November 2015).
- Erik Nordkamp, Non-Executive Director (January 2016).

The Board also bid farewell to a number of executive directors providing interim support including Jeremy Tozer, Interim Chief Operating Officer, Alan Goldsman, Interim Chief Financial Officer and Interim Director of Strategic Development.

The current Board members can be found on pages 59-62.



Current Board of Directors



Directors' Biographies

Non-Executive directors

Lord Bob Kerslake (Chair)

Graduating with a first class degree in Mathematics from Warwick University, Lord Kerslake trained as an accountant and worked at the Greater London Council, the Inner London Educational Authority and the London Borough of Hounslow in finance roles before becoming Chief Executive of the London Borough of Hounslow in 1990. In 1997 he moved to take over as Chief Executive of Sheffield City Council – the fourth largest local authority in the UK.

From 2008 to 2010 Lord Kerslake was Chief Executive of the Homes and Communities Agency. He served as Permanent Secretary of the Department for Communities and Local Government from 2010 to February 2015 and was also Head of the Civil Service from January 2012 until September 2014.

He was made a life peer in March 2015 and became Chair of King's on 1 April 2015.

Term in office: April 2015 to Current

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 non-Executive Adviser to London's Deputy Mayor for Policing and Crime. She also took on the role of trustee on the Trust's charity from April 2014 to 2016.

Term in office: March 2012 to Current

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 currently 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.

Term in office: September 2015 to Current

Erik Nordkamp

Erik Nordkamp has been Managing Director for Pfizer Ltd since February 2015, having worked at the company in other senior roles since 2010. These roles

include President and Managing Director, Greece, Cyprus and Malta (2012-15) and Europe Strategy Lead (2010-12).

Prior to this, Mr Nordkamp worked at Eli Lilly and Company as European Senior Director of Transformation and Lean Six Sigma. He has an MSc in Biomedical Sciences from Radboud University, Nijmegen (1992) and an MBA from the Erasmus University Rotterdam (1999). He is originally from Holland but lives and works in the UK. He is married with two children.

Term in office: January 2016 to Current

Professor Ghulam Mufti

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 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.

Term in office: December 2012 to Current

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 leading role in the delivery of TV Digital Switchover and the BBC's groundbreaking coverage of London 2012. In 2014, Alix was recruited by Vodafone to head the UK's Consumer Innovation team.

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.

Term in office: November 2015 to Current

Sue Slipman

Sue Slipman was the founding Chief Executive of the Foundation Trust Network, the national trades associations 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 and is currently a trustee of NEST Corporation, the pension scheme set up by government to support auto-enrolment.

Term in office from July 2012 to Current

Christopher Stooke (Vice- Chair)

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 one 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 October 2015.

Term in office: November 2011 to Current

Executive Directors

Nick Moberly (Chief Executive)

Nick joined King's in November 2015. Prior to this he served as Chief Executive at Royal Surrey County Hospital NHS Foundation Trust for nine years.

Nick previously worked at King's as Director of Strategic Development from 2003 until 2006, when he played a key role in securing Foundation status for the Trust. He has held a variety of strategy and management roles in both the public and private sectors. He is a former First Secretary at the Foreign and Commonwealth Office, and has worked as a strategy consultant for a range of blue chip organisations.

Term in office: November 2015 to Current

Dawn Brodrick (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.

Term in office: October 2015 to Current

Colin Gentile (Chief Financial Officer)

Colin joined King's in 2016. Colin is a professional accountant by background; he worked in central government and local government before taking his first role with the NHS in 1990. He has been a finance director in a number of Trusts, including St George's and Brighton and Sussex University Hospitals, both of which are teaching Hospitals.

Colin has a strong track record of helping NHS Trusts generate savings and improving financial performance. He is equally passionate about the standards of patient care. Colin has also, in conjunction with his finance director roles, worked as a turnaround lead and as a PFI project director. He has lived in Lewisham for over 30 years.

Term in office: January 2016 to Current

Alan Goldsman (Interim Director of Strategy)

Alan joined King's in August 2015. He has worked in the NHS for a number of years, most recently at Imperial College Healthcare NHS Trust, where he served as interim Chief Financial Officer. Before this, Alan was the Director of Finance and Deputy Chief Executive at the Royal Marsden NHS Foundation Trust for 12 years.

He also was Interim Director of Strategy, covering Dr Trudi Kemp's role.

Term in office: August 2015 to Current

Dr Trudi Kemp (Director of Strategy)

Trudi joined King's in October 2014. Prior to her appointment she was Director of Strategic Development at St George's

Healthcare NHS Trust, having joined as a consultant in Public Health Medicine in 2002.

Qualifying in Medicine in 1986, she holds masters degrees in Medical Law and Ethics and in Public Health. She is a Fellow of the Faculty of Public Health and an educational supervisor for specialist trainees in public health.

Trudi is responsible for developing and implementing the Trust's strategy, ensuring our service developments meet the needs of the populations we serve.

Term in office: October 2014 – Current (on long-term sickness absence since December 2015)

Judith Seddon (Interim Director of Corporate Affairs)

Judith is a chartered company secretary. She has worked at King's for more than 20 years in a variety of roles covering patient safety, patient experience, legal services, governance and assurance. Judith previously worked at British Gas plc in the Company Secretaries department.

Term in office: November 2015 to Current

Ahmad Toumadij (Interim Director of Capital Estates & Facilities)

Ahmad was born in Iran and educated in the UK. He holds a master's degree in Architecture from University College London and is a Fellow of The Chartered Institute of Building.

After working in the construction industry he joined the NHS in 1979, where he has worked as a Technical Officer and Director of Capital, Estates and Facilities in a number of prestigious hospitals in London. During his 37 years in the NHS he has been responsible for the commissioning of the Chelsea and Westminster Hospital

and the master planning of consolidating the Atkinson Morley's Hospital at St. George's Hospital in South West London.

Ahmad has been employed by King's since 1997. He has overseen its modernisation and the commissioning of its flagship Golden Jubilee building. Ahmad remains integral to King's, where he currently works as Technical Consultant at King's Commercial Services. In March 2015 he was invited to join the Executive Team again as Interim Director of Capital, Estates and Facilities, until a permanent appointment is made.

Term in office: March 2015 to Current

Jeremy Tozer (Interim Chief Operating Officer)

Jeremy joined King's in March 2015. He is a qualified pharmacist; after becoming a Chief Pharmacist early on in his career, he moved into various areas of general management before taking his first Board position nine years ago. Since then he has been part of several Trust Boards up and down the country in the position of Chief Operating Officer and has a specific focus on delivering sustainable operational performance and introducing systems of performance management.

Term in office: March 2015 to March 2016.

Dr Geraldine Walters (Director of Nursing & Midwifery and Infection Control & Prevention)

A cardiac nurse by background, Geraldine has held a number of executive nurse director posts in acute NHS Trusts in London. Geraldine is Visiting Professor at both Buckinghamshire New University and the Florence Nightingale School at King's College London. Geraldine is an advisor to the Florence Nightingale Foundation, a member of the National Advisory Group on Clinical Audit and Enquiries and a

trustee of Trinity Hospice. She served as a member on the Morecambe Bay Inquiry Panel. Geraldine worked in a variety of hospitals in her early career, including King's, and subsequently gained a PhD and an MBA.

Term in office: September 2009 to Current

Professor Julia Wendon (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.

Term in office: November 2015 to Current

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 on a regular basis 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. During the period the Chair commissioned a high-

level governance review at the start of his chairmanship. The Trust engaged Price WaterhouseCoopers to conduct this review with the purpose to provide a high-level view of the Board governance that was forward looking to help ensure that governance arrangements were fit for purpose to take the Trust forward through what was a challenging period.

The scope of the review included individual interviews with each member of the board, completion of a survey, a review of some past board and committee papers and PwC observing a number of Board and committee meetings including a Council of Governors meeting.

The Board has implemented most of the PwC recommendations and actions plans are in place to address outstanding actions.

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. Annual performance appraisals were completed.

The process for evaluating the performance of the Chair and non-executive directors has been agreed in consultation with the Council of Governors.

Board meetings and committees

The Board of Directors met regularly throughout the year. The Board has five

Committees which also meet regularly and are each chaired by a non-executive director.

The Board of Directors approves the terms of reference which detail the remit and the 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.

Table 6/7on pages 59-62 records the membership of each Board committee.

Audit Committee

The Audit Committee is responsible for monitoring the externally reported performance of King's and for providing independent assurance to the Board of Directors in a range of areas including internal control, risk management, external assurance of risk management processes, internal and external audit and financial reporting. King's also has a zero-tolerance policy towards fraud and bribery and this committee is responsible for overseeing the work of the counter fraud team. It continues to closely monitor the effectiveness of internal control and audit processes on behalf of the Board of Directors.

The Committee was chaired by Christopher Stooke who also brings a wealth of financial expertise to the Committee until December 2015 and it is now chaired by Dr Alix Pryde. The internal and external auditors regularly attend committee meetings in addition to the Chief Financial Officer, Chief Executive and the Director of Corporate Affairs, although they are not members of the committee. The Trust Chair 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.

During the reporting period the Committee considered reports from internal and external auditors around significant issues including Safeguarding vulnerable adults, Information governance, BAF development and gap analysis, Delayed transfers of care, RTT Recovery plan, Data Quality, Clinical Coding, CIPs Management, Recruitment Review and PFI Management. It also received reports on counter fraud investigations and recommendations.

In May 2015 the Committee fulfilled its oversight responsibilities with regard to monitoring the integrity of the financial statements, the annual accounts and the annual governance statement (formally known as the statement of internal control), before submission to the Board.

The Audit Committee met with the external auditors and considered the significant risks they identified in both their audit plan and subsequent conversations. The Committee were in agreement that these represent the significant risks to the Trust. Further details of these risks and the External Audit findings and conclusions can be found as part of the External Auditor's Opinion on the Accounts on page 183-190.

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 review;
- 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.

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

Education and Workforce Development Committee

This Committee is responsible for providing assurance to the board on the Trust's strategy and plans for its entire workforce focusing on education, learning and organisational development, workforce information, planning, resourcing and deployment and staff engagement, reward, recognition, health and wellbeing.

Finance and Performance Committee

This committee is responsible for reviewing and monitoring King's operational and financial performance against core targets and indicators and for ensuring that King's remains compliant with Monitor's financial and governance risk ratings.

Quality and Governance Committee

This committee is responsible for overseeing the three key dimensions of quality: patient safety, patient experience and patient outcomes as well as organisational safety, risk management

and compliance and information governance. Patient complaints and/or video stories were a regular item on the agenda.

Remuneration and Appointments Committee

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 pages 70-71.

Early Surgery at King's

Following training and qualification in Edinburgh Sir William Fergusson, (1808-1877) was appointed as professor of surgery at KCH in 1840. Led by Fergusson, who was the first to tie the subclavian artery and to perform surgery for imperforate anus in babies, the surgical department achieved international fame. The speed of his operations was legendary and operations for the removal of bladder stones were timed at 30 seconds. He would operate in front of as many as 200 people who would cheer at the end of each procedure.

Fergusson was elected President of the Royal College of Surgeons and sergeant-surgeon to Queen Victoria

Board of Directors Tenures and Meeting Attendances – April – August 2015

	Term of Office	Board of Directors	Audit Committee	Education & Workforce Committee	Finance & Performance Committee	Quality & Governance Committee	Remunerations & Appointments Committee
Number of Meetings Held		4	2	1	5	2	3
Membership/Attendance							
Lord Kerslake Trust Chair	Current	Chair (3)	Attendee		√	√	Chair (3)
Faith Boardman Non-Executive Director	Current	√ (2)	√ (2)	Chair	√	√	√ (3)
Graham Meek Non-Executive Director	Resigned	√ (4)	√ (2)		Chair	√	
Professor Ghulam Mutti Non-Executive Director	Current	√ (2)			√	Chair	√ (3)
Sue Slipman Non-Executive Director	Current	√ (3)			√	√	√ (3)
Christopher Stooke Non-Executive Director	Current	√ (4)	Chair (2)		√		√ (2)
Angela Huxham Director of Workforce & Development	Resigned	√ (3)		√	√	√	Attendee
Mr Michael Marrinan Medical Director	Resigned	√ (4)			√	√	
Roland Sinker Acting Chief Executive	Resigned	√ (3)	Attendee		√	√	Attendee
Simon Taylor Chief Financial Officer	Resigned	√ (4)	Attendee		√	√	
Dr Geraldine Walters Director of Nursing & Midwifery	Current	√ (4)	Attendee		√	√	
Jane Walters (non-voting) Director of Corporate Affairs & Trust Secretary	Resigned	√ (4)	Attendee		√	√	

Board of Directors Tenures and Meeting Attendances – April – August 2015

	Term of Office	Board of Directors	Audit Committee	Education & Workforce Committee	Finance & Performance Committee	Quality & Governance Committee	Remunerations & Appointments Committee
Number of Meetings Held		4	2	1	5	2	3
Trudi Kemp (non-voting) Director of Strategic Development	Current	✓ (4)			✓		
Ahmad Toumadj (non-voting) Interim Director of Capital & Estates	Current	✓ (4)		✓	✓	✓	
Steve Leivers Director of Transformation & Turnaround	Resigned	✓ (0)			✓		
Jeremy Tozer Interim Chief Operating Officer	2015-2016	✓ (3)			✓	✓	
Paul Jones Interim Director of Workforce Development	2015-2015	✓ (1)			✓		
Paul Donohoe Interim Medical Director	2015-2015	N/A					
Dawn Brodrick Director of Workforce Development	Current	N/A					
Judith Seddon Interim Director of Corporate Affairs & Trust Secretary	Current	N/A				✓	
Colin Gentile Chief Financial Officer	Current	N/A					
Prof Julia Wendon Medical Director	Current	N/A					
Nick Moberly Chief Executive Officer	Current	N/A					

Table 5: Board of Directors - Meetings, Attendance, Committee Memberships - April-August 2015

Board of Directors and Meeting Attendances - September 2015 – March 2016

Term of Office	Board of Directors	Audit Committee	Education & Workforce Committee	Finance & Performance Committee	Quality & Governance Committee	Remunerations & Appointments Committee
Number of Meetings Held	6	2	3	7	4	1
Membership/Attendance						
Lord Kerslake Trust Chair	Current	✓ (6)	Attendee	✓	✓	✓
Faith Boardman Non-Executive Director	Current	✓ (5)	✓ (1)	Chair	✓	✓ (1)
Graham Meek Non-Executive Director	Resigned	✓ (2)		✓		✓ (1)
Professor Ghulam Mufti Non-Executive Director	Current	✓ (5)		✓	Chair	✓ (1)
Sue Slipman Non-Executive Director	Current	✓ (6)		✓		✓ (1)
Christopher Stooke Non-Executive Director	Current	✓ (6)	✓ (2)		Chair	✓ (1)
Dr Alix Pryde Non-Executive Director	Current	✓ (4)	Chair (2)			
Erik Nordkamp Non-Executive Director	Current	✓ (1)				
Angela Huxham Director of Workforce & Development	Resigned	N/A				
Mr Michael Marrinan Medical Director	Resigned	✓ (1)		✓		
Roland Sinker Acting Chief Executive	Resigned	✓ (2)		✓		
Simon Taylor Chief Financial Officer	Resigned	✓ (1)				
Dr Geraldine Walters, Director of Nursing & Midwifery	Current	✓ (6)		✓	✓	✓

Board of Directors and Meeting Attendances - September 2015 – March 2016

Term of Office	Board of Directors	Audit Committee	Education & Workforce Committee	Finance & Performance Committee	Quality & Governance Committee	Remunerations & Appointments Committee
Number of Meetings Held	6	2	3	7	4	1
Jane Walters (non-voting) Director of Corporate Affairs & Trust Secretary	Resigned	√ (1)		√		
Trudi Kemp (non-voting) Director of Strategic Development	Current*	√ (3)	√	√	√	
Ahmad Toumadj (non-voting) Interim Director of Capital & Estates	Current	√ (5)		√	√	
Steve Leivers Director of Transformation & Turnaround	Resigned	N/A		√		
Jeremy Tozer Interim Chief Operating Officer	2015-2016	√ (6)		√	√	
Paul Jones Interim Director of Workforce Development	2015-2015	√ (1)				Attendee
Paul Donohoe Interim Medical Director	2015-2015	N/A		√		
Dawn Brodrick Director of Workforce Development	Current	√ (5)	Attendee	√	√	√
Judith Seddon Interim Director of Corporate Affairs & Trust Secretary	Current	√ (3)	Attendee	√	√	
Colin Gentile Chief Financial Officer	Current	√ (2)	Attendee	√	√	
Prof Julia Wendon Medical Director	Current	√ (1)		√	√	
Nick Moberly Chief Executive Officer	Current	√ (4)	Attendee	√	√	√

Table 6: Board of Directors - Meetings, Attendance, Committee Memberships - September 2015-March 2016

Council of Governors

The council of governors is made up of elected and appointed stakeholders.

Elected governors make up the majority of the council and appointed stakeholder governors include representatives from clinical commissioning groups and local councils, which play an important part of 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 can be found in the tables on pages 67-69.

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 pages 70-72.

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.

The term of office for governors is four years.

During the reporting period, the Council of Governors:

- Received and considered the Trust Annual Report and Accounts and the auditor's report on the accounts.
- Received regular updates on the operational and financial challenges facing the Trust. Governors also inputted on the strategic document submitted to Monitor in October 2015.
- Received regular information on and discussed the financial and performance challenges facing the Trust.
- Appointed the external auditors.
- Appointed the new non-executive directors.
- Endorsed the Board's recommendation to appoint the new Chief Executive.

Governors in the community

Governors are active within the community, helping to facilitate communication between King's, members and the local community. Governors are pivotal to sharing King'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.

Further information about governor engagement can be found on 75-96.

Governor sub-committees

The Council of Governors has sub-

committees which provide the opportunity for governors to delve deeper into issues that are of interest to members, patients and the local community.

All governors are eligible to sit on governor sub-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 King's, and opportunities for facilitating communication between governors and the membership are explored. More information about these opportunities can be found on pages 72-83.

Patient Experience and Safety Committee

This committee acts as a reference group for King's planned activity around 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 King'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 was involved in the numerous appointments of non-executive directors detailed on page 59-62. The committee in line with the process outlined in the Trust's constitution engaged recruitment consultancy Saxton Bampfylde to support the recruitment process.

The process for recruiting Professor Cohen was completed without the support of external consultancy but instead undertook a campaign including open advertisement and external searches managed through the Trust's HR resources and Secretariat.

The members of the committee are detailed in table 6/7 page 65. The committee met four times during the reporting period. It also makes recommendations to the Council on the remuneration and terms and conditions of non-executive directors.

Governor development and engagement

King's is committed to providing on-going support and training for governors and opportunities to engage with staff, directors, member 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, one of which was delivered to governors from all three foundation trusts within King's Health Partners by the NHS Provider.

Governors have also received presentations from external speakers invited to sub-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 was also an annual joint meeting of the Board

of Directors and Council of Governors and all governors are invited to attend Board of Directors meetings.

Governors are provided with a secure remote resources centre through which they can access information relevant to their role. Some governors attended external events hosted by organisations such as Deloitte and NHS Providers during the reporting period.

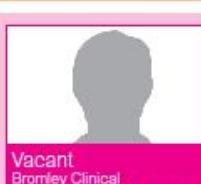
Company directorships and other significant interests and commitments

King's maintains a register of interests for its governors, which is open to the public. Arrangements to view the register can be made by contacting the Foundation Trust Office on kch-tr.FTO@nhs.net

Nominations Committee Members	Status	Constituency
Lord Kerslake, Committee Chair	Current	Trust Chair
Nandakumar Ratnavel, Vice Chair	Current	Public Governor
Fiona Clark	Current	Public Governor
Thomas Duffy	Current	Patient Governor
Pam Cohen	Current	Public Governor
Andrew McCall	Current	Public Governor

Table 7: Nominations Committee Members

Current Council of Governors

 <p>Helen Ahmet</p>	 <p>Tom Duffy</p>	 <p>Pida Ripley</p>	 <p>Jan Thomas</p>	 <p>Derek St Clair Cattrall</p>	<p>Patient</p>
 <p>Anoushka de Almeida-Carragher Bromley</p>	 <p>Eniko Benfield Bromley</p>	 <p>Paul Corben Bromley</p>	 <p>Penny Dale Bromley</p>	 <p>Craig Jacob</p>	<p>Public</p>
 <p>Fiona Clark Lambeth</p>	 <p>Chris North Lambeth</p>	 <p>Nanda Ratnaval Lambeth</p>	 <p>Grace Okoli Lambeth</p>	 <p>Tim Bradley Lewisham</p>	<p>Staff</p>
 <p>Barbara Pattinson Southwark</p>	 <p>Pam Cohen Southwark</p>	 <p>Andrew McCall Southwark</p>	 <p>Victoria Silvester Southwark</p>	 <p>Daniel Beazley Allied Health Professionals</p>	<p>Nominated</p>
 <p>Dr Anand Arya Medical & Dentistry</p>	 <p>Jo Millett Nurses & Midwives</p>	 <p>Nicky Hayes Nurses & Midwives</p>	 <p>Roger Engwell Admin, Clerical & Management</p>	 <p>Vacant Bromley Clinical Commissioning Group (CCG)</p>	
 <p>Cllr Robert Evans Bromley Council</p>	 <p>Diane Summers Guy's & St.Thomas NHS Foundation Trust</p>	 <p>Phidelma Iisowska Joint Staff Office</p>	 <p>Chris Mottershead King's College London</p>	 <p>Cllr Jim Dickson Lambeth Council</p>	
 <p>Dr Noel Baxter Southwark Clinical Commissioning Group (CCG)</p>	 <p>Dr Sadru Kheraj Lambeth Clinical Commissioning Group (CCG)</p>	 <p>Roger Paffard South London & Maudsley NHS Foundation Trust</p>	 <p>Kieron Williams Southwark Council</p>		

Council of Governors Tenures & Meeting Attendances April 2015 – March 2016						
	Term	CONSTITUENCY		Meetings 15/16	NOTES	
Number of Meetings Held						4
Helen	Ahmet	01/01/2015 – 30/11/2018	Patient	Patient	✓ (4/4)	
Tim	Bradley	25/09/2015 – 30/01/2017	Patient	Patient	✓ (2/2)	Joined on 25/09/2015
Derek St Clair	Cattrall	01/01/2015 – 30/11/2018	Patient	Patient	✓ (2/4)	
Thomas	Duffy	01/01/2015 – 30/11/2018	Patient	Patient	✓ (4/4)	
Craig	Jacobs	25/09/2015 – 30/11/2018	Patient	Patient	✓ (1/2)	Joined on 25/09/2015
Catriona	Ogilvy	01/01/2015 – 30/11/2018	Patient	Patient	N/A	Governor Role Terminated
Pida	Ripley	01/01/2015 – 30/11/2018	Patient	Patient	✓ (3/4)	
Jan	Thomas	01/01/2015 – 30/11/2018	Patient	Patient	✓ (3/4)	
Anand	Arya	08/03/2016 – 30/11/2018	Staff	Medical and Dental Staff Group	✓ (1/1)	Joined on 08/03/2016
Daniel	Beazley	02/04/2016 – 30/11/2018	Staff	Allied Health Professionals, Scientific & Technical	✓ (1/1)	Joined on 02/04/2016
Roger	Engwell	01/01/2015 – 30/11/2018	Staff	Administration and Clerical	✓ (4/4)	
Nicky	Hayes	01/01/2015 – 30/11/2018	Staff	Nurses and Midwives	✓ (4/4)	

Council of Governors Tenures & Meeting Attendances April 2015 – March 2016						
		Term	CONSTITUENCY		Meetings 15/16	NOTES
Cornelius	Lewis	01/01/2015 – 30/11/2018	Staff	Allied Health Professionals	✓ (2/4)	Resigned on 01/04/2016
Jo	Millett (<i>nee Artus</i>)	01/01/2015 – 30/11/2018	Staff	Nurses and Midwives	✓ (4/4)	
CV	Praveen	01/01/2015 – 30/11/2018	Staff	Medical and Dentistry	✓ (1/3)	Resigned on 07/03/2016
Eniko	Benfield	30/01/2014 – 30/01/2017	Public	Bromley	✓ (2/4)	
Fiona	Clark	01/01/2015 – 30/11/2018	Public	Lewisham	✓ (4/4)	
Pam	Cohen	01/01/2015 – 30/11/2018	Public	Southwark	✓ (3/4)	
Paul	Corben	30/01/2014 – 30/01/2017	Public	Bromley	✓ (2/4)	
Penny	Dale	30/01/2014 – 30/01/2017	Public	Bromley	✓ (2/4)	
Anoushka	de Almeida-Carragher	30/01/2014 – 30/01/2017	Public	Bromley	✓ (3/4)	
Alan	Hall	30/01/2014 – 30/01/2017	Public	Lewisham	✓ (1/2)	Resigned on 10/09/2015
Andrew	McCall	01/01/2015 – 30/11/2018	Public	Southwark	✓ (4/4)	
Christopher	North	01/01/2015 – 30/11/2018	Public	Lambeth	✓ (4/4)	
Grace	Okoli	01/01/2015 – 30/11/2018	Public	Lambeth	✓ (4/4)	
Barbara	Pattinson	01/01/2015 – 30/11/2018	Public	Southwark	✓ (2/4)	
Nandakumar	Ratnavel	01/01/2015 – 30/11/2018	Public	Lambeth	✓ (4/4)	
Victoria	Silvester	01/01/2015 – 30/11/2018	Public	Southwark	✓ (4/4)	

Council of Governors Tenures & Meeting Attendances April 2015 – March 2016						
		Term	CONSTITUENCY		Meetings 15/16	NOTES
Noel	Baxter	01/02/2016 – 31/01/2019	Stakeholder	Southwark Clinical Commissioning Group	✓ (0/1)	Joined on 01/02/2016
Jim	Dickson	01/03/2015 – 30/04/2018	Stakeholder	Lambeth Council	✓ (4/4)	
Robert	Evans	05/03/2014 – 05/03/2017	Stakeholder	Bromley Council	✓ (2/4)	
Sue	Gallagher	01/01/2013 – 31/12/2015	Stakeholder	Lambeth Clinical Commissioning Group	✓ (2/4)	Resigned on 24/10/2015
Richard	Gibbs	09/05/2011 – 08/05/2015	Stakeholder	Southwark Clinical Commissioning Group	✓ (1/1)	Resigned on 22/10/2015
Jim	Gunner	16/12/2013 – 15/12/2016	Stakeholder	Bromley Clinical Commissioning Group	N/A	Resigned on 29/04/2015
Sadru	Kheraj	01/01/2016 – 31/12/2019	Stakeholder	Lambeth Clinical Commissioning Group	✓ (1/1)	Joined on 01/01/2016
Phidelma	Lisowska	01/09/2013 – 30/08/2016	Stakeholder	Joint Staff Committee	✓ (4/4)	
Chris	Mottershead	01/07/2012 – 30/06/2015	Stakeholder	King's College London	✓ (3/4)	
Roger	Paffard	02/01/2015 – 01/01/2018	Stakeholder	South London and Maudsley NHS Foundation Trust	✓ (1/4)	
Diane	Summers	06/10/2013 – 05/10/2016	Stakeholder	Guy's & St Thomas' Hospital NHS Foundation Trust	✓ (3/4)	
Kieron	Williams	03/11/2014 - 02/11/2017	Stakeholder	Southwark Council	✓ (4/4)	

Table 8: Council of Governors and Attendance at Meetings 01 April 2015 - 31 March 2016

Remuneration Report

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 78-79.

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 tables 6/7 on pages 59-62 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 Director of Workforce Development who is not a member of the committee.

The Trust Board took the decision in early 2015 to appoint an Interim Turnaround Director, due to the financial challenges. Cross-cutting cost improvement programmes were developed and led by the Interim Turnaround Director.

An Interim Chief Operating Officer was appointed to cover the role, whilst the substantive post-holder was Acting Chief Executive.

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 222-225 of the annual accounts. Note 1.9 on page 200 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 £142,500. These steps include:

- Vacant posts at Executive level require review in line with Trust requirements and 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, to which King's is a member. Hays provide the Trust with a salary range and recommendation.
- Due cognisance is referred to the VSM annual pay survey which includes Executive pay levels.
- The post is advertised and once appointed and remuneration agreed the Trust seeks the guidance from the NHSI to support the salary range.

Department of Health Pay, Pensions and Employment Services Branch is informed and Lord Pryor's office has in turn has 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

A new Chair, Lord Kerslake, was appointed and took up his post in April 2015.

A number of new Executive and Senior appointments were made during the year following retirements and resignations. This included the Chief Executive, Chief Operating Officer, Medical Director, Chief Financial Officer, Director of Workforce Development. The Director of Corporate Affairs became a vacant post being filled internally on a fixed term basis.

An interim Director of Capital, Estates and Facilities was employed during the financial year. A substantive appointment has been made for the post-holder to commence in this role during 2016/17.

Compensation in the event of early termination for substantive directors would be in accordance with contractual entitlements as set out in the Agenda for Change national terms and conditions of service.

Signed:

Nick Moberly
Chief Executive Officer

27 May 2016



Throughout his life Sir Thomas Fairbank (1879-1961) was regarded at King's with great affection by his students, colleagues and nursing staff. He was appointed as the first consultant orthopaedic surgeon in London, and gained a wide experience of trauma during WW1 when he was awarded the DSO. He established the first fracture clinic in London and insisted that consultants should teach regularly in the out-patient department – a new concept for many of his colleagues.

Putting our Patients & Public in Focus

Improving Patient Care

King's is committed to addressing healthcare inequalities and responding to the needs of the local population. This is one reason why the majority of foundation trust members and the governors who are elected to represent them are drawn from the London boroughs of Lambeth, Southwark, Lewisham and Bromley. Other members have an association with King's because they are patients, staff or affiliated to partner organisations. More information about membership constituencies can be found on pages 78.

During the year 2015/16, members and governors have continued to play an active role in helping to improve services and ensuring that they meet the health needs of the diverse community served by the hospital.

Council of Governors: representing the patient voice

As outlined on pages 63-69 the key functions of the Council of Governors are to hold non-executive directors to account for the performance of the Board and to represent the interests of members and the public.

In order to meet these responsibilities governors ensure that the patient voice remains at the forefront of King's work by providing lay representation and an external perspective on a range of committees and working groups. These include:

- End of Life Care Group;
- Older People's Committee;
- Maternity Services Liaison;
- Nutrition Support Steering Group
- Patient Experience Committee.

Governors also have their own committees, which focus on strategy, patient experience and safety, membership and community engagement.

More information about governors and their sub-committees can be found on 66-77.

Patient experience

Both governors and members continue to volunteer to help with a range of projects aiming to improve the experience of patients. Some of these projects are outlined below.

PLACE assessments

Governors and members have joined multi-disciplinary teams to take part in our annual Patient Led Assessments of the Care Environment (PLACE). Teams of assessors go into all our hospitals to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. The focus is entirely on the care environment, not clinical care provision or staff competency.

Improving Patient Food Service

Governors and Members have continued to take part in patient food service audits on our wards to help to improve the quality of patient food. These audits include interviews with patients about different aspects of patient food.

This year, some of our Bromley Members have joined us to help gather feedback from our South East London outpatient clinics. Members received training

through the PPI team and King's Volunteer Service and are now actively getting valuable feedback from our outpatients.

Annual Members Meeting

On 24 September 2015 governors and members gathered for the Annual Members Meeting. The event was well attended and members were offered the chance to have routine health checks.

A review of the past year and a financial review was presented by Roland Sinker, Acting Chief Executive and Chris North, reported to members on the activities of the Council of Governors during the year and how they have discharged their responsibilities. The formal part of the meeting was followed by break-out sessions on three of King's key services: Rheumatology, Dermatology and Dementia and Older People services.

Service improvements following staff or patient surveys or comments and Care Quality Commission reports

National patient surveys

This year, results were published for the annual CQC inpatient survey and national Children and Young People's surveys and Maternity surveys. The Department of Health also commissioned its annual national cancer patient experience survey.

Inpatient survey

Results for the 2015 National Inpatient Survey were not published by the time the Annual Review went to press.

National Children and Young People's Inpatient and Day Case Survey 2014

The survey includes patients who are aged 0 – 15. There are surveys for both patients and their parents.

King's was rated amber – the same as expected for all questions in the survey 'the same as expected'. There were no green or red ratings.

The Trust wants to make sure it has good feedback from all the services it provides. Accordingly the Trust has introduced new versions of its 'How are we doing surveys?'. This will enable us to get feedback directly from children and young people about their experience of our services.

Department of Health national cancer patient experience survey 2014/2015

Due to changes in the survey design, fieldwork for the NCPES started later than usual. There are therefore no results available at the time of writing.

National Maternity Survey

In December the CQC published the results of the 2015 National Maternity Survey which saw King's rated amber 'as expected'. This is the first set of results for King's as an enlarged organisation. Overall, the service improved although there remain key areas for improvement with KING'S maintaining a strong position against London and national peer trusts, but there is some way to go to be amongst the best trust in the country. As part of improvement work for maternity, two 'Whose Shoes' events were held at both the DH and Bromley sites.

Patient Experience Surveys

King's gathers patient feedback through its How are we doing patient survey programme. The How are we doing surveys ask patients the Friends and Family Test and a series of questions that are key drivers of patient satisfaction such as treating patients with respect and dignity and involving them in decisions about their care and treatment.

Inpatients: overall performance in the How are we doing survey has been very positive with the trust achieving target of 89 over the year. Both the DH and PRUH sites achieved an overall score of 92 with Orpington scoring 95. The PRUH has continued to make excellent improvements to raise patient satisfaction levels to those at the DH site

When comparing the Trust with other trusts nationally using Friends and Family Test feedback King's performance is mixed. A good number of our wards are in line or above the national average but there are other areas which are trending below and where there is more work to be done.

How are we doing? outpatient survey

The experience of outpatients is less positive. Although there are areas where we are doing well, such as kindness and understanding of clinical staff, there are clear areas for improvement, particularly in:

- Experience with the appointment system and appointment centre
- Waiting times in clinic
- Being given information about waiting times in clinic
- Some aspects of staff attitude

Looking at the trust overall, just under 5% less outpatients would recommend King's compared to other trusts nationally.

There is work to do to improve response rates in outpatient areas to ensure that we can base improvement work on robust data that truly reflects what our patients think.

Emergency Services

In our emergency settings which include our Emergency Departments, Acute Dental Service and our acute medical

wards, we ask patients the Friends and Family Test.

Overall, performance is well below both the London and National averages but there have been positives over the year with improvement in experience of patients at the PRUH.

Negative feedback continues to focus on waiting times, the environment and staff attitude.

Maternity services

Overall, results are positive with King's performing well compared to other London hospitals. The PRUH Oasis birthing unit, in particular, has had very positive results over the last year.

Service improvements

Below are some examples of improvements that have been introduced as a result of feedback from our patients:

- Our nursing teams have been working on our wards to promote compassionate leadership to enhance the experience of patients;
- In the Derek Mitchell Unit, patients feel that it takes too long sometimes to answer the call bell. So, the staff have reinforced intentional rounding so that staff can pick up any needs that a patient has before they have a need to use the call bell. They have also introduced daily planning sessions so that all staff are aware of what is going on in the unit and can support each other.
- Parents on Rays of Sunshine Ward said cleanliness would be improved if you didn't have to touch door handles to open the doors. New electric doors have been ordered.

Patient experience priorities

Detailed information about the work undertaken this year around patient experience quality priorities can be found in the Quality Account from page 105.

On the Children's Ward at the PRUH, families tell us through informal feedback and complaints that provided is not provided. It is not possible to provide food on this ward so we haave made clear the message. The ward cannot provide so have produced poster telling families about different aspects of the ward including the food service so that they understand what is available to them and what is not.

Enhanced patient experience reporting

We have introduced a new patient experience feedback tool which provides staff with timely and accessible information about what their patient are telling us about their care. It includes detailed analysis of patient comments which are a key driver for improvement.

King's Volunteers

This past year, as the volunteer programme celebrated its fifth year, we took the opportunity to reflect on what the programme has achieved but also what we wish for the future.

We engaged with staff and volunteers to decide what needed to be put in place to ensure the continued success of the programme going forward and how we can support both King's and national strategic goals to maximise the positive impact of our volunteers.

As our volunteers have time to have the longer conversation, going forward we need to ensure that we have the right processes and systems in place so that the quality of the experience for both

volunteers and the people they support is the best possible.

With this is in mind, we have refreshed some of our administration systems including as our application form, interviews, role descriptions and training so that we are fit for purpose and succeed in all that we wish to achieve.

We have created the following six streams of work which will be our focus in the years ahead:

- Demonstrating Impact and Value
 - Staff Engagement
 - Continued Excellence
 - Development and Innovation
 - Volunteer Experience and Engagement
 - Collaboration and Influencing
- Alongside the day to day operation of the service, we are continually reflecting on how we can grow the number and scope of opportunities for volunteers to be involved across all our sites to support patients and staff. For example:
- At Denmark Hill, we have a new volunteer role of 'theatre helper', supporting staff in many ways, thus allowing them to focus solely on the patient at this critical time in their care.
 - At the PRUH, we have a volunteer that helps coordinate the 'Home Hamper' programme, engaging with the local community to promote the service and increase donations of food so that we can help more vulnerable patients when they go home.

- Volunteers have also been involved in one-off opportunities or micro-volunteering. Volunteers have been involved in conducting surveys for pharmacy, our ED department and a food survey on behalf of the Patients' Association.

- Volunteers have also helped the King's Charity by supporting their events such as the Carol service at Christmas as well as Get Colourful week.
- Volunteers have provided tours of the garden at Jennie Lee House run by the Lambeth Food Co-op on NHS Sustainability Day. Volunteers have also been trained as assessors helping us with the interview process for potential volunteers.
- Externally, we are seen as a centre of volunteer excellence and this was reflected in the BBC Radio 4 documentary, Volunteer Nation which featured the King's Volunteer Programme.
- We regularly have visits from other hospitals in England wishing to know more about our volunteer programme but this year we also had visitors from EU as we received a visit from a non-profit organisation in Slovenia.

We are proud that we have increased our links into the local community.

- In partnership with Southwark libraries we have stands on a regular basis in their main libraries, using it as an opportunity to raise awareness of the volunteer programme as well as recruit volunteers.
- We have also exploring links with businesses encouraging their staff to consider volunteering or fundraising for our programmes. Recently, we received a donation of books from Michael O'Mara books which we will add to our activity boxes, a tool that we are hoping to roll out across the

hospital to assist volunteers in their interactions with patients.

- Links have also been extended to my peers across London as we have started a London Hospital Volunteering Network with five other London Trusts to share best knowledge and best practice and seek opportunities to collaborate with each other.

The main purpose of the volunteer programme is to improve patient experience and supporting staff in doing so. This comment from one of our volunteers illustrates that something as simple as a smile from one of our volunteers goes a long way to making a difference.

"I know that I only help patients and visitors in a very small way, but I hope it adds to their positive experience of this brilliant hospital. The reception is the first place patients and visitors come to in the hospital, and I feel that a welcoming smile and greeting somewhat allays the fears of anxious patients."





Responding to complaints

Overall King's received 811 complaints in 2015/16 which represents a 16% reduction compared to 2014/15, when 974 complaints were recorded. In year 465 complaints were received concerning the Denmark Hill site which is a 20% reduction from the previous year at 579. A total of 346 complaints were made during the reporting period concerning the Princess Royal University Hospital and other sites in Bromley. This is a 12% reduction in complaints from the previous year (379).

We continue to focus on dealing with complaints as soon as they are reported and wherever possible providing immediate support in fixing the problem and ensuring dialogue is established between the complainant and the service/clinical staff. This approach has been positively received both by our patients and staff, and complements the established role of the Patient Advice and Liaison Service (PALS) in resolving concerns and problems. During 2015/16 PALS handled 9,212 enquiries, an activity increase of 10% from 2014/15 (8,363).

As an organisation we welcome complaints as a means of improving

performance and learning from complaints is ongoing and is often linked with outcomes following clinical incident investigations. Complainants and patients have participated in meetings with staff and also in listening events, patient video stories, and contributed to a range of general improvements across the organisation.

Stakeholder engagement

The Board of Directors has continued to prioritise dialogue and engagement with stakeholders.

The Trust has taken a planned approach to this engagement through regular meetings with stakeholders including Clinical Commissioning Groups, NHS England, Monitor, Local Authorities, Healthwatch and Members of Parliament.

Throughout the year we have attended Health Overview and Scrutiny Committees of our local authorities; reporting to them on progress in key areas, service developments and taking part in discussions around developing local strategies.

We have held a series of dedicated events for our external stakeholders. These events provide a platform for us to bring together a wide range of stakeholders from across the system and involve them in our work. The events cover updates on our current performance, quality initiatives, financial recovery plan and emerging strategy including work with commissioners in south east London to address system wide challenges. Through focused workshop sessions we actively involve them in our strategic thinking and development process.

We have also held events for our membership and Governors. This includes the Annual Members Meeting and Members Community events which ensure

that their views are communicated to the Board and considered as part of the annual strategic planning process, whilst being reflected in the work we do. Among many ways we engage with our membership and patients is through working with local groups in the communities we serve to share information and support important initiatives for example around public transport.

As the Trust has been working on ensuring financial sustainability whilst improving the quality of care for our patients we have focused our engagement efforts on constructive dialogue to support this. We recognise that developing deeper partnerships with others in our health economies and changing the way we deliver services is the key to achieving this stability for the benefit of our patients.

A Representative Membership

A strategy for membership development is incorporated within King's Engagement and Experience Strategy. It outlines the approach to ensuring that it has a membership reflective of local communities, how the membership is involved in the work of King's and how King's can make a difference in the local community.

King's membership is split into three constituencies: public, patient 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.

In 2013/2014, in accordance with the revised membership development strategy, a target of maintaining a patient and public membership of between 9,800 and 11,100 members was set.

King's currently has 11,025 Patient and Public Members and circa 11,600 staff members.

King's continues to work hard to ensure that its membership is representative of the local community, and takes steps to ensure that membership is accessible to all who are eligible, irrespective of age, gender, race or social background. Demographics of the membership are monitored using the King's membership database and any gaps can be addressed with targeted recruitment.

King's has focused on building Membership engagement during the period.

An involved membership

A number of initiatives were undertaken to involve members with activities at King's.

- Regular publication of @King's magazine to update members on news and events, as well as opportunities to get more involved, along with notification of all Council of Governor activities.

- Programme of Member Health talks on public health and how services are structured and delivered across both acute sites at the DH and PRUH which have continued to be very popular and are often over-subscribed.
 - Member's E-Bulletin is sent once a month. This contains information about upcoming Health Talks, involvement events and opportunities and information from external partners about activities of interest in the community including Healthwatch, SLIC Citizen's Forum.
 - The Trust held two community events for members to share the Trust's strategic plans for the future with the membership and to give them an opportunity to share their views with King's. One was held at Denmark Hill and one in Bromley. 73 members attended the two events.
 - The Annual Public Meeting again proved popular with over 89 attendees. As always, the evening began with our popular health checks including Blood Pressure, Glucose and BMI and an opportunity to look at information stands. There were presentations on the trust's five year strategy and an overview of the work of the Council of Governors. After the formal part Members were invited to attend 3 different health information seminars on the topics of Dermatology, Rheumatology and Dementia and older people.
 - Patient Led Assessments of the Care Environment (PLACE). PLACE is a collaboration between staff and patient/member assessors, with patients/members making up at least 50 per cent of the assessment team. Governors, Members and Healthwatch stakeholders were also involved in this year's PLACE assessments both at the PRUH, Denmark Hill and Orpington Hospitals.
 - King's partnered Bromley College on a project to refresh the membership offer for younger people. A group of 23 health and social care students worked with staff from King's Membership Team and Communications Department to develop new and exciting ways to promote the benefits of joining the Trust to young people.
 - As part of the project with King's, the students conducted research and carried out surveys with their peers, which has given the Trust some great ideas about how to encourage young people to join King's.
 - As well as being beneficial to the Trust, the project helped students gain experience of team working, research, report writing, presentation skills, as well as design and marketing.
- Student Emily Bryant (pictured) said:
- 
- "The King's Project has helped me develop new skills and view the organisation in a different way. My team working skills have vastly increased through both working with peers and King's staff members. It is exciting to be part of something that could engage people in the NHS and"*

my understanding of what makes a hospital work, how busy it is and the different aspects that are part of it."

King's will now take the findings from the group and use them to inform future recruitment initiatives with young people in Bromley.

- Members and Governors have continued to help on the wards at both Denmark Hill and the PRUH helping patients, especially on the elderly wards complete feedback surveys about their experiences.
- We recruited and trained a group of Members to gather feedback in our outpatient clinics at the PRUH and other SE London sites and they are proving a huge asset in making sure we get feedback from as many patients as possible.

Integrated Care

King's has continued to work with health and social partners across Lambeth, Southwark and Bromley boroughs to integrate services to improve patient care, health and wellbeing. These will be taken forward through Local Care Networks over the next year.

Southwark and Lambeth Integrated Care (SLIC)

SLIC has been a federation of the leading commissioning and provider organisations across Southwark and Lambeth. This included the two local authorities, the two local clinical commissioning groups, representation from local medical committees, three foundation trusts (encompassing acute and community services and physical and mental health), as well as King's Health Partners and Guy's and St Thomas' Charity. In practice SLIC has fulfilled two main functions: it provided a neutral space

where partners came together to work through the difficult practical challenges associated with leading system transformation.

The SLIC programme has formally come to an end (31st March 2016) but King's will continue to contribute to the many integrated care schemes introduced over the last 4 years that support early intervention to prevent older people going into crisis and prevent admission to hospital as well as reduced length of stay in hospital by providing care and support for people at home or in nursing/residential care

There have been a number of well evaluated interventions/schemes aimed at improving the value of care received by the frail elderly:

- Acute care home interface – improving transfer of care processes between hospital and care homes.
- Embedding Safe and Independent Living (SAIL) navigators have supported over 175 people in the last year.
- New catheter pathways to improve care and support for people with a catheter will result in fewer emergency attendances and admissions.
- Mental Health Care Home intervention Team (CHIT) – helping to support elderly residents and staff with challenging behaviours related to mental health issues such as dementia.
- Community Multidisciplinary Teams – set within a geographic group of GP practices supported by the hospital, community services, social care and mental health professionals to discuss

complex and vulnerable people and collectively try to address care issues.

- Community dietetic team – to support older people with malnutrition or at risk of malnutrition.
- Creation of a digital Directory of services – supporting patients and health care professionals to identify and access the plethora of services on offer (1700 services currently within the directory).
- Falls prevention – early identification of people at low risk of falling with additional strength and balance exercise classes.
- Locality geriatricians are being tested in Lambeth – to provide support and education for primary care teams in managing frail and complex older people in primary care as well as developing new methods for screening frailty.
- GP telephone advice line (Geriatrician, Acute Medicine and Paediatrician) - GPs and community staff can get specialist advice and support 24/7 with same day or next day access to a specialist appointment if needed.
- Geriatrician telephone advice line and rapid access to ‘hot’ clinics – GPs and community staff can get specialist advice over the phone 24/7 with same day or next day access to a specialist appointment if needed.

The development of the Local Care Record (LCR) has been a key development and enables the GP to view their patient records in the hospital IT system and for hospital teams to view the patient record in the GP practice IT system.

King's remains very committed to developing integrated care and will continue to work with our health and social care partners within Local Care Networks which are starting to take shape.

To make fundamental changes in the care system, King's will need to work closely with commissioners and partners to transform how care is commissioned, paid for and provided. This work will:

- Identify if and how health and social care budgets are brought together to fund services for specified segments of the population;
- Recommend different financial mechanisms and incentives to help providers focus on preventing avoidable activity and providing care in the right place at the right time; and
- Establish ways in which the various providers can come together across the full value-chain, either in formal or virtual organisations and networks, to manage contracts and sub-contracts for the provision of coordinated care.

However, it is widely recognised that such a transformation will require a fundamental change in the way that resources, including people, buildings and infrastructure, are utilised within the whole health economy.

Bromley and PRUH

The multi-agency Transfer of Care Bureau (ToCB) was set up in October 2015 at the PRUH, by co-locating the Hospital Adult Social Care Team with colleagues from Bromley Healthcare (BHC) and King's College Hospital (KCH) with input from St. Christopher's, LBB brokers and continuing healthcare team as part of the CCG including voluntary sector organisations.

The team is set up to work in a more integrated way when planning patient discharges (or transfers of care), primarily to prevent hospital admission or readmission and to reduce delayed transfers of care. Care managers (along with colleagues from KCH and BHC) act as case managers and ‘trusted assessors’ to manage the transfer of care for patients in the PRUH requiring supported discharge. This new way of working is currently being evaluated to determine success and improvement to the patient experience. Early indications suggest a reduction in hospital length of stay for Bromley patients.

Children and Young People in Lambeth and Southwark

King’s are key players in the Lambeth and Southwark Children and Young People’s Programme (CHYPP) and support integrated working through schemes such as:

- GP telephone advice line enabling GPs to discuss children they are worried about with a paediatrician – there were more than 300 calls received in the first 6 months and increasing. Whilst some GPs and parents are reassured over the phone some patients are offered rapid access appointments preventing Emergency Department attendances.
- The paediatric inreach clinics ran in a local GP surgery in Lambeth are very well utilised where paediatricians see children and parents alongside the GP. We hope to provide more of this in other Lambeth and Southwark GP practices

We recognise successful integrated care cannot be delivered by any one party and will require a fundamental change in the way that resources, including people,

buildings and infrastructure are utilised within the whole health economy.

Patient information Brochures

All King’s patient information, produced to support consent, follows a set template to ensure that all necessary information is included and that it is written in jargon-free English. Braille versions are available on request, as are translations for those patients whose first language is not English. Brochures are available in printed formats, on the hospital intranet for use by staff and on the external website for download by patients and carers.

Over the last year we have worked hard to achieve consistency of patient information across our five sites, producing Trust wide brochures where possible, avoiding duplication and reducing costs. Where services and procedures differ, we continue to produce site specific information to support patients with consent.

In response to the development of the Transfer of Care Bureau at the Princess Royal University Hospital, we have developed a guide for patients. It outlines how King’s works with social service, and primary and community care services to improve the discharge process for patients in the Bromley area.

Websites

King’s is committed to providing online information that is accessible to the widest possible audience, regardless of technology or ability, including disabled people, people with visual impairments and those with motor and cognitive disabilities. The King’s website conforms to the World Wide Web Consortium (W3C) Web Content Accessibility Guidelines 2.0 at the AA standard, making it more user friendly for everyone.

During the year we developed websites have been planning, designing and developing a new Trust website to incorporate information from all the King's locations. The new responsive (mobile friendly) site will ensure a smoother user journey covering all services and facilities at each site and will be completed by summer 2016.

King's People

2015/16 was a year coming to grips with the service and financial demands on the Trust and identifying ways in which the Trust could operate more effectively with reduced resources.

Leadership, learning and organisation development

Key themes for 2015-16

- Supporting leadership development and professional education
- Apprenticeships and vocational training
- Organisation development: reviewing the organisation's operating model

In the 2014 staff survey, we asked about whether staff received job-relevant training, learning or development in previous 12 months. The question in 2015 was concerning the quality of that training:

Year	NHS Staff Survey Data KF6 - % of staff received job relevant learning, training and development
2014	84% (81% national Average)
Key finding has changed	KF13 – Quality of non-mandatory training, learning or development (score out of 5)
2015	4.01 (4.03 national average/4.18 national best)

Leadership development and professional education

A wide range of programmes are available to staff at King's, designed to support the development of staff and "skilled, can-do teams" at every level. These are either delivered internally, or accessed via one of our partner universities.

In the past year over 1200 internal training courses have been delivered to staff by the education, training and development team - of which 70% were for statutory and mandatory training- and 300 internal courses were provided by the PGMDE department.

During the academic year starting September 2014, over 600 non-medical staff were funded to undertake external courses at one of our partner universities.

Examples of some of the courses we offer internally include:

- A new 4-day modular programme aimed at administrative staff at bands 1-5.
- First-time leaders: a programme to develop new leaders' self-awareness and confidence.
- Aspiring band 7 leaders: a programme aimed at band 6 nurses and midwives who are aspiring to move into their first leadership role (this programme will be extended to AHPs in 2016-17).

Profession-specific development achievements include:

- Continued delivery of a robust preceptorship programme for all newly-qualified nurses.
- Monthly 'bite size' training sessions in both leadership development and mental health awareness to support the CPD requirements for NMC revalidation for

qualified nurses.

- The development of two bespoke programmes for medical staff: a modular development programme for SASG doctors; and an Overseas Doctors Development programme.
- Leadership training for all grades of doctors encompassing quality improvement; “Training Tomorrow’s Trainers” for senior registrars preparing for their first consultant appointment; and a new consultants’ development programme.

The Trust is on track to meet the GMC standards for the recognition and approval of medical educators and trainers. The target set by Health Education England South London is 100% by April 2016.

In addition the trust supports individual development through:

- the establishment of a new CPPD funding panel through which non-medical staff can bid for funding support for external courses and programmes (the Panel awarded over £500K worth of individual and group funding during 2015-16).
- promoting access to individual coaching and mentoring, either using internally-trained coaches and mentors or via the London Leadership Academy’s coaching service.
- supporting staff to undertake national Leadership Academy programmes. Around 40 staff have completed, or are currently completing national programmes, and a further 10 have been awarded funding to undertake these programmes during 2016-17.

The Trust also delivers multi-professional simulation training to support the patient

safety agenda and to encourage clinical staff to work across physical and mental health. This training is tailored to support the requirements of the teams and specialty training, with both in-situ and high-fidelity specialised programmes.

Development of compassionate leadership

In June 2015 a successful bid was made to the KCH Charity for a two-phase project aiming to improve staff engagement, patient experience and develop compassionate leadership amongst staff working in four wards (two at Denmark Hill and two at PRUH). The approach uses innovative learning methods, including a two-day workshop for Ward Managers and Matrons, and a 1-day workshop using forum theatre for all other nursing staff (including Healthcare Assistants). These events are followed by bespoke work to develop people’s ability to deliver compassionate care and increase their engagement. Phase 1 has been completed and is currently being reviewed prior to delivery of phase 2 during 2016/17.

Apprenticeships and vocational training

During 2015-16, 40 apprentices were recruited onto programmes across the Trust to take up support roles in business administration, clinical support and health & social care. These apprenticeships provide opportunities for young people to gain entry routes into the NHS and work towards a nationally recognised qualification at level 2 or 3. Of the apprentices who have completed their programmes in the past year, 50% have gained permanent roles at King’s.

We are also working with Guy’s & St Thomas NHS FT to set up a joint pre-employment programme that will from June 2016 provide the opportunity for local

young people from across SE London to attend a 2-3 week pre-employment training course delivered by a local training provider. All candidates who complete the programme will be guaranteed an interview for a suitable apprenticeship opportunity within the NHS. As well as supporting local employment, this programme will provide a pool of candidates from which King's can recruit onto future apprenticeship programmes.

In addition, the in-house vocational training team supports around 100 internal staff at any one time to undertake City & Guilds and Institute of Leadership and Management (ILM) qualifications.

Organisation development: reviewing the organisation's operating model

In order to support the transformation of King's into an organisation that is consistently world-class across the board, the organisation has set out to redesign its operating model and associated organisation structures. Implementation of the new organisation design is one of the key workforce objectives for 2016/17 and will run alongside delivery of service transformation over the coming year.

To help shape and develop the new operating model and engage senior leaders, an organisation design steering group has been established. This group will help inform the progress and direction of the new organisational structure.

Regular communication and engagement with staff at all levels of the organisation will be key to successful implementation of the proposed structure. The high-level organisation design, including the transition from six to four clinical divisions, has already been communicated to staff, and ongoing communication and engagement will continue throughout the first half of 2016-17.

To further support the change process, 1:1 coaching support with an experienced external coaching provider will be offered to directly affected staff during 2016-17.

Awards and recognitions received by King's staff during 2015/16

- **Stephany Baladas, Assistant Clinical Technologist Apprentice**, was chosen from a field of 200 other young women to win a national WISE girl (women in science, technology and engineering) award
- **Jennifer Caguioa, Lead Intravascular Practitioner**, won the British Journal of Nursing, Infection Control Nurse of the Year award.
- **Mini Joseph, Cardiac Clinical Coordinator**, was awarded the Association for Peri-Operative Practice, Theatre Practitioner of the Year.
- **Dr Fliss Murtagh, consultant in palliative care and Senior Lecturer at KCL**, was joint winner of the London Leadership Academy's award for outstanding collaborative leadership

Staff health and wellbeing

- King's are committed to the health and wellbeing of its staff and will be reviewing the staff health and wellbeing priorities to meet the needs of our staff and the requirements set out in the NHS Five Year Forward View.
- A recommendation of the NHS Five Year Forward View is that Trusts are accredited by the Mayor's London Healthy Workplace Charter. Workplace, King's currently holds achievement level accreditation.

- King's are signed up to the Public Health Responsibility Deal, King's pledges to actively support staff to lead healthier lives.
- King's has secured accreditation against a set of nationally approved standards known as a Safe Effective Quality Occupational Health Service (SEQOHS). These services provide a range of staff health and wellbeing interventions such as annual flu vaccinations, physiotherapy services, face to face counselling, an employee assistance programme for confidential telephone advice and support for the management of sickness absence.
- The most common known reasons for sickness are colds/coughs/flu, and then gastrointestinal problems

The rate of sickness for financial year 2015/16 was 3.5%. figure for Jan 16

Reward and recognition

- King's Commendation: recognises outstanding contributions to patient care or hospital services by an individual or team. 18 King's Commendation Awards were awarded to teams and individuals in 2015/2016 (12 individuals and 6 teams).
- King's Long Service awards ceremony in April 2015 recognised 100 staff who had attained 25 or 40 years with King's in the last three years.
- Annual awards ceremonies also recognise achievers in education and development across all disciplines.

Actions taken in the financial year to provide employees systematically with

information on matters of concern to them as employees:

- At induction, new staff are introduced to the King'sweb intranet and provided with the necessary tools and training to access regular corporate communications.
- King's Daily Bulletin, King'sdocs, Kwiki and the Chief Executive's monthly bulletin are examples of important information sources and communication.
- King's intranet also provides easy links and access to information about King's Health Partners.
- King's management/ committee structure and culture of regular team meetings ensure that key issues are cascaded throughout the organisation.
- Bi-monthly Joint Consultation Committee (JCC) involves and informs staff representatives on matters of significance.
- The JCC nominates a staff side representative to serve as a stakeholder governor on the Council of Governors.

Actions taken in the financial year to encourage the involvement of employees in King's performance:

- The 2015 national NHS staff survey reported King's 'above average' nationally for good communication between staff and senior managers and this is moving in the right direction since 2014/15.
- Challenges and success are regularly communicated by the Chief Executive in his monthly brief to staff and Director Road shows.

- With the managerial challenges of 2016/17, only 40% (Jan 16 figure) of staff with 12 months or more service received performance appraisals.

Actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of King's:

- The Chief Executive maintained a strong focus on King's financial position and longer term strategy throughout the year, keeping staff informed through his monthly brief.
- Emphasis was placed on the importance of achieving significant cost reductions and the role of individual staff.
- The JCC received regular updates on the financial position.

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

- Throughout 2015/16, the JCC was regularly well attended by representatives of recognised trade unions and staff associations and senior management.
- The British Medical Association has a seat at the JCC table but, in practice, specific matters relating to medical and dental staff are discussed at the Local Negotiating Committee.
- Staff Friends and Family test run quarterly.

A Diverse Workforce

King's College Hospital NHS Foundation Trust's aim is to develop a culture which values each person equally as a unique individual. We aim to have in place the systems which pro-actively promote equality of opportunity, fairness and justice and the Trust now employs circa 11,600 staff across five main sites and a number of satellite sites in south east London and Kent.

The breakdown of our diverse workforce can be found in table 10 on page 91.

The Trust is committed and indeed has a legal obligation, to ensure that staff are trained and kept up-to-date on equality and diversity issues.

We continue to use the Department of Health'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

We are continuing to embed and monitor inclusion through Trust assurance processes and in 2015 we have monitored this via the Finance & Performance Committee, Education & Workforce Development Committee, and Patient Experience Committee.

We have established an effective approach to ensure that equality and diversity messages are being communicated successfully to staff.

Currently we offer the following:

- All new staff receive diversity training as part of corporate induction.

- An E&D Induction leaflet “Inclusion” has been produced to highlight the work of the Trust’s equality forums and networks.
- An on-line e-learning E&D package is available for staff.
- Training and written guidance is available for staff responsible for undertaking Equality Impact Assessments.
- We offer an e-learning package on the use of British Sign Language.
- Access to the Disability Forum has been established through NHS Employers.
- There is a mandatory workshop for Board members on their statutory duties.
- Awareness training on gay, lesbian, bisexual and transgender issues has been rolled out.
- Band 7 and 8 staff are being offered training in unconscious bias.

In addition inclusion awareness is woven throughout the content of our mandatory training programme for line managers and recruitment and selection workshops. As well as the mandatory training we offer the Trust also supports the following:

Staff Led Diversity Groups

King's has three staff-led diversity groups: the Cultural Diversity Group (CDG), the Disability Inclusivity Network (DIN) and the Lesbian, Gay, Bisexual and transgender Forum (LGBt).

The groups have been working on a number of initiatives to support diversity

across the Trust (i.e. Stonewall Healthy Lives, holding annual events, etc). Support for the work of the groups is being maintained at senior management level through attendance at meetings, (including the Annual Diversity Event), and by the making of public statements in support of those groups (e.g. through the Chief Executive’s Brief).

Promotion of Dignity and Respect

The Trust has put in place clear processes for dealing with reported cases of bullying and these are monitored on a regular basis to ensure they are effective.

We continue to provide 24/7 access to an independently-run “Dignity at Work” helpline as well as providing an Employee Assistance Programme which staff can access to support them with a number of different issues (e.g. work concerns, financial issues, relationship advice, etc).

We also have 11 formally accredited staff mediators who work with managers and staff to attempt to resolve work related issues informally.

Stonewall Top 100 Employers Index

The Trust’s 2014 submission, whilst not gaining a place in the Top 100 employers, scored significantly higher than previous applications submitted to Stonewall. We will be receiving the results of our 2015 submission shortly.

We are ‘positively diverse’

King's is accredited as a nationally recognised Positive About Disabled People ‘Two-Ticks’ employer and is reassessed on a regular basis.

Positive about disabled people

King's has a Disability Charter which sets out its ethos and a firm commitment to disability equality. King's also has a Disability and Deaf Guide which outlines

the responsibilities and behaviours expected of staff and managers.

King's recruitment, training and equal opportunities policies are designed to support those who declare a disability. Policies apply from the pre-employment stage, when applying for vacancies, to supporting those who become disabled during the course of their employment and ensure that all staff have equal access to promotion and development opportunities.

To help improve the experience of those working at King's with a disability, staff are signposted to relevant support provided through the Occupational Health & Wellbeing service and Disability Inclusivity Network. 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.

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A listening organisation

Each year King's collates staff views through the NHS national staff survey and

the quarterly staff Friends and Family Test.

Staff Friends & Family Test (FFT)

Staff FFT is run on a quarterly basis (four times per year). For the third quarter the FFT is included within the annual national staff survey.

Staff are asked their opinion on whether they would; recommend the Trust as a place to receive treatment and as a place to work.

In Q3 the Trust has seen a slight decline in staff recommending the Trust as a place to work and be treated. This result contributes to the overall staff engagement score in the National Staff Survey. The Q4 FFT test is currently open and all staff are asked to participate.

National Staff Survey

The 2015 response rate to King's participation in the national NHS staff survey remained the same as last year. The survey closed with a 30% (national average is 40.6%) response rate (255 staff) from a random sample of 850 staff. This is a very low representation of the Trust's workforce.

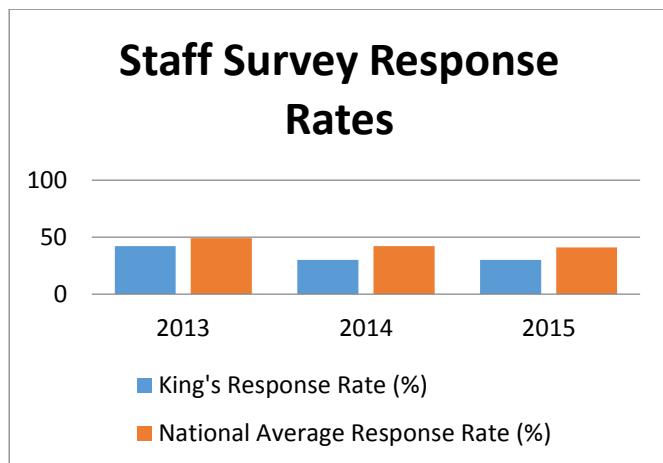


Figure 1: National Staff Survey Response Rates

King's scored well for overall staff engagement despite the decline in the FFT. A score of 3.81 out of a possible score of 5 placed King's slightly better than the national average (3.79).

Of the 32 national key findings, King's ranked above average for 14 and in the worst 20% for 9.

Most Favourable Comparisons with Other Trusts

King's recorded the following as the most favourable Key Findings compared to other Trusts:

- Staff ability to contribute toward improvements at work
- Support from immediate managers
- Percentage reporting most recent experience of harassment, bullying or abuse
- Effective use of patient / service user feedback
- Percentage experiencing physical violence from staff in last 12 months

The results have highlighted some areas for improvement that we are already in the process of developing initiatives for, as part of the King's BEST strategy and workforce strategy.

The results have highlighted some areas for improvement that we are already in the process of developing initiatives for, as part of the King's BEST strategy and workforce strategy development process (e.g. Appraisals, Equality, Staff Engagement/Morale, Health and Wellbeing, Line Manager Capability) Due to the low numbers of staff responding we are not proposing to develop specific Divisional or Occupational Group Staff Survey action plans for this year

A significant increase in staff feedback through the staff survey is required to get a better understanding of staff views. In 2016 the survey will be open for all staff to participate and we also need to increase the overall Trust response rate

Key Finding	Kings 2015	Kings 2014	Average National score '15	Best National Score '15
<i>Top 4 rankings</i>				
KF7 % able to contribute towards improvements at work				
KF10 Support from immediate managers	3.78	3.67	3.69	3.96
KF23 % experiencing physical violence from staff in last 12 mths				
KF27 % staff/ colleagues reporting most recent experience of harassment, bullying or abuse	45%	51%	37%	52%
KF32 Effective use of patient/ service user feedback				
<i>Bottom 4 rankings</i>				
KF28 % staff witnessing potentially harmful errors, near misses or incidents in last month				
KF11 % appraised in last 12 months	73%	65%	86%	95%
KF15 % staff satisfied with the opportunities for flexible working patterns				
KF16 % working extra hours	79%	74%	72%	61%
KF17 % suffering work related stress				

Table 9: Top & Bottom 4 Rankings in National Survey

	2012/13		2013/14		2014/15		2015/16	
	Headcount	%	Headcount	%	Headcount	%	Headcount	%
Age								
0-16	0	0%	0	0%	1	0%	1	0%
17-21	69	1%	117	1%	109	1%	111	1%
22+	7845	99%	10984	99%	11658	99%	11536	99%
Ethnicity								
White	4119	52%	6148	55%	6356	54%	6250	54%
Mixed	242	3%	314	3%	329	3%	313	3%
Asian or Asian British	1366	17%	1861	16%	2155	18%	2126	18%
Black or Black British	1838	23%	2214	20%	2299	20%	2291	20%
Other	154	2%	208	2%	249	2%	260	2%
Unknown	195	2%	356	3%	380	3%	408	4%
Gender (all staff)								
Male	1986	25%	2641	24%	2771	24%	2803	24%
Female	5928	75%	8460	76%	8997	76%	8845	76%
Gender (senior managers)								
Male			10	36%	12	52%	14	54%
Female			18	64%	11	48%	12	46%
Gender (directors)								
Male			11	69%	10	59%	10	50%
Female			5	31%	7	41%	10	50%
Recorded Disability								
Yes	223	3%	291	3%	280	2%	269	2%
No	6771	86%	9103	82%	9949	85%	10061	86%
Not Declared	216	3%	888	8%	839	7%	820	7%
Unknown	704	9%	819	7%	700	6%	498	4%
Sexual Orientation								
Bisexual	56	1%	77	1%	74	1%	87	1%
Gay	97	1%	123	1%	161	1%	176	2%
Heterosexual	5141	65%	7596	68%	8830	75%	8928	77%
Lesbian	33	0%	41	0%	50	0%	45	0%
I do not wish to disclose	1366	17%	1941	17%	1866	16%	1795	15%
Unknown	1221	15%	1323	12%	787	7%	617	5%
Religion								
Atheism	601	8%	913	8%	1117	9%	1179	10%
Buddhism	52	1%	79	1%	139	1%	157	1%
Christianity	3705	47%	5193	47%	5925	50%	5924	51%
Hinduism	249	3%	336	3%	389	3%	402	3%
Islam	293	4%	375	3%	461	4%	479	4%
Jainism	12	0%	11	0%	14	0%	15	0%
Judaism	19	0%	24	0%	27	0%	31	0%
Sikhism	35	0%	53	0%	98	1%	104	1%
Other	397	5%	549	5%	619	5%	637	5%
I do not wish to disclose	1334	17%	2258	20%	2201	19%	2114	18%
Unknown	1217	15%	1310	12%	778	7%	606	5%
Total Staff Numbers	7914		11101		11768		11648	

Table 10: Breakdown of Trust Diverse Workforce

Health and Safety Activity

In 2015/16 the focus on Health and Safety activity was on assurance and compliance for the Trust following a major restructure of the department.

As of July 2015, the Operational Safety Department evolved to become the Regulatory Governance Department (RGD). Separating from the Operations Directorate, it is now a key component of the Capital Estates Directorate, absorbing new roles and responsibilities. Key activities include:

- The management of safety for operations of the Trust's new Helipad.
- Upgrading Trust Safety Policies in line with recent legislative changes.
- The revision of the Trust's RIDDOR reporting procedures.
- Re-development of the risk assessment library to include COSHH, First Aid and Fire.
- Improving risk profiling using HSE Health and Social Care guidance.

A Memorandum of Understanding (MoU) between the HSE and CQC came into effect in Q1 2015, reflecting the new enforcement powers granted to the CQC by the Regulated Activities Regulations 2014. From 01 April 2015, the CQC will take the lead role for patient & service user health & safety in health and adult social care in England. The RGD has recognised the new responsibilities of the CQC, HSE and Local Authorities and has adjusted policies and procedures accordingly.

RIDDOR

There has been a continual reduction in the number of RIDDORs submitted to the HSE from the Trust. The total number of RIDDORs reported for the period 2015-2016 is 47, a decrease of 14.8% compared to last year. The ongoing decline in RIDDORs is encouraging but the causes of the injuries remain the focus of RGD attention. The most common injuries are:

- | | |
|------------------------|----|
| • Sharp Injuries: | 13 |
| • Splash Injuries: | 06 |
| • Slips, Trip & Falls: | 11 |
| • Others: | 16 |

Two Members of staff received wounds following an assault, 19 x members of staff required leave for over 7 days and 2 x staff were seriously injured resulting with fractures or breakages.

Historically, sharp injuries have been the source of the highest proportion of RIDDOR submissions, followed closely by Slip, Trips and Falls. The challenge remains to continually reduce these via procedural and doctrinal implementation, supported by a robust and dynamic training regime.

Significant Incidents:

- Dermatitis Aug 2015: Two HSE Inspectors visited the PRUH to investigate a previous dermatitis case involving an member of staff. Following interviews with the RGD and OH, there came some minor recommendations, including formal regular hand checking, which have now been absorbed into the Trust.
- Asbestos Nov 2015: Two HSE Inspectors visited DH in regards to a Breach in Asbestos protocol and operating procedures. The shortfall

was identified and measures have been taken to address these.

Accident Investigations

- A member of public sustained injuries when she slipped on the wet floor of the main entrance to Orpington Hospital. Following extensive investigations, it was concluded that the surface area of the main entrance required further anti-slip control measures, which were put into place in Aug 15. No further incidents have been reported.
- The new Medical Records (MedRecs) facility in Orpington developed structural deficiencies in Sep 15, resulting with a complete relocation to Abbey Wood after a comprehensive investigation. The recommendations were to remove the racking and replace the flooring prior to re-instating the MedRecs in 2016.
- A potential increases in the cases of contact dermatitis within the Sexual Health Clinic in Camberwell Road prompted an urgent investigation. Under HSE regulations, any new dermatitis cases must be reported under RIDDOR, completed by a formal investigation. The outcome of this appears that staff members were incorrectly using CUTAN hand washing substances, and developed dried skin from this. Although staff members affected have been referred to OH, it is anticipated that the cause of the skin discomfort is a reaction to the hand gel due to poor hand washing regime, and not dermatitis as was originally thought.

Training

The RGD monitors safety training against the Trust target of 80%. Overall

compliance with H&S training stood at 92.1 % at the end of Q4 2015, representing a rise of 10.1% as compared to Q4 2014.

In addition to this, bespoke training programmes continue across the Trust, addressing areas such as Theatres, Midwifery and in particular, staff working at nights or in the community.

Helipad Safety Training has also been scheduled to take place in quarter 1 of 2016.

Violence and Aggression

V&A against healthcare workers have increased across the UK over the last 12 months. King's Staff have also seen a rise in assaults (verbal and physical) over the reporting period. Total number of V&A incidents is 401 for 2015/16 and represents an increase of 48.3%. These are categorised by areas:

- | | |
|---------|-----|
| • PRUH: | 74 |
| • DH: | 322 |
| • Other | 5 |

Summary

The report illustrates the substantial work that has been undertaken over the last reporting period, following a major re-structure of the Safety Teams.

The Regulatory Governance Department has embedded itself within the CEF Directorate and maintains a proactive work schedule with local managers to improve the quality of risk assessments and further control of hazards within the Trust whilst reporting these results to the Organisational Safety Committee.

Statement of Accounting Officer's Responsibility

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 Monitor.

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

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

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

- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statements on a going concern basis.

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

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


Signed:

Nick Moberly
Chief Executive Officer

27 May 2016

Annual Governance Statement & 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 of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the 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 the Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

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 Trust operates a unified approach covering both clinical and non-clinical risks which are recorded on a computerised risk register. The Board reviews the risk register quarterly and areas of risk are assigned to particular Board committees. Supported by a Patient Safety and Risk Management Team, the Medical Director leads on clinical risks. The Chief Operating Officer has accountability for the development, implementation and testing of the Trust's business continuity plan.

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 the corporate and local induction staff are provided with guidance and training on the Trust' 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.

NHS Providers and other external sources of healthcare intelligence such as Dr Foster and Care Quality Commission's (CQC) reports and inspections. The Trust uses the Healthcare Evaluation database (HED) 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 Department of Health, KHP partners and our Governors to provide an independent critical eye. The Trust is also working collaboratively with other external providers through OHSEL.

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. Local Risk Groups identify risks and potential hazards and formulate actions plans to deal with them. Each risk is scored on a common basis across the Trust for likelihood and potential impact. If risks cannot be satisfactorily resolved at a local level, they are considered by the relevant corporate risk management group.

Key elements of quality governance arrangements

The Chair commissioned a high-level governance review undertaken by independent advisors during 2015 to ensure that the governance arrangements were fit for purpose for a changing organisation in challenging times. Changes have been made to the Executive Team and Board Committee membership and structure. NED leadership has been assigned for each of the key strategic and forward planning priorities. Work is underway to embed board development and to ensure effective succession planning and appraising mechanisms. A number of measures have been proposed to enhance the governors' collective performance, including two joint NED and Council meetings.

The Trust's quality governance framework has at its centre the Quality & Governance Committee with a membership comprising four Non – Executive Directors and all Executive Directors with Commissioner representation from Southwark and Bromley CCGs. Since January 2016, a Governor representative attends the monthly Quality and Governance Committee, providing a written report to the Council Governors on the matters discussed. The quality and governance reporting committees, patient outcomes, patient safety, patient experience and organisational safety, are all chaired by executive directors. The executive director is also accountable for reporting to the Quality & Governance 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 organisational safety and patient experience at all sites are integrated within an 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 already in place at King's. Compliance with this requirement is subject to internal audit, and a further review is scheduled for May 2016. Any recommendations arising from this audit will be acted upon in a timely way.

Through a defined reporting programme the Quality and Governance Committee, which is a committee of the Board, and its reporting committees: patient safety, patient outcomes, patient experience and organisational 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 monthly Performance Report and performance scorecard which provides up to date information of 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. In addition the Board considers a quarterly update of the Trust Risk Register and reviews the Board Assurance Framework. The Executive Director of Nursing provides a monthly report to the Board of Directors on nursing

numbers in comparison to an acuity based evaluation of safe staffing levels.

At the monthly Quality and Governance quarterly report addressing the three dimension of quality – patient safety, patient outcomes, patient experience are presented by the Medical Director, Director of Nursing & Midwifery and Director of Corporate Affairs respectively. The reports include updates on quality priorities 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 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
- **Organisational Safety:** analysis of health and safety incidents, inspection findings etc.

A quarterly report on Infection and Prevention Control is provided by the Director of Nursing who is also the Trust's DIPC.

The Divisional score cards include the quality dimensions and other specialist indicators. These are formally reviewed at the monthly Divisional performance review meetings led by the Chief Operating Officer in partnership with the Medical

Director and Nursing & Midwifery Director (& Trust DIPC). These discussions inform the monthly Performance Report and Trust score card 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 & Governance 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 Business Resource and Strategy Group and, if necessary by the Trust 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 October 2015, the Board undertook a substantive review of the Assurance Framework to align it with the current 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:

- **Demand and Capacity:** Unprecedented demand on the services is currently being addressed through integrated care initiatives, Emergency Department and Referral to Treatment Recovery Plans, scoping of a Transformation Programme and standardisation and reduction of duplication in service delivery. The Trust is also completing detailed demand and capacity modelling.
- Refreshed retention and recruitment and training programmes are currently rolled out across the organisation to meet the **workforce capacity and capability** requirements of services across the organisation.
- Financial pressure remains high on the Trust, but a cost improvement programme and the 5-year financial recovery plan have been put in place to improve **financial sustainability**. Work is ongoing to secure **sufficient cash flow and commissioner income**, with a review of financial processes under way.
- Organisational re-structure will improve lines of accountability; innovative and transformational approaches to quality improvement are being developed to ensure that patients receive **high quality care**.

consistently and that **operational performance** is achieved.

Overall, the risk ratings have decreased as effective, in-year actions have started to control the risks. The Assurance Framework updated by the Executive Directors and reviewed by the Board on a quarterly basis.

Assurance on compliance with relevant regulations, internal policies and procedures is undertaken through the Trust's committee structure for example CQC registration via the QGC and fire regulations through the Health and Safety Committee. Compliance assessments are also undertaken by Internal Audit. The CQC inspected all Trust sites in April 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*. See table 11 for the Trust's rating.

Key issues highlighted in the report CQC were:

- **Patient flow** in Outpatients and ED as well as referral to treatment times at Denmark Hill and PRUH.
- **Documentation of care** (including DNACPR, safer surgery checklist and 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 implemented.
- Training and implementation of reviewed processes for end of life are patients admitted with T34 syringe drivers at Denmark Hill has been carried out and assurances have been received that risks are managed appropriately.

More information on how the Trust' plans to improve on the key areas for improve can be found in the Quality Report section from page 105 onwards.

The Trust continues to work on delivering actions against each of the 'must do' and 'should do' actions identified by CQC following their inspection in April 2015. Whilst the Trust continues to face challenges related to activity levels it is generally meeting all the key milestones set out its CQC Action Plan. These actions are being reviewed through the CQC Steering Group, at executive meetings and at the Board of Directors. A plan to communicate progress to internal and external stakeholder is currently being developed.

Table 11: 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

An internal audit report on the effectiveness of the CQC action plan is currently awaited and will inform any further actions that need to be taken.

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

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

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

The Board of Directors ensures that resources are used economically, efficiently and effectively by means of monthly finance and performance reports. These are considered in detail by the Finance and Performance Committee which is a committee of the Board, chaired by Non-Executive Directors. The Audit

Committee receives regular reports from the Trust's Internal Auditors, KPMG LLP and its External Auditors, Deloitte LLP. The Trust has developed a robust one-year operational plan which was submitted to Monitor. As part of the plans the Trust is developing robust cost savings programme to deliver £71m of savings in 2016/17. In addition, together with local commissioning partners the Trust will develop and submit a robust five year sustainability plan. The Trust has also made applications to the Department of Health for additional funding and working capital facilities to cover any liquidity issues.

During March 2015, Monitor launched a formal investigation into the longstanding financial operational challenges at the PRUH. Following the investigation, Monitor agreed that the Trust will:

- develop and implement an effective short-term recovery plan to deliver the required improvements at the PRUH that King's planned to make when it took over the hospital; and
- develop and implement a longer-term plan by working closely with other national and local health care organisations (including NHS England and local commissioners) to ensure patient services are improved, and also provided in a sustainable way for the future.

The Trust met the requirements of the formal enforcement actions.

The Trust already has methods of promoting good practice in place such as:

- A commitment to individual appraisal and personal development planning for all staff;
- Policies to encourage the open reporting and investigation of adverse

incidents including near misses. In addition the web based incident reporting system allows anonymous reporting;

- A commitment to root cause analysis of problems and incidents and the avoidance of blaming and ‘scape-goating’;
- A range of problem resolution policies and procedures, including capability, raising concerns or ‘whistle-blowing’, workplace stress, mediation, harassment and discipline, which are designed to identify and remedy problems at an early stage;
- A range of individual support mechanisms to encourage individuals to raise concerns about their own performance in ways which will not threaten their security or livelihood, e.g. appraisal, substance abuse policies, professional counselling and occupational health services; and
- A range of clinical and non-clinical audit mechanisms.

All staff are trained in these policies as part of the corporate and local induction policies and updated via regular staff briefings and the Trust intranet.

As part of the recovery plans developed in collaboration with Monitor, these were enhanced by strengthened governance arrangements to deliver financial cost improvements without adversely affecting patient safety and quality.

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 only 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 September 2015 was very well attended.

In order to address the risk and control implications of the Trust’s financial recovery plans, the Trust has further strengthened the existing arrangements. The frequency of full Board meetings has been increased to bi-monthly and a new Savings Board established.

The remit of the Savings Board is to

- Receive monthly reports on progress of delivery against the target.
- Hold programme sponsors and project managers to account to ensure progress is made in line with agreed timescales
- Ensure divisions and service lines are ready and able to realise benefits in line with changes implemented.
- Allocate the Trust’s programme management and service improvement resource to scope, define and implement efficiency and savings ideas and projects raised by divisions as part of the executive review process.
- To ensure there is no increase to clinical risk or decrease in quality of care as a result of changes implemented by reviewing the clinical risk assessment of CIPs, specifically those schemes that have been given a high-risk rating.
- To provide leadership, advice and guidance to sponsors and project managers including unlocking issues or barriers preventing progress and

adjudicating on any contentious issues.

- To ensure service changes align to Trust strategy and values.

Membership includes all Executive Directors and other relevant senior managers and meetings are chaired by the CEO.

All divisions have committed to completion of a risk assessment of CIP schemes contained within their plans. These are signed off and reviewed by each Divisional Manager, Head of Nursing, Finance Manager and Clinical Director as a regular item on the agenda of their Divisional Board. Consequently 16/17 CIP schemes are routinely risk assessed and RAG rated by divisions and logged onto the central repository for CIP plans. The Savings Board reviews the detail of these clinical risk assessments of CIPs, specifically those schemes that have been given a 'High-Risk' rating.

Information on the Trust's going concern can be found on page 179-243.

Information governance

Information Governance (IG) is overseen by the Information Governance Steering Group (IGSG) which reports to the Trust's Quality and Governance Committee. The IGSG is chaired by King's Chief Financial Officer in his capacity as Senior Information Risk Owner (SIRO).

Membership includes the Caldicott Guardian, Director of ICT, Information Security Manager, Freedom of Information Lead/Deputy SIRO, Information Governance & Records Manager and Patient Records Service Managers. The IG agenda is driven by key standards set down in the NHS Operating Framework and measured by compliance with

Information Governance Toolkit requirements.

The Trust is required to process information (personal and corporate) in line with standards set out in statute, regulation and government guidance. Information Governance (IG) at King's comprises identified responsibilities and strategy, policy and procedure that enable staff to handle information in line with these requirements. Annual IG training is mandatory for all staff and is topped up throughout the year by a communication programme focussing on hot topics.

Assurance of compliance with IG standards is provided by achievement of requirements set out in the information Governance Toolkit (IGTK); the standard NHS contract requires attainment of level 2 of the IGTK. The Trust's 2015/16 IGTK submission met this requirement with an overall 74% score made up of 76% level 2 and 24% level 3. This is a slight improvement on 2014/15.

During the year 2015/16 there were four serious incidents related to a confidentiality breach, which were reported to the ICO one of which was subsequently downgraded to a near miss, the details of which and the actions taken are summarised below.

Incident 1

Description: April 2015: Two individuals systematically removed patient documentation from Trust property on multiple occasions over a period of five months contrary to Trust policies. Documents containing sensitive clinical information on 853 patients were found in the main individual's home.

Action taken by the Trust: The Trust reviewed and updated relevant training, guidance and policies. Targeted training was undertaken and Trust-wide

communications issued to remind staff of the requirements. Assurances were obtained from a third party that their staff had completed IG training and that they do not request Trust staff to provide patient documentation.

Further action required by ICO: No further action required

Incident 2

Description: August 2015: As part of a research study sponsored by the Trust some patients were contacted by email to participate in a survey. Their name, email address and specific diagnosis were disclosed in error when the addressees were “carbon copied” instead of blind copied into the email. 33 people were affected.

Action taken by Trust: Once identified the incident was reported to the Trust and the responsible Research Ethics Committee and investigated. The data subjects were contacted and informed of the breach and apologised to. Refresher IG training was provided to the research team.

Further action required by ICO: No further action required

Incident 3

Description: November 2015: Healthcare information relating to patients was sent to the company providing payroll services to the Trust as evidence of hours worked. 35 people were affected.

Action taken by Trust: The information was returned to the Trust and secured. Staff involved were required to refresh their IG training, the Trust has undertaken targeted training and communications including updated guidance.

Further action required by ICO: o/s.

Incident 4

Description: Near miss; In October 2015 patient identifiable data was sent to an external consultancy firm for theatre

productivity analysis. However, the breach was recognised and contained; all records containing personal identifiable data were deleted from external consultancy systems preventing any disclosure of confidential information.

Action taken by Trust: On-going communications to all staff about sharing information with external organisations including consultancy firms. Further specific actions identified in relation to; data flow mapping, consultancy work, data provision, training and communications.

Further action required by ICO: No action required, but recommended Trust to complete the specific actions.

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. 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.

The Board's clinical plans and core quality priorities have been developed in consultation with a wide range of internal and external stakeholders including senior clinical teams, Commissioners, Health Overview and Scrutiny Committees, Healthwatch Governors and members of the enlarged organisation. The Board receives regular reports on all aspects of quality through monthly performance reports and scorecards, and quarterly reports on patient safety, patient outcomes and patient experience and organisational safety. The Board also receives a separate quarterly Quality and Governance Report which includes detailed analyses of all serious complaints and adverse incidents together with

actions taken and related service developments/ improvements. The Board considers the Assurance Framework and the Trust Risk Register on a quarterly basis and agrees actions as necessary to mitigate risks.

The data included within the Quality Report is subject to audit by both internal and external audit to assure the Board that the underlying data is robust. This is supplemented by regular clinical audits of data within specialties and national audits. Further information on the data included in the Quality Report can be found from page 105.

A review of elective waiting data (Referral to Treatment Time) by KPMG revealed some weaknesses in accurately recording the date patients are placed on the waiting list. In order to address these issues, the Trust has appointed a RTT coordinator to oversee the process.

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 this 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 and the quality and governance committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The processes that has been applied in maintaining and reviewing the effectiveness of the system of internal control are described above in this Annual Governance Statement and throughout this report. No significant issues of internal control have been identified.

Signed:

Nick Moberly
Chief Executive Officer

27 May 2016



Quality Report

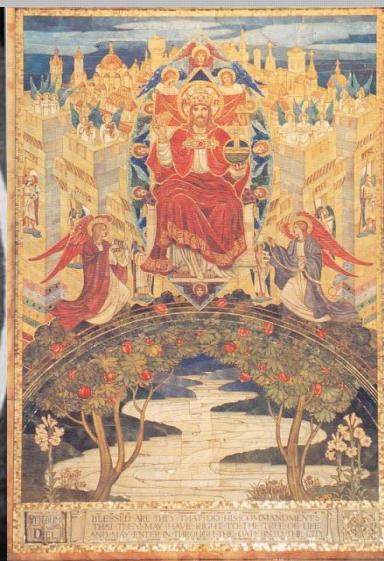


Nursing – early developments

In common with most hospitals nursing standards in the first few years of KCH were almost non-existent. In 1848 Todd and Bowman, with the help of the Bishop of London, founded the Church of England Nursing Sisterhood of St. John. St John's House, led by the superintendent Sister Mary Jones, took over the nursing at KCH and founded the first nursing school in England. Katherine Henrietta Monk was appointed as Sister Matron in 1885 and retired in 1906. She was an active member of the KCH building committee helping to design the 3rd KCH which would be built in 1913 at Denmark Hill. Her influence was enormous and the beautiful mosaic reredos in the St. Luke chapel was dedicated to her memory in 1917. This work of art was designed by William Aikan for William Powell, a firm of stained glass and mosaic makers.



Katherine Monk. First Matron of KCH



The mosaic reredos in the hospital chapel

King's College Hospital NHS Foundation Trust

Quality Account 2015/16

*Presented as part of the “Annual Report and Accounts 2015-2016”
to Parliament pursuant to the Health Act 2009 and supporting
regulations, e.g. the National Health Service (Quality Accounts)
Regulations 2010 and Amendments Regulations 2011, 2012 and
2013.*

Part 1: Chief Executive's statement of quality

King's has always put quality and safety at the forefront of everything that we do. This year we have increased our efforts even further by launching '**Best Quality of Care**' as one of our four key strategies. We have also developed a robust Quality Strategy. Our values are deeply embedded in our culture and form the foundation of our key strategies as we enter a new year forged with challenges and opportunities.

Our staff have been actively engaged in the development of our strategies and they have helped us identify the changes we need to make to ensure King's remains a positive figurehead of healthcare delivery in the NHS in the current financial and operational environment.

We recognise that our Skilled, Can Do Teams are key to the quality of service we provide. We do not underestimate the impact the ongoing pressure on our staff so an integral part of our workforce strategy will be more engagement opportunities, robust career development and progression systems and compassionate leadership.

Our developing pioneering, ambitious and innovative transformation programme will catapult King's into long term stability and sustainability.

We are improving our operational structures to ensure our patient pathways are systematic and good clinical standards embedded in the care we provide.

We were inspected by the Care Quality Commission during the period (April 2015). This inspection resulted in the Trust

attaining a 'requires improvement' rating (see pages 99-100). Whilst this was disappointing we are proud to have been rated **good** in the caring domain across all our sites. We received an overall rating for good at our Orpington Hospital site and good ratings for maternity and gynaecology and children and young adult services at the Denmark Hill and Princess Royal University Hospital site. The Denmark Hill urgent care services also received a good rating.

Quality Priorities

Each year in consultation with our key stakeholders and governors in Bromley, Lambeth and Southwark, we choose quality priorities for improvement.

In 2014/15, we chose six challenging quality priorities. Outstanding progress has been made in the outcomes for patients following hip fracture and interventions to reduce preventable ill health. Good progress has also been made in some areas to improve the experience of cancer patients but we recognise more needs to be done and that will form part of our transformation programme. Unfortunately, we did not make the level of progress wanted to improve the safer surgery culture and in particular reduce the number of never events to zero. This initiative will be carried forward for another year.

Our 2016/17 quality improvement priorities include:

1. Enhanced recovery after surgery (ERAS).

2. Improved outcomes after emergency abdominal surgery.
3. Improve implementation of sepsis bundles for patients with positive blood cultures and diagnosis of sepsis.
4. Improve the quality of the surgical safety.
5. Improve access to information for patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.
6. Improving outpatient experience.

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 is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.
- Data is 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.

During the period, we took a reporting holiday for referral to treatment (RTT) data with the endorsement of Monitor and commissioners. During the reporting holiday, we have worked hard on the robustness of our data to ensure we have best information and can treat our patients effectively. We return to reporting in March 2016 with renewed confidence in our systems and accuracy of our RTT data.

The Trust also recognised the limitation to the data for 4-hour A&E wait. This was the first time this indicator was tested and the Trust accepts the comments from the auditors and will improve the data available for future testing.

Information about elective waiting times and associated risks and actions can be found in the Key Performance Report.

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.

There are no other significant control issues that have been identified.

Having had due regard for the contents of this statement to the best of my knowledge, the information contained in the following Quality Account is accurate.

Signed:

 Nick Moberly
 Chief Executive Officer

27 May 2016

Part 2: Priorities for improvement and assurance statements

Selecting our improvement priorities

This quality report provides a summary of our performance against our chosen quality improvement priorities for 2015/16 and outline what we aim to achieve in 2016/17.

In choosing the quality improvement priorities, we consult with local commissioners, healthwatch, staff, governors, senior executives and the Board of Directors.

We are committed to driving our patient focus strategy which informs our decision making processes.

Embedded in the fabric of the Trust's culture is the ethos of providing of the best quality of care to patients always. We are a busy acute hospital and as such are always making improvements to our services and practices.

In addition to our regular programme of improvement works, we chose six priorities within the patient outcomes, patient experience and patient safety domains to give additional focus each year.

Periodically we may decide to give more focus to some improvement priorities hence they span more than one year. The table overleaf details our past and present priorities.

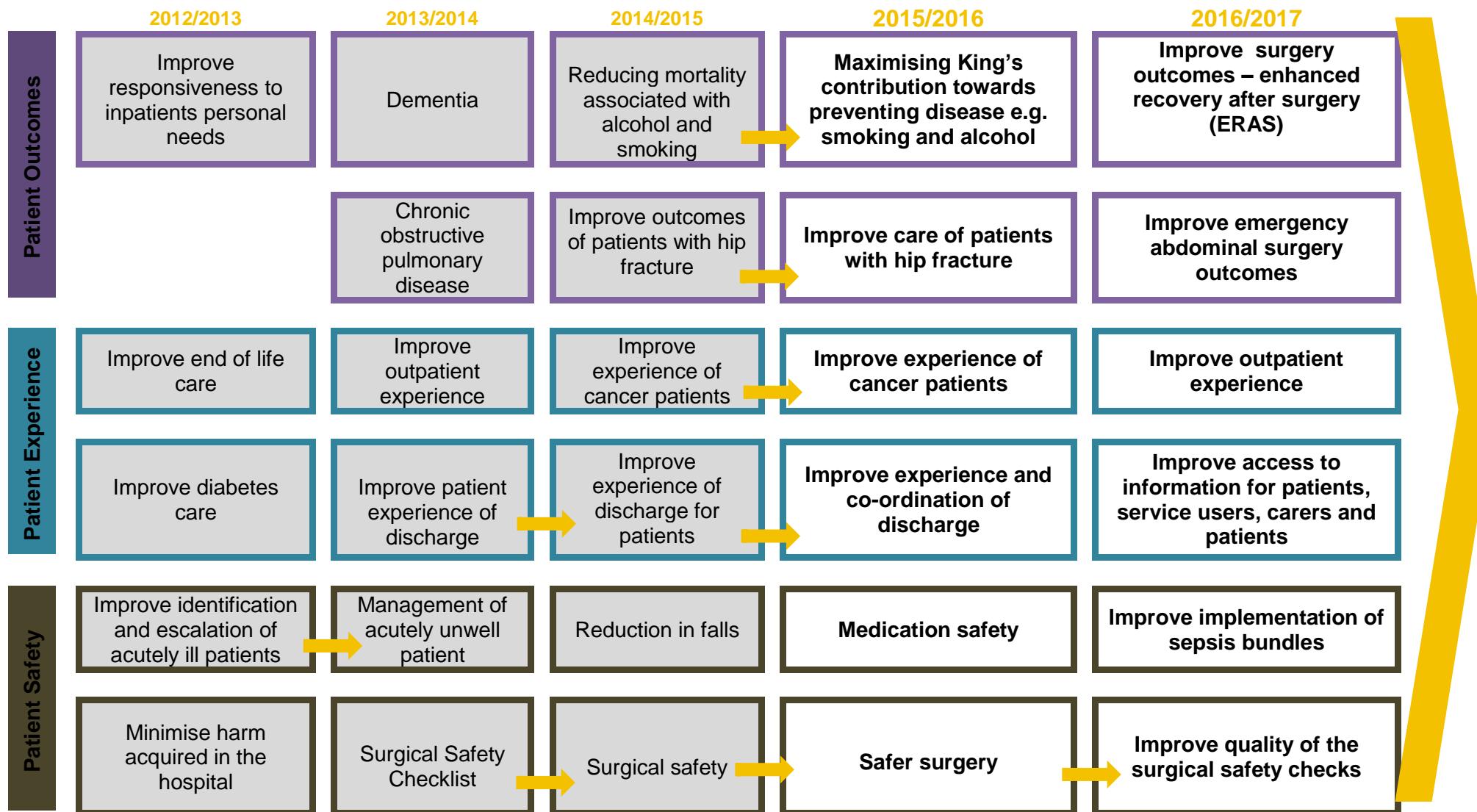
In accordance with the NHS Quality Accounts Amendment Regulations 2013

and the guidelines set out by Monitor and the Department of health, we have included the following in this report:

- standardised statements of assurances from the Board and the required evidence;
- performance against key quality indicators;
- other information including data key performance indicators and quality information;
- statements from commissioners' local healthwatch organisations and overview and scrutiny committees; and
- published statement of the directors' responsibilities for the quality report.

Our performance against 2015/16 improvement priorities can be found on pages 113-119.

Past and Present – Our Quality Improvement Priorities



Performance against 2015/16 Quality Priorities

Priority	Title	RAG
PRIORITY 1.	Maximising King's contribution towards preventing disease e.g. smoking and alcohol	
PRIORITY 2.	Improve care of patients with hip fracture	
PRIORITY 3.	Improve experience of cancer patients	
PRIORITY 4.	Improve experience and coordination of discharge	
PRIORITY 5.	Medication safety	
PRIORITY 6.	Safer surgery	

Key:	No on target	Partial achievement	Not on target
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PRIORITY 1. Maximising King's contribution towards preventing disease e.g. smoking and alcohol

We said we would:

- Develop our acute sites as 'health promoting hospitals', continuing the culture change started in 2014/15 to make health promotion mainstream.
- Increase the number of staff trained to support patients in reducing smoking and harmful alcohol use.
- Increase provision of advice and brief interventions relating to smoking and harmful alcohol use.
- Increase referrals into smoking cessation and alcohol services.
- Work with the providers of hospital food, both on the wards and in our cafes, to promote and deliver healthier food.
- Review ways in which we can increase promotion of exercise to improve health.
- Continue work to implement NICE public health guidance.

We were successful in:

- Rolling out screening programmes for alcohol and smoking in 31 wards across both acute sites.
- Providing brief intervention to all patients that smoke, and those who scored higher than three on the Fast Alcohol Screening Test (FAST) audit tool for alcohol.
- Making both acute sites smoke free and offering patients nicotine replacement therapy whilst in the hospitals.
- Launching Carbon Monoxide monitoring on two wards.
- Increasing the numbers of referrals for smoking.
- Reviewing the food provided and launching initiatives for promoting healthier eating for patients and staff.

Ongoing activities:

- Completing training for staff, including clinical and nurse leads, so they can support and provide screening and brief intervention for alcohol and smoking.

- With the Department of Health's Prevention, Obesity and Diabetes team take forward obesity screening and related health promotion.
- Expanding the screening programme into paediatric asthma clinics and maternity services.
- Developing plans for advice around physical activity for patients and staff.
- Developing more initiatives around balanced diet and healthier food choices.

PRIORITY 2. Improving outcomes following hip fracture

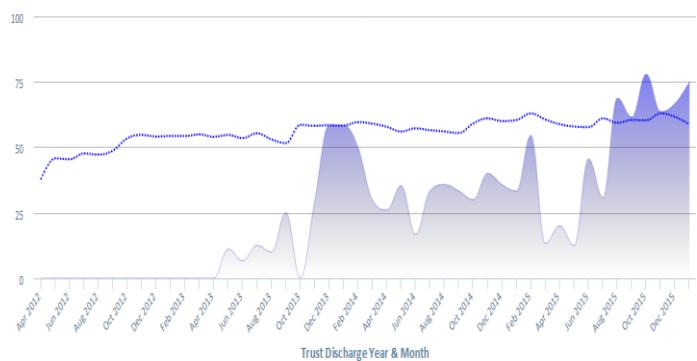
We said we would:

- Increase the proportion of patients getting the surgery they need to repair their hips in less than 36 hours.
- Ensure that all patients receive the physiotherapy they need.
- Ensure effective shared care between orthopaedics and geriatrics.
- Increase the proportion of patients who have a geriatric assessment within 72 hours.
- Ensure all patients are tested for delirium before and after surgery.
- Ensure all patients have a falls assessment and a bone health review.
- Increase the proportion of our patients who have an admission anaesthetic review prior to surgery, to ensure that our patients are in the best health for surgery.
- Focus on the care pathway for hip fracture patients on both of our acute hospital sites of, Denmark Hill and the PRUH.

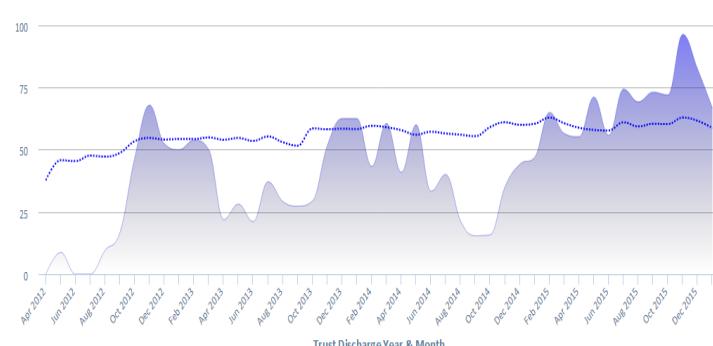
We were successful in:

- Achieving all these criteria for all our patients above the national target level since August 2015 (see Figures 1 and 2). When we began this work three years ago, we met the criteria for all patients in just 4% of cases on our Denmark Hill site. We now meet all the criteria for 70% of patients, exceeding the national target of 60%, and meaning that King's is now one of the best performing Trusts in the country.
- Reducing the length of stay for our hip fracture patients cared for in our new hip fracture care areas – by an average of 10 days at Denmark Hill and 9 days at the PRUH.

5: Achievement of all best practice criteria (Denmark Hill)



6: Achievement of all best practice criteria (PRUH)



Ongoing activities:

- Developing an early mobilisation protocol for patients.
- Development of post-operative care protocol, across both of our sites, and

embed this in our Electronic Patient Record system.

- Continuing to ensure effective support for these vulnerable patients from our care-of-the-elderly teams.
- To streamline our discharge processes and ensure patient and family involvement.
- To ensure that our new care pathways are embedded and continue to work well to improve patient care on both of our main acute sites.

PRIORITY 3. Improving experience and coordination of discharge

We said we would:

- Southwark and Lambeth Integrated Care (SLIC): Achieve integrated working in the hospital environment building better communications between all parties (internal & external) to facilitate safer patient discharge.
- SLIC: Increase and embed Care Home interface meetings - group including hospital and care home managers to enable effective admission and discharge communications.
- Continue to increase usage and profile of Homeless team.
- Increased usage of the @Home service across all specialties.
- Improve timeliness and quality of information around medications for patients and carers.
- Ensure all inpatient wards have individual actions plans to improve discharge, share good practice and innovative ideas.
- Ensure all patients who have received care from a therapist has a detailed

discharge summary sent to their GPs.

- Increase the number of discharges before 11:00 at PRUH.
- Ensure a robust referral system to external agencies such as, Bromley Health and Medihome.
- Implement criteria led discharge throughout medicine and surgery at PRUH.
- Commit to Care ward accreditation system discharge indicators to be green across the organisation.
- Embed telephone follow-up calls as routine in all appropriate in patient wards areas (50% in first 6 months up to 85% by year end).

We were successful in:

- With SLIC, implementing a successful pilot of an integrated approach to discharge on Donne ward which is now informing how we develop our teams going forward. Time taken for ward based assessments reduced from 22 days to 6 days during the pilot period.
- With SLIC, developing and rolling out a Transfer of Care Bundle setting out best practice steps for discharge from hospital to Care Homes. Readmission rates from Care Homes reduced from 22% to 6% during the test period.
- Getting @Home established as the first choice provider for acute out of hospital care for our local Lambeth and Southwark discharges.
- Developing our KHP Homeless Team, linking directly with the new SLaM service to join up support and planning for patients with mental and physical health needs.
- Establishing a Transfer of Care Bureau in autumn 2015 to support discharges and associated communication across the PRUH site.

- Finalising a SOP for board rounds at the PRUH with clear roles and responsibilities for discharging patients before lunch.
- Introducing registered nurses to the discharge lounge of the PRUH to facilitate patients moving from ward areas.
- Introducing use of electronic integrated assessment from now on EMIS system which is used by Bromley GP and community providers.
- Rolling out electronic notifications of assessment and discharge now.
- Commencing criteria led discharge on surgical wards at weekends at the PRUH site.
- Adopting C2C ward accreditation system for discharge indicators to reflect the changes above.

Ongoing activities:

- Developing our Integrated Care and Partnership structure as SLIC comes to an end (March 2016) ensuring effective ongoing links with community, social care and voluntary sector providers.
- Developing a more integrated approach to hospital discharge, responding to both local CCG and NHS England CQUINs.
- Completing baseline ward audits which use the safer care bundle to assess ward discharge processes.
- Identifying an exemplar ward to and then developing appropriate actions plans.

PRIORITY 4. Improving the experience of cancer patients

We said we would:

- Ensure that all the core MDT members (doctors and CNSs) are trained in national advanced communication skills training.
- Ensure that all patients are seen by the CNS/support worker at diagnosis.
- Increase the number of holistic needs assessments undertaken within 31 days of diagnosis and within 6 weeks of completion of treatment.
- Ensure all patients receive a FU call from the CNS teams within 48 hours of diagnosis, and within 24 hours of discharge from hospital following treatment.
- Ensure that the CNS teams review inpatients at least once during their in-patient stay in order to provide further information and support.
- Ensure patients and GPs are provided with an end of treatment summary or care plan.
- Establish health and well-being events for patients (for example HOPE courses).
- Undertake specialist training for nurses and HCAs on the in-patient wards.
- Work with Macmillan to develop the band 4 support worker role in each MDT – an innovative role aimed at helping patients to navigate through their pathways and to provide ‘one to one support’.
- Introduce designated nurse led pre-assessment clinics for patients commencing chemotherapy treatment.
- Continue with the rolling annual internal peer review of each MDT – holding teams to account for progress

being made against their patient experience action plans.

- Develop a designated cancer information hub in the PRUH Chartwell unit and work with Macmillan to ensure that information pods are available in key areas throughout the PRUH.
- Establish a Trust cancer patient experience steering group.
- Develop KPIs for the CNS teams, which aid to hold the teams to account for quality improvements.

We were successful in:

- Securing funding to run four advanced communication courses for 40 MDT members.
- Getting 88% of patients seen by the CNS at diagnosis. The LCA data showed that the Trust was ranked 7th for compliance out of 157 trusts.
- Offering patients a HNA at diagnosis in all services and approximately 20% receive one at completion of treatment and this is on an upward trajectory.
- Getting more clinical specialties to provide end-of-treatment summaries. This is on an upward trend.
- Having a higher presence of CNS's visiting the wards providing some teaching.
- Holding Health and Well Being (HWB) sessions. Two breast specific sessions took place in 2015 with approximately 30 patients in attendance. One generic HWB session focusing on mainly colorectal, haematology and hepatobiliary was also held with 14 patient's attending.
- Inviting all patients to a nurse led pre-assessment clinic prior to commencing chemotherapy.
- Rolling programme of peer review continues for all Cancer MDT's with

patient experience being the core element for discussion

- 3 information stands have been funded for the PRUH by Macmillan.

Ongoing activities:

- KPI's for the CNS's have been written and will be implemented by April 2016.
- Plans to hold six HWB events in 2016 (2 breast and 4 generic).
- Continuing to engage patients' help to design services to meet their needs.

7: Macmillan Information Pods



PRIORITY 5. Medication Safety

We said we would:

- Reduce incidents involving administration of drugs to patients with known allergies.
- Increase in the percentage of nursing staff passing the drug calculation competency assessment at 100%.

- Reduce the number of medication errors involving the wrong patient.
- Reduce incidents involving 10-fold errors.

We were successful in:

- Achieving a modest reduction in the number of incidents involving administration drugs to patient with known allergies reported. This moved from 59 in 2014/15 to 51 in 2015/16. The majority of clinical areas are recording 0-1 per month – these are very low compared to the total number of medications administered and further benchmarking is required to assess the scale of this as an issue.
- Our aim was to reassess all registered nursing staff and retraining were necessary. This was achieved and 52% of nursing staff (excluding new starters) passed the drug calculation competency. This is a good result given it was a new initiative starting from a baseline of zero in 2015 (calculation based on existing workforce).
- Reducing the total number of medication errors to 71 in 2015/16 (79 in 2014/15). The small reduction is very positive but has now plateaued at 7-8 per month.
- In year, we have seen no change in the incidence of 10-fold errors data (10 in Q1; 7 in Q2; 9 in Q3; and 9 Q4). Because the data for 2014/15 was incomplete, it is not possible to carry out a year on year analysis but it is encouraging to note the reduction in each quarter.

Ongoing activities:

- Developing dose verification chart in paediatrics to further reduce incidence of tenfold errors.
- Amending Denmark Hill discharge letters to include allergy status as part of new EPR upgrade – this will

improve the communication of allergy statuses between secondary and primary care.

- Rolling out patient wristband printers for Minors and Urgent Care Centre in the Emergency Department to help reduce medication errors from patient misidentification.
- An emerging theme from medication incidents in the last year is the number of delayed or omitted medications. Work has been targeted to reduce the number of medicines omitted, including specific training sessions for PDNs and focus groups to identify the underlying reasons for omissions.

PRIORITY 6. Safer Surgery

We said we would:

- Develop and implement a strategy to ensure the surgical safety checklist (SSC) is integrated into the working practices of all theatre and/or interventional teams.

Improvement was to be assessed against the following objectives:

- Zero Surgical Never Events.
- 100% compliance with completion of safer surgical checklist.
- >75% compliance with quality of checks performed.
- 20% improvement in Surgical Safety Culture rating.

We were successful in:

- Improving the quality of the surgical safety checks that are performed from 41% in 2014/15 to 61% in 2015/16 (as measured by the annual observational audit). As one of the Trust's Sign-Up to Safety priorities the Trust has committed to improving the quality of checks by 10% year-on-year
- In 2015/16, there was 97% compliance with completion of the checklist (in

only 1 endoscopy list at PRUH was there no evidence it was completed).

- In 2015/16, 8 surgical Never Events have been reported (as at 14/3/16) which is the same number as were reported in 2014-15. A number of the actions being taken to drive out Never Events are listed below.
- action (such as simulation training) to be focussed on high risk areas.
- An externally facilitated training session, run annually on the combined surgical safety consultant development morning. Providing in-house simulation training to areas where particular concerns have been raised through audit or incident data.
- Adding 'Team Brief' and 'Debrief' as a specific time slot on the Trust's electronic theatre system (Galaxy) to ensure that time is available to perform team briefings and debriefings before and after each theatre list & that performance can be monitored.
- Developing local surgical safety interventional procedure standards (LOCSSIPs) in accordance with recently published national standards for all specialties that undertake invasive procedures. Specialties will be asked to present these at the Surgical Safety Improvement Group by September 2016. Higher risk specialties (based on Never Event occurrence) will be prioritised.
- A review of junior doctor competency sign-off to ensure that adequate

Ongoing activities:

- Revising doctor's induction and e-learning to reference surgical safety.
- Making routine checklist completion data (broken down by speciality, theatre and surgeon) available on a regular basis to enable remedial training and support is available to junior staff undertaking invasive procedures using seldinger technique
- Continued rollout of the seldinger invasive device insertion sticker and process (2 person contemporaneous check) across all areas (including non-ICU areas) where seldinger technique used.

Dr. Arthur Whitfield (1868-1947) entered the King's medical school in 1887 and his general medical training included work in Vienna and Berlin. He developed a deep interest in dermatology but there were only three purely dermatological appointments in London hospitals. However, King's gave him his own dermatology department with two beds and office space in 1899. Having achieved the rare recognition as a pure dermatologist he helped in the establishment of other special departments such as paediatrics which had been struggling for recognition. Whitfield is recognised for identifying, in 1908, fungal infection as the cause of athlete's foot, (Tinea pedis) and Whitfield's ointment is still sometimes used today for treatment of the condition.

2016/17 Improvement Quality Priorities

2016/17 IMPROVEMENT PRIORITY 1.

Enhanced recovery after surgery (ERAS)

Our aim is to improve outcomes following surgery by ensuring that all interventions clinically proven to have a positive impact are provided, and working well, in our hospitals.

We will:

- Take actions to ensure that all the relevant steps in the pathways are undertaken on all the Trust's sites.
- Review the pre-assessment, admission and discharge information provided to patients.
- Initially work to build and develop from areas already undertaking ERAS (colorectal, orthopaedic, cardiac and hepatobiliary).

Measures of success:

- Reduced length of stay.
- No increase in emergency readmission rate.
- Increased day-of-surgery admission.

2016/17 IMPROVEMENT PRIORITY 2.

Emergency abdominal surgery

Aim is to improve outcomes following emergency abdominal surgery by ensuring a well-coordinated, standardised care pathway is in place at Denmark Hill and PRUH.

We will:

- Improve data entry to the National Emergency Laparotomy (abdominal surgery) Audit project and take local action to improve against the key audit criteria.
- Develop internal outcomes monitoring management including sepsis management and decrease AKI progression.

- Co-ordinate care of emergency surgery pathways and patient management.

- iMobile review of post operative emergency laparotomy and or admission to critical care.

Measures of success:

- Improvement against key National Emergency Laparotomy Audit (NELA) criteria, including:
 - Consultant surgeon review within 12 hours of admission.
 - CT scan reported before surgery by a Consultant Radiologist or post FRCR SpR.
 - Documentation of risk preoperatively.
 - Preoperative review by consultant surgeon and consultant anaesthetists.
 - Consultant surgeon and consultant anaesthetist present in theatre.
 - Postoperative assessment by care of the elderly specialist in patients aged over 70.
 - Daily consultant review and clear management pathway
 - Reduced length of stay.
 - Reduced mortality.

2016/17 IMPROVEMENT PRIORITY 3.

Sepsis

Our aim is to improve implementation of sepsis bundles for patients with positive blood cultures and diagnosis of sepsis as defined by EPR order set.

We will:

- Undertake an audit of all positive blood cultures in early 2016-17 and review

adherence to sepsis bundles in order to achieve baseline data.

- Patients with positive blood cultures to be reviewed at least once per day (7 days per week) by a consultant with a clear management plan and microbiology input into drug treatment and duration.
- Develop an EPR order set for sepsis (culture set) this will then allow assessment of this identified cohort against sepsis bundles, consultant and microbiology review

Measures of success:

- We will expect the sepsis bundle implementation to capture screening, action and audit data on 50 % of those coded with sepsis in the first year with an improvement of 50 % annually each year until the end of 2018-19. The baseline denominator would be the number coded with sepsis in 2015-16
- Improvement in the identification of sepsis will be measured by the percentage of patients screened for sepsis who met the septic screening criteria. The Trust is currently developing the screening criteria (which can be set locally according to the national CQUIN relating to sepsis). Once the screening criteria are confirmed a baseline audit will be conducted in early 2016-17 to ascertain base screening rate. An improvement target in septic screening can then be set and will be expected to be met at the end of 2018-19. Note that the rates will be reported as adult and paediatric rates for both inpatient and emergency department patients.
- Improvement in the management of sepsis will be measured by the proportion of septic patients (as defined by septic screen) who have received antibiotics and empiric review within the prescribed timescales. A baseline audit will be

conducted in early 2016-17 to ascertain the proportion of patients appropriately treated. An improvement target in the proportion of patients treated appropriately can then be set and will be expected to be met at the end of 2018-19. Note that the rates will be reported as adult and paediatric rates for both inpatient and emergency department patients.

2016/17 IMPROVEMENT PRIORITY 4.

Surgical Safety

Aim is to improve the quality of the surgical safety checks by 10% year-on-year, as measured by the annual surgical safety checklist observational audit and quality assessment. Specific focus on sign out.

We will:

Training:

- Provide Annual simulation training on one of the combined audit mornings.
- Deliver in-house scenario training in hotspot areas.
- Specific slot on new doctor's induction and e-learning.

Procedure and policy:

- Add 'Team Brief' and 'Debrief' as a specific time slot on Galaxy to ensure that time is available to perform it and performance can be tracked.
- Implementation of Local surgical safety invasive procedure standards (LocSSIPs) in all interventional areas by September 2016, focussing on high risk areas first (as identified by previous Never Event and audit data).
- Audit compliance of all areas as per Safer Surgery Improvement Group (SSIG) and ensure feedback to SSIG committee.

Feedback and audit

- Twice-yearly observational audits in hotspot areas.

- Continuation of annual observational audit of invasive procedures across all areas and sites.
- Audit specific areas e.g. handover of plan and procedures to Recovery, ward and critical care areas. Define baseline mid-2016.

Measures of success:

- Audit of overall quality checks needs to be increased to 92% from 62% by March 2019. Several associated performance indicators will also be measured:
 - Improvement in the documentation of surgical handover to recovery and the ward. 50% improvement against baseline expected by March 2019.
 - Audit of seldinger technique device insertion checklists. A baseline audit will be undertaken in early 2016-17 and a 50% improvement against baseline expected by March 2019.
 - Audit of junior doctor competency documents (to include competency in central line insertion, chest drain insertion, NGT placement confirmation through aspirate and x-ray interpretation).
 - Improvement in the overall % of procedures that have sign-in, time-out and sign-out recorded on Galaxy (to at least 95% by March 2019).

2016/17 IMPROVEMENT PRIORITY 5.

Accessible information

Aim is to improve access to information for patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

We will:

- Put systems in place to ensure that invite letters for appointments and admission provide opportunity for

patients and carers to highlight any adjustments that need to be made for their visits.

- Put systems in place to ensure that inpatients assessment includes identification of any impairment or sensory loss and subsequent actions and adjustments.
- Develop, pilot and implement feedback tools for patients with communication difficulties / learning disability.
- Training and support King's Foundation Trust Members / Volunteers to support gathering of feedback in targeted areas of need
- Ensure admission, pre assessment and discharge information is appropriate.

Measures of success:

- Associated audits demonstrate good rates of responsiveness, action and patient feedback.

2016/17 IMPROVEMENT PRIORITY 6.

Improving outpatient experience

Aim improve one key metric where our performance is particularly disappointing – communication in clinic about delays

We will

- Identify specific divisions and specialties where the most improvement is required for the question “If you had to wait for your appointment, were you told how long you would have to wait?”
- Roll-out the Trust’s ‘Experience’ patient feedback reporting system within target areas to provide staff with timely and accessible patient feedback.
- Increase survey response rates in our focus areas to ensure that improvement plans are based on robust data.

- Improve information and communication about waiting.

Measures of success

- Based on the ‘how are we doing?’ survey and Friends and Family Test data, identify clinics in two of our clinical divisions at both the PRUH and Denmark Hill which are most in need of improvement.
- Identify areas where performance is good as a means to share good practice and learning.
- Gather a better understanding of what makes for poor experience and, importantly, how patients think we can improve by conducting interviews with patients and relatives.
- Establish baseline data and agree improvement targets.
- Key staff will have access to and training on ‘Experience’ system
- Regular discussion of patient feedback at clinical and operational team meetings.
- ‘You Said We Did’ posters to be displayed in clinic areas.
- Develop plan to increase survey responses.
- Implement a range of accessible options for patients to provide feedback about their experience, e.g. the use of electronic surveys and SMS and supported completion with the help of King’s volunteers.
- Develop action plan for improvement.
- Implement agreed improvement interventions.
- Increase scores for “If you had to wait for your appointment, were you told how long you would have to wait?”

- Decrease in the number of negative comments relating to information on waiting.



Statements of assurance from the board

Relevant health services

During 2015/16 the Trust provided and/or sub-contracted **9** relevant health services

The Trust has reviewed all data available to them on the quality of care in [all] these relevant health services.

The income generated by the relevant health services reviewed 2015/16 represents **100%** of the total income generated from heprovision of relevant health services by the Trust for 2015/16.

Clinical Audits and National Confidential Enquiries

During the 2015/16, 50 national clinical audits and 2 national confidential enquires covered relevant health services that the Trust provides.

During that period the Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquires which it was eligible to participate in.

The national clinical audits and national confidential enquires that the Trust was eligible to participate in during 2015/16 are listed on pages 129-143.

The national clinical audits and national confidential enquires that the Trust participated (with data collection completed) during 2015/16 can be found on pages 129-143.

The national clinical audits and national confidential enquires that the Trust participated in and for which data collection was completed during 2015/16 are listed on pages 129-143 alongside the

number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The NCEPOD studies the Trust participated in are detailed on pages 129-143.

The reports of 50 national clinical audit were reviewed by the provider in 2015/16 and the Trust intends to take the actions detailed on pages 129-143 to improve the quality of healthcare provided.

The reports of 30 local clinical audits were reviewed by the provider in 2015/16 and The Trust intends to take the actions described on pages 129-143.

Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 13,384.

Clinical coding error rate

Payment by Results (PbR)

King's was not identified as necessary for a Payment by Results (PbR) clinical coding audit in 2015/16, however for Trusts that were subjected to PbR audit in 2014/15, the national average coding error rate identified in the Data Assurance Framework was 8.0% for inpatients.

From the above statements, assurance can be offered to the public that the Trust has in 2015/16:

- Performed to essential standards (e.g. meeting CQC registration), as well as excelling beyond these to provide high

- quality care;
- Measured clinical processes and performance to inform and monitor continuous quality improvement;
- Participated in national cross-cutting project and initiatives for quality improvement e.g. strong and growing recruitment to clinical trials.

Payment by Results (PbR)

The Trust was not identified as necessary for a Payment by Results (PbR) clinical coding audit in 2015/16, however for Trusts that were subjected to PbR audit in 2015/16, the national average coding error rate identified in the Data Assurance Framework was [8]% for inpatients.

The percentage of records in the published data:

- Patient's valid NHS Number:
 - 98% for admitted patient care;
 - 99% for outpatient (non-admitted) patient care; and
 - 92.5% for accident and emergency care.
- Patient's valid General Medical Practice code:
 - 100% for admitted patient care;
 - 99.8% for outpatient (non-admitted) patient care; and
 - 99.8% for accident and emergency care.

Information Governance Assessment

The Trust's Information Governance Assessment Report overall score 2015/16 was 74% and was graded green (satisfactory)

Commissioning for Quality and Innovation (CQUIN) framework

The Trust income in 2015/16 was not conditional on achieving quality

improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the Trust was operating on the default rollover tariff (DTR) and was therefore not entitled to access CQUIN funding. Therefore, King's has agreed with its Commissioners the implementation of four Local Incentive Premium initiatives for the 2015/16 (£6.4m) in place of local CQUIN schemes and are listed below:

- Local Incentive Premium Scheme 1 - Medicines Optimisation (DH)
- Local Incentive Premium Scheme 2 - Care Planning (DH)
- Local Incentive Premium Scheme 3 – Prevention - Every Contact Counts (DH and PRUH)
- Local Incentive Premium Scheme 4 – Emergency Care (PRUH).

The value of the CQUIN for 14/15 was £17.5m.

Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is requires improvement with no conditions.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

For more details and ratings see the Annual Governance Statement on pages 95-104.

The CQC inspected all three hospital sites in April 2015. The Trust received a rating of *requires improvement* for the Denmark Hill and PRUH sites. Orpington Hospital received an overall rating of *good*. The Trust continues to work on delivering actions against each of the 'must do' and 'should do' actions. These actions are

being reviewed through the CQC Steering Group and at executive meetings, with updates to the Board of Directors.

The Trust continues to face challenges related to activity levels in the ED at the PRUH. An external review was undertaken to refresh the Emergency Pathways at PRUH by the end of April 2016 and key findings from this review will be incorporated into the PRUH ED Recovery. The re-launch of the ED recovery is planned for early May 2016.

Inadequate ratings at core services level at the PRUH related to below.

Patient flow in PRUH urgent and emergency services

The Trust commissioned and delivered an Emergency Pathway Whole System review. We engaged with over 100 stakeholders to understand the root causes of poor performance in Emergency Care across the entire South East health care economy and what needs to be put in place for the end to end emergency care pathway to achieve the desired quality, safety and patient experience.

The resulting PRUH Emergency Care Recovery Plan has been put in place comprising:

- Improvement to patient flow for supported and simple discharge through creation of a supported Transfer of Care Bureau with the mandate and authority to manage the interface between in-hospital and out-of-hospital services.
- Improvement to the management of patient flow through the Emergency Department and enhancement of Emergency Department's controllable processes.

- Improvement of time from referral to be seen by specialists through agreement of new Standard Operating Procedures for timely patient handover and its implementation between Emergency Department and specialty teams.
- Creation and implementation of a sustainable performance management system (in-hospital and between PRUH and out of hospital services)
- Creation of a separate emergency pathway for frail elderly patients and provision of alternative treatment options beyond inpatient care.

All key milestones on the Emergency Department Recovery Plan have been met, but the Trust still continues to face challenges related to activity levels.

Waiting times and patient flow in PRUH outpatient department are being addressed through:

- A review of booking and scheduling of existing capacity to support demand and capacity analysis of key specialties, which was completed.
- **Ongoing review of utilisation of Outpatient Department capacity across the Trust** by Outpatient Steering Group and review of how QUIPP Programme can be utilised to reduce new and follow-up attendances. This will feed into the scoping of the outpatient transformation programme (see below).
- **Scoping of outpatient transformation work stream** currently undertaken to achieve step change in outpatient patient flow. Work to cover all areas from booking to in-clinic processes. The

Transformation Programme Business Case approved by NHS Improvement in May 2016, enabling mobilisation plans for all services, including outpatients, to be developed.

Actions to address key issues underlying the rating of *requires improvement*

Referral to treatment times at Denmark Hill and PRUH:

To enable the Trust to improve its performance against the national referral to treatment targets a Referral to Treatment Recovery Plan has been in place since 2015/16.

The Trust's RTT recovery programme for 2016/17 addresses:

- RTT Policy and procedures,
- RTT Monitoring & Reporting,
- RTT Education & Training,
- RTT Validation.
- RTT Backlog Clearance and a Demand & Capacity Modelling.

Documentation of care, including incomplete records, DNACPR documentation and safer surgery checklist

These actions all include improvement of process, staff skills and knowledge as well as improvement in monitoring and ensuring that processes are being followed. This work is still ongoing and we expect to achieve significant milestones in Quarter 4 2015/16 and in autumn 2016. We are also introducing e-DNACPR forms by the end of 2016 at DH and in December 2017 at the PRUH.

CQC also commented on availability of paper records at the PRUH. Availability of paper notes in clinic at PRUH improved to 94% in November 2015.

Work is ongoing with next milestones to be achieved in March 2016 and

introduction of EPR at the PRUH towards beginning of 2017.

Environment and Capacity

Denmark Hill's environments for Liver and Renal outpatients, Maternity and Critical Care wards and PRUH's Surgical Admission Lounge were found to require improvement. Where possible, changes to the environment have been, or are currently being made. Alternatively services have been moved to locations that better meet patients' needs.

Regular reviews of capacity are in place for areas with capacity constraints ensuring that patient safety is maintained. Where required practice has been reviewed and changes communicated to staff to ensure that capacity is managed as efficiently as possible. All capacity issues have been resolved within the limitations of the existing estate of DH. We are in the process of building a new Critical Care Unit with a planned completion date of early 2018. A consultation for the move of the surgical admission lounge at the PRUH is currently being undertaken and the move will take place as soon as issues have been resolved.

Improving skills, knowledge and processes to improve patient safety

The trust is improving the up-take of training on Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards for staff working in the Emergency Department, Medical Care, Surgery and Children's. We also appointed MCA leads for both sites and are reviewing all policies and guidance to support staff in meeting their responsibilities. This work is progressing at pace and completion is planned for December 2016.

At the DH site a clear pathway for the admission and discharge of end of life

care patients with T34 pumps in situ has been developed, published and communicated to relevant staff. Relevant staff have been trained to switch pumps on admission. 24/7 access to trained staff is available to ensure patients receive appropriate care at the right time. Assurances have been received that risks are managed appropriately.

An internal audit report on the effectiveness of the CQC action plan is currently awaited and will inform any further actions that need to be taken to ensure robustness of our actions on our journey to an outstanding CQC rating.

Data Quality

The Trust will be taking the following actions to improve data quality:

- Training programmes have been established in 2015/16 to deliver education on waiting list and RTT and the impact of poor data quality on these items.
- Uncashed appointments have been highlighted trust-wide as an area of focus. These have a significant financial impact along with impact on waiting lists, operational planning and finances.
- In conjunction with the RTT training a review was undertaken of outpatient procedures undertaken at Denmark Hill and recording commenced in September 2015.
- GP practice closures have now had a systematic approach applied to them and all patients at these practices are traced to minimise clinical risk.
- A significant amount of work has been invested across BIU to improve the

data quality of our SUS and contract monitoring data which has suffered significantly since the acquisition of SLHT services. The work has also uncovered many data quality issues relating to commissioning data – this work has informed the 2016/17 planning round and has enabled a more robust understanding of our data both internally and externally.

- Work has been continuing on aligning all centrally reported data which has allowed many operational reports to be rolled out across all sites, allowing greater transparency across the trust.

Actions planned for 2016/17:

- Continuing the existing trust-wide training programme for all outpatient staff to ensure all outcome fields and referral information is complete to assist with waiting list monitoring, therefore improving quality of care and also to ensure all appointments are charged for.
- The recording of outpatient procedures at Denmark Hill will continue to be monitored and will become a key income stream for 2017/18 – this has historically been an area of very poor data quality for the trust and some services running at a loss due to under-recovery of income.
- Continue progress on aligning all data systems trust-wide to allow for easier operational reporting and minimising duplication of work.

These statements are included in accordance with both Monitor's NHS Foundation Trust Annual Reporting Manual (2015) for the quality report, as well as the Department of Health's Quality Accounts Regulations (2015).

Statement of assurance evidence

The following list is based on that produced by the Department of Health and Healthcare Quality Improvement Partnership (HQIP).

Participation in the National Clinical Audit Projects

Audit Title	Reporting period	Participation	Number (%) of cases submit
National Diabetes Adult	01/01/13 - 31/03/15	Yes	5323 cases (100%).
National Diabetes Footcare Audit	14/07/15 - 31/03/16	Yes	Data collection in progress until Jul-16.
National Inpatient Audit	21/09/15 - 25/09/15	Yes	Due to be published Jul-16.
Pregnancy Care in Women with Diabetes	01/01/15 - 31/12/15	Yes	Due to be published in 2016.
Adult Cataract Surgery	21/09/15 - 25/09/15	Yes	Due to be published Dec-16.
Rheumatoid and Early Inflammatory Arthritis	Organisational audit: 01/07/15 - 31/07/15 Clinical Audit: 01/07/15 - 30/09/15	Yes	Due to be published Jan-17.
Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme - General Intensive Care Unit	01/04/15 – 30/06/15	Yes	100%.
National Emergency Laparotomy Audit	01/12/14 - 30/11/15	Yes	Due to be published Jun-16.
NHS Blood and Transplant – Audit of Patient Blood Management in Scheduled Surgery	01/02/15 – 30/04/15	Yes	55 cases (100%).
NHS Blood and Transplant – Audit of the Use of Blood in Haematology	01/01/16- 26/02/16	Yes	Due to be published Jul-16.
NHS Blood and Transplant – Audit of the Use of Blood in Lower Gastrointestinal Bleeding	01/09/15 – 31/10/15	Yes	Due to be published Mar-16.
Inflammatory Bowel Disease	11/09/11 – 29/02/16	Yes	Data collection in progress

Audit Title	Reporting period	Participation	Number (%) of cases submitted until Mar-16.
- Biologics Audit			
Oesophago-gastric Cancer	01/04/14 – 31/03/15	Yes	Data collection in progress until Mar-16.
ICNARC Case Mix Programme	01/07/15 – 30/09/15	Yes	100%
- Liver Intensive Therapy Unit (LITU)			
Liver Transplant	01/04/06 – 31/03/16	Yes	Due to be published Sep-16.
Renal Registry	01/01/15 – 31/12/15	Yes	Due to be published Dec-16.
Bowel Cancer	01/04/14 – 31/03/15	Yes	Due to be published Dec-16.
Falls and Fragility Fractures Programme - National Hip Fracture Database	01/01/15 – 31/12/15	Yes	Due to be published Sep-16.
Falls and Fragility Fractures Programme - Fracture Liaison Service Database	01/01/16 – (end date TBC)	Yes	Data submission cut-off date and publication date not yet confirmed by audit supplier.
Falls and Fragility Fractures Programme - National Audit of Inpatient Falls	12/05/15 – 13/05/15	Yes	60 cases (100%)
National Complicated Acute Diverticulitis	01/07/15 – 30/09/15	Yes	Due to be published Feb-16.
National Joint Registry	01/01/15 – 31/12/15	Yes	Due to be published Sep-16.
Prostate Cancer	01/08/14 – (end date TBC)	Yes	Data submission cut-off date and publication date not yet confirmed by audit supplier.
National Patient Reported Outcome Measures (PROMs) Programme	01/04/14 – 31/03/15	Yes	Groin hernia surgery: 16% Varicose vein surgery: 69% Hip replacement surgery: 88% Knee replacement surgery: 98%
National Adult Cardiac Surgery Audit	01/04/14 – 31/03/15	Yes	Due to be published Sep-16.
Acute Coronary Syndrome or	01/04/14 – 31/03/15	Yes	Due to be published Apr-16.

Audit Title	Reporting period	Participation	Number (%) of cases submit
Acute Myocardial Infarction (MINAP)			
Cardiac Rhythm Management	01/04/14 – 31/03/15	Yes	Due to be published Apr-16.
Congenital Heart Disease - Adults	01/04/14 – 31/03/15	Yes	Due to be published Apr-16.
National Audit of Percutaneous Coronary Interventional Procedures	01/01/2015 - 31/12/2015	Yes	Publication date not yet confirmed by audit supplier.
National Heart Failure Audit	01/04/14 – 31/03/15	Yes	Due to be published Apr-16.
Sentinel Stroke National Audit Programme (SSNAP) - Clinical Audit	01/04/14 – 31/03/15	Yes	DH HASU = 80-89%; PRUH HASU = 90%; DH and PRUH stroke units = 90%+
National Vascular Registry – Abdominal Aortic Aneurysm Repairs	01/10/14 – 31/09/15	Yes	Publication date not yet confirmed by audit supplier.
National Vascular Registry – Carotid Endarterectomy	01/10/14 – 31/09/15	Yes	Publication date not yet confirmed by audit supplier.
UK Parkinson's Audit: <ul style="list-style-type: none">• Occupational Therapy• Speech and Language Therapy• Physiotherapy• Patient Management Elderly Care and Neurology	30/04/15 - 30/09/15	Yes	Due to be published Mar-16.
College of Emergency Medicine - Procedural Sedation in Adults	01/08/15 – 31/01/16	Yes	Due to be published May-16.
College of Emergency Medicine - VTE Risk in Lower Limb Immobilisation	01/08/15 – 31/01/16	Yes	Due to be published May-16.
Emergency Oxygen	15/08/15 – 01/11/15	Yes	186 cases
Lung Cancer	01/01/15 – 31/12/15	Yes	Due to be published Dec-16.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – Pulmonary Rehabilitation Service Clinical Audit	12/01/15 – 10/04/15	Yes	Due to be published Feb-16.
National COPD Audit	12/01/15 – 24/04/15	Yes	100%

Audit Title	Reporting period	Participation	Number (%) of cases submitted
Programme – Pulmonary Rehabilitation Service Organisational Audit			
Trauma Audit and Research Network (TARN)	01/01/15 – 31/12/15	Yes	715 cases
UK Cystic Fibrosis	01/01/15 – 31/12/15	Yes	Due to be published Aug-16.
ICNARC National Cardiac Arrest Audit	01/04/15 – 31/03/16	Yes	Due to be published Jun-16.
Maternal, Newborn and Infant Clinical Outcome Review Programme	01/04/13 – 31/12/15	Yes	100%.
Medical and Surgical Clinical Outcome Review Programme	See information below on NCEPOD participation	Yes	See information below on NCEPOD participation.
National Neonatal Audit Programme	01/01/15 – 31/12/15	Yes	Due to be published Nov-16.
National Paediatric Diabetes Audit	01/04/15 – 31/03/16	Yes	Due to be published Nov-16.
Paediatric Asthma	01/11/15 - 30/11/15	Yes	Data collection in progress.
Paediatric Intensive Care Audit Network	01/01/12 – 31/12/14	Yes	Data collection in progress.
College of Emergency Medicine - Vital Signs in Children	01/08/15 – 31/01/16	Yes	Due to be published May-16.
Adult Asthma	N/A	N/A	Did not collect data 2015/16.
Child Health Clinical Outcomes Programme	N/A	N/A	Did not collect data 2015/16.
Chronic Kidney Disease in Primary Care	N/A	N/A	Not applicable to secondary care providers.
Congenital Heart Disease - Paediatric	N/A	N/A	Service not provided at KCH.
Head and Neck Oncology	N/A	N/A	Service not provided at KCH.
National Audit of Dementia	N/A	N/A	Did not collect data 2015/16.
National Audit of Intermediate Care	N/A	N/A	Service not provided at KCH.
Mental Health Clinical	N/A	N/A	Service not provided at KCH.

Audit Title	Reporting period	Participation	Number (%) of cases submitted
Outcome Review Programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness			
Non-Invasive Ventilation - Adults	N/A	N/A	Did not collect data 2015/16.
Paediatric Pneumonia	N/A	N/A	Did not collect data 2015/16.
Prescribing Observatory for Mental Health	N/A	N/A	Service not provided at KCH.
Pulmonary Hypertension Audit	N/A	N/A	Service not provided at KCH.

Trust participation in NCEPOD Studies

NCEPOD Title	Reporting period	Participation	% of cases submitted
Acute Pancreatitis	01/01/14 – 30/06/14	Yes	Clinical Questionnaire returned = 10/10 (100%). Case notes returned = 8/10 (80%); Organisational questionnaire returned = 2/2 (100%)
Mental Health in General Hospitals	13/10/14 – 13/11/14	Yes	Due to be published Oct-16.

Clinical audit projects reviewed by the Trust

Key:

King's National Clinical Audit Rating	
Symbol	Definition
●	Positive analysis: Outcome measures better than or within expected range, underperformance against <50% process targets with no demonstrable impact on patient outcome.
○	Neutral analysis: Outcome measure within expected range, underperformance against >50% process targets with no demonstrable impact on patient outcome.
●	Negative analysis: Outcome measure outside (below) expected range - negative outlier, underperformance against significant key process targets.
●	Not applicable – service not provided at this location.

National Audit	Data source	Summary of analysis	Rating	DH	PRUH
National Neonatal Audit Programme	Royal College of Paediatrics and Child Health (RCPCH), Nov-15	KCH performs above average for 3/5 process criteria. Reduced proportion of babies receiving mother's milk on DH site – action is in progress.		●	●

National Audit	Data source	Summary of analysis	Rating DH	Rating PRUH
Rheumatoid and Early Inflammatory Arthritis	British Society for Rheumatology, Jan-16	Reduction in Disease Activity Score by at least 1.2 – KCH achieved 71% for this key outcome measure – above national average (62%). 79% of patients were seen within 3 weeks (national average 38%). Similar to national average for referral, treatment initiation, educational support and treatment target achieved. Data quality issues in completing Rheumatoid Arthritis Impact of Disease score (RAID) – action in progress.		●
(ICNARC) Case Mix Programme - General Intensive Care Unit	ICNARC, 02/04/15 – 30/06/15	PRUH is within expected range for survival.	●	●
(ICNARC) Case Mix Programme - General Intensive Care Unit	ICNARC, 01/01/15 – 31/03/15	DH is within expected range for survival.	●	●
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists, Jun-15	KCH is below national average against many criteria, significantly influenced by data collection issues. Actions are being taken to improve data collection in the current cycle. This is a Trust Quality Priority for 2016-17.	●	●
Audit of Patient Blood Management in Adults undergoing Elective, Scheduled Surgery	NHS Blood and Transplant, Oct-15	KCH performed in line with or above the national average for 8/11 key indicators.	●	●
UK Inflammatory Bowel Disease (IBD) Audit: National Clinical Audit of Biological Therapies - Adult	Royal College of Physicians, Sep-15	Numbers too small to make quality of care conclusions from results (small numbers nationally). Actions taken at DH and PRUH demonstrate improved data capture across sites.	●	●
IBD Audit: National Clinical Audit of Biological Therapies – Paediatric	Royal College of Physicians, Sep-15	DH demonstrated compliance with NICE Technology Appraisal 187.	●	●

National Audit	Data source	Summary of analysis	Rating	
			DH	PRUH
National Oesophago-Gastric Cancer Audit	Health and Social Care Information Centre (HSCIC), published Nov-15	<p>DH and PRUH patients receive treatment at GSTT. The complication rate achieved by GSTT, at 5.2%, is the lowest achieved by a London Trust. The adjusted 30-day and 90-day mortality rates achieved by GSTT are within expected range at 1.4% and 2.9% respectively.</p> <p>King's adjusted emergency re-admission rate of 23% has been incorrectly assigned a green rating in the audit report - it should have received a red rating and is currently under investigation.</p>		
(ICNARC) Case Mix Programme - Liver Intensive Care Unit (LITU)	ICNARC, 01/07/15 – 31/09/15	DH is within expected range for survival.		
Liver Transplantation Audit – Adults and Paediatrics	NHS Blood & Transplant, Apr-15	KCH has the highest 90-day survival rate nationally for elective liver transplants in adults. KCH within expected range for all indicators.		
Annual Report on Liver Transplantation – Adult	NHS Blood and Transplant, Sep-15	DH has the highest 1-year risk-adjusted survival rate nationally for super-urgent transplants. DH within expected range for survival.		
Annual Report on Liver Transplantation – Paediatric	NHS Blood and Transplant, Sep-15	DH is within expected range for survival.		
Renal Registry	Renal Registry, Dec-16	KCH one-year-after-90-day incident survival (adjusted to age 60) from the start of renal replacement therapy is similar to the national average (KCH 90.0%, national average 91.8%), even though King's has the 2nd highest rate in England of patients starting on renal replacement therapy who have diabetes, and the highest in London, at 39.2%.		
National Bowel Cancer Audit	Health and Social Care Information Centre, Dec-15	KCH (and network) adjusted 90-day and 2 year mortality rates are within expected range, 90-day unplanned readmission and 18-month stoma rate within expected range.		
National Bowel	Health and Social	The Trust achieved a lower risk adjusted		

National Audit	Data source	Summary of analysis	Rating DH	Rating PRUH
Cancer Audit – Consultant-level Outcomes	Care Information Centre, Dec-15	90-day mortality than the national average.		
Falls and Fragility Fractures Programme: National Hip Fracture Database (NHFD) Annual Report 2015 – published report (based on Jan – Dec 2014 data).	National Hip Fracture Database, Sep-15	<p>The published report, based on 2014 data, shows both sites below national average against many criteria. At the PRUH the rates for patients sustaining a hip fracture as an in-patient and the 30 day mortality rate are reported as being above the NHFD average.</p> <p>NHFD online, however (based on data to Dec-15), shows that both sites have performed above the national average from August 2015. Hip Fracture was a Trust Quality Priority 2015-16, focusing on improving the achievement of all 9 best practice criteria – significant improvements have been achieved at both Trust sites (see Quality Priorities section).</p>	●	●
Falls and Fragility Fractures Programme: National Audit of Inpatient Falls	National Hip Fracture Database, Oct-15	<p>KCH has the lowest rate of falls per 1,000 occupied bed days (OBDs) in London and the 3rd lowest rate nationally. KCH has the 3rd lowest rate of falls leading to moderate/ severe harm or death per 1,000 OBDs in London.</p> <p>KCH is below national average against a number of process measures. Actions already planned across sites to improve practice.</p>	●	●
National Joint Registry – Enhanced Surgeon and Hospital Information	National Joint Registry, May-15	KCH is within expected range for patient-reported outcomes for hip and knee replacement surgery.	●	● Orpington
National Joint Registry	National Joint Registry Centre, Sep-15	KCH is within expected range for 90-day mortality following hip and knee replacement and for hip and knee revision rate.	●	● Orpington
National Joint Registry – Enhanced Surgeon and Hospital Information	National Joint Registry – online, Nov-15	Patient-Reported Improvement Measures, 90-day mortality and revision rates are within expected range for hip and knee replacement. Consent rate is	●	● Orpington

National Audit	Data source	Summary of analysis	Rating	
			DH	PRUH
		better than expected at Denmark Hill and Orpington.		
National Prostate Cancer Audit – a) Organisational Audit, and b) Clinical Audit	National Prostate Cancer Audit, Feb-15	Treatment is provided by an integrated Guy's and St Thomas' (GSTT) & King's College Hospital (KCH) team – KCH provides all recommended diagnostic and support service facilities. Results are reported by GSTT.	●	●
Adherence to British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing	British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS), Nov-15	DH achieved 100% for 10/11 criteria. The recording of hand temperature requires improvement, which is consistent with the national picture.	●	●
Adult Cardiac Surgery	Society for Cardiothoracic Surgery in Great Britain & Ireland (SCTS), Sep-15	Mortality rates are within expected range.	●	●
National Audit of Cardiac Rhythm Management Ablation Audit	National Institute Cardiac Outcomes & Research, Mar-15	DH undertakes in excess of the minimum number of procedures and is therefore not identified as an outlier.	●	●
Congenital Heart Disease Audit	British Congenital Cardiac Assoc, Jun-15	Mortality rates are within expected range.	●	●
Percutaneous Coronary Intervention (PCI) Audit	British Cardiovascular Intervention Society (BCIS), Oct-15	DH performed better than expected for freedom from in-hospital major adverse cardiac and cerebrovascular events. DH is within expected range for 30-day post-PCI survival.	●	●
National Heart Failure Audit	National Institute Cardiac Outcomes & Research, Sep-15	Mortality rates are within expected range.	●	●
Neurosurgical National Audit	Society of British Neurological	KCH is within expected range for 30-day standardised mortality rate.	●	●

National Audit	Data source	Summary of analysis	Rating	
			DH	PRUH
Programme	Surgeons, Dec-15			
Sentinel Stroke National Audit Programme – Hyper Acute Stroke Unit (HASU)	Royal College of Physicians, Jun-15	DH HASU 3 rd highest score compared to national peers; PRUH HASU 2 nd highest.		
Sentinel Stroke National Audit Programme - Hyper Acute Stroke Unit (HASU) data	Royal College of Physicians, Sep-15	PRUH HASU achieved the 2 nd highest score compared to national peers; DH HASU 3 rd highest.		
Vascular Outcomes – Abdominal Aortic Aneurysm Repair and Carotid Endarterectomy Outcomes	NHS England Consultant Outcomes Publication, Sep-15	Mortality rates are within expected range.		
College of Emergency Medicine Audit - Assessing for Cognitive Impairment in Older People in the Emergency Department	Royal College of Emergency Medicine, Jun-15	DH performed better or similar to national average for 3/6 standards, and PRUH for 5/6. Cognitive assessment at DH was recorded in 5% of cases (PRUH 60%, national average 11%).		
College of Emergency Medicine Audit - Initial Management of the Fitting Child in the Emergency Department	Royal College of Emergency Medicine, Jun-15	Both sites performed at 98-100% against 4/5 standards. The provision of written safety information provided at discharge requires improvement, which is consistent with national picture.		
College of Emergency Medicine Audit - Mental Health in the Emergency Department	Royal College of Emergency Medicine, Jun-15	DH performed better than national average for 7/8 standards, and PRUH for 6/8. Assessment by mental health practitioner within 1 hour: DH = 39%, PRUH = 0%, national average = 0%. Documentation requires improvement.		
Emergency Oxygen Audit	British Thoracic Society, Nov-15	61% of DH patients and 41% of PRUH patient did not have a prescription or bedside order in place. An action plan is in place.		
National Adult Community Acquired	British Thoracic Society, Jun-15	Fewer in-patient deaths were reported compared to national average (but small		

National Audit	Data source	Summary of analysis	Rating	
			DH	PRUH
Pneumonia Audit		numbers). Median length of stay at KCH was similar to national average (DH = 6 days, PRUH = 4 days, national average = 5 days).		
National Lung Cancer Audit (NCLA)	The Royal College of Physicians, Dec-15	<p>King's performance equals or exceeds the level suggested in the NLCA report 2014, and is statistically better than the national average for:</p> <ul style="list-style-type: none"> • Anticancer treatment • Non-small-cell lung cancer (NSCLC) stage IIIB/IV and PS 0–1 having chemotherapy <p>3 out of 4 process, imaging and nursing measures equal or exceed the level suggested in the NLCA report.</p> <p>King's performance is statistically similar to the national average for:</p> <ul style="list-style-type: none"> • NSCLC having surgery • Small-cell lung cancer (SCLC) patients having chemotherapy. <p>King's is below the level suggested for 'Patient seen by nurse specialist', achieving 51.1% for this measure, compared to 80% recommended by the NLCA.</p>	●	●
National Chronic Obstructive Pulmonary Disease Audit Programme - Clinical Audit	Royal College of Physicians, Feb-15	DH performed in line with or above the national average for 26/30 measures linked to national standards. PRUH performed in line with or above the national average for 18/30 measures. (4.3%).	●	●
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: Resources and Organisation of Pulmonary Rehabilitation Services in England and Wales	Royal College of Physicians and British Thoracic Society, Nov-15	Both DH and PRUH met all 10 organisational Quality Standards specified by the British Thoracic Society.	●	●
National Chronic Obstructive Pulmonary Disease (COPD) Audit	Royal College of Physicians, Feb-16	KCH performance was above national average for all key functional outcomes measures.	●	●

National Audit	Data source	Summary of analysis	Rating	
			DH	PRUH
Programme: Pulmonary Rehabilitation Services in England and Wales Clinical Audit				
Trauma Audit & Research Network (TARN) - Clinical Report Core Measures for All Patients: Thoracic and Abdominal Injuries/ Patients in Shock	TARN, Mar-15	<p>South East London, Kent and Medway Trauma Network is the best performing network in comparison to all other Trauma Networks nationally.</p> <p>DH survival is within expected range.</p>	●	●
TARN - Major Trauma Dashboard	TARN, Jun-15	DH performance is better than or similar to national average for 7/8 criteria. The underperforming criteria relate to admission delays, mainly for stable spinal injury cases, due to in-patient capacity, flow and rehab capacity, which is on the Trust Risk Register.	●	●
TARN - Online Survival Data	TARN, Jul-15	More trauma patients admitted to KCH are surviving compared to the number expected, based on the severity of their injury.	●	●
TARN - Clinical Report II Core Measures for all patients: BOAST 4 eligible fractures, Open limb fractures, Severe pelvic fractures	TARN, Aug-15	South East London, Kent and Medway Trauma Network is the best performing network in comparison to all other Trauma Networks nationally. DH survival is within expected range.	●	●
TARN - Major Trauma Dashboard	TARN, Aug-15	DH performed better than previous for 5/10 process criteria.	●	●
UK Cystic Fibrosis Registry 2014 Annual Data Report: Strength in Numbers a) Adults, and b) Paediatrics	Cystic Fibrosis Trust, Aug-15	The number of patients with chronic pseudomonas aeruginosa at KCH is below the national average; and KCH has the 2 nd highest proportion of adult patients using preventative inhaled medication DNase, 8 th highest for children.	●	●
National Cardiac Arrest Audit (NCAA)	ICNARC, Sep-15	KCH survival is within expected range.	●	●

National Audit	Data source	Summary of analysis	Rating	
			DH	PRUH
National Paediatric Diabetes Audit Report 2013 - 14: Part One, Care Processes and Outcomes	Royal College of Paediatrics and Child Health (RCPCH), Sep-15	PRUH performed better than national average for 6/7 process criteria. DH and PRUH performed within NICE target range. DH performed better than national average for 3/7 process criteria. No patients received all process criteria.	●	●
Paediatric Intensive Care Audit Network (PICANet)	PICANet, Nov-15	The standardised mortality ratio at DH is one of the lowest nationally and the lowest compared to all London peer trusts.	●	●
Potential Donor Audit	NHS Blood & Transplant	All process targets were exceeded. The total number of organ donors fell, in line with the national picture.	●	●
Surgical Outcomes Audit - Nephrectomy	British Association of Urological Surgeons, Sep-15	DH is below the national average for the risk-adjusted complication, transfusion and mortality rates.	●	●
Surgical Outcomes Audit - Radical Prostatectomy	British Association of Urological Surgeons, Sep-15	DH achieved a 0% transfusion and complication rate.	●	●

Local Audits

Local Clinical Audit	Headline results and/ or actions taken
Audit of NICE derogation CG122 Ovarian cancer	An audit on gynaecological cancers including ovarian cancer and rapid access service is performed annually. Audit results demonstrate KCH cross site compliance with the NICE guidance.
Audit of NICE derogation CG154 Ectopic pregnancy and miscarriage	The Early Pregnancy Unit audits its outcomes on an annual basis including outcome of management options. The data generated from this informs the continuous updating of the unit management protocols.
Audit of NICE derogation CG95 Chest pain of recent onset	Attendance, investigation and outcomes are audited for all patients who are managed in the rapid access chest pain clinic.
Audit of NICE derogation CG112 Sedation in children and young people	The audit demonstrated a high-level of compliance with the paediatric sedation protocol. The audit identified several areas for improvement in the quality of documentation, currently being addressed.
Audit of NICE derogation CG151 Neutropenic sepsis	Ongoing monthly mortality audit of deaths within 30 days of chemotherapy, including participation in network neutropenic sepsis audit with development of local action plan.

Local Clinical Audit	Headline results and/ or actions taken
Audit of NICE derogation CG156 Fertility: assessment and treatment of people with fertility problems	Routine audit of outcomes is undertaken. A review of KPIs is undertaken on a monthly basis.
KCH Divisional Clinical Audit Programme	<p>Each Division has a detailed clinical audit programme in place:</p> <ul style="list-style-type: none"> • Ambulatory Care and Local Networks. • Critical Care, Theatres and Diagnostics. • Liver, Renal, Surgery and Orthopaedics. • Networked Services. • Trauma, Emergency and Acute Medicine. • Women's and Children's. <p>Several hundred clinical audits are undertaken every year – a few examples are provided below.</p>
<p>Patient Safety Audit Programme:</p> <ul style="list-style-type: none"> • Clinical record-keeping • Consent • Surgical Safety Checklist • Discharge • Moving and handling • Falls assessment • Patient observations (deteriorating patient) • Clinical handover (nursing) • Skin integrity and pressure ulcers • Patient identification • Infection prevention and control • Nutrition • Nasogastric and orogastric tube placement • Availability of patient records • Screening procedures and diagnostic test procedures • Blood transfusion • Hospital Acquired Thrombosis (HAT) • Medicines management • Resuscitation • Piped medical gas administration • Safeguarding • Tracheostomy • 	The Patient Safety Audit Programme sets out King's approach to ensuring that areas identified as high risk are subject to routine review and, where required, improvement. The Programme is a key component of King's Risk Management Strategy and is reported through the Patient Safety Committee to the Trust's Quality Governance Committee at least annually.
KCH Divisional Clinical Audit Programme: clinical audit project examples	<ol style="list-style-type: none"> 1. Gynaecology: HSA1 documentation audit. Rationale: To ensure appropriate consent. Conclusion: The audit showed that all HSA1 forms completed were compliant with the Abortion Act. 2. Clinical Gerontology: Advance Care Planning (PEACE) for care home residents. Rationale: Local priority quality improvement project. Conclusion: The data shows that when PEACE is used for patients on a palliative trajectory it is effective in promoting advanced care planning. Readmissions are significantly reduced and patients are more likely to die at their nursing home than patients discharged without PEACE.

Local Clinical Audit	Headline results and/ or actions taken
	<p>3. Sexual Health & HIV: Audit on testing and management of rectal gonorrhoea. Rationale: To determine CSHC meets sufficient standards on testing and management of rectal GC Conclusion: Triple site testing in MSM achieved. Improvement in culture and sensitivity , partner notification, test of cure attendance and documentation needed. Recommendation- call recall system by SHIP team, easier testing system and access by SH24 and self testing kits.</p>
	<p>4. Major Trauma: Analgesia audit. Rationale: Audit against local standard operating procedure (SOP) for analgesia. Conclusion: Significant improvements achieved in patient controlled analgesia (PCAs). Re-audit planned.</p>
	<p>5. Liver: Peroral endoscopic myotomy (POEM) for achalasia Rationale: Outcomes of new clinical procedure audited in line with governance requirements Conclusions: <ul style="list-style-type: none"> • The procedure has been performed on eight occasions. All procedures were completed safely and the patients discharged home from hospital as planned after two nights post-procedure. No immediate short or medium-term complications reported. • The first four cases have been reviewed at 3 months and had post-procedure pH/manometry performed. There are no cases of clinically significant reflux requiring treatment in these cases, and a significant symptomatic improvement has been reported by all patients. In particular one patient who had failed surgical myotomy is now symptom-free post-procedure. • Publication planned to British Society of Gastroenterology national conference when ten patients have all achieved 3-month follow-up. </p>
	<p>6. Anaesthetics: Audit of Intrathecal Opiate Use for Hip Fracture Surgery. Rationale: To assess compliance against the Association of Anaesthetists of Great Britain and Ireland standards. Conclusions: Diamorphine provides superior pain relief with no increase in Side effects. Scope for Further Audit into IT Bupivacaine doses and Cardiovascular stability and Vasopressor use in theatre.</p>

Reporting against core indicators

All trusts are required to report against a core set of indicators, for at least the last two reporting periods, using a standardised statement set out in the NHS (Quality Accounts) Amendment Regulations 2012. Only indicators that are relevant to the services provided at King's are included in the tables below.

Performance Measures										Foundation Trusts Comparable Value	
Indicator	Measure	Current Period	Value	Previous Period	Value	Highest	Lowest	National Average	Source	Regulatory Statement	
Summary Hospital Mortality Index (SHMI)	%	01 July 2014 - 30 June 2015	89	01 July 2013 - 30 June 2014	91	94.5	77.5	101.6	NHS IC	The Trust has a monthly Mortality Committee, which reviews actions and attributes them to the appropriate division accordingly.	
Patients deaths with palliative care coded at either diagnosis or specialty level	%	01 October 2014 - 30 September 2015	41.84	01 October 2013 - 30 September 2014	34.3	47.2	23.9	26.7	NHS IC	The Trust has a monthly Mortality Committee which review actions and attributes them to the appropriate division accordingly.	

Performance Measures							Foundation Trusts Comparable Value		Source	Regulatory Statement
Indicator	Measure	Current Period	Value	Previous Period	Value	Highest	Lowest	National Average		
Patients aged 0-15 (emergency) readmitted within 28 days of being discharged	%	01 April 2015 - 31 January 2016	1.6	01 April - 31 December 2014	3.9	7.7	4.2	7.4	PiMS (2015/16), CHKS (2014)	The Trust has a monthly Divisional Performance Meeting which review actions and attributes them to the appropriate division accordingly
Patients aged 16+ or over (emergency) readmitted within 28 days of being discharged	%	01 April 2015 - 31 January 2016	8.7	01 April - 31 December 2014	4.5	8.9	4.5	7.3	PiMS (2015/16), CHKS (2014)	The Trust has a monthly Divisional Performance Meeting which review actions and attributes them to the appropriate division accordingly
Admitted patients who were risk assessed for venous thromboembolism	%	01 April 2015 - 31 December 2015	96.53	01 April 2014 - 31 March 2015	97.28	97.1	95.4	95.8	VTE returns	The Trust has a VTE Team that review performance and will work with areas that are performing below the National Target.

Performance Measures										Regulatory Statement
Indicator	Measure	Current Period	Value	Previous Period	Value	Highest	Lowest	National Average	Source	
Cases of C difficile infection reported for patients aged 2 or over	Rate per 100K bed days	KCH APR15 - FEB16 Reportable cases rate /100,000 bed days	(80) 18.49%	KCH 2014/15 Reportable cases rate /100,000 bed days	(75) 15.4 3%	36.5 (16/17 Target)	5.4 (16/17 Target)	16.3	C-diff cases/KH 03 G&A + Obs per 100,000. Note: KH03 excludes Well babies & Critical Care	The Trust has a monthly Divisional Performance Meeting which review actions and attributes them to the appropriate division accordingly.
4-hour A&E	%	01 April 2015 – 31 March 2016	88.59%	01 April 2014 – 31 March 2015	87.2					

Responsiveness to patients personal needs

Indicator	National 2014 Scores						Regulatory Statement			
	Measure	Current Period	Value	Previous Period	Value	Highest	Lowest	National Average	Data Source	
Were you involved as much as you wanted to be in decisions about your care and treatment?	Score out of 10 trust-wide	2014 National Inpatient Survey	7.0	2013 National Inpatient Survey	7.5	9.2	6.1	Not available	CQC	The Trust considers that this data is as described as it was taken from the published report on the Care Quality Commission's (CQC) website: http://www.cqc.org.uk/content/surveys
Did you find someone on the hospital staff to talk to about your worries and fears?	Score out of 10 trust-wide	2014 National Inpatient Survey	5.2	2013 National Inpatient Survey	5.5	8.2	4.3	Not available	CQC	
Were you given enough privacy when discussing your condition or treatment?	Score out of 10 trust-wide	2014 National Inpatient Survey	8.0	2013 National Inpatient Survey	8.7	9.4	7.5	Not available	CQC	

Responsiveness to patients personal needs

Indicator	Measure	Current Period	Value	Previous Period	National 2014 Scores			Data Source	Regulatory Statement
					Highest	Lowest	National Average		
Did hospital tell you who to contact if you were worried about your condition or treatment after you left hospital?	Score out of 10 trust-wide	2014 National Inpatient Survey	4.3	2013 National Inpatient Survey	4.7	7.6	3.7	CQC	
	Score out of 10 trust-wide	2014 National Inpatient Survey	7.3	2013 National Inpatient Survey	7.8	9.7	6.5	CQC	

Patient Friends & Family Tests

Indicator	Measure	Current Period	Value	Previous Period	Value	Comparable Foundation Trust Value			Data Source	Regulatory Statement
						Highest	Lowest	National Average April 15 - Jan 16		
Patients discharged from Accident & Emergency (types 1/2) who would recommend the Trust as a provider of care to their family or friends.	%	April 2015 - Jan 2016 (latest available data)	82	Oct 2014 March 15 (scoring changed Oct 14)	80	100	52	86	NHS England	The Trust considers that this data is as described for the following reasons as it has been taken from the NHS England Friends & Family Test data website: https://www.england..nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
Inpatients the Trust as a provider of care to their family or friends?	%	April 2015 - Jan 2016 (latest available data)	94	Oct 2014 March 15 (scoring changed Oct 14)	94	100	73	96	NHS England	

Staff – Friends & Family Test and National Staff Surveys

Indicator	Measure	Current Period	Value	Previous Period	Value	Comparable Foundation Trust Value			Data Source	Regulatory Statement
						Highest	Lowest	National Average		
Staff employed by, or under contract who would recommend the Trust as a provider of care to their family or friends.	% * %	2015 National Staff Survey (Quarter 3)	3.7	2014 National Staff Survey (Quarter 3)	3.88	4.10	3.3	3.76	NHS Annual Staff Survey Results	The Trust considers that this data is as described as it has been taken from the nationally published staff survey results: http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2015_RJZ_full.pdf
Staff experiencing harassment, bullying or abuse from staff in the last 12 months.	% * %	2015 National Staff Survey (Quarter 3)	29	2014 National Staff Survey (Quarter 3)	25	16	42	26	NHS Annual Staff Survey Results	

Staff – Friends & Family Test and National Staff Surveys

Indicator	Measure	Current Period	Value	Previous Period	Value	Comparable Foundation Trust Value		Data Source	Regulatory Statement
						Highest	Lowest		
Staff believing the Trust provides equal opportunities for career progression or promotion	% *	2015 National Staff Survey (Quarter 3)	84	2014 National Staff Survey (Quarter 3)	79	96	76	87	NHS Annual Staff Survey Results

*30% (255 staff responded from a sample of 850 staff)

Patient Reported Outcomes

Indicator	Measure	Current Period	Value	Comparable Foundation Trust Value			Data Source	Regulatory Statement	
				Previous Period	Value	Highest	Lowest	National Average	
Patient reported outcomes measures varicose vein surgery	Patient reported outcomes measures groin hernia surgery	EQ VAS 50 modelled records	EQ-5D Index: 17 modelled recordings	April 2013 – March 2014	Adjusted average health gain: * 0.74	Adjusted average health gain: * 0.89 (CUH)	0.85 (UCL)	0.87	HSCIC 'Select 10' table, April 2013 - March 2014, published 13 August 2015
Patient reported outcomes measures varicose vein surgery		EQ-5D Index: 22 modelled records	EQ-5D Index: 17 modelled recordings	April 2013 – March 2014	Adjusted average health gain: * 0.74	Adjusted average health gain: * 0.89 (CUH)	0.85 (UCL)	0.87	HSCIC 'Select 10' table, April 2013 - March 2014, published 13 August 2015

Patient Reported Outcomes

Indicator	Measure	Comparable Foundation Trust Value				Regulatory Statement						
		Current Period	Previous Period	Value	Value	Highest	Lowest	National Average	Data Source			
Patient reported outcomes measures hip replacement surgery	Aberdeen Varicose Vein Questionnaire: 26 modelled records	EQ-5D Index: 82 modelled records	April 2013 – March 2014	Adjusted average health gain: 0.45	April 2012 – March 2013	Adjusted average health gain: 14.19	Adjusted average health gain: -4.22	Adjusted average health gain: 0.14	1.22 (NUTH)	-5.26 (OUH)	-0.55	
									11.23 (OUH)	-12.46 (NUTH)	-8.70	
									0.47 (ICH)	0.40 (STH)	0.44	

Patient Reported Outcomes

Indicator	Measure	Current Period	Value	Comparable Foundation Trust Value				Regulatory Statement
				Previous Period	Value	Highest	Lowest	
Patient reported outcomes measures knee replacement surgery	EQ-5D Index: 74 modelled records	April 2013 – March 2014	Adjusted average health gain: 0.28	Adjusted average health gain: 22.14	Adjusted average health gain: 14.19	12.7 (OUT)	8.80 (UCL)	11.46 21.38 0.32

Patient Reported Outcomes

Indicator	Measure	Current Period	Value	Comparable Foundation Trust Value			Data Source	Regulatory Statement	
				Previous Period	Value	Highest	Lowest	National Average	
Oxford Knee Score: 79 modelled records	EQ VAS: 64 modelled records	Adjusted average health gain: 14.71	Adjusted average health gain: 2.62	Adjusted average health gain: 14.79	Adjusted average health gain: 6.01 7.07 (GSTT) 16.891 (OUH)	4.12 (ICH) 12.85 (ICH)	5.59 16.27		

* Figure suppressed by HSCIC to protect patient confidentiality.

** Shelford Group trusts used as comparator

Part 3: Other information

Access & Performance - Quality of care indicators

Indicator	Measure	Current Period	Value	Previous Period	Value	Comparable Foundation Trust values (as at Q3 or Feb 16)			Data Source	Regulatory Statement
						Highest	Lowest	National Average		
6-week diagnostic waits	%	March 2016	5.8	March 2015	5.5	0	9.3	1.3	PiMs/ CRIS	The Trust has a weekly diagnostic waiting list meeting which reviews the breach portfolio and signs off action plans for the test modality as appropriate.
Maximum waiting time of 62 days from urgent GP referral to first treatment for cancers	%	Jan-March 2016	88.8	Jan-March 2015	84.2	93.5	55.5	83.5	Open Exeter	The Trust discusses all the cancer metrics weekly at the Performance Improvement Group and monthly at the Patient Access Board where key actions are reviewed and updated.

Access & Performance - Quality of care indicators

Indicator	Measure	Current Period	Value	Previous Period	Value	Comparable Foundation Trust values (as at Q3 or Feb 16)			Data Source	Regulatory Statement
						Highest	Lowest	National Average		
Percentage on incomplete pathway within 18 weeks for patients on incomplete pathway at the end of the reporting period	%	March 2016	80.4	March 2015	92.2	98	73.8	92.1	PiMs/ Oasis	The Trust took a reporting holiday with the agreement of local commissioners and Monitor during the period. The Trust returned to reporting in March 2016. Auditors will conduct a review of the Trust's data as part of the external assurance process for the Quality Report. The Trust has taken robust action during the period to improve the quality of its data for this indicator and to ensure that longer waiting patients are cared for in the short-term.

Patient Safety - Quality of care indicators

Indicator	Measure	Current Period	Value	Previous Period	Comparable Foundation Trust values			Data Source	Regulatory Statement
					Value	Highest	Lowest		
Patient safety incidents reported to the NRLS where degree of harm is recorded as 'severe harm or death' as a percentage of all patient safety incidents reported	%	Oct 2014 – Mar 2015	0.96	Apr-Sept 2014	0.6	5.19	0.5	0.6	NRLS
Rate patient safety incidents	Number/1000 bed days	Oct 2014- Mar 2015	36.06	Apr-Sept 2014	40.7	82.21	3.57	37	NRLS

Patient Safety - Quality of care indicators

Indicator	Measure	Current Period	Value	Previous Period	Comparable Foundation Trust values				Data Source	Regulatory Statement
					Value	Highest	Lowest	National Average		
Number of patient safety incidents	Number	Oct 2014-Mar 2015	8350	Apr-Sept 2014	9844	12784	443	4572	NRLS	Data for the period Apr 2015 – Sep 2015 shows that the total number of incidents has risen to around 10,000 which suggest that reporting is improving on an already solid baseline.

The Trust considers that the data is as described because it was taken directly from the National Reporting & Learning System database and relates to acute non-specialist trusts.

Medication safety errors

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest	Lowest	National Average	Data Source	Comparable Foundation Trust Value	Regulatory Statement
Pa10-fold dosing errors 2015 by stage of the medicines process	Number	April 2015 – March 2016	41	April 2014-March 2015	46	Not Available	Not Available	N/A	N/A	The Trust conducted an extensive local audit into medication safety errors. The Trust is confident in its data because it has been tested by auditors and is supported by an robust process. Details and further actions can be found on pages 117-118. The weakness of this data is that it is no longer measured with the closest comparable measure was the last measures from HSCIC on the number of incidents of medication errors causing serious harm which states that between April 2011 and March 2012 which was 0.49 per population	Regulatory Statement

Medication safety errors

Indicator	Measure	Current Period	Value	Comparable Foundation Trust Value			National Average	Data Source	Regulatory Statement
				Value	Highest	Lowest			
Reduction in the number of medication errors involving the wrong patient	Number	April 2015 – March 2016	81	April 2014-March 2015	97	Not Available	Not Available		of 100,000

Trust Scorecards as at 31 March 2016

King's@Denmark Hill		Mar-16				King's College Hospital				NHS	
Metric		Units	Last Year	Last Mnth	This Mnth	Target	Status	Trend	Graph	R	G
Clinical Effectiveness											
Elective Crude Mortality	%	0.3	0.3	0.4	0.3	0.3			Worse	1.03	
SHMI (National external)	Index	—	84	84	100				—	1.01	
Average Length of Stay - Elective ALoS	Days	5.2	4.8	4.9	4.7			Worse	1.05		
Average Length of Stay - Non - Elective ALoS	Days	6.5	5.9	6.4	5.4			Worse	1.07		
Outliers	Beds	43.9	40.8	44.6	0			Worse	1.09		
Elective Inpatients with EDD	%	66.6	49.7	45.4	90.0			Worse	1.11		
Diagnostic waits > 4 weeks	Number	234	726	941	115			Worse	1.13		
Cancer Waiting Times	Index	98.5	95.7	99.1	100.0			—	1.15		
Unplanned admissions to ICU/HDU	Number	47	49	72	37			Worse	1.17		
Emergency Readmissions within 30 Days	%	5.5	6.2	4.7	5.9			Better	1.12		
Repatriation bedday delays	Beddays	170	559	857	90			Worse	1.21		
No. RTT 40+ week Admitted waiters	Number	—	—	No Data	0			—	1.23		
No. RTT 40+ week Non-Admitted waiters	Number	—	—	No Data	0			—			
No. RTT 18+ week Admitted waiters	Number	0	—	No Data	—			—			
No. RTT 52+ week waiters	Number	0	—	No Data	0			—			
Emergency Care Performance	%	90.9	83.8	82.4	95.0			Worse	1.31		
Safety											
-MRSA Bacteraemias (YTD)	Cases	6	4	4	0			—	2.01		
-VRE Bacteraemias (YTD)	Cases	28	34	40	19			—	2.01		
-CDT Cases (YTD)	Cases	57	58	60	53			—	2.01		
Hand Hygiene Audit	%	95.1	92.7	92.8	95.0			Better	2.03		
MRSA Screening	%	96.6	95.4	94.9	100.0			Worse	2.05		
Total Hospital Acquired Alert Organisms (YTD)	Cases	1,328	1,184	1,314	—			—	2.07		
Deteriorating Patient Incidents	Number	13	6	4	9			Better	2.09		
Never Events	Number	1	0	0	0			—	2.11		
Red Shifts	Number	47	147	185	0			Worse	2.13		
Red Adverse Incidents (inc medication errors)	Number	19	5	4	0			Better	2.15		
Slips, Trips & Falls	Number	1	2	4	1			Worse	2.17		
Pressure Sores - Hospital Acquired	Number	42	17	21	8			Worse	2.19		
% VTE Assessed	%	95.7	97.2	97.2	95.0			—	2.21		
Patient Experience											
How are we doing? (Inpatient)	%	90	90	91	89			Better	3.01		
Friends & Family Inpatient & Day case	Number	95.0	92.0	96.0	93.0			Better	3.03		
Friends & Family ED	Number	79.0	81.0	77.0	89.0			Worse	3.05		
28 Day Cancelled Operation Rule	%	4.3	12.2	21.3	5.0			Worse			
Number of Inpatient Cancellations	Number	48	47	52	0			Worse	3.07		
Outpatient Cancellations < 6 weeks notice (Hosp)	Number	4,878	5,364	6,219	0			Worse	3.09		
Number of Complaints	Number	48	39	41	45			Worse	3.11		
Complaints - High & Severe	Number	6	4	3	0			Better	3.13		
Complaint Responses > 25 Working Days	Number	18	16	20	0			Worse			
Single Sex Accommodation	Number	0	0	0	0			—	3.15		
Financial & Operational Efficiency											
Financial - Net Variance (YTD)	(000s)	(19,034)	7,210	(19,117)	0			Worse	4.01		
Theatre Utilisation Rate	%	78	78	76	80			Worse	4.03		
Weekend Discharges	%	19.5	20.6	17.9	28.0			Worse	4.05		
Activity - Electives Inpatients (YTD)	Spells	84,099	70,432	76,901	80,944			—	4.07		
- Emergency Inpatients (YTD)	Spells	59,944	50,550	54,951	59,908			—	4.07		
- Other Inpatients (YTD)	Spells	20,149	16,790	18,134	20,141			—	4.07		
- Outpatient Attendances (YTD)	Number	589,701	551,691	601,280	584,841			—	4.09		
- ED attendances (YTD)	Number	138,968	129,075	141,865	134,760			—	4.11		
DNA Rate	%	11.6	11.0	11.0	11.2			—	4.13		
Staffing Measures											
Vacancy Rate	%	5.9	10.2	10.8	5.0 - 8.0			Worse	5.01		
No. of Appraisals Completed vs. Required (YTD)	Number	3,931	—	No Data	1,595			—	5.03		
Sickness & Absence (Rolling YTD)	%	—	—	No Data	3.0			—	5.05		
Mandatory & Statutory Training and Induction	Index	74	80	81	80			Better	5.07		

Kings@PRUH		Mar-16		King's College Hospital		NHS					
Metric		Units	Last Year	Last Month	This Month	Target	Status	Trend	Graph		
<table border="1"> <thead> <tr> <th>R</th><th>G</th></tr> </thead> </table>										R	G
R	G										
Clinical Effectiveness											
Elective Crude Mortality											
SHMI (National external)	%	0.3	0.2	0.2	0.3	█	—	1.03			
Average Length of Stay - Elective ALoS	Index	—	90	91	100	█	Worse				
Outliers	Days	2.2	3.0	2.4	4.7	█	Better	1.05			
Diagnostic waits > 4 weeks	Days	5.6	5.2	5.8	5.4	█	Worse	1.07			
Cancer Waiting Times	Beds	57.5	64.4	71.2	0	█	Worse	1.09			
Unplanned admissions to ICU/IHDU	Number	613	208	621	535	█	Worse	1.13			
Emergency Readmissions within 30 Days	Index	96.3	97.3	95.7	100.0	█	—				
Reappraisal bed/day delays	Number	62	45	46	—		—				
No. RTT 40+ week Admitted waiters	%	9.4	9.4	8.5	8.5	█	Better	1.19			
No. RTT 40+ week Non-Admitted waiters	Beddays	25	310	165	0	█	Better	1.21			
No. RTT 18+ week Admitted waiters	Number	—	—	No Data	0		—	1.23			
No. RTT 52+ week waiters	Number	0	—	No Data	—		—				
Emergency Care Performance	Number	0	—	No Data	0		—				
Safety	%	82.2	81.5	79.8	95.0	█	Worse	1.31			
-MRSA Bacteraemias (YTD)	Cases	0	0	0	0	█	—	2.01			
-VRE Bacteraemias (YTD)	Cases	5	2	2	5	█	—	2.01			
-CDT Cases (YTD)	Cases	19	22	22	19	█	—	2.01			
Hand Hygiene Audit	%	86.5	86.5	88.0	95.0	█	Better	2.03			
MRSA Screening	%	—	—	No Data	100.0		—	2.05			
Total Hospital Acquired Alert Organisms (YTD)	Cases	—	240	275	—		—	2.07			
Deteriorating Patient Incidents	Number	2	10	8	—		—	2.09			
Never Events	Number	0	1	0	0	█	Better	2.11			
Red Shifts	Number	38	32	49	0	█	Worse	2.13			
Red Adverse Incidents (inc medication errors)	Number	9	7	6	0	█	Better	2.15			
Slips, Trips & Falls	Number	1	1	0	—		—	2.17			
Pressure Sores - Hospital Acquired	Number	15	2	6	—		—	2.19			
% VTE Assessed	%	—	96.4	97.1	95.0	█	Better	2.21			
Patient Experience											
How are we doing? (Inpatient)	%	89	92	92	89	█	—	3.01			
Friends & Family Inpatient & Day case	Number	94.0	95.0	97.0	93.0	█	Better	3.03			
Friends & Family ED	Number	75.0	85.0	81.0	89.0	█	Worse	3.05			
28 Day Cancelled Operation Rule	%	4.1	8.3	10.6	5.0	█	Worse				
Number of Inpatient Cancellations	Number	43	66	52	0	█	Better	3.07			
Outpatient Cancellations < 6 weeks notice (Hosp)	Number	2,226	1,834	2,024	0	█	Worse	3.09			
Number of Complaints	Number	21	41	24	—		—	3.11			
Complaints - High & Severe	Number	3	7	3	0	█	Better				
Complaint Responses > 25 Working Days	Number	14	21	20	0	█	Better	3.13			
Single Sex Accommodation	Number	11	12	11	0	█	Better	3.15			
Financial & Operational Efficiency											
Financial - Net Variance (YTD)	(000s)	(24,598)	2,642	1,620	0	█	Worse	4.01			
Theatre Utilisation Rate	%	67	68	65	80	█	Worse	4.03			
Weekend Discharges	%	20.2	20.5	18.5	28.0	█	Worse	4.05			
Activity - Electives Inpatients (YTD)	Spells	40,234	40,271	43,718	39,546	█	—	4.07			
- Emergency Inpatients (YTD)	Spells	35,124	40,039	43,704	35,112	█	—	4.07			
- Other Inpatients (YTD)	Spells	8,296	7,593	8,294	8,284	█	—	4.07			
- Outpatient Attendances (YTD)	Number	394,999	369,459	402,981	393,350	█	—	4.09			
- ED attendances (YTD)	Number	65,426	59,650	65,275	—		—	4.11			
DNA Rate	%	11.5	11.1	10.4	12.2	█	Better	4.13			
Staffing Measures											
Vacancy Rate	%	12.0	15.4	15.8	5.0 - 8.0	█	Worse	5.01			
No. of Appraisals Completed vs. Required (YTD)	Number	1,096	964	No Data	1,188		—	5.03			
Sickness & Absence (Rolling YTD)	%	—	—	No Data	—		—	5.05			
Mandatory & Statutory Training and Induction	Index	0	—	No Data	80		—	5.07			

Trust actions on duty of candour (incidents/actions)

Initial Implementation:

- Policy ratified and published on 30th September 2014.
- Standardised documentation for recording Duty of Candour conversations
- 'Candour Guardian' role identified - Dr Rob Elias, Consultant Nephrologist
- Presentations at Consultant Development Mornings, Audit Days, Divisional Governance meetings, Nursing for and significant Trust committees were facilitated by the Candour Guardian and the Patient Safety Team.
- A series (~10) of Candour drop in sessions were organised across all KCH sites to allow staff to find out more information.
- KWIKI webpages developed (accessed over 4000 times to date)

Ongoing work to embed best practice in Candour:

- Candour Working Group: a team of interested senior clinicians meet 2-3 monthly to review complicated/difficult cases and assess ways of improving the pathway in future and supporting the clinicians involved
- Development of standardised Duty of Candour Letters
- Changes to the Duty of Candour form in line with feedback from staff
- Roll out of EPR duty of candour form for DH & Orpington and access through the Clinical Portal for PRUH and QMS ('How to Guides' developed)
- Development of standardised letters to feedback the outcome of investigations into falls, pressure ulcers and hospital acquired thrombosis.

- Education, focussed mainly on process, continued. As of February 2015, it was estimated that >800 staff had received face to face training.
- Collaborative presentation on with KHP colleagues at National Safety Connections event

Plans for 2016

- Duty of Candour Lead is in discussion with a Human Factors training group to develop a ½ day and 1 day training course for KCH staff
- KCH is now involved in the HIN Communities of Practice about Duty of Candour (first meeting in November 2015, next meeting Jan 2016)
- Development of FAQ based on comments from the Survey
- Update of the KWIKI page to include some case studies from complex cases
- Publication of the Audit Results
- Develop a methodology in conjunction with PPI to get feedback from patients involved in Duty of Candour conversations to evaluate their experience.

March 2015 audit - This included a review of 50 cases showed:

- In 83% of confirmed candour cases there was documented evidence that a candour discussion had occurred
- The requirement to have a candour discussion within 10 working days was not always met (75%) – this was often due to the fact that the level of harm was not clear and was being discussed within clinical teams
- In 91% of cases senior staff held the candour conversation

Trust action plan for Sign-Up to Safety Campaign

Campaign Pledges	Trust Pledges
<p>1. Putting safety first. Committing to reduce avoidable harm in the NHS by half through taking a systematic approach to safety and making public your locally developed goals, plans and progress. Instil a preoccupation with failure so that systems are designed to prevent error and avoidable harm</p>	<p>We will make sure our staff have the right skills, information and support to put patient safety first by:</p> <ul style="list-style-type: none"> • Refining the incident reporting system to ensure that information about patient harm is accurate and comprehensive and that trends can easily be extracted from the dataset • Ensuring we have easily available and clear information for our staff and patients on known risks and what help is available to mitigate these risks • Ensuring that training and staff development responds to regular analyses of what is reported – this will include reference to topical safety issues at induction • Improving the recognition and reporting of harms relating to sepsis, medication omissions and surgical safety • Developing robust targets to underpin our efforts to reduce the highest risk harms reported, as reflected in the Trust's Quality Strategy
<p>2. Continually learn. Reviewing your incident reporting and investigation processes to make sure that you are truly learning from them and using these lessons to make your organisation more resilient to risks. Listen, learn and act on the feedback from patients and staff and by constantly measuring and monitoring how safe your services are.</p>	<p>We will ensure that actions and learning from patient safety and patient experience information (incidents, complaints, patient and staff surveys, etc) drive safety improvements by:</p> <ul style="list-style-type: none"> • Ensuring that patient safety and patient experience information is aggregated allowing for more sophisticated risk identification (e.g.. through the Patient Safety Scorecard and Quarterly Patient Safety Report) • Improve the feedback given to staff who report incidents through the development of automated email feedback, safety newsletters, and incident case studies • Making sure that staff involved in incidents receive appropriate support • Audit of governance systems to ensure they provide assurance that the Trust is responsive to patient safety and experience information, and take action where these systems need improvement

Trust action plan for Sign-Up to Safety Campaign

Campaign Pledges	Trust Pledges
	<ul style="list-style-type: none"> • Inviting patients to sit as members on safety committees and ensuring that they have sufficient support and mentoring so that the patient voice is heard • Ensuring that patient feedback • Extending our reported outcome measures so that they include shared measures that are coproduced with our patients.
3. Being honest. Being open and transparent with people about your progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong	<p>We will embed an understanding of Duty of Candour in a way that it becomes part of everybody's daily activities, by:</p> <ul style="list-style-type: none"> • Clear support including mentoring staff that have to deal with incidents, in particular serious incidents • Appointing a Candour Guardian to advise staff on complex candour issues and provide support to staff involved in candour discussions • Ensuring staff awareness of the Duty of Candour requirements through training at induction, and bespoke training for those staff involved in candour conversations • Regular audit of candour with feedback to staff involved • Developing a culture in which staff never hesitate to raise a concern if they feel safety is compromised
4. Collaborate. Stepping up and actively collaborating with other organisations and teams; share your work, your ideas and your learning to create a truly national approach to safety. Work together with others, join forces and create partnerships that ensure a sustained approach to sharing and learning across the system	<p>We will ensure multidisciplinary approaches to safety issues and work with patients and carers to agree our priorities</p> <p>We will take a leading role in the work of the collaborative patient safety networks (Health Innovation Network - South London, CLARC - South London Research Network, King's Improvement Science, King's Health Partners Safety Connections) by:</p> <ul style="list-style-type: none"> • Active participation • Supporting staff and students who want to join collaborative learning, evaluation or research programmes linked to these

Trust action plan for Sign-Up to Safety Campaign

Campaign Pledges	Trust Pledges
<p>5. Being supportive. Be kind to your staff, help them bring joy and pride to their work. Be thoughtful when things go wrong; help staff cope and create a positive just culture that asks why things go wrong in order to put them right. Give staff the time, resources and support to work safely and to work on improvements. Thank your staff, reward and recognise their efforts and celebrate your progress towards safer care.</p>	<p>Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.</p> <p>We will listen to our staff, our patients and their carers</p> <p>We will celebrate those staff that make significant contributions towards improved patient safety, particularly in the areas that are high priority</p> <p>We will improve our support for staff in developing their knowledge and leadership skills relating to harm reduction and quality improvement</p> <p>We will establish “Care To Share” events to provide a forum for staff to discuss difficult and emotional issues that arise when caring for patients</p>

Safety Improvement Projects in the Safety Improvement Plan

	Trust Patient Improvement Plans
<p>1. Identification and Management of Sepsis:</p>	<p>Improvement in the identification of sepsis will be measured by the percentage of patients screened for sepsis who met the septic screening criteria. The Trust is currently developing the screening criteria (which can be set locally according to the national CQUIN relating to sepsis). Once the screening criteria are confirmed a baseline audit will be conducted in early 2016-17 to ascertain base screening rate. A 50% improvement in septic screening will be expected at the end of 2018-19. Note that the rates will be reported as adult and paediatric rates for both inpatient and emergency department patients.</p> <p>Improvement in the management of sepsis will be measured by the proportion of septic patients (as defined by septic screen) who have received antibiotics and empiric review within the prescribed timescales. A baseline audit will be conducted in early 2016-17 to ascertain the proportion of patients appropriately treated. A 50% improvement in the proportion of patients treated appropriately</p>

Safety Improvement Projects in the Safety Improvement Plan

Trust Patient Improvement Plans	
	<p>will be expected at the end of 2018-19. Note that the rates will be reported as adult and paediatric rates for both inpatient and emergency department patients.</p> <p>Executive Sponsor: Director of Nursing & Midwifery and Medical Director</p>
2. Reduction in Medication Omissions	<p>This will be measured by a reduction in medication omissions associated with the following omission categories: drug not available; other; refused by patient. EPMA provides robust data on medication omissions including categorisation of the reasons for medication omission and data will be extracted from this system (EPMA is not available at the PRUH but should become available in the Summer of 2016 from which point the data can be extracted - this means the target reductions listed below are likely to be staggered in time with the PRUH following 6-12 months behind DH)</p> <ul style="list-style-type: none"> • 10% year-on-year reduction in medication omissions categorised as “drug no available”, “other” or “refused by patient” • Omissions of drugs classified as “life-sustaining” should be reported separately according to the categorisation above <p>Executive Sponsor: Director of Nursing & Midwifery</p>
3. Improvement in Quality of Surgical Safety Checks	<p>The overall aim is to improve the quality of the surgical safety checks by 10% year-on-year, as measured by the annual surgical safety checklist observational audit. The Sep 2015 audit found the overall quality of the checks was 62%. This needs to be increased to 92% by March 2019.</p> <p>Several associated performance indicators will also be measured:</p> <ul style="list-style-type: none"> • Improvement in the documentation of surgical handover to recovery and the ward. A baseline audit will be undertaken in early 2016-17 and a 50% improvement against

Safety Improvement Projects in the Safety Improvement Plan

Trust Patient Improvement Plans

baseline expected by March 2019

- Audit of the quality of seldinger technique procedures should be included in the observational audits, and should reach 92% by March 2019
- Audit of junior doctor competency documents (to include competency in central line insertion, chest drain insertion, NGT placement confirmation through aspirate and x-ray interpretation)
- Improvement in the overall % of procedures that have sign-in, time-out and sign-out recorded on Galaxy (to at least 95% by March 2019)

Executive Sponsor: Medical Director



Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

Healthwatch Bromley and Lewisham, Lambeth and Southwark's response to King's College Hospital NHS Foundation Quality Account for 2015/2016

This is a joint response to the King's Quality Account 2015-2016 from local Healthwatch in Bromley and Lewisham, Lambeth and Southwark. We share King's services across the boroughs and welcome the opportunity to comment on the quality of service provided by King's College NHS Trust at their main two sites: Denmark Hill (DH) and the Princess Royal University Hospital (PRUH).

General Comments

Healthwatch is pleased to see a focus on improved access to information for patients, service users, carers and parents, especially where those needs relate to a disability, impairment or sensory loss. Improved outpatient experience and discharge are also of particular interest. Healthwatch is encouraged to see collaborative working with the SLaM Homeless Team. On an aside there are several spelling and grammatical errors in the document that need rectifying.

Engagement

The quality account states that the priorities have been "devised and agreed with local stakeholder groups". The Trust could provide more information on this engagement process, especially in light of

the Quality Accounts Stakeholder Event on 28th January 2016 being cancelled. Whilst we welcome the opportunity to comment on this quality account, we feel the document in itself is quite difficult to follow for an external layperson. At points, it is not clear to us how these priorities have been chosen and developed and we feel there could be more explanation and transparency around this.

CQC and Healthwatch intelligence

The CQC report and patient feedback to Healthwatch highlighted problems with outpatient experience, so we strongly support the inclusion of this goal. Healthwatch is very pleased to see that the goal of providing more accessible information has also been included, which reflects many concerns raised with us about communication with Deaf people and those with learning disabilities, dementia or language needs.

It was clear from the findings of the CQC report, and recent events, that safety issues needed to be included in the priorities, so the inclusion of safer surgery is logical. However, some of the incidents occurring are still around medication, so we question why medication safety has been removed from the goals.

Both the CQC report and our intelligence indicate problems with waiting times for surgery and cancelled operations, and with unsafe and pressured staffing levels in maternity, NICU, gynaecology and obstetrics. We previously suggested their inclusion in the new priorities. For transparency, it would be useful for us to

know why these were not chosen or how priorities were selected.

Healthwatch also suggested the inclusion of a goal around improving the experience of attending A&E in a mental health crisis, which is a recurrent theme in feedback and has also been raised as concerning at Southwark CCG's Quality and Safety Subcommittee. This could possibly expand to looking at the experience of patients across the hospital regarding mental health needs, in line with the 'parity of esteem' agenda. Mental health is conspicuously absent from this document, despite its importance even at acute trusts.

Healthwatch suggested the continuation of the goal around improving discharge due to issues raised with us about communication with social care and information provided to patients, and the need to embed improvements.

The CQC report also raised concerns about documentation of DNACPR, uptake of training on MHA and DOLS, and waiting times in A&E, on which work has been begun but not completed. The reason for the non-inclusion of these programmes could do with further clarification.

Data charts

The data presented at the back of the report may help explain why collecting better data on laparotomy, and addressing safety incidents, are among the priorities. However, there are other areas where the trust is underperforming which have not been chosen as priorities (e.g. emergency oxygen prescriptions, bedside orders being in place, admission delays for major trauma.) The data also has considerable gaps particularly with regard to comparison with national averages.

It is also not transparent as to why improved sepsis management and enhanced recovery after surgery have been included among the priorities.

Improvement Priorities

Enhanced recovery after surgery: This goal seems less developed in comparison to the others. As part of this goal, following on from last year's theme of improving discharge experiences, it would be useful to discuss how King's can work with services outside hospital to ensure that recovery continues after discharge. The CQC stated that King's should consider how to improve the discharge process by engaging with external organisations.

Improve emergency abdominal surgery outcomes: Well-coordinated and standardised care pathways are important to patients so it is positive that this goal includes measures to achieve this.

Improve implementation of sepsis bundles: For a layperson it is very hard to understand the actions to be taken. Some of them seem to revolve around establishing baseline and future datasets. What is included in a 'sepsis bundle', and how exactly is King's going to ensure that it is always being implemented?

Improve quality of the surgical safety checks: It may be worthwhile having more than a twice yearly observational audit to prevent against future incidents within the trust.

Developing feedback tools for patients with LD: This is an excellent initiative but also needs to include provision of easy-read information to patients about their condition/care. We agree with HW Lambeth's suggestion that these materials should be developed in partnership with the appropriate end users. The priority has not included anything about staff providing

appropriate support and communication for patients with dementia.

Improve outpatient experience: This action seems under-ambitious and focused around providing people with information about their wait. We feel this needs more focus on actually reducing the waits, as well as referral to treatment times. The ‘measures of success’ seem to apply only to information about waiting times rather than waiting times themselves.

We support use of patient surveys, the FFT and patient interviews to analyse patient experience, but this relies on adequate response levels. The Trust should also continue to use the CQC report, its own data, feedback from Healthwatch, as well as complaints data, to establish emerging themes and appropriate responses.

Access to information: We are pleased to see the Trust’s focus on improving access to information for people living with a disability, an impairment or sensory loss. We encourage you to find ways to co-produce the planned initiatives with your target groups to increase the effectiveness of these interventions.

Discharge: We welcome the Trust's ongoing commitment to developing integrated discharge processes and we appreciate the opportunities we have had to contribute patient perspectives, for example in the development of the discharge protocol and gathering participants' experiences of the Discharge to Assess extra care project. We note the extensive progress made on implementing a range of activities to improve discharge coordination and experience, but recognise that time is needed for activities to be embedded into systems and translated into good patient experience outcomes. Healthwatch will continue to collect patient stories regarding discharge

over the next year and we look forward to discussing our findings with you.

*Healthwatch Bromley and Lewisham,
Lambeth and Southwark*

May 2016

Noel Baxter, Governor

The document is very comprehensive and well written, we liked the layout, writing style and the grid on page 112 showing priorities over recent years was particularly helpful. It would also be nice to see some further complaints, patient experience and “you said, we did” type information to demonstrate triangulation with the quality agenda

The 2016-17 Quality Priorities were initially discussed with commissioners at the CQRG in February 2016. Bromley, Lambeth and Southwark CCGs were represented, and NHS England's Specialised Commissioning team. After those discussions I wrote to the Trust on behalf of the CCGs to confirm that the areas commissioners had prioritised were:

- Improved discharge information for patients
- Sepsis management
- Safety in invasive procedures

It is good to see that these priorities have been included in your final proposals.

As there are so many possibilities for quality priorities within healthcare it is important not to make each objective too broad and hence lose focus. Within your proposal for improved patient information we particularly support improving discharge information as this is an important area which often scores poorly

within patients' overall hospital experience. And for safety in invasive procedures it is very good that the Trust have increased the quality of safer surgical checklist compliance by 50% from 2013/14 to 2015/16 though KCH have experienced a high number of Never Events during 2015/16 which is a concern.

We wish you well with your quality priorities and look forward to continuing to

work in a productive partnership with you through 2016/17.

Dr Noel Baxter
Chair, KCH CQRG
On behalf of Bromley, Lambeth and Southwark CCGs



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.

Monitor 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 2015/16 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
 - board minutes and papers for the period April 2015 to 31 March 2016
 - papers relating to Quality reported to the board over the period April 2015 to 31 March 2016
 - feedback from commissioners dated 04 May 2016 – 10 May 2016
 - feedback from governors dated 04 May 2016
 - feedback from local Healthwatch organisations dated February and May 2016
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 22 September 2015
- the latest national patient survey
- the national staff survey dated 23 February 2016
- the Head of Internal Audit's annual opinion over the trust's control environment dated 23 May 2016
- 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; and
- the Quality Report has been prepared in accordance with Monitor'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



Lord Kerslake, Chair



Nick Moberly, Chief Executive Officer

27 May 2016



Annex 3: 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 2016 (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 2016, 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 2016 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- referral to treatment within 18 weeks for patients on incomplete pathways; and
- 4 hours A&E waiting times.

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 Monitor.

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';
- the quality report is not consistent in all material respects with the sources specified in the 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 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 documents specified within 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;
- analytical procedures on monthly and departmental data;

- 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*'.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Basis for qualified conclusion

As set out in the 'Statement on quality from the chief executive of the NHS Foundation Trust' section of the Trust's Quality Report, the Trust did not maintain monthly datasets for the 18 week referral to treatment incomplete pathway indicator for the entirety of the year and has acknowledged data quality issues with respect to the data it does possess. The key issues include cases where incorrect pathway start dates or stop dates are being applied, or where pathway pause rules are being applied incorrectly.

We performed substantive procedures on a limited sample of cases which confirmed the variety and nature of issues identified by Management. As a result of the lack of a complete data set and the issues identified above, we have concluded that there are errors in the calculation of the 18 week Referral-to-Treatment incomplete pathway indicator. We are unable to quantify the effect of these errors on the reported indicator for the year ended 31 March 2016.

The annualised Accident and Emergency ("A&E) four-hour wait indicator 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 discharge, transfer, or admission as an inpatient. We have tested a random sample of unplanned A&E attendances during the year.

Our testing identified that insufficient documentation was not available to identify where individual A&E attendance durations were amended through validation. There were also a number of samples where insufficient evidence was

available in the form of patient records to support the reported result including clock starts, clock ends and ward transfers, and a further sample where an incorrect start date was entered.

As a result there is a limitation upon 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 A&E 4 hour waiting times.

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- 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';
- the quality report is not consistent in all material respects with the sources specified in the 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'.

Deloitte LLP

Deloitte LLP

Chartered Accountants

St Albans

27 May 2016

Annual Accounts





Picture VIII: Newspaper drawing of the third KCH site

Early history of the 3rd KCH

Edward the 7th laid the foundation stone in 1909 and George 5th opened the building in 1913. The building was designed for 600 beds but only 300 were opened in 1913 because of financial constraints. The start of WW1 in 1914 brought the building under military control and it was renamed the Fourth London General Military Hospital. The rapid increase in casualty numbers resulted in the addition of tents and huts in Ruskin Park as a hospital extension. Access was via a bridge built across the railway between KCH and the Park. The military cost to the hospital was not fully honoured by the Government and by 1921 hospital had accrued debt of £6 million in today's money. Fortunately, in spite of severe financial problems KCH continued to attract first class physicians and surgeons and excellent nursing staff.

FOREWORD TO THE ACCOUNTS

King's College Hospital NHS Foundation Trust

Annual Accounts 2015/16

These accounts, for the year ending March 31 2016, have been prepared by King's College Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Signed:



Nick Moberly
Chief Executive Officer

27 May 2016

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 Monitor.

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

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

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable

accounting policies on a consistent basis

- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statements on a going concern basis.

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

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


Signed:

Nick Moberly
Chief Executive Officer

27 May 2016

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST

Opinion on financial statements of King's College Hospital NHS Foundation Trust

In our opinion the financial statements:

- give a true and fair view of the state of the Group and Trust's affairs as at 31 March 2016 and of the Group's and Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

The financial statements comprise the Group Statement of Comprehensive Income, the Group and Trust Statements of Financial Position, the Group and Trust Statements of Changes in Taxpayers' Equity, the Group and Trust Statements of Cash Flow and the related notes 1 to 27. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies

directed by Monitor – Independent Regulator of NHS Foundation Trusts.

Emphasis of matter – Going concern

We have considered the adequacy of the disclosures made in the Performance Report and the disclosures made in Note 1.26 in respect of the Group's ability to continue as a going concern.

The Group incurred a net deficit of £65.4m before impairments and revaluations during the year ended 31 March 2016 and is projecting a further significant deficit for 2016/17 of £7.8m before impairments and revaluations, together with a cost improvement plan of £50m. The Group has identified additional funding is required before the end of 2016/17 to support the Trust which is yet to be agreed.

Whilst we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate, the forecasted deficit and reliance on future funding being arranged indicate the existence of a material uncertainty which may give rise to significant doubt over the Group's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Group was unable to continue as a going concern. We describe below how the scope of our audit has responded to this risk. Our opinion is not modified in respect of this matter.

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.

Independence

We are required to comply with the Financial Reporting Council's Ethical Standards for Auditors and we confirm that we are independent of the group and we have fulfilled our other ethical responsibilities in accordance with those standards. We also confirm we have not provided any of the prohibited non-audit services referred to in those standards.

Our assessment of risks of material misstatement

The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team.

Risk	How the scope of our audit responded to the risk
Going concern Given the uncertainties in respect of the Group's funding and reliance of external funding, which are explained above in the Emphasis of matter - Going concern section, we considered going concern to be a significant risk. The Group is forecasting a deficit of £7.8m before impairments and revaluations for 2016/17 and discussions with management have highlighted the requirement to obtain further funding before the end of 2016/17 to support the Group.	<p>We reviewed the Group's financial performance in 2015/16 including its achievement of planned cost improvements in the year.</p> <p>We held discussion with management to understand the funding arrangements that have been agreed, confirming to signed loan agreements. Discussions were held regarding management's expectation around further funding requirements.</p> <p>We reviewed the Group's cash flow forecasts and the Group's financial plan submitted to Monitor.</p> <p>We held discussions with management to understand the current status of contract negotiations with its commissioners.</p> <p>We reviewed the annual report and financial statement disclosures in Note 1.26 made by the Group in respect of the material uncertainties in respect of going concern.</p> <p>We have included an emphasis of matter paragraph above in respect of this matter.</p>
NHS revenue and provisions As described in note 1.8 and 1.27, there are significant judgements in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to: <ul style="list-style-type: none">• the complexity of the Payment by Results regime, in particular in determining the level of	<p>We evaluated the design and implementation of controls over recognition of Payment by Results income, with IT specialists reviewing the system controls and updating our understanding of the process.</p> <p>We performed detailed substantive testing on a sample basis of the recoverability of overperformance income and adequacy of provision for underperformance through the year, and evaluated the results of the</p>

Risk	How the scope of our audit responded to the risk
<p>overperformance revenue to recognise;</p> <ul style="list-style-type: none"> • the judgemental nature of provisions for disputes, including in respect of outstanding overperformance income for quarters 3 and 4; and • the risk of revenue not being recognised at fair value due to adjustments agreed in settling current year disputes and agreement of future year contracts. <p>Details of the Group's income, including £929.9m of Commissioner Requested Services and £9.4m of 'Additional income for delivery of healthcare services' relating to the capital to revenue transfer, are shown in note 2.1 to the financial statements. NHS debtors are shown in note 13 to the financial statements.</p> <p>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.</p>	<p>agreement of balances exercise.</p> <p>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,</p>
<p>Property valuations</p> <p>The Group holds property assets within Property, Plant and Equipment at a modern equivalent use valuation of £451.9m. 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.</p> <p>As detailed in note 1.11, the Group has reassessed a number of valuation assumptions in the current year, including the use of the alternative site basis. The net valuation movement on the Group's estate shown in note 10.1 is an impairment of £90.5m.</p>	<p>We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Group to the valuer.</p> <p>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, including through benchmarking against revaluations performed by other Groups at 31 January 2016.</p> <p>We challenged the Group's assumption that an alternative, lower value, site could be used in calculating a Modern Equivalent Asset value by reviewing the Group's Clinical Strategy, and critically evaluating whether the alternatives considered would be viable given the nature of the Group's activities.</p> <p>We have reviewed the disclosures in note 1.11 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in</p>

Risk	How the scope of our audit responded to the risk
	<p>preparing the valuation.</p> <p>We assessed whether the valuation and the accounting treatment of the impairment was compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.</p>
Management override of controls <p>We consider that in the current year there is 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 tight financial circumstances of the NHS and close scrutiny of the reported financial performance of individual organisations.</p> <p>All NHS Trusts and Foundation Trusts have been requested by NHS Improvement to consider a series of “technical” accounting areas and assess both whether their current accounting approach meets the requirements of International Financial Reporting Standards, and to remove “excess prudence” to support the overall NHS reported financial position. The areas of accounting estimate highlighted included accruals, deferred income, injury cost recovery debtors, partially completed patient spells, bad debt provisions, property valuations, and useful economic lives of assets.</p> <p>Details of critical accounting judgements and key sources of estimation uncertainty are included in note 1.27.</p>	Manipulation of accounting estimates <p>Our work on accounting estimates included considering each of the areas of judgement identified by NHS Improvement. We have considered both the individual judgements and their impact individually and in aggregate upon the financial statements. In testing each of the accounting estimates included in the NHS Improvement letter, 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.</p> <p>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.</p> <p>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.</p> Manipulation of journal entries <p>We used data analytic techniques to select journals for testing with characteristics indicative of potential manipulation of reporting focusing in particular upon manual journals.</p> <p>We traced the journals to supporting documentation, considered whether they had been appropriately approved, and evaluated</p>

Risk	How the scope of our audit responded to the risk
	<p>the accounting rationale for the posting. We evaluated individually and in aggregate whether the journals tested were indicative of fraud or bias.</p> <p>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.</p> <p>Accounting for significant or unusual transactions</p> <p>We considered whether any transactions identified in the year required specific consideration and did not identify any requiring additional procedures to address this risk.</p>

Our report includes an additional risk, management override of controls, which was not included in our report last year. This was identified as a risk in 2014/15, but has had an increased effect upon the conduct of our audit this year due to the increased focus upon reported financial position and estimates and estimation techniques.

The description of risks above should be read in conjunction with the significant issues considered by the Audit Committee discussed in the Director's Report.

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.

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.

We determined materiality for the Group to be £8.5m (2014/15: £8.7m), which is below 1% of revenue and below 5% of equity (2014/15: below 1% of revenue and below 3% of equity). Revenue was chosen as a benchmark as the Trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £170k (2014/15: £173k), 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.

The focus of our audit work was on the Trust, with work performed at the Trust's head offices in Denmark Hill directly by the audit engagement team, led by the audit partner.

We performed specific audit procedures on the Trust's subsidiaries, where the extent of our testing was based on our assessment of the risks of material misstatement and the materiality of the subsidiaries to the Group.

Our audit covered all of the entities within the Group, and account for 100% (2014/15: 100%) of the Group's net assets, revenue and surplus.

Our audit work was executed at the level of materiality as set for the Group.

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.

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the part of the Directors' Remuneration Report to be audited has 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

The Group has described the following matters in its Annual Governance Statement which we consider to be relevant to the Group's arrangements to secure economy, efficiency and effectiveness:

- the risks to the Group in respect of its financial performance and liquidity in 2015/16 and plan for 2016/17;
- the Monitor financial risk rating as at 31 March 2016 and those forecasted for 2015/16;
- the enforcement actions taken by Monitor in March 2015;
- weaknesses in the Trust's arrangements to ensure the quality of reported data.

These issues are evidence of widespread and significant weaknesses in proper arrangements for securing economy, efficiency and effectiveness.

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.

Our duty to read other information in the Annual Report

Under International Standards on Auditing (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements;
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Group acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed. We confirm that we have not identified any such inconsistencies or misleading statements.

Respective responsibilities of the accounting officer and auditor

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. Our responsibility is to audit and

express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice and International Standards on Auditing (UK and Ireland). We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our dedicated professional standards review team and independent partner reviews.

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 trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Group's and the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any

information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or

inconsistencies we consider the implications for our report.

Craig Wisdom

Craig Wisdom (Senior statutory auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor, St Albans, United Kingdom

27 May 2016



Consolidated Statement of Comprehensive Income for year ended 31 March 2016

	Group	2015-16 £000	2014-15 £000
	Note		
Operating income and costs			
Operating income from continuing operations	2	1,067,005	1,083,782
Operating expenses from continuing operations	3	(1,119,308)	(1,099,712)
Operating deficit		(52,303)	(15,930)
Finance income and costs			
Finance income	5	108	213
Finance expense - financial liabilities	6	(26,966)	(25,252)
Finance expense - unwinding of discount on provisions	18	(82)	(153)
Public Dividend Capital Dividends payable		(8,465)	(11,450)
Net finance costs		(35,405)	(36,642)
Share of profit of Associates/Joint Ventures accounted for using the equity method	11.2	652	757
Gain/(Loss) from transfer by absorption		-	-
Movement in fair value of investment property and other investments		-	-
Corporate tax expense		(47)	(250)
Deficit from continuing operations		(87,103)	(52,065)
Deficit of discontinued operations and the gain/loss on disposal of discontinued operations		-	-
Deficit for the year		(87,103)	(52,065)
Other comprehensive income, that will not be reclassified subsequently to income and expenditure			
Impairments	7	(85,459)	(5,595)
Revaluations	21	16,807	26,261
Share of comprehensive income from associates and joint ventures		-	-
Other recognised gains and losses		-	-
Remeasurements of net defined benefit pension scheme liability/asset		-	-
Transfer to public dividend capital reserve		-	(280)
Fair value gains/(losses) on available-for-sale financial investments		-	-
Recycling gains/(losses) on available-for-sale financial investments		-	-
Total other comprehensive income		(68,652)	20,386
Total comprehensive expense for the year		(155,755)	(31,679)

Consolidated Statement of Comprehensive Income (continued)

Note to Statement of Comprehensive Income	£000	£000
Total comprehensive expense for the year	(155,755)	(31,679)
Plus other comprehensive income	68,652	(20,386)
Deficit for the year	(87,103)	(52,065)
Add back impairments and reversal of impairments	a 21,708	4,535
Net deficit excluding items above	(65,395)	(47,530)

This is the primary view which is used by the Board of Directors to monitor the Trust's financial performance.

a This is the total impairments and impairment reversals charged to Consolidated Statement of Comprehensive Income in the year as disclosed in note 3.1

The Trust's deficit for the year was £87.1m and this figure includes the asset impairment cost of £21.7m. 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 Trust's consolidated operational deficit for the year was £65.4m which was in line with the Trust's financial recovery plan for 2015/16.

Allocation of losses for the year

(a) Deficit for the year attributable to:

(i) non-controlling interest; and	-	-
(ii) owners of the parent	(87,103)	(52,065)
Total	(87,103)	(52,065)

(b) Total comprehensive expense for the year attributable to:

(i) non-controlling interest; and	-	-
(ii) owners of the parent	(155,755)	(31,679)
Total	(155,755)	(31,679)

The Trust has taken advantage of the exception afforded by the Companies Act to omit the Statement of Comprehensive Income for the Foundation Trust parent. The deficit relating to the parent Trust for the year ended 31 March 2016 is £87.999m (2015: £59.409m).

Statements of Financial Position as at 31 March 2016

	Note	31 March 2016	31 March 2015	Group	31 March 2016	31 March 2015	Trust
					£000	£000	£000
Non-current assets							
Intangible assets	9	3,670	3,495		3,670		3,495
Property, plant and equipment	10	532,001	612,695		532,001		612,695
Investment property	11	-	-		-		-
Investment in associates (and joint controlled operations)	11	4,103	4,386		250		250
Other investments	11	935	-		-		-
Trade and other receivables	13	6,107	7,272		7,579		8,645
Other financial assets		-	-		-		-
Other assets		-	-		-		-
Total non-current assets		546,816	627,848		543,500		625,085
Current assets							
Inventories	12	17,748	17,090		17,748		17,090
Trade and other receivables	13	116,711	98,040		119,212		98,867
Other financial assets		-	-		-		-
Non-current assets for sale and assets in disposal groups		-	-		-		-
Cash and cash equivalents	14	18,982	43,445		17,237		42,663
Total current assets		153,441	158,575		154,197		158,620
Total assets		700,257	786,423		697,697		783,705
Current liabilities							
Trade and other payables	15	(151,607)	(164,095)		(152,344)		(163,944)
Borrowings	17	(7,960)	(7,624)		(7,764)		(7,435)
Other financial liabilities		-	-		-		-
Provisions	18	(1,472)	(1,239)		(1,472)		(1,239)
Other liabilities	16	(7,933)	(10,189)		(7,933)		(10,189)
Total current liabilities		(168,972)	(183,147)		(169,513)		(182,807)
Net current assets/(liabilities)		(15,531)	(24,572)		(15,316)		(24,187)
Total assets less current liabilities		531,285	603,276		528,184		600,898
Non-current liabilities							
Trade and other payables		-	-		-		-
Borrowings	17	(314,651)	(222,570)		(313,334)		(221,082)
Other financial liabilities		-	-		-		-
Provisions	18	(5,456)	(6,295)		(5,456)		(6,295)
Other liabilities		-	-		-		-
Total non-current liabilities		(320,107)	(228,865)		(318,790)		(227,377)
Total assets employed		211,178	374,411		209,394		373,521
Financed by:							
Taxpayers' equity							
Public Dividend Capital		223,838	231,316		223,838		231,316
Revaluation reserve		96,393	165,236		96,393		165,236
Available for sale investments reserve		-	-		-		-
Other reserves		-	-		-		-
Merger reserves		-	-		-		-
Income and expenditure reserve		(109,053)	(22,141)		(110,837)		(23,031)
Total taxpayers' equity		211,178	374,411		209,394		373,521

The notes on pages 179-243 form part of these accounts.

The financial statements on pages 179-243 were approved by the Board on 26 May 2016 and signed on its behalf by

Signed: 

Nick Moberly
Chief Executive Officer

27 May 2016



Statement of Changes in Taxpayers' Equity for the year ended 31 March 2016

Group	Public Dividend Capital £000	Income and expenditure reserve £000	Revaluation reserve £000	Total reserves £000
Balance at 1 April 2015	231,316	(22,141)	165,236	374,411
Deficit for the year	-	(87,103)	-	(87,103)
Transfers by normal absorption: transfers between reserves	-	-	-	-
Impairments	-	-	(85,459)	(85,459)
Revaluations - property, plant and equipment	-	-	16,807	16,807
Transfer to retained earnings on disposal of assets	-	191	(191)	-
Share of comprehensive income from associates and joint ventures	-	-	-	-
Gains/losses on available-for-sale financial investments	-	-	-	-
Other recognised gains and losses	-	-	-	-
Public Dividend Capital received	1,922	-	-	1,922
Public Dividend Capital repaid	(9,400)	-	-	(9,400)
Public Dividend Capital written off	-	-	-	-
Other reserve movements	-	-	-	-
Balance at 31 March 2016	223,838	(109,053)	96,393	211,178
 Balance at 1 April 2014	 228,136	 29,777	 144,997	 402,910
Deficit for the year	-	(52,065)	-	(52,065)
Transfers by normal absorption: transfers between reserves	-	-	-	-
Impairments	-	-	(5,595)	(5,595)
Revaluations - property, plant and equipment	-	-	26,261	26,261
Transfer to retained earnings on disposal of assets	-	427	(427)	-
Share of comprehensive income from associates and joint ventures	-	-	-	-
Gains/losses on available-for-sale financial investments	-	-	-	-
Other recognised gains and losses	-	-	-	-
Public Dividend Capital received	2,900	-	-	2,900
Public Dividend Capital repaid	-	-	-	-
Public Dividend Capital written off	-	-	-	-
Other reserve movements	280	(280)	-	-
Balance at 31 March 2015	231,316	(22,141)	165,236	374,411

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2016

Trust	Public Dividend Capital £000	Income and expenditure reserve £000	Revaluation reserve £000	Total reserves £000
Balance at 1 April 2015	231,316	(23,031)	165,236	373,521
Deficit for the year	-	(87,997)	-	(87,997)
Transfers by normal absorption: transfers between reserves	-	-	-	-
Impairments	-	-	(85,459)	(85,459)
Revaluations - property, plant and equipment	-	-	16,807	16,807
Transfer to retained earnings on disposal of assets	-	191	(191)	-
Share of comprehensive income from associates and joint ventures	-	-	-	-
Gains/losses on available-for-sale financial investments	-	-	-	-
Other recognised gains and losses	-	-	-	-
Public Dividend Capital received	1,922	-	-	1,922
Public Dividend Capital repaid	(9,400)	-	-	(9,400)
Public Dividend Capital written off	-	-	-	-
Other reserve movements	-	-	-	-
Balance at 31 March 2016	223,838	(110,837)	96,393	209,394
 Balance at 1 April 2014	 228,136	 29,312	 144,997	 402,445
Deficit for the year	-	(52,490)	-	(52,490)
Transfers by normal absorption: transfers between reserves	-	-	-	-
Impairments	-	-	(5,595)	(5,595)
Revaluations - property, plant and equipment	-	-	26,261	26,261
Transfer to retained earnings on disposal of assets	-	427	(427)	-
Share of comprehensive income from associates and joint ventures	-	-	-	-
Gains/losses on available-for-sale financial investments	-	-	-	-
Other recognised gains and losses	-	-	-	-
Public Dividend Capital received	2,900	-	-	2,900
Public Dividend Capital repaid	-	-	-	-
Public Dividend Capital written off	-	-	-	-
Other reserve movements	280	(280)	-	-
Balance at 31 March 2015	231,316	(23,031)	165,236	373,521

Statement of Cash Flows for the year ended 31 March 2016

		Group		Trust
	Note	2015-16 £000	2014-15 £000	2015-16 £000
Cash flows from operating activities				
Operating surplus/(deficit) from continuing operations		<u>(52,303)</u>	<u>(15,930)</u>	<u>(52,582)</u>
Operating surplus/(deficit)		<u>(52,303)</u>	<u>(15,930)</u>	<u>(52,582)</u>
Non-cash income and expense				
Depreciation and amortisation		19,792	22,154	19,792
Impairments		21,708	4,535	21,708
Loss on disposal		110	285	110
Non-cash donations/grants credited to income		(1,334)	(550)	(1,334)
(Increase)/decrease in trade and other receivables		(15,950)	17,257	(17,725)
(Increase) in inventories		(658)	(1,798)	(658)
(Decrease)/increase in trade and other payables		(15,186)	28,882	(14,298)
(Decrease)/increase in other liabilities		(2,256)	200	(2,256)
(Decrease) in provisions		(688)	(649)	(688)
Tax (paid)		(47)	(250)	-
Other movements in operating cash flows		-	(37)	-
Net cash (used in)/generated from operations		<u>(46,812)</u>	<u>54,099</u>	<u>(47,931)</u>
				53,918
Cash flows from investing activities				
Interest received		119	213	111
Purchase of intangible assets		(508)	(2,664)	(508)
Purchase of property, plant and equipment		(25,626)	(46,614)	(25,626)
Sales of property, plant and equipment		26	131	26
Receipt of cash donation to purchase asset		1,334	550	1,334
Cash flows attributable to acquisitions or disposals of business units and subsidiaries (not absorption transfers)		-	-	-
Net cash generated from/(used in) investing activities		<u>(24,655)</u>	<u>(48,384)</u>	<u>(24,663)</u>
				(51,575)
Cash flows from financing activities				
Public Dividend Capital received		1,922	2,900	1,922
Public Dividend Capital repaid		(9,400)	-	(9,400)
Loans received from the Department of Health		98,900	22,000	98,900
Other loans received		-	-	-
Loans repaid to the Department of Health		(3,868)	(1,012)	(3,868)
Other loans repaid		(180)	(78)	(16)
Capital element of PFI and other service concession payments		(3,550)	(3,199)	(3,550)
Other capital receipts		-	95	-
Interest paid		(3,478)	(1,452)	(3,478)
Interest element of PFI and other service concession obligations		(23,310)	(23,443)	(23,310)
Public Dividend Capital dividend paid		(10,032)	(12,616)	(10,032)
Net cash generated from/(used in) financing activities		<u>47,004</u>	<u>(16,805)</u>	<u>47,168</u>
				(13,864)
Decrease in cash and cash equivalents		<u>(24,463)</u>	<u>(11,090)</u>	<u>(25,426)</u>
Cash and cash equivalents at 1 April		<u>43,445</u>	<u>54,535</u>	<u>42,663</u>
Cash and cash equivalents at 31 March		<u>18,982</u>	<u>43,445</u>	<u>17,237</u>
				42,663

Notes to the accounts

1. Accounting policies

Monitor is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Foundation Trust Annual Reporting Manual (FT ARM), which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2015-16 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (the FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts. They 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. Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3. Charitable funds

For 2015-16, the divergence from the FReM that NHS charitable funds are not consolidated with NHS foundation trusts'

own returns is removed. Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those charitable funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior year accounts are presented where the adoption of the new policy has a material impact. The King's College Hospital Charity is an independent charity and is not under the control of the Foundation Trust. Therefore, the charity has not been consolidated within these accounts.

1.4. 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 capital and reserves attributable to non-controlling interests are included as a separate item in the Statement of Financial Position.

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 Trust has a wholly owned subsidiary company, KCH Commercial Services Ltd, who wholly own Agnentis Ltd and KCH Management Ltd. The accounts for this

company 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. The Trust has taken advantage of the exception afforded by the Companies Act to omit the Statement of Comprehensive Income for the Foundation Trust parent. The deficit relating to the parent Trust for the year ended 31 March 2016 is £87.999m (2015: £59.409m). Where the difference between the 'Group' and 'Trust' figures is considered immaterial, the 'Trust' version of the note has been omitted.

1.5. 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. 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.

1.6. Joint ventures

Joint ventures are arrangements in which the 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.

1.7. Joint operations

Joint operations are arrangements in which the 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.

1.8. Income

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

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

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

The Foundation Trust has accounted for income for incomplete spells of patient activity at 31 March. The work in progress is derived from patients admitted before the year end but not discharged as at 31 March. The calculation is based on the number of bed days and the average bed price.

The Foundation Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The foundation trust recognises the

income when it receives notification from the Department of Work and Pensions' Compensation Recovery Unit that the individual has logged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Additional contributions from central bodies (such as the Department of Health) designated as revenue contributions are recognised as revenue when received or receivable, and are separately disclosed, in accordance with the requirements of the 2015/16 Foundation Trust Annual Reporting Manual.

1.9. Expenditure on employee benefits

Short-term employee benefits

Short-term employee benefits

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

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. It is not possible for the foundation trust to identify its share of the underlying scheme 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.

1.10. 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.

1.11. 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.

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.

Land and buildings are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment. 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.

Fair values are determined as follows:

- non-specialised buildings – market value for existing use; and
- land and specialised buildings – depreciated replacement cost.

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 in 2016.

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.

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, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

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

An item of property, plant and equipment 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 or IFRS 5.

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 GVA James Barr. Leaseholds are depreciated over the primary lease term.

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

- 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.

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 has 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'.

Impairments

In accordance with the FT ARM, 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 income 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. As at 31 March 2016, the Foundation Trust did not hold any assets intended for disposal.

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 and the charges for services.

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.

1.12. Intangible assets recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the 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, eg, 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.

Amortisation

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

The Trust amortise intangibles over the following useful lives range:

- software license, 3 - 10 years;

- development cost, 5 - 10 years.

1.13. 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.

1.14. 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.

1.15. Financial instruments and financial liabilities Recognition

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

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

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

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired, or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification

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

Loans and receivables

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

The Trust's loans and receivables comprise: cash at bank and in hand, NHS debtors, accrued income and 'other debtors'. Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income. Loans from the Department of Health are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date. Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'Finance Costs' in the Statement of Comprehensive Income.

Financial liabilities

All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

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

Impairment of financial assets

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

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

The carrying amount of the financial assets is reduced when the outstanding debt is greater than one year and payment has not been agreed with the respective debtor. Due to the complexities of Private Patient debt recovery the reduction in these debts is based on outstanding debts greater than one year where payment has

not been agreed with the respective debtor.

1.16. Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as 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

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

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.

1.17. 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

The NHS Litigation Authority (NHLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHLA, which, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHLA on behalf of the foundation trust is disclosed at Note 18 but is not recognised in the NHS foundation trust's accounts.

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 Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when the liability arises.

1.18. 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 19 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 19, 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.

1.19. 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 Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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;
- any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out 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.

1.20. 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.

1.21. 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 2015/16 as the Trust did not generate any taxable income.

1.22. Foreign exchange

The functional and presentational currencies of the trust are 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.

1.23. 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 24 to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.24. 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.

1.25. 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 "Other Operating Income" includes the relevant income figures for these services.

The subsidiary figures have not been disclosed separately in this note as the figures have been considered to be not material.

1.26. Going concern

IAS 1 requires management to undertake an assessment of the NHS Foundation's Trusts ability to continue as a going concern. Due to the materiality of the financial issues, the Board has carefully considered whether the accounts should be prepared on the basis of being a 'Going Concern'. The Board considered the advice in the Government Reporting Manual 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."

The Trust has prepared its financial plans and cash flow forecasts on the assumption that support funding will continue to be received through the Department of Health/NHSI. The Trust has been offered a non-recurrent £30m Sustainability and Transformation income stream subject to provider eligibility and conditions and an agreed financial control total for 2016/17. These funds are expected to be sufficient to prevent the Trust from failing to meet its obligations as they fall due and to continue until adequate plans are in place to achieve financial sustainability for the

Trust.

The current economic environment for all NHS Trusts and NHS Foundation Trusts is challenging with on-going internal efficiency gains necessary due to annual tariff (price) reductions; cost pressures in respect of national pay structures; non-pay and drug cost inflation; as well as nationally set contract penalties for contract performance deviations, combined with local commissioner (CCG) QIPP targets such as reducing activity through local area networks. The QIPP plans for 16/17 are all at Commissioner risk for 16/17. The Trust is working with local commissioners to deliver a combined sustainability plan for South East London NHS.

The Trust has incurred a deficit of £87.1m (£65.4m before impairment of assets) for the year ended 31 March 2016. The Directors consider that the outlook presents significant challenges in terms of cash-flow for the reasons outlined above, including planned reductions in activity commissioned from the Trust and the need to reduce the underlying cost base of the Trust to continuously align capacity and demand.

The Trust has secured £89.4m of Interim Revolving Working Capital Support Funding from Monitor/DoH to support the Trust's revenue position for working capital. This funding will be required for the duration of the financial year whilst the internal savings plans are embedded. The 16/17 savings plans consist of new schemes to a value of £50m as well as the full year effect of 15/16 schemes totalling £20m.

The Trust is facing a period of transformation over the coming years and planning undertaken by the Trust has recognised that without significant change, the Trust will remain in deficit during the

foreseeable future.

Positive cash balances are likely to be maintained throughout the period through successfully securing commitments to necessary funding from external bodies (DoH/Monitor) and contracts with the lead commissioners which give assurance of income flows. The Trust has agreed contract values with the key local CCG's for 16/17.

The significant risks facing the Trust are summarised as follows:

- 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 the agreed interim funding and thus continue on a going concern basis.
- The Trust is working with NHSI to secure additional distressed capital resource.
- There is uncertainty over whether the Trust can deliver its financial plans including efficiency savings of £70m, which has been assumed in its financial plan for 2016/17. This is a level of savings which is extremely challenging and must be supported with adequate clinical focus and engagement in quality process improvement against agreed and appropriately detailed and delivery plans.

NHSI financial support is not yet confirmed, which in combination with the above, 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 be 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. The Directors have a reasonable expectation that this will be the case and have therefore prepared these financial statements on a going concern basis.

1.27. Critical accounting judgements and key sources of estimation uncertainty

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. Two significant changes to estimate used during the year relates to bad debt provision and the valuation basis used, with respect to the alternative site basis.

Management has made the following critical judgements in the process of applying the entity's accounting policies and this has had a significant effect on the amounts recognised in the accounts:

- Land and buildings have been valued on a Depreciated Replacement Cost (DRC) basis as at 31st January 2016 by an independent professionally qualified valuer (see Note 1.11). In between formal valuations, management make judgements about the condition of assets and review their estimated lives;
 - 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 has used their judgement to decide when to write-off receivables or to provide against the probability of not being able to collect debt.
- part-completed at the year end (see note 1.8);
- 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 1.11 and 1.12); and
 - Provisions for early voluntary retirement pension contributions and injury benefit obligations are estimated using expected life tables and discounted at the pensions rate.

1.28. Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2015/16.

1.29. Future changes in accounting policy

The following changes to standards issued by the IASB have not been implemented in these accounts. The foundation trust does not expect these changes to have a significant impact in the period of initial application.

The following are the key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing 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

Change published	Published by IASB	Financial year for which the change first applies
IFRS 11 (amendment) – acquisition of an interest in a joint operation	May 2014	Not yet EU adopted. Expected to be effective from 2016/17.
IAS 16 (amendment) and IAS 38 (amendment) – depreciation and amortisation	May 2014	Not yet EU adopted. Expected to be effective from 2016/17.
IAS 16 (amendment) and IAS 41 (amendment) – bearer plants	June 2014	Not yet EU adopted. Expected to be effective from 2016/17.
IAS 27 (amendment) – equity method in separate financial statements	August 2014	Not yet EU adopted. Expected to be effective from 2016/17.
IFRS 10 (amendment) and IAS 28 (amendment) – sale or contribution of assets	September 2014	Not yet EU adopted. Expected to be effective from 2016/17.
IFRS 10 (amendment) and IAS 28 (amendment) – investment entities applying the consolidation exception	December 2014	Not yet EU adopted. Expected to be effective from 2016/17.
IAS 1 (amendment) – disclosure initiative	December 2014	Not yet EU adopted. Expected to be effective from 2016/17.
IFRS 15 Revenue from contracts with customers	May 2014	Not yet EU adopted. Expected to be effective from 2017/18.
Annual improvements to IFRS: 2012-15 cycle	September 2014	Not yet EU adopted. Expected to be effective from 2017/18.
IFRS 9 Financial Instruments	July 2014	Not yet EU adopted. Expected to be effective from 2018/19.

* This reflects the EU-adopted effective date rather than the effective date in the standard. There will be no material impact of these new standards in the period of initial application

2. Operating income

2.1 Income from activities by classification

	Group	2014-15
	£000	£000
Elective income	147,765	160,444
Non-elective income	180,384	183,300
Outpatient income	133,145	153,000
Accident and emergency income	26,340	28,000
Other NHS clinical income*	414,494	364,508
Additional income for delivery of healthcare services	9,400	-
Private Patient income	13,723	12,648
Other non-protected clinical income	6,928	3,703
Total income from activities	932,179	905,603
Other operating income	134,826	178,179
Total operating income	1,067,005	1,083,782

* Other NHS clinical income includes HIV/AIDS funding, NSCG funding for liver services, bone marrow transplant funding, critical care funding from CCGs, 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	2014-15
	£000	£000
Research and development	12,175	11,474
Education and training	47,822	49,101
Received from NHS charities: donations for capital acquisitions	699	134
Received from NHS charities: other charitable and other contributions to expenditure	-	10
Non-patient care services to other bodies	63,224	89,153
Other**	9,444	26,912
Rental revenue from operating leases	1,462	1,395
Total	134,826	178,179

** Other income includes NHS provider-to-provider services, staff nursery, car parking, accommodation and commercial rents.

2.2 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	2014-15
	£000	£000
Commissioner requested services	929,868	911,092
Non-commissioner requested services	137,137	172,690
Total	1,067,005	1,083,782

2.3 Operating lease income

	Group 2015-16 £000	2014-15 £000
	31 March 2016 £000	31 March 2015 £000
Rental revenue from operating leases	1,462	1,395
Future minimum lease payments due on leases of buildings expiring		
- not later than one year	1,444	1,392
- between one and five years	553	760
Total	1,997	2,152

2.4 Income from activities by type

	Group 2015-16 £000	2014-15 £000
NHS Foundation Trusts	2,044	1,574
NHS Trusts	1,413	1,313
Clinical Commissioning Groups and NHS England	882,045	862,345
Department of Health	-	7,200
NHS Other (including Public Health England and Prop Co)	2,389	2,123
Non-NHS		
Local Authorities	6,386	5,136
Private patients	13,723	12,648
Overseas patients (non-reciprocal)	6,928	3,703
Injury costs recovery*	4,084	4,277
Other**	3,767	5,284
Additional income for delivery of healthcare services ***	9,400	-
Total	932,179	905,603

* NHS Injury Scheme income is subject to a provision for doubtful debts of 21.99% (2014/15: 18.9%) to reflect expected rates of collection. The total outstanding claims against this scheme at 31 March 2016 were £11.711m (31 March 2015: £10.403m), and a provision of £2.575m (31 March 2015: £1.966m) 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.

*** The Trust received £9.4m from the Department of Health on 1 February 2016 as part of the Department's "Capital to Revenue" transfers, and was required to repay a matching £9.4m of Public Dividend Capital to the Department on 3 February 2016. This relates to the delivery of safe deferral in capital expenditure as agreed with Monitor and the Department of Health. The combination of transactions had no net effect on the Trust's net asset position. In accordance with the requirements of the Foundation Trust Annual Reporting Manual, the cash received has been treated as revenue, and are disclosed as "Additional income for delivery of healthcare services". The repayment of Public Dividend Capital has been treated as a reserves movement and is shown in the Statement of Changes in Taxpayer's Equity.

2.5 Overseas visitors

	Group	2014-15
	2015-16 £000	£000
Income recognised this year	6,928	3,703
Cash payments received in-year (relating to invoices raised in current and previous years)	1,223	1,100
Provision for impairment of receivables (relating to invoices raised in current and prior years)	2,124	2,256
Amounts written off in-year (relating to invoices raised in current and previous years)	2,257	2,305

3. Operating expenses

3.1 Operating expenses by type

	Group 2015-16 £000	2014-15 £000
Drug inventories consumed	133,392	117,959
Supplies and services - clinical	94,699	96,228
Supplies and services - general	6,181	3,848
Establishment	5,854	4,538
Transport	8,781	10,991
Premises	32,096	26,571
Rentals under operating leases - minimum lease payments	10,725	11,998
PFI service costs	45,893	43,468
Clinical negligence	33,196	20,796
Purchase of healthcare from non-NHS bodies	27,597	31,970
Services from NHS bodies		
CCGs and NHS England	74	-
NHS Foundation Trusts	5,951	6,091
NHS Trusts	8,407	12,399
Other NHS bodies	45	17
Non-cash movements on non-current assets		
Depreciation on property, plant and equipment	19,426	21,148
Amortisation on intangible assets	366	1,006
Impairments and reversals of property, plant and equipment	21,708	4,535
Loss on disposal of property, plant and equipment	110	285
Non-cash movements on provisions		
Increase in provision for impairment of receivables	2,879	13,333
Consultancy costs	10,548	2,088
Audit fees payable to the external auditor		
Statutory audit	115	118
Regulatory reporting	10	10
Other auditor remuneration	20	19
Internal audit costs	509	228
Non-Executive Director benefits	155	137
Other *	<u>23,720</u>	<u>50,013</u>
Total operating expenses (excluding employee benefits)	<u>492,457</u>	<u>479,794</u>
 Employee benefits		
Executive Director benefits	3,133	1,642
Other employee benefits	<u>623,718</u>	<u>618,276</u>
Total employee benefits	<u>626,851</u>	<u>619,918</u>
 Total	<u>1,119,308</u>	<u>1,099,712</u>

* Other operating expenses include expenditure on leasing equipment, training and legal fees.

3.2 Operating leases

Rentals under operating leases include the following:

	Group	2014-15
	2015-16 £000	£000
Hire of plant and machinery	7,374	8,343
Rental of buildings	3,351	3,655
Total	10,725	11,998

Future minimum lease payments fall due as follows:

	2014-15
	2015-16 £000
Hire of plant and machinery	7,809
- not later than one year	6,378
- between one and five years	16,954
- later than five years	6,203
Total hire of plant and machinery	29,535
Rental of buildings	3,272
- not later than one year	3,469
- between one and five years	2,749
- later than five years	2,015
Total rental of buildings	6,871
Total	36,421

3.3 Late Payment of Commercial Debts (Interest) Act 1998

	2014-15
	2015-16 £000
Compensation paid to cover debt recovery costs under this legislation	29

3.4 Audit fees (external auditors)

There was no limitation on auditor's liability in 2015-16 or in 2014-15.

4 Employee benefits and staff numbers

4.1 Employee benefits

	Total £000	Permanently employed £000	Other £000
Salaries and wages	489,366	487,862	1,504
Social security costs	37,020	37,020	-
Employer contributions to NHS Pensions	53,965	53,965	-
Agency and contract staff	47,590	-	47,590
Gross employee benefits	627,941	578,847	49,094
Less income where netted off expenditure from:			
NHS bodies	(76)	(76)	-
Other bodies	(1,014)	(1,014)	-
Total	626,851	577,757	49,094
	Total £000	Permanently employed £000	Other £000
Salaries and wages	477,863	475,621	2,242
Social security costs	36,427	36,427	-
Employer contributions to NHS Pensions	52,486	52,486	-
Agency and contract staff	54,961	-	54,961
Gross employee benefits	621,737	564,534	57,203
Less income where netted off expenditure from:			
NHS bodies	(601)	(601)	-
Other bodies	(1,218)	(1,218)	-
Total	619,918	562,715	57,203

4.2 Employee numbers

	Total	Permanently employed	Other	Group 2014-15
Average employee numbers				
Medical and dental	1,850	765	1,085	1,802
Administration and estates	2,210	2,028	182	2,104
Healthcare assistants and other support staff	992	983	9	936
Nursing, midwifery and health visiting staff	3,833	3,558	275	3,678
Nursing, midwifery and health visiting learners	17	7	10	16
Scientific, therapeutic and technical staff	1,372	1,198	174	1,601
Social care staff	11	10	1	10
Other	1,232	276	956	1,315
Total	11,517	8,825	2,692	11,462

4.3 Staff sickness absence

	2015-16 Number	2014-15 Number
Total days lost	137,334	83,183
Total staff years	10,753	10,280
Average working days lost	12.8	8.1

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

4.4 Early retirements due to ill health

	2015-16 Number	2014-15 Number
Early retirements on the grounds of ill-health	4	6
	£000	£000
Early retirements on the grounds of ill-health	116	170

The cost of ill-health retirements is borne by NHS Pensions.

4.5 Termination benefits

4.5a By number of cases:

	2015-16	2014-15
Exit package cost band (including any special payment element)		
Less than £10,000	15	7
£10,000-£25,000	7	1
£25,001-£50,000	4	1
£50,001-£100,000	1	-
£100,001 - £150,000	1	-
£150,001 - £200,000	-	-
Greater than £200,000	-	-
Total	28	9

4.5b By value of payments:

	2015-16	2014-15
Exit package cost band (including any special payment element)		
	Total £000	Total £000
Less than £10,000	49	27
£10,000-£25,000	118	14
£25,001-£50,000	125	36
£50,001-£100,000	55	-
£100,001 - £150,000	147	-
£150,001 - £200,000	-	-
Greater than £200,000	-	-
Total	494	77

All termination benefits related to other agreed departures. There were no amounts payable as a result of compulsory redundancies

4.5c Other departures agreed are as follows:

	2015-16	
	Number	£000

Contractual payments in lieu of notice	15	211
Exit payments following Employment Tribunal or court orders	-	-

Of which:

Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	-	-
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	2014-15	
	Number	£000

Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunal or court orders	9	77

Of which:

Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	-	-
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4.6 Salary and pension entitlements of senior managers

4.6a Median salary disclosures

	2015-16 (bands of £5,000)	2014-15 (bands of £5,000)
Band of highest paid director's total remuneration	715 - 720	255 - 260
Median total remuneration (£)	25,647	38,067
Ratio	27.9	6.8

The above note discloses the median remuneration of the Trust's staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director. The calculation is based on full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis.

4.6b Business related travel and subsistence expenses

Three Executive Directors received travel and subsistence expenses totalling £2,606 (2014-15: four, £7,218).

Three Non-Executive Directors received travel and subsistence expenses totalling £485 (2014-15: one, £721).

One Governor received travel and subsistence expenses totalling £357 (2014-15: two, £482).

4.6 Salary and pension entitlements of senior managers

4.6c Remuneration

Name	Title	2015-16				2014-15			
		Salary & Fees (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Other remuneration (bands of £5,000)	Total (bands of £5,000)	Salary & Fees (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Other remuneration (bands of £5,000)	Total (bands of £5,000)
Chairman and Non-Executive Directors									
Professor Sir George Alberti	Chair	60 - 65	-	-	60 - 65	55 - 60	-	-	55 - 60
Lord Kerslake	Chair	5 - 10	-	-	5 - 10	10 - 15	-	-	10 - 15
Graham Meek	Non-Executive Director	10 - 15	-	-	10 - 15	10 - 15	-	-	10 - 15
Faith Boardman	Non-Executive Director	15 - 20	-	-	15 - 20	10 - 15	-	-	10 - 15
Professor Gulam J Mutti	Non-Executive Director	10 - 15	-	-	10 - 15	10 - 15	-	-	10 - 15
Sue Slipman	Non-Executive Director	10 - 15	-	-	10 - 15	10 - 15	-	-	10 - 15
Chris Stooke	Non-Executive Director	10 - 15	-	-	10 - 15	10 - 15	-	-	10 - 15
Professor Jon Cohen	Non-Executive Director	5 - 10	-	-	5 - 10				
Dr Alix Pryde	Non-Executive Director	5 - 10	-	-	5 - 10				
Erik Nordkamp	Non-Executive Director	0 - 5	-	-	0 - 5				
Executive Directors									
Tim Smart	Chief Executive	160 - 165	-	-	160 - 165	255 - 260	-	-	255 - 260
Roland Sinker	Executive Director of Operations	155 - 160	-	-	155 - 160	185 - 190	42.5 - 45	-	230 - 235
Nicholas Moberly	Chief Executive	100 - 105	-	-	100 - 105				
Simon Taylor	Chief Financial Officer	60 - 65	-	15 - 20	75 - 80	150 - 155	20 - 22.5	35 - 40	210 - 215
Alan Goldsman	Interim Chief Financial Officer	110 - 115	-	-	110 - 115				
Colin Gentile	Chief Financial Officer	40 - 45	-	-	40 - 45				
Michael Marrinan	Executive Medical Director	25 - 30	10 - 12.5	95 - 100	135 - 140	105 - 110	20 - 22.5	105 - 110	235 - 240
Professor Julia Wendon	Executive Medical Director	15 - 20	-	65 - 70	85 - 90				
Dr Geraldine Walters	Executive Director of Nursing, Midwifery and Infection Control	160 - 165	22.5 - 25	-	180 - 185	155 - 160	70 - 72.5	-	230 - 235
Angela Huxham	Executive Director of Workforce Development	50 - 55	-	-	50 - 55	155 - 160	40 - 42.5	-	200 - 205
Paul Jones	Interim Executive Director of Workforce Development	70 - 75	-	-	70 - 75				
Dawn Brodrick	Executive Director of Workforce Development	70 - 75	-	-	70 - 75				
Dr Trudi Kemp	Director of Strategy	140 - 145	212.5 - 215	-	355 - 360	70 - 75	145 - 147.5	-	215 - 220
Alan Goldsman	Interim Director of Strategy	100 - 105	-	-	100 - 105				
Co-opted members of the Trust's board									
Jane Walters	Director of Corporate Affairs	75 - 80	-	-	75 - 80	130 - 135	117.5 - 120	-	250 - 255
Judith Seddon	Director of Corporate Affairs	50 - 55	62.5 - 65	-	115 - 120				
Pedro Castro	Interim Director of Strategy		-	-	-	55 - 60	-		55 - 60
David Dawson	Interim Director of Strategy		-	-	-	15 - 20			20 - 25
Steve Leiver	Director of Turnaround	610 - 615	-	-	610 - 615	20 - 25	-	-	20 - 25
Jeremy Tozier	Interim Chief Operating Officer	505 - 510	-	-	505 - 510	5 - 10	-	-	5 - 10
Ahmad Toumajd	Interim Director of Estates and Capital	245 - 250	222	-	245 - 250	15 - 20	-	-	15 - 20

The remuneration of the interim directors include agency fees and VAT

Lord Kerslake	Chair	1 April 2015 - 31 March 2016
Graham Meek	Non-Executive Director	1 April 2015 - 30 November 2015
Faith Boardman	Non-Executive Director	1 April 2015 - 17 March 2016
Professor Ghulam J Mufti	Non-Executive Director	1 April 2015 - 31 March 2016
Sue Slipman	Non-Executive Director	1 April 2015 - 31 March 2016
Chris Stooke	Non-Executive Director	1 April 2015 - 31 March 2016
Professor Jon Cohen	Non-Executive Director	1 September 2015 - 31 March 2016
Dr Alix Pryde	Non-Executive Director	1 November 2015 - 31 March 2016
Erik Nordkamp	Non-Executive Director	1 January 2016 - 31 March 2016
Tim Smart	Chief Executive	1 April 2015 -
Roland Sinker	Chief Operating Officer	1 April 2015 - 30 November 2015
Nicholas Moberly	Chief Executive	1 November 2015 - 31 March 2016
Simon Taylor	Chief Financial Officer	1 April 2015 - 31 July 2015
Alan Goldsman	Interim Chief Financial Officer	1 August 2015 - 31 December 2015
Colin Gentile	Chief Financial Officer	1 January 2016 - 31 March 2016
Michael Marrinan	Executive Medical Director	1 April 2015 - 31 October 2015
Professor Julia Wendon	Executive Medical Director	1 November 2015 - 31 March 2016
Dr Geraldine Walters	Executive Director of Nursing, Midwifery and Infection Control	1 April 2015 - 31 March 2016
Angela Huxham	Executive Director of Workforce Development	1 April 2015 - 31 July 2015
Paul Jones	Interim Executive Director of Workforce Development	1 July 2015 - 30 September 2015
Dawn Brodrick	Executive Director of Workforce Development	1 October 2015 - 31 March 2016
Dr Trudi Kemp	Director of Strategy	1 April 2015 - 31 March 2016
Alan Goldsman	Interim Director of Strategy	1 January 2016 - 31 March 2016
Jane Walters	Director of Corporate Affairs	1 April 2015 - 31 October 2015
Judith Seddon	Director of Corporate Affairs	1 November 2015 - 31 March 2016
Steve Leiver	Director of Turnaround	1 April 2015 - 11 February 2016
Jeremy Tozier	Interim Chief Operating Officer	1 April 2015 - 31 March 2016
Ahmad Toumadj	Interim Director of Estates and Capital	1 April 2015 - 31 March 2016

None of the Non-Executive or Executive Directors received benefits in kinds in 2015-16 or 2014-15.

4.6d Pension entitlements at 31 March 2016

Name	Title	Real increase in pension										Real increase in CETV £000	Normal Retirement Age		
		Real increase in pension at pension age		Total accrued pension at pension age		Lump sum at pension age		CETV at start of year £000		CETV at end of year £000					
		£000 (bands of £2,500)	age £000 (bands of £2,500)	£000 (bands of £5,000)	age £000 (bands of £5,000)	£000 (bands of £5,000)	age £000 (bands of £5,000)	£000 (bands of £5,000)	age £000 (bands of £5,000)	£000 (bands of £5,000)	age £000 (bands of £5,000)				
Non-Executive Directors															
Non-Executive Directors do not receive pensionable remuneration.															
Executive Directors															
Roland Sinker	Chief Operating Officer & Acting CEO	-2.5 - 0	-	15 - 20	-	185	158	(16)	65						
Michael Marrinan	Executive Medical Director	0 - 2.5	0 - 2.5	40 - 45	120 - 125	-	-	-	60						
	Executive Director of Nursing, Midwifery and														
Dr Geraldine Walters	Infection Control	0 - 2.5	5 - 7.5	65 - 70	195 - 200	1,459	1,520	61	60						
Dr Trudi Kemp	Director of Strategy	10 - 12.5	30 - 32.5	45 - 50	145 - 150	720	918	198	60						
Co-opted members of the Trust's board															
Jane Walters	Director of Corporate Affairs	0 - 2.5	0 - 2.5	55 - 60	165 - 170	-	-	-	60						
Judith Seddon	Interim Director of Corporate Affairs	0 - 2.5	2.5 - 5	20 - 25	65 - 70	411	495	35	65						

During the 2015-16 the total value of employer contributions to the pension scheme in respect of Board member directors was £77k (2014-15: £114k).

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.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

4.7 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 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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme

liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

5 Finance revenue

	Group	
	2015-16 £000	2014-15 £000
Interest on bank accounts	94	143
Interest on loans and receivables	14	70
Total	108	213

6 Finance expenses

	Group	
	2015-16 £000	2014-15 £000
Capital loans from the Department of Health	1,839	1,809
Working capital loans from the Department of Health	1,817	-
Finance costs on PFI and other service concession arrangements		
Main finance cost	16,962	17,279
Contingent finance cost	6,348	6,164
Total	26,966	25,252

7 Impairments

	Group	
	2015-16 £000	2014-15 £000
Changes in market price - charged to operating expenses	21,708	4,535
Changes in market price - charged to the revaluation reserve	85,459	5,595
Total	107,167	10,130

Asset valuations were undertaken in 2015 as at the prospective valuation date of 31 January 2016. 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 overall decrease of £22.1m in the value of land owned by the Trust and £68.4m in the net book value of buildings and dwellings.

Impairment amount of £21.708m has been charged to the Statement of Comprehensive Income and £85.459m to revaluation reserve and a revaluation surplus of £16.616 transferred to revaluation reserve.

The land and buildings with material decrease in value include Denmark Hill land (£19.7m), Golden Jubilee (£16m), Ruskin Wing (£9.4m), PRUH (£7.3m), Denmark Wing (£5.9m), Dental Institute (£4.4m), Hamblen Wing North (£3.8m), Orpington Hospital (£1.9m) and other buildings (21.6m).

8 Share of operating profit in associates and joint ventures

	Group	
	2015-16 £000	2014-15 £000
Viapath Group LLP	652	1,357
King's College Hospital Clinics LLC (KCHC)	-	(600)
NIHR/Wellcome Trust Clinical Research Facility	(332)	(266)
King's Hewitt Fertility Centre	-	1
KCH Healthcare LLC (KCHH)	-	-
	320	492

9 Intangible non-current assets

9.1 Intangible non-current assets - current year

Group	Software licences £000	Development expenditure £000	Total £000
Cost or valuation			
At 1 April 2015	8,338	707	9,045
Additions purchased	508	-	508
Reclassifications	36	-	36
Disposals	(148)	-	(148)
At 31 March 2016	8,734	707	9,441
Amortisation			
At 1 April 2015	4,843	707	5,550
Charged during the year	366	-	366
Reclassifications	3	-	3
Disposals	(148)	-	(148)
At 31 March 2016	5,064	707	5,771
Net book value			
Purchased	3,670	-	3,670
Total at 31 March 2016	3,670	-	3,670
Revaluation reserve balance			
At 1 April 2015	37	-	37
At 31 March 2016	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 - prior year

Group	Software licences £000	Development expenditure £000	Total £000
Cost or valuation			
At 1 April 2014	9,344	687	10,031
Additions purchased	2,664	-	2,664
Reclassifications	90	-	90
Revaluations	-	20	20
Disposals	(3,760)	-	(3,760)
At 31 March 2015	8,338	707	9,045
At 1 April 2014	7,575	687	8,262
Charged during the year	1,006	-	1,006
Reclassifications	22	-	22
-	-	20	20
Disposals	(3,760)	-	(3,760)
At 31 March 2015	4,843	707	5,550
Net book value			
Purchased	3,495	-	3,495
Total at 31 March 2015	3,495	-	3,495

Revaluation reserve balance

At 1 April 2014	48	-	48
Indexation movement in year	(11)	-	(11)
At 31 March 2015	37	-	37

'Trust' figures have not been included in this note as the subsidiary does not hold any intangible non-current assets.



10 Property, plant and equipment

10.1 Property, plant and equipment - current year

Group and 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 2015	78,121	465,043	3,015	27,454	67,411	15,905	1,880	658,829
Additions purchased	-	1,120	-	18,802	3,189	3,494	207	26,812
Additions leased	-	-	-	-	1,115	-	-	1,115
Additions donated	-	30	-	774	484	46	-	1,334
Reclassifications	-	9,650	-	(9,650)	240	(277)	1	(36)
Disposals	-	-	-	-	(2,970)	(323)	(2)	(3,295)
Upward revaluation/positive indexation	4,129	12,478	37	-	312	-	12	16,968
Impairments/negative indexation	(26,237)	(92,770)	(234)	-	-	-	-	(119,241)
At 31 March 2016	56,013	395,551	2,818	37,380	69,781	18,845	2,098	582,486
Depreciation								
At 1 April 2015	-	37	-	-	38,795	6,475	827	46,134
Charged during the year	-	14,428	95	-	3,153	1,574	176	19,426
Reclassifications	-	-	-	-	23	(26)	-	(3)
Disposals	-	-	-	-	(2,834)	(323)	(2)	(3,159)
Upward revaluation/positive indexation	-	-	-	-	156	-	5	161
Impairments/negative indexation	-	(11,997)	(77)	-	-	-	-	(12,074)
At 31 March 2016	-	2,468	18	-	39,293	7,700	1,006	50,485
Net book value								
Owned - purchased	38,817	188,163	2,493	35,845	23,814	11,053	1,077	301,262
Owned - donated	1,843	11,183	307	1,535	1,883	92	15	16,858
On balance sheet PFI	15,353	193,737	-	-	4,791	-	-	213,881
Total at 31 March 2016	56,013	393,083	2,800	37,380	30,488	11,145	1,092	532,001
Revaluation reserve balance								
At 1 April 2015	42,055	112,851	1,735	-	8,312	-	246	165,199
Revaluation and indexation in year	(21,516)	(47,178)	(120)	-	(35)	-	6	(68,843)
At 31 March 2016	20,539	65,673	1,615	-	8,277	-	252	96,356

The effective date of land and building revaluation was 31 January 2016 and the valuation was carried out by independent valuer. "Trust" figures have not been included in this note as the subsidiary does not hold any property, plant or equipment non-current assets.

10.2 Property, plant and equipment - prior year

Group and Trust	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation								
At 1 April 2014								
Additions purchased	-	5,681	-	30,216	4,974	3,472	52	44,395
Additions leased	-	-	-	-	1,635	-	-	1,635
Additions donated	-	-	-	500	-	50	-	550
Reclassifications	-	16,790	-	(16,799)	105	(181)	(5)	(90)
Disposals	-	-	-	-	(8,753)	(1,700)	(8)	(10,461)
Upward revaluation/positive indexation	2,441	5,654	545	(1,188)	917	-	32	8,401
Impairments/negative indexation	-	(5,595)	-	-	-	-	-	(5,595)
Reversal of impairments	-	-	-	-	-	-	-	-
At 31 March 2015	78,121	465,043	3,015	27,454	67,411	15,905	1,880	658,829
Depreciation								
At 1 April 2014	-	4	-	-	41,383	6,354	637	48,378
Charged during the year	-	13,770	58	-	5,254	1,882	184	21,148
Reclassifications	-	-	-	-	39	(61)	-	(22)
Disposals	-	-	-	-	(8,337)	(1,700)	(8)	(10,045)
Upward revaluation/positive indexation	-	(17,084)	(58)	(1,188)	456	-	14	(17,860)
Impairments/negative indexation	-	3,347	-	1,188	-	-	-	4,535
Reversal of impairments	-	-	-	-	-	-	-	-
At 31 March 2015	-	37	-	-	38,795	6,475	827	46,134
Net book value								
Owned - purchased	62,217	222,867	2,546	26,665	21,856	9,373	1,031	346,555
Owned - donated	2,514	13,177	469	789	1,763	57	22	18,791
On balance sheet PFI	13,390	228,962	-	-	4,997	-	-	247,349
Total at 31 March 2015	78,121	465,006	3,015	27,454	28,616	9,430	1,053	612,695
Revaluation reserve balance								
At 1 April 2014	39,614	95,707	1,132	-	8,268	-	228	144,949
Revaluation and indexation in year	2,441	17,144	603	-	44	-	18	20,250
At 31 March 2015	42,055	112,851	1,735	-	8,312	-	246	165,199

Trust' figures have not been included in this note as the subsidiary does not hold any property, plant or equipment non-current assets.

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 2016, and for the associate, 31 December 2015. For the associate undertaking that has a different accounting year end date, interim accounts to 31 March 2016 have been consolidated.

	Country of Incorporation	Beneficial interest	Principal activity
Directly owned subsidiary undertakings			
KCH Commercial Services Ltd	UK	100%	Holding company
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
Other investment			
KCH Healthcare LLC (KCHH)	UAE	2.58%	Specialist outpatient healthcare treatment
Joint operations			
NIHR/Wellcome Trust	UK		
Clinical Research Facility* (CRF)			
Equity		35%	Research
Constructions		54%	Research
King's Hewitt Fertility Centre**	UK	50%	Assisted Conception

* 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.

** The Foundation Trust entered into a joint operation with Liverpool Women's NHS Foundation Trust through the development of satellites to improve access to the Assisted Conception Unit (ACU) and improve the best outcomes in London. The joint operation started in December 2014. The Foundation Trust does not have beneficial interest in the assets and liabilities of the operation but does have contract right to equal share of profit and loss.

11.2 Carrying value of investments held

	2015-16 Viapath £000	2015-16 KCHC £000	2015-16 KCHH £000	2015-16 Total £000	2014-15 Total £000
Balance of 1 April	3,451	935	-	4,386	3,598
Acquisitions in year	-	-	935	935	-
Share of profit	652	-	-	652	757
Other equity movements	-	(935)	-	(935)	31
Balance at 31 March	4,103	-	935	5,038	4,386

11.3 Fair value of investments held

	2015-16 Viapath £000	2015-16 Total £000	2014-15 Total £000
Total gross assets of the entity as at 31 March	46,403	46,403	44,583
Total gross liabilities of the entity as at 31 March	(40,967)	(40,967)	(35,827)
Total revenues for the year ending 31 March	98,022	98,022	97,086
Profit/(loss) for the year ending 31 March	2,620	2,620	2,924

12 Inventories

12.1 Inventories - current year

	Drugs £000	Group and Trust Consumables £000	Energy £000	Total £000
At 1 April 2015	6,360	10,718	12	17,090
Additions	133,410	93,325	266	227,001
Inventories consumed and expensed	(133,282)	(92,795)	(266)	(226,343)
At 31 March 2016	6,488	11,248	12	17,748

12.2 Inventories - prior year

	Drugs £000	Group and Trust Consumables £000	Energy £000	Total £000
At 1 April 2014	4,893	10,385	14	15,292
Additions	119,379	95,332	712	215,423
Inventories consumed and expensed	(117,912)	(94,999)	(714)	(213,625)
At 31 March 2015	6,360	10,718	12	17,090

13 Trade and other receivables

13.1 Trade and other receivables

	Group	Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000
Current			
Trade receivables due from NHS bodies	35,848	40,156	35,848
Receivables due from NHS charities	172	212	172
Other receivables due from related parties	4,962	4,021	4,962
Provision for impaired receivables	(8,325)	(18,321)	(8,325)
Deposits and advances	1,732	2,027	1,732
Prepayments (non-PFI)	5,970	7,581	5,962
Accrued income	30,671	27,913	30,671
Interest receivable	-	11	-
PDC dividend receivable	1,929	362	1,929
VAT receivable	3,976	3,753	3,976
Other receivables	39,776	30,325	42,011
Total current receivables	116,711	98,040	118,938
Non-current			
Receivables with related parties - revenue	4,434	5,459	5,906
Non-NHS receivables - revenue	1,673	1,813	1,673
Total non-current receivables	6,107	7,272	7,579
Total	122,818	105,312	126,517

The majority of trade is with NHS England and Clinical Commissioning Groups. As these bodies are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

The largest debtor at 31 March 2016 was NHS England, with outstanding debt totalling £26.397m (2015: 8.058m).

13.2 Receivables past their due date but not impaired		Group and Trust	
		31 March 2016 £000	March 2015 £000
By up to three months		13,772	10,894
By three to six months		8,158	7,612
By more than six months		24,771	16,469
Total		46,701	34,975
13.3 Provision for impairment of receivables		Group and Trust	
		31 March 2016 £000	March 2015 £000
Balance at 1 April		18,321	7,576
Amount written off during the year		(12,875)	(2,588)
Amount recovered during the year		(1,029)	(655)
Increase in receivables impaired		3,908	13,988
Balance at 31 March		8,325	18,321
13.4 Impaired receivables past their due date		Group and Trust	
		31 March 2016 £000	March 2015 £000
By up to three months		21	10,582
By three to six months		129	59
By more than six months		8,175	7,680
Total		8,325	18,321
14 Cash and cash equivalents		Group	
		31 March 2016 £000	31 March 2016 £000
		31 March 2016 £000	31 March 2015 £000
Opening balance		43,445	54,535
Net change in year		(24,463)	(11,090)
Closing balance		18,982	43,445
Made up of			
Cash with Government Banking Service		12,568	40,117
Commercial banks and cash in hand		6,414	3,328
Cash and cash equivalents as in statement of financial position		18,982	43,445
Patients' money held by the Foundation Trust, not included above		9	8

15 Trade and other payables

	Group		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Current				
Receipts in advance	1,483	1,651	1,483	1,651
NHS trade payables	9,255	9,735	9,255	9,735
Other trade payables	46,201	41,600	47,050	41,536
Capital payables	4,261	1,741	4,261	1,741
Social security costs	5,536	5,460	5,536	5,460
Other taxes payable	5,717	5,757	5,717	5,757
Other payables	7,864	8,272	7,821	8,240
Accruals	71,290	89,879	71,221	89,824
Total	151,607	164,095	152,344	163,944

All trade and other payables are current; there are no non-current balances.

16 Deferred income

	Group and Trust	
	31 March 2016	31 March 2015
	£000	£000
Current		
Deferred income	7,933	
Total	7,933	10,189

All deferred income is current; there are no non-current balances.

17 Borrowings

	Group		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Current				
Capital loans from Department of Health	3,868	3,868	3,868	3,868
Other loans	195	206	-	17
Obligations under PFI contracts	3,897	3,550	3,897	3,550
Total current borrowings	7,960	7,624	7,765	7,435
Non-current				
Capital loans from Department of Health	62,107	65,974	62,107	65,974
Working capital loans from Department of Health	98,900	-	98,900	-
Other loans	1,317	1,488	-	-
Obligations under PFI contracts	152,327	155,108	152,327	155,108
Total non-current borrowings	314,651	222,570	313,334	221,082
Total	322,611	230,194	321,099	228,517

The Trust has secured an interim working capital loan of £98.9m from the Department which is repayable on 18 May 2018.

18 Provisions

18.1 Provisions - current year

Group and Trust	Total £000	Early Departure costs £000	Legal claims £000	Redundancy £000	Other £000
At 1 April 2015	7,534	6,705	585	-	244
Arising during the year	315	-	60	-	255
Utilised during the year - cash	(823)	(749)	(74)	-	-
Reversed unused	(237)	(174)	(63)	-	-
Change in discount rate	57	(59)	116	-	-
Unwinding of discount	82	75	7	-	-
At 31 March 2016	6,928	5,798	631	-	499

Expected timing of cash flows:

No later than one year	1,472	749	224	-	499
Later than one year and not later than five years	3,216	2,994	222	-	-
Later than five years	2,240	2,055	185	-	-
Total	6,928	5,798	631	-	499

18.2 Provisions - prior year

Group and Trust	Total £000	Early Departure costs £000	Legal claims £000	Redundancy £000	Other £000
At 1 April 2014	8,030	7,307	562	90	71
Arising during the year	382	-	207	-	175
Utilised during the year - non-cash	(90)	-	-	(90)	-
Utilised during the year - cash	(816)	(746)	(70)	-	-
Reversed unused	(125)	-	(123)	-	(2)
Unwinding of discount	153	144	9	-	-
At 31 March 2015	7,534	6,705	585	-	244

Expected timing of cash flows:

No later than one year	1,239	747	248	-	244
Later than one year and not later than five years	3,215	2,988	227	-	-
Later than five years	3,080	2,970	110	-	-
Total	7,534	6,705	585	-	244

18.3 Provisions - further information

Clinical negligence

£374,426m (31 March 2015: £194,211m) is included in the provisions of the NHS Litigation Authority at 31 March 2016, 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

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 1.37% (2014/15: 2.2%) (set by HM Treasury) to determine the full liability.

Legal claims

The provision is based upon information provided by the NHS Litigation Authority and refers to non-clinical claims against the Foundation Trust (e.g. public and employer's liability cases).

Other

The Foundation Trust has provided £0.499m (31 March 2015: £0.244m) for outstanding Employment Tribunal cases and associated legal fees.

19 Contingencies

	Group and Trust	
	31 March 2016 £000	31 March 2015 £000
Contingent liabilities		
Non-clinical legal claims	146	96

The above contingencies refer to non-clinical legal claims, dealt with by the NHS Litigation Authority on behalf of the Foundation Trust.

The Foundation Trust has no contingent assets.

20 Contracted capital commitments

	Group and Trust	
	31 March 2016 £000	31 March 2015 £000
Property, plant and equipment	52,347	38,657

These contracts include the Critical Care Unit (£51.5m), the Helipad (£286k) and Alex Mowatt Learning Hub (£465k). It is anticipated that all these projects will be completed in the next financial year except Critical Care Unit.

21 Revaluation reserve

Group and Trust		31 March 2016	31 March 2015
	Intangibles £000	Property, plant and equipment £000	Total £000
At 1 April	37	165,199	165,236
Impairments	-	(85,459)	(85,459)
Revaluations	-	16,807	16,807
Disposals	-	(191)	(191)
At 31 March	37	96,356	165,236

22 PFI - additional information

22.1 On SoFP liabilities

Group and Trust	31 March 2016	31 March 2015
	£000	£000
Gross PFI liabilities	411,701	431,926
Of which liabilities are due:		
- not later than one year	20,538	20,512
- later than one year and not later than five years	80,064	81,355
- later than five years	311,099	330,059
Total	411,701	431,926
Finance charges allocated to future periods	(255,477)	(273,268)
Net PFI liabilities	156,224	158,658
Of which liabilities are due:		
- not later than one year	3,897	3,550
- later than one year and not later than five years	13,345	13,168
- later than five years	138,982	141,940
Total	156,224	158,658

22.2 Commitments

Group and Trust	31 March 2016	31 March 2015
	£000	£000
Total future payments committed of which will fall due:		
- not later than one year	69,559	67,901
- later than one year and not later than five years	296,347	289,015
- later than five years	1,613,078	1,689,969
Total	1,978,984	2,046,885

22.3 Total unitary payment payable to service concession operators	Group and Trust	
	31 March 2016	31 March 2015
	£000	£000
Consisting of:		
- Interest charge	16,962	17,279
- Repayment of finance lease liability	3,550	3,199
- Service element	45,893	43,468
- Capital lifecycle maintenance	2,682	2,648
- Contingent rent	6,348	6,164
	<hr/>	<hr/>
	75,435	72,758
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment		
Consisting of:		
- Services purchased	8,791	10,863
Total	<u>84,226</u>	<u>83,621</u>

22.4 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, Sodexo 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 1.16% based on the rate used for 2015-16.

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.

23 Financial instruments

23.1 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

85% of the Foundation Trust's financial assets and 99.7% 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 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

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.

23.2 Financial assets

	Total	Floating rate	Fixed rate	Non-interest bearing
Group	£000	£000	£000	£000
Gross financial assets				
at 31 March 2016	123,716	18,982	-	104,734
at 31 March 2015	133,283	43,445	-	89,838

Trust

Gross financial assets

at 31 March 2016	118,949	17,237	-	101,712
at 31 March 2015	128,620	42,663	-	85,957

The weighted average interest rate for total financial assets was 0.14% (2014-15: 0.2%).

The weighted average period for which fixed years was unlimited (2014-15: unlimited).

The non-interest bearing weighted average term years was nil (2014-15: nil).

23.3 Financial liabilities

	Total	Floating rate	Fixed rate	Non- interest bearing
Group	£000	£000	£000	£000
Gross financial liabilities				
at 31 March 2016	468,398	1,513	328,026	138,859
at 31 March 2015	388,964	1,677	236,035	151,252

Trust

Gross financial liabilities

at 31 March 2016	469,116	1,513	326,512	141,091
at 31 March 2015	387,313	-	236,034	151,279

The weighted average interest rate for total financial liabilities was 6.1% (2014-15: 8.0%).

The weighted average period for which fixed years was unlimited (2014-15: unlimited).

The non-interest bearing weighted average term years was nil (2014-15: nil).

23.4 Fair values of financial assets by category

	Group		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Trade and other receivables	104,734	89,838	101,712	85,957
Cash and cash equivalents	18,982	43,445	17,237	42,663
Total	123,716	133,283	118,949	128,620

23.5 Fair values of financial liabilities by category

	Group		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Borrowings (excluding finance leases and the PFI liability)	166,387	71,536	164,874	69,859
Obligations under PFI arrangements	156,224	158,658	156,223	158,658
Trade and other payables excluding non-financial liabilities	138,859	151,412	141,091	151,262
Provisions under contract	6,928	7,534	6,928	7,534
Total	468,398	389,140	469,116	387,313

Fair value is not significantly different to book value, because in the calculation of book value the expected cash flows have been discounted by the HM Treasury discount rate of 1.37% in real terms.

23.6 Maturity of financial liabilities

	Group		Trust	
	31 March 2016	31 March 2015 £000	31 March 2016	31 March 2015 £000
In one year or less	148,097	160,084	150,329	159,934
In more than one year but not more than two years	8,580	7,669	8,580	7,669
In more than two years but not more than five years	126,305	24,183	126,305	24,183
In more than five years	185,416	197,204	183,902	195,527
Total	468,398	389,140	469,116	387,313

24 Third party assets

At 31 March 2016, the Foundation Trust held £8,456 (31 March 2015: £7,570) 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.

25 Events after the reporting period

There have been no material adjusting or non-adjusting events after 31 March 2016.

26 Related parties

King's College Hospital NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

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 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 department.

The main local commissioners are Lambeth, Southwark, Lewisham, and Bromley Clinical Commissioning Groups (CCGs). Significant commissioning is also carried out by NHS England.

In addition, the Foundation Trust has transacted with a large number of other CCGs and NHS Trusts, as well as the NHS Litigation Authority and the NHS Business Services Authority (including NHS Supply Chain).

The Foundation Trust has also received revenue and capital payments from a number of charitable funds, principally the King's College Hospital Charitable Fund.

Entities which have provided key management personnel services to the NHS foundation trust are also considered related parties.

The Foundation Trust has entered into the following material related party transactions:

	Income £000	Expenditure £000	Receivables £000	Payables £000
Department of Health	13,446	-	-	4
NHS England	401,349	74	26,397	2,320
NHS Bexley CCG	37,781	-	1,095	-
NHS Bromley CCG	168,666	-	1,674	-
NHS Croydon CCG	19,918	-	753	-
NHS Dartford, Gravesham And Swanley CCG	11,646	-	323	-
NHS Greenwich CCG	20,378	-	334	-
NHS Lambeth CCG	81,170	-	861	69
NHS Lewisham CCG	34,206	-	144	-
NHS Medway CCG	3,512	-	113	-
NHS Southwark CCG	95,783	-	2,594	69
NHS Wandsworth CCG	2,655	-	71	-
NHS West Kent CCG	9,486	-	281	-
Guys And St Thomas NHS Foundation Trust	6,231	3,679	2,006	2,697
South London and Maudsley NHS Foundation Trust	2,179	1,326	666	402
Lewisham and Greenwich NHS Trust	691	5,496	3,101	4,365
NHS Litigation Authority	221	33,196	-	-
NHS Blood and Transplant	149	7,283	-	-
HM Revenue and Customs	-	37,020	3,976	11,253
NHS Pension Scheme	-	53,956	-	-
King's College Hospital Charitable Fund	1,740	-	159	-
Viapath Group LLP	3,511	23,055	3,933	2,113
King's College Hospital Clinics LLC	259	-	869	-
PricewaterhouseCoopers LLP	-	9,123	-	947
Four Eyes Insight Ltd	-	1,060	-	174

In addition, there were many transactions with King's College London (which is not a related party) in respect of education, training and research and development.

27 Losses and special payments

Group and Trust	2015-16		2014-15	
	Number	Value £000	Number	Value £000
Losses of cash due to:				
- theft, fraud etc	-	-	2	1
- overpayment of salaries	5	23	119	43
Bad debts and claims abandoned in relation to:				
- private patients	-	-	93	131
- overseas visitors	462	2,257	613	2,305
- other	35	10,154	36	66
Damage to buildings, property etc due to:				
- theft, fraud etc	10	2	20	10
Total losses	512	12,436	883	2,556
Special, ex-gratia, payments due to:				
- loss of personal effects	15	4	33	15
Total special payments	15	4	33	15
Total losses and special payments	527	12,440	916	2,571

In 2015-16 there were 3 cases totalling £9.9m where the loss or special payment exceeded £300,000 (2014-15: 0).

1. NHS Trust Development Agency (£7.6m) - £5m relates to reimbursement claim of cost outside the indemnity agreement e.g. clinical review initiated by SLHT (South London Healthcare Trust) and NHSLA additional contribution due to the disestablishment of SLHT. £2.6m relates to the transfer of SLHT working capital to Lewisham and Greenwich NHS Trust. The above debt was provided for and did not impact on the Trust income and expenditure account.
2. Lewisham and Greenwich NHS Trust (£1.4m) - Recharge of urology services resolved through mediation.
3. Health Education England (£0.9m) - This relates to the allocation transfer of dental SIFT from King's to GSTT (Guy's and St Thomas NHS Trust)

Losses and special payments are disclosed on an accruals, rather than a cash, basis, but exclude provision for future losses.

This year we have included some historical information about the Trust in recognition of King's achievements as we embark on an exciting journey of transformation to achieve our strategic goals.

We thank Professor Ted Howard for contributing these vignettes.

To clarify details in this report please contact:
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