King's College Hospital
NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2020-21

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Annual Report and Accounts 2020/21

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GLOSSARY

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

ACRONYM	MEANING
ICT	Information Computer Technology
IFRS	International Financial Recording Standards
IGSC	Information Governance Steering Committee
ISO	International Organization for Standardization
IT	Information Technology
JSCC	Joint Staff Consultative Committee
KCH	King's College Hospital
KCL	King's College London
KE	King's Executive
KFM	King's Facilities Management
KHP	King's Health Partners
KITE	King's Improvement Through Engagement
KWfW	King's Way for Wards
LGFC	Lambeth GP's Food Co-op
LGBT	Lesbian, Gay, Bisexual, Transgender
MRSA	Meticillin-resistant staphylococcus aureus
NCEPODS	National Confidential Enquiry into Patient Outcome and Death Studies
NED	Non-Executive Director
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
OHSEL	Our Healthy South East London
PbR	Payment by Results
PHE	Public Health England
PPE	Personal Protective Equipment
PRUH	Princess Royal University Hospital
PSF	Provider Sustainability Fund
PTL	Patient Tracking List
QI	Quality Improvement
R&I	Research and Innovation
QPPC	Quality, People and Performance Committee
RGD	Regulatory Governance Department
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RTT	Referral to Treatment
SDEC	Same Day Emergency Care
SDMP	Sustainable Development Management Plan
SDU	Sustainable Development Unit
SHMI	Standardised Hospital-level Mortality Index
SIRO	Senior Information Risk Owner
SLAM	South London and Maudsley NHS Foundation Trust

ACRONYM	MEANING
SOF	Single Oversight Framework
UCC	Urgent Care Centre
ULEZ	Ultra Low Emission Zone
USP	Unique Selling Point
VBHC	Value Based Healthcare
VR	Virtual Reality
WRA	Workplace Risk Assessment
WRES	Workforce Race Equality Scheme

INTRODUCTION

Chairman's Statement

I have been Chairman of the Trust for just over two years, and as a local resident, the Hospital at Denmark Hill has been my local hospital for many more. In this most challenging of years, I am proud of what this Trust has achieved, of how well the staff have responded to the challenges they faced, and of the patient-focused care that they continue to deliver in very difficult circumstances.

The Trust has been one of the busiest in the country in dealing with COVID-19. The impact of this, social distancing and enhanced cleaning, impacted on already limited capacity. The Trust did not meet its core access targets and must continue to address these as a matter of urgency. However, the recovery plans that have been put in place in areas such as the Emergency Department and Diagnostics have shown initial promise. Additionally, greater collaboration with the regulators and partners, demonstrates that the Executive is determined to put in place the right checks and balances to eliminate these issues permanently.

We must ensure that the momentum that King's has achieved in the past year is not lost. The Trust must be commended for its response to the COVID-19 pandemic. The expert planning and execution enabled it not only to manage the first surge of patients in all three of its hospitals but also to ensure that its lessons were learnt for Wave Two. During this time the Trust was also at the forefront of the vaccination programme, having delivered its first vaccine in early December 2020.

As we look forward, the NHS is facing a period of unprecedented change, including significant and increased pressure on services. As the Chairman of two Trusts, both must embrace the opportunities afforded by greater collaboration and partnership working. The Acute Provider Collaborative that has been established over the past 12 months with Guy's and St Thomas' NHS Foundation Trust and Lewisham and Greenwich NHS Trust will enable us to build robust and sustainable health systems at a borough level across south-east London as well as develop specialised services for patients from across the country.

I would also like to take this opportunity to thank our Governors and Members for their ongoing support both for the Board and everyone who works at King's. Both groups have always been passionate advocates and critical friends of the Trust.

Finally, I would like to echo and reinforce Clive's praise for all our staff. Everyone I have met has been a passionate and proud advocate, not only of providing the very best care, but also of the Trust's future role in delivering the very best services. Most importantly, it is also very clear from the patients who I have had the privilege to speak to as Chairman, that they cherish King's as their local hospital at the heart of their community.

This last year has been incredibly challenging for the Trust, and across the NHS and country as a whole. I would like to ask the Board to join me in thanking all King's staff for their hard work and leadership through this very difficult time, and further incredible resilience and dedication.

I would also like to thank our King's College Hospital Charity, along with our volunteers, and our local community for their kind donations and support.

I am incredibly grateful to everyone who has collectively and individually contributed to the Trust. I am confident in the Trust's ability to continue to build as we move towards and continue to focus on the recovery of our services.

Sir Hugh Taylor, Chairman

PERFORMANCE REPORT

Chief Executive's Statement

Before I came to King's, I was aware of its reputation for putting patients first, its teaching and its innovative research. Today, I am incredibly proud to be part of this organisation and to lead its incredible staff into the future.

I would like to pay tribute to everyone at the Trust and across the NHS for their response to COVID-19. Under incredibly pressured and constantly evolving circumstances, King's and our colleagues rose to the challenge. From transforming wards to treating the increasing number of COVID-19 patients, retraining and redeploying staff, and collaborating on global vaccine research, and then being at the forefront of the nation's vaccination programme, our own provision of care and support for one another never faltered. Just as COVID-19 will continue to be part of our lives, the Trust will continue to play a key role in mitigating and hopefully one day eradicating this dreadful pandemic in the UK and globally.

While the Trust remains in financial special measures, I am delighted to say that we have ended the 2020/2021 financial year having delivered a balanced budget. Although COVID-19 has meant that the NHS financial framework was different this year, this is still a significant achievement for the Trust. It is the second year in a row that we have achieved our financial 'control total' which has helped us to further improve the confidence of internal and external stakeholders in the Trust's financial performance. We have delivered a capital budget of over £95m, which has allowed us to make significant improvements to wards across all sites as well as to theatres. We have created critical care surge capacity and improved urgency and emergency care facilities at Denmark Hill and the Princess Royal University Hospital. We have also made significant investments in new equipment and created the staff health and wellbeing hubs on the three main sites.

In terms of patient care, King's has continued to report excellent outcomes in terms of mortality using the Summary Hospital-level Mortality Indicator (SHMI). The Trust's COVID-19 case fatality rates also reflected the excellent care our staff delivered during very difficult times. However, delivering consistent operational performance has been more difficult. This year, King's failed either to maintain or improve its patient access standards in emergency, elective, cancer and diagnostic care.

Achieving the Emergency Care Standard has proved challenging for hospitals across the capital. Although attendances were lower for much of the year, social distancing, the need for testing and enhanced cleaning measures impacted on performance. As a result, King's did not meet its performance target. The Trust also failed to meet its targets in cancer and diagnostic testing. Referral to Treatment performance remained unsatisfactory, and we are grateful to the regulators and system partners for their support in this area.

The Trust has had to innovate during the year in order to meet the ongoing needs of our patients. This has included extending the use of virtual clinics, redesigning care pathways and increasing the number of assessments undertaken by telephone. At the end of 2020/21, the Trust implemented a number of recovery programmes and increased innovation will be key to achieving those goals.

As with every Trust, our workforce defines who we are. I have witnessed outstanding care and been inspired by my colleagues on countless occasions. Our staff exemplify the highest standards of patient care, even at a time when the NHS has faced its most formidable and devastating challenge in decades.

King's must continue to foster a workforce culture that is inclusive, and celebrates the diversity of its staff and the communities we serve. Therefore, I am personally committed to ensuring that every member of staff can realise their full potential. During the year we have continued to invest in our staff networks and in the health and wellbeing of all our staff.

There is no doubt that this has been one of the most challenging years in the history of the NHS. I would like to thank our Chairman, Sir Hugh Taylor, the Board of Directors, and our partners for their support. I would also like to pay special tribute to our staff, for the compassionate and safe patient care they provide.

Professor Clive Kay
Chief Executive

Overview of Performance

This section provides information about the Trust, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

Purpose

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

Activities

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

For people across south-east London and Kent, King's College Hospital is the designated major trauma centre, as well as a heart attack centre and the regional hyperacute stroke centre. The helipad at King's College Hospital, which opened in November 2016, has reinforced the hospital's position as a major trauma centre for the south of England.

The Trust provides services to local residents of the London Boroughs of Lambeth, Southwark, Bromley, Bexley and Lewisham from its sites at King's College Hospital (Denmark Hill), Princess Royal University Hospital, Farnborough Common, and Orpington Hospital. It also provides services at Beckenham Beacon and Queen Mary's Hospital, Sidcup. These include accident and emergency services, maternity, care of the elderly, orthopaedics, diabetes, ophthalmology, oncology, dermatology and many more. The Trust provides a number of community-based services including dentistry.

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

Brief History

King's College London was founded in 1829. Clinical teaching in the medical faculty was dependent upon the Middlesex Hospital until 1839 when King's College London gained its own hospital in Portugal Street, which was rebuilt in 1861.

Established in 1840, the original King's College Hospital – a former workhouse – was based on Portugal Street, Holborn, close to Lincoln's Inn Fields in central London. It was first used as a training facility for students at King's College London, but quickly developed into a major hospital for the area.

The hospital moved to its Camberwell site in 1913.

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

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

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

Structure
During 2020/21, the Trust moved to a group structure, based around the two main hospital sites, Denmark Hill and the Princess Royal University Hospital and South Sites (PRUH). The Trust has twenty-three care groups, aligned to the site structure as well as a number of pan-Trust corporate services such as Workforce, Finance and ICT.

By organising in this way, the Trust is able to group the resources required for delivering similar types of care so that it could improve patient pathways and increase the efficiency of service delivery. It also aims to provide clearer accountability.

More about the Trust governance model can be found on page 43.

The Trust's Strategic Objectives 2020/21
During 2020/21, the Trust has been working to achieve the following strategic objectives:

- **People and culture**
- **Clinical care**
- **Collaboration & partnership**
- **Research, innovation and education**
- **Enablers**

Sections later in this report outline how we have met these objectives.

Risks to achieving our strategic goals
The Trust's approach to managing risk is outlined in the accountability report later in this document The Trust has identified a number of risks that could affect the delivery of its strategy including:

- Increased demand for health services and a constrained site: these limit opportunities for expansion and the Trust's ability to meet access targets is made more difficult. Additional waiting list pressure has come as a result of COVID-19.
- Financial and capital constraints: the Trust has recorded a significant deficit in recent years and has limited access to capital monies, an aging estate and a significant maintenance backlog.
- Workforce constraints: attracting and retaining staff as well as ensuring the health and wellbeing of staff.
- Strategic landscape: the Trust works in a complex and changing strategic landscape with multiple partners and stakeholders.
- Clinical and patient safety: the Trust has been slow to deal with complaints and investigations arising out of serious and moderate incidents.

These are covered in more detail on page 97 in this report.

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

Integrated Care System
King's is a partner in Our Healthier South East London (OHSEL), the Integrated Care System that covers the London boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark. This comprises Commissioners, local authorities, acute provider Trusts, primary and community care providers.

Acute Provider Collaborative
In partnership with Lewisham and Greenwich NHS Trust, and Guy's and St Thomas' NHS Foundation Trust, King's established an Acute Provider Collaborative (APC). The initial focus of the APC has been to develop a system wide response to the backlog of patients waiting for treatment in a number of high volume, low complexity areas. Overseen by a Committee-in Common, the APC is working to establish specialty-based hubs across South East London, to ensure that all capacity in the system is utilised as far as possible.

Details of Overseas Operations and Subsidiaries
King's Commercial Services Limited is the company established to oversee some key commercial operations on behalf of the Trust. It has continued to diversify income by expanding commercial activities both in the UK and overseas. It has now been in operation for 10 years.

KCS delivered a surplus of £3.85m to the Trust in 2020/21 including income from its ownership of the Viapath LLP pathology joint venture. During the year, the Viapath structure was changed with the buy-out of Serco in May 2020 and the subsequent buy-in of Synlab in March 2021. The surplus includes KCS's share in Viapath's profit for the 2020 financial year and its share of the disposal profit on the part sale of Viapath to Synlab.

KCH Management Limited continues to develop a hospital management and consultancy business both in the UK and overseas, predominantly in the Middle East. There are currently two outpatient clinics and a full-scale inpatient hospital open in Dubai. The company operates a successful international recruitment business covering nurses and doctors for both King's and other healthcare organisations, although activity in 2020/21 has been hampered by restrictions as a result of COVID-19. The company also delivers education programmes. The company delivered a surplus of £0.93m to the Trust.

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

Separately, KFM provides an end-to-end procurement and supply chain function for the Trust, working with operational leads to identify future requirements for equipment and consumables. KFM seeks to contribute to the Trust through the identification and delivery of cost improvement programme savings through more focused contract management. During 2019, the Trust transferred the management of its outpatient pharmacy service to KFM from Lloyds Pharmacy.

The Trust has consolidated a contribution of £6.647m from KFM for 2020/21.

Financial Performance and Sustainability
2020/21 was an exceptional year for the Trust's finances due to COVID-19. The Trust was funded to reflect 2019/20 costs, with the expectation it would deliver a balanced budget at the end of the year. In practice, the Trust delivered a small surplus.

Liquidity and Capital

In 2020/21 the Trust drew down £34.929m of Central Programme PDC funding and 32.334m Interim Support Capital PDC funding against 2020/21 capital projects. Capital expenditure incurred is in line with the Trust's CDEL allowance.

Total capital expenditure in 2020/21was £94.412m, which was significantly higher than in previous years. The programme included the continued construction of the CCU, ward refurbishments as well as investment in ICT infrastructure and device upgrades, and medical equipment. The Trust also continued to invest in the buildings infrastructure to ensure the most pressing maintenance needs were addressed. In recent months the main theatres complex at the King's College Hospital (KCH) site has been extensively refurbished.

In order to provide additional critical care capacity through COVID-19, the Trust took the decision to open part of the new Critical Care Unit, leading to the recognition of the CCU as an asset in the accounts. As a result of this, the Trust's annual accounts also recognise an impairment of £50m.

Borrowings and Capital Plan

The Trust's reported total borrowings include past expenditure on the Private Finance Initiative (PFI) schemes for the Golden Jubilee Wing and Ruskin Wing at KCH and the PRUH, and total £141.825.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 of £735m were extinguished and replaced with the issue of Public Dividend Capital (PDC).

Going Concern

IAS 1 requires management to undertake an assessment of the NHS Foundation Trust's ability to continue as a going concern.

The Trust has prepared its accounts on a going concern basis based on the requirements of the DHSC Group Accounting Manual that: "DHSC group bodies must prepare their accounts on a going concern basis unless informed by the relevant body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity".

After making enquiries, the Directors have concluded that there is sufficient evidence that services currently delivered by the Trust will continue to be provided and that there is financial provision for this within the forward plans of commissioners. The Directors have therefore prepared these financial statements on a going concern basis.

COVID-19

2020/21 has been an unprecedented year for healthcare. At King's we faced the toughest of challenges, with two significant waves of COVID-19 and at the peak in January 2021, over 770beds were occupied by COVID-19 patients.

The first COVID-19 positive swab was processed at King's College Hospital (KCH) on the 25th February 2020. One week later on the 3rd March 2020, the Trust admitted the first COVID-19 inpatient, and the number of COVID-19 inpatients rose rapidly during the month. On 4th March 2020 the Trust declared a Critical Incident, and then declared a Major Incident on the 12th March 2020, and moved into a seven day a week Incident Response. On 11th March 2020 the first patient died from COVID-19 at The Princess Royal University Hospital (PRUH), and 4 days later - on the 15th March 2020 - the first death occurred at Denmark Hill (DH).

The Trust moved quickly to implement operational changes in order to increase bed capacity to treat COVID-19 patients and release staff to reallocate them as needed, whilst ensuring the Trust continues to deliver high quality care for all our patients including:

- Instigating the gold-silver-bronze command structure designed to provide the Trust with a clear and easy to understand process for strategic planning and decision making in times of crisis. Gold command being responsible for strategy, and overall management of the Trust; silver being responsible for developing a tactical plan or response; and bronze implementing the tactical plan on the ground.
- Stopping all elective inpatient activity, with the exception of life- or limb-threatening conditions.
- Changing staff roles and responsibilities, for both clinical and non-clinical staff to meet the needs of King's during these challenging times. Staff affected have been provided with the appropriate training and support to upskill them.
- Staff health and wellbeing hubs to provide a space for staff to take a break and learn techniques for managing stress have been established and staff testing for COVID-19 is in place.
- Ensuring adequate provision of personal protective equipment (PPE) in line with PHE guidance, providing fit-testing and fit-checking of PPE.
- Procuring additional medical equipment and supplies as demand increases.
- Extending the seven-day working model to clinical and non-clinical areas to support our staff that are on the frontline.
- Strengthening our 'deteriorating patients' quality improvement workstream through development of a COVID-19 specific resource to enable our staff to recognise early patient deterioration, to assess the patient in a systematic approach, early escalation and prioritise safety at all times.
- Ensuring appropriate and robust financial governance frameworks were in place to support a fast-moving situation.
- Opened part of the new Critical Care Unit to provide additional critical care capacity for very sick patients.

It is important to recognise the speed at which the COVID-19 pandemic has impacted the Trust. King's College Hospital has been one of the largest treatment centres for COVID-19 in the country.

Between Waves One and Two of the pandemic there was a period of approximately 5 months where, as an organisation, and as a system, the process for recovery commenced.

As with all organisations in the NHS, COVID-19 has triggered incredible transformation. The Trust accelerated innovative ways of working and expanded its horizons to imagine a radically different way of providing patient care.

The Trust developed and implemented a Reset and Recovery programme focusing on using the opportunity of our learning to embed the transformation afforded by the first Wave, to manage the very significant patient backlogs, and to build resilience for a second and any subsequent waves.

A South East London (SEL) Acute Provider Collaborative (APC) with neighboring acute Trusts was established with the goal of working together to provide equity of care across our sector. Worked at a London region level to standardize and formalize our approach in a range of areas including critical care, diagnostics, elective care hubs, and workforce.

The Trust carried out a Wave One Review and identified what had worked well, what the Trust needed to do better in future, and what had not been addressed but needed to be in subsequent waves. This Review proved invaluable in dealing with the second wave of the pandemic.

The ongoing pandemic has led to us facing further significant operational, clinical and workforce challenges, and the response of our staff has continued to be inspirational. Not only have our colleagues

delivered exceptional care to patients often in some of the most difficult circumstances, but they have also continued to provide each other with great kindness and support.

The second wave of the COVID-19 Pandemic arrived quickly. On the 18th December 2020 there were 90 patients in the Trust with COVID-19, and by the 11th January 2021 this had risen to 776 - a nearly 9-fold increase within a 24 day period. Operationally, the approach was not dissimilar to wave one, with a continuous cycle of converting wards to accommodate COVID-19 patients, redeployment of staff across the Trust, and with a similar command and control structure in place. However, there were some notable differences:

- Our approach to staff wellbeing was enhanced by a psychosocial offer to support teams, with a focus on trauma, fatigue, anxiety and retention.
- Patients were younger (average age 64) and the balance between white and BAME patients was more reflective of the general population.
- Mortality rates were lower in Wave 2 than in Wave 1 and average length of stay for patients under 80 was lower.
- There were changes to clinical treatment including increased use of drugs such as Remdesivir and Dexamethasone.

PERFORMANCE ANALYSIS

Summary of performance

As noted elsewhere in this report, 2020/21 has been unprecedented for King's. The Trust dealt with two waves of COVID-19 over several months. In turn, this has impacted on the Trust's ability to meet its core constitutional targets, particularly in relation to referral to treatment targets. The need to ensure social distancing measures as well as the need for enhanced cleaning regimes has reduced the Trust's efficiency and impacted on all aspects of our delivery.

Nevertheless, the Trust made some progress in delivering against its strategic objectives as shown below.

King's College Hospital
NHS Foundation Trust

Quality Account 2020-21

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Part 1: Introduction

Statement on Quality from the Chief Executive

I am delighted to introduce the Quality Account for King's College Hospital NHS Foundation Trust. This report summarises the progress the Trust has made across our quality domains during 2020/21. It highlights our successes and also acknowledges the areas in which we partially met our quality priority targets. High quality care demands a responsive approach, one which enables our teams to be able to react effectively to the immediate needs of our patients. In 2020/21 it is fair to say that our priorities for quality care changed.

The last year has been a year like no other. Our staff rose to meet the toughest challenge in the history of King's and the NHS during the COVID-19 pandemic. I could not be more proud of them. This includes our volunteer workforce who continued to support the Trust throughout the year providing valuable resource, expertise, compassion and kindness to our staff and patients.

We treated 7421 patients with COVID-19 over the year. This puts King's in the top 10% of all NHS Trusts in England and Wales for primary COVID-19 admissions. The impact of COVID-19 has been devastating and tragic for many of our patients, our staff and their families. The sacrifices and losses are impossible to describe in words. Every single death from COVID-19 is heartbreaking in its own right. I have been reassured to see early data suggesting that the expertise, skill and dedication of our clinical teams ensured that the COVID-19 mortality rate at King's has remain amongst the lowest in the country.

The experiences of the last year have reinforced the need to ensure that staff safety and wellbeing is at the heart of everything we do. We worked alongside colleagues from South London and the Maudsley (SLaM) and King's Health Partners (KHP) to develop a staff wellbeing programme to support our 14,000 staff in response to the COVID-19 pandemic. The programme was awarded the Health Service Journal (HSJ) Workforce Initiative of the Year in March 2021. The COVID-19 Staff Support and Wellbeing Programme was recognised for its ambition and demonstrable positive impact on patient and staff experiences. I was delighted to see this vital collaborative programme recognised nationally, but I am even more pleased that our staff are benefitting from this evidence-based approach. Our staff survey results are clear on the areas that we need to improve, and this work helps us to deliver a much-improved working environment.

Outside of our pandemic response, we have achieved a great deal during 2020/21. I include a number of highlights below. This is by no means an exhaustive list:

- The King's Variety Children's Hospital Neuro Team were named Neuro Team of the Year by the Brain Tumour Charity UK. The team were selected from over 300 nominations from across the country. The charity specifically recognised the team's collaborative and innovative approach to caring for children and their families following the diagnosis of a brain and/or spinal tumour.
- Our Denmark Hill team of orthopaedic and plastic surgeons successfully completed their first combined orthoplastic surgical "fix and flap" procedure. This involved combining the fixing of complex fractures of the femur and tibia, followed by the use of microsurgical techniques to tackle soft tissue injuries using a 'free flap' transfer of skin and muscle from the chest wall. This landmark first for King's is the culmination of over four years of planning and the team aims to establish this as a regular part of the treatment pathway for severely injured patients.
- Newsweek has ranked the King's College Hospital's gastroenterology service 7th in the world and best in the UK. Our Endocrinology and Diabetes Department also made it into the Newsweek Top 50 for Endocrinology - ranked 45th in the world. Newsweek's ranKing's are based on a global survey of healthcare professionals who would refer or use the service themselves.
- The European Association for the Study of Obesity (EASO) has assessed our bariatric unit and accredited it as a Collaborating Centre for Obesity Management. The unit is only the 4th to be awarded this status in the

UK and it will allow our specialist staff to join European expertise exchange programmes.
- Channel 4 broadcast a feature length documentary on the experience of four COVID-19 patients at Denmark Hill. Filmmakers followed the patients and their families over six months showing their struggles with the virus and the incredible care they received from our staff. This will be aired as a Netflix documentary.
- King's researchers were awarded a prestigious grant, totalling more than £1.7m to trial new liver treatment. This will be a "world first" in the treatment of children with liver disease.
- Our recent "Big Thank You" campaign won the prestigious recruitment award at the RAD Awards. Under the Employee Engagement category, our work with the creative agency TMP Worldwide has brought our sites to life with vibrant and colourful images of various staff displayed. Each image is accompanied by a message of thanks from the person's management team, producing a really powerful display.

During the year we have completed the organisational structure review implementing a clinically-led model with 25 Clinical Care Groups each with a Clinical Director, Head of Nursing and General Manager to lead on quality, operational performance, workforce and financial stability.

The last year has also reinforced the crucial need to have a renewed and robust focus on equality and diversity for our staff and for our patients. We have conducted a full review of our Equality, Diversity and Inclusion (EDI) programme to ensure our deliverables were clearly articulated and aligned to what our patients and staff are telling us. We have designed and tested a new Equality Impact Assessment (EIA) Toolkit, guidance and training for managers. We have appointed an EDI Director who reports directly to the Chief Executive, we have developed an EDI training programme and we continue to engage with our three staff neworks to ensure we are able to hear and respond to the needs of our staff.

We know that the recovery from the pandemic will prove challenging, and we recognise the impact of delayed tests, treatments and admissions for our population. We have a Reset and Recovery work-stream which is helping to ensure that we are proactively working to manage and reduce delays and ensure patients who most need our care are able to access it.

During the year we have completed a number of capital projects to improve our estate. This included oxygen equipment at the PRUH; high voltage cabling extensions; comfort cooling for Fisk and Cheere Wards; an additional endoscopy suite to increase capacity; new modular MRI, new modular buildings for PRUH Urgent and Emergency Care to support mental health, frailty, waiting areas and assessment; PRUH and Orpington Staff wellbeing hubs; ward refurbishments; replacement of 8 of the sites oldest lifts and refurbishment of the main theatre block at Denmark Hill. Improving our estate and infrastructure remains a key area of focus for us.

Our electronic health record (EHR) system is in need of a major overhaul to significantly support clinical staff with managing patients across the trust and other organisations and in October 2020, , we developed and approved the business case for Apollo, which is the most ambitious programme of clinical pathway transformation we have undertaken. Powered by Epic software, this new system will replace many of the systems we currently use with a single, integrated and comprehensive source of information. At King's, we plan to roll out this programme from late 2023.

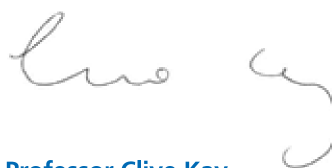
The Care Quality Commission has continued with close monitoring of our services during the pandemic such as reviewing our COVID-19 infection prevention and control framework, emergency department Patient First reviews for both sites and regular monitoring meetings.

The challenges of the last year have impacted our ability to deliver against all of the aims we set for ourselves last year. We welcome the input and feedback from our commissioners and from Healthwatch on our assessments of progress for last year and we look forward to working more closely with them this year to monitor our progress towards achieving our aims for this year and to shape our priorities for the future. Based on their feedback and our assessments of progress, we are carrying forward three of our four priorities from last year so that we can effectively deliver on these important targets and embed the changes that we know will support our people to continuously deliver higher quality care. The three which we will carry forward are:
- Reducing harm to the deteriorating patient
- Reducing violence and aggression towards staff and improving patient safety
- Improving patient experience for inpatients

We recognise that our work to improve the clinical outcomes for patients with Chronic Obstructive Pulmonary Disease (COPD) was severely impacted by the pandemic last year. This works remains very important to us, and we will continue to support this collaborative work with the British Lung Foundation. However, we have prioritised the need to focus on the delivery of a 'Long Covid' service in 2021/22 in order to be responsive to the broader needs of our population at this time.

I am incredibly proud to be the Chief Executive of King's College Hospital NHS Foundation Trust. Our dedicated and passionate staff provide high quality care for every patient, every time.

There are a number of inherent limitations which may affect the reliability or accuracy of the data reported in this Quality Account. These include data being derived from a large number of different systems; local interpretations of national data and evolving data collection practices and data definitions. The Trust and its Board have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to these inherent limitations. To the best of my knowledge, the information contained in the following Quality Account is accurate.



Professor Clive Kay
Chief Executive

About us and the service we provide

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

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

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

Specialist services such as:
- Specialist care for the most seriously injured people via our Major Trauma Centre, our two Hyper Acute Stroke Units, our Heart Attack Centre and a bed base of 98 critical care beds on the King's College Hospital site
- Europe's largest liver centre
- Internationally renowned specialist care for people with blood cancers and sickle cell disease
- World leading Neurosciences Institute providing research, education and care for patients who have suffered major head trauma and brain haemorrhages as well as brain and spinal tumours
- A centre of excellence for primary angioplasty, thrombosis and Parkinson's disease
- The Variety Children's Hospital based at King's College Hospital
- COVID-19 vaccination clinics at King's College Hospital and Princess Royal University Hospital and a mass vaccination centre at Bromley Civic Centre.

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

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

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

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

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

2.1 Priorities for improvement

Results and achievements for the 2020-21 Quality Account Priorities

Progress with the quality priorities has been affected by the COVID-19 pandemic as our all our resources moved to supporting the trust in treating patients and establishing new systems. Whenever possible we continued to work on the priorities. Table 1 below summarises the achievements made against the targets in 2020-21.

Table 1: Summary of results and achievements for the 2020-21 Quality Account priorities

Domain		Quality Account Priority Targets for 2020-21
Patient Safety		
Priority 1	Reducing harm to deteriorating patients	**Partially achieved**
Aim 1	Support staff in documenting observations at the time they are taken, improve oversight of patient observations, improve dashboards for patients scoring NEWS ≥ 5, collate reasons for delayed documentation	**Partially achieved**
Aim 2	Review and standardise education in relation to deteriorating patients for all staff:	**Achieved**
Aim 3	Learn from incidents relating to deteriorating patients and improve practice	**Achieved**
Priority 2	Reducing violence and aggression to staff and increasing patient safety	**Partially achieved**
Aim 1	Complete listening workshops with staff across the Trust. We held approximately 40 listening	**Achieved**
Aim 2	Engage with staff to identify and try ideas for improvement.	**Achieved**
Aim 3	Provide robust training for staff to prevent and manage violence and aggression.	**Partially achieved**
Patient Experience		
Priority 3	Improving patient experience for inpatients, outpatients, emergency departments, maternity services and cancer services	**Partially achieved**
Aim 1	Establish and deliver the Connected Leadership Programme for 24 wards.	**Achieved**
Aim 2	Support provided to all the wards from the central corporate teams such as Patient Experience, Kings Way Team and Quality Improvement Team.	**Achieved**
Aim 3	Involvement of patient representatives for feedback and progress.	**Partially achieved**
Aim 4	Identification of 4-5 core themes to work on based on the survey results and other feedback that will have the greatest impact on improved patient experience for inpatient area, outpatients, maternity, cancer services and emergency departments.	**Partially achieved**

Clinical Effectiveness / Patient Outcomes		
Priority 4	Improving outcomes for people with Chronic Obstructive Pulmonary Disease (COPD)	**Partially achieved**
Aim 1	Identify the outcomes that are most important to our patients. We will work with the British Lung Foundation to get feedback from people with COPD on their experience of living with the condition, the things that matter most to them and the things that make the greatest difference to their quality of life.	**Partially achieved**
Aim 2	Identify the key clinical outcomes. We will work with the integrated respiratory team to define the outcomes measures that provide clinicians with the best indication of an improvement in health status.	**Partially achieved**
Aim 3 to 6	• Measure outcomes. We will develop the feedback from our patients and clinicians into clear measures and we will gather data against these to give us a clear picture of the outcomes we achieve for people with COPD at King's. • Obtain qualitative feedback. We will present this information to our clinical teams and understand how this data might influence their practice. We intend to include general practitioners in this work. • Embed outcomes measurement. We will refine our measures and then work with the Trust's support teams to incorporate into our clinical systems, as well as into our performance and governance frameworks, as the most important measure of our performance and care quality. • Identify key changes that will lead to an improvement in our provision of care to our patients.	**Not achieved [2][1]**

[2][1] This work could not be undertaken due to the COVID-19 response.

2020-21 Quality Priority 1: Reducing harm to deteriorating patients

Why was this a priority?

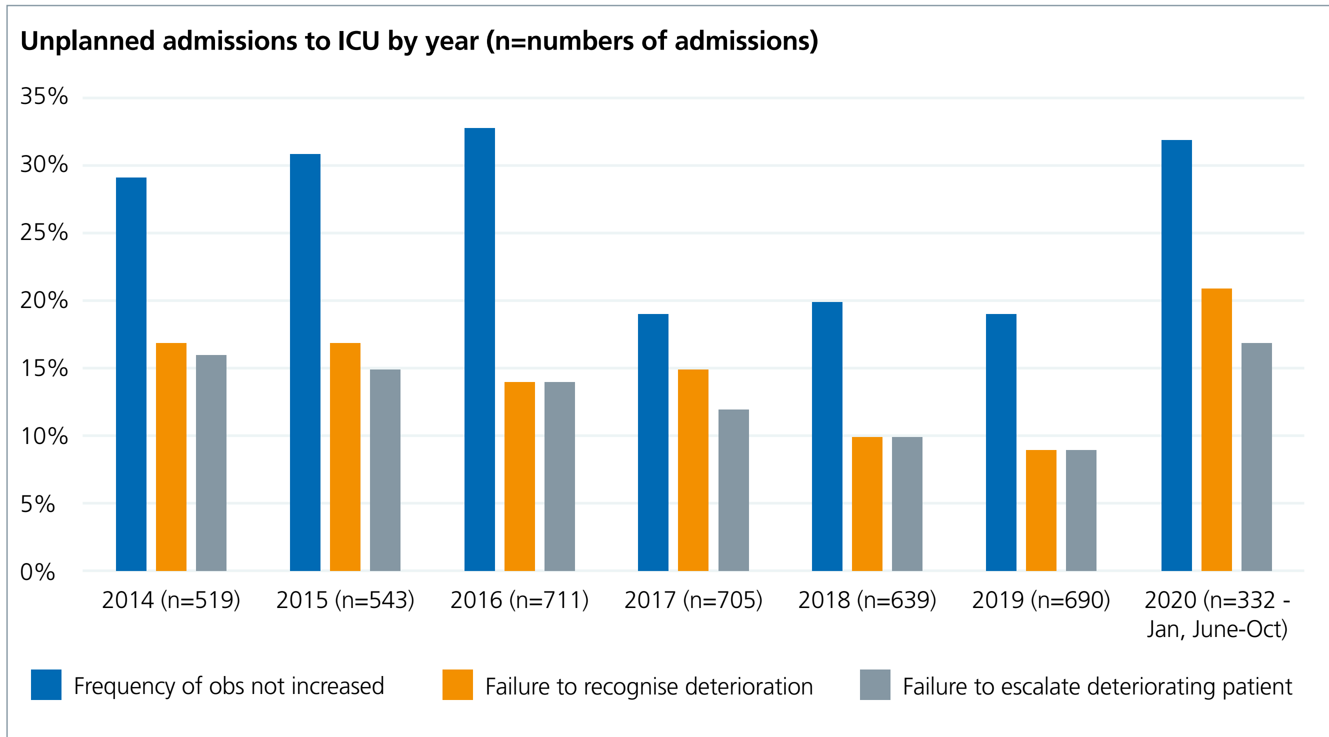
Reducing harm to deteriorating patients is one of the quality priorities for King's because detailed analysis has shown that we have opportunities to improve how we recognise, record, manage and escalate deteriorating patients.

We know, through learning from our incidents and complaints, that patient harm has been caused through delays in identifying and escalating patients who have deteriorated. We recognise that these incidents could be avoided if vital signs are taken at appropriate intervals, recorded, triggered on the National Early Warning Scoring System (NEWS 2) so that the iMobile Team (Critical Care Outreach) can be contacted to provide additional clinical support.

Between 2017 and 2019 we saw sustained improvement in both recognition and escalation of unwell patients. However, we recognise there is still work to do to keep our patients safe particularly in relation to escalating the frequency of observations in response to patient need. There were significant changes to our patient dynamics in 2020/21 as we dealt with large volumes of COVID-19 patients through wave 1 and wave 2, that make data comparisons more complex.

The graph in figure 1 below shows data collected from 2014. Data during 2020 only covers January and June to October and is vastly affected by the COVID-19 pandemic

Figure 1: Unplanned admissions to ICU from 2014 to 2020



Unplanned admissions to ICU 2014-2020– areas for focus. Sophie Hadfield, November 2020

Aims and progress made in 2020-21

Partially Achieved: Aim 1 - Support staff in documenting observations at the time they are taken, improve oversight of patient observations, improve dashboards for patients scoring NEWS ≥ 5, collate reasons for delayed documentation:
We have continued to work hard on improving safety in this area, and over the last year we have successfully implemented the following measures to support the oversight of patient observations:

- A new observation guideline has been ratified, published and cascaded (September 2020)
- In conjunction with the Electronic Patient Record team, amendments have been made to the e-Observations section so that staff can document and visualise data relating to their patients early warning score more easily.
- We have designed new reports for clinical leaders to help them identify and respond to emerging safety issues more quickly. This enables us to be more responsive day to day, but also to better identify emerging trends and themes so we can act more quickly to prevent harmful incidents.

We plan to do further work on ensuring that observations are entered onto the electronic patient record as soon as they have been completed so that staff receive an immediate prompt to escalate, if required. We can now see reasons for delay in entering observations and will work directly at ward level to understand the systems and human factors which may be causing these delays and support staff in overcoming them.

Achieved: Aim 2 - Review and standardise education in relation to deteriorating patients for all staff:
While COVID-19 has created delays in some project work, it has provided an opportunity to expedite training. This training has been instrumental in helping King's to achieve a lower mortality rate for COVID-19 patients that that seen nationally in both waves of the pandemic. King's also saw a further decrease in the mortality of patients with COVID-19 during the second wave. While all the reasons for this are being explored and we know this will include variations in treatments, age, demographics and differences in COVID-19 variants, there is no doubt that providing staff with the skills and expertise to treat patients has had a beneficial effect on patient outcomes.

Early in March 2020 the Trust recognised the need to train staff at pace, to best prepare for wave one of the pandemic. Nearly 500 staff were trained in care of the deteriorating patient in six weeks. Following the initial peak, a further 240 nurses from surgery and medicine care groups were trained in a two-week programme as follows:

Week 1: Modified in-house ALERT themed course

Week 2: Simulation training for nurses in charge.

The Trust collected feedback at each of these sessions. Themes identified included:

- Human factors training is as important as physiological teaching
- A multi-disciplinary approach is vital to mirror practice and improve confidence.

Between waves 1 and 2 of the pandemic the iMobile Team ran facilitated sessions aimed at the medical nursing teams. These sessions were designed with a respiratory focus taking into account the learning from wave one and the need to optimise patients' respiratory systems in areas outside of Critical Care Units (CCU). Topics covered included:

- Acute respiratory failure and COVID-19, safe monitoring, care of the patient receiving Optiflow, CPAP and NIV, safe transfer of acutely unwell patients, fluid management, skills sessions covering ABCDE assessments and oxygen delivery methods, basic life support and practicalities of setting up advanced non-invasive respiratory support

An education package was designed with the intention of each nurse spending protected time with iMobile, specialist Practice Educator Nurses and in specialist areas to ensure confidence and competence in caring for higher acuity patients. As wave two approached at pace the education plan was put on hold. Wards caring for higher acuity patients were allocated the support of a supernumerary senior ICU nurse to support the ward teams to safely care for patients seven days a week. This was supplemented by the iMobile team and overseen by the Deputy Director of Nursing.

Next steps:
Taking account of the discovery work with ward teams as part of this quality improvement programme, and the direct feedback given by staff during and after training, the Trust has reviewed and redesigned its training needs analysis (TNA) for deteriorating patients. This face-to-face and simulated training will commence in June 2021.

The Trust is also addressing human factors elements in escalating deterioration and films have been commissioned and completed to reflect patient, relative and staff stories around real life unplanned admissions to King's ICUs. These will be shown as part of facilitated sessions to the MDT to foster discussion, reflection and learning.

In addition to the TNA, an enhanced training package, with practical one-to-one bedside support is underway focusing on the care of tracheostomies. This is to support staff with the care of patient discharges from the Critical Care Units.
The Trust has also seconded a nurse full-time for several months to the Deteriorating Patient programme to work directly with wards in improving observation compliance and upskilling wards on each site.

Achieved: Aim 3 - Learn from incidents relating to deteriorating patients and improve practice

The Trust refocused the Harm Free Care (HFC) Forum between COVID-19 waves to encourage shared MDT discussion among care groups and teams. The forum agenda was balanced to examine root causes and actions in well-managed cases as well as incidents, so that we could learn from what we do well in addition to where we should be doing better. The HFC Forum was paused during the second wave of COVID-19. Further development and refinement of the terms of reference is underway and the group was relaunched in April 2021.

The Trust recognises that there are opportunities to improve the data collection about the harm that patients suffer as a result of incidents, so that we can readily translate that into changes in practice. A quality improvement project was commenced in 2020 with frontline clinical staff and the Electronic Patient Record teams to identify root causes and solutions to these issues. Project work was suspended as we focused all efforts on our COVID-19 response. However, we have now recommenced the project and will drive improvements in this area over 2021.

2020-21 Quality Priority 2: Reducing violence and aggression to staff and increasing patient safety

Why was this a priority?

The national staff survey (2018/19 and 2019/20) made it clear that King's College Hospital that our staff are experiencing some of the highest levels of violence and aggression in the workplace. The Trust's incident reports also reflects the day to day challenges our staff face in trying to deliver high quality care to our patient population. These incidents are detrimental to our peoples' health and wellbeing, which in turn, may impact on patient care. In the 2020, NHS staff survey the trust results showed in an improved position against the national picture comparative to other hospitals. However, the percentage of staff experiencing violence and aggression at King's has remained broadly similar, with a 1.4% reduction in the number of times staff reported experiencing physical violence at work from patients and members of the public.

The Trust has implemented a range of measures over the last decade based on learning from our incident reports. Although incidents have started to reduce in 2020/21 it is not clear if this is because of the number of related restrictions such as reduced visiting and the positive messaging around NHS staff and the response to the pandemic.

The Trust remains committed to preventing and dealing robustly with violence against our staff. We also recognise that we can help to build staff resilience and their ability to de-escalate volatile situations and resolve conflict.

Violence and Aggression programme work was suspended twice during 2020/21 to allow all staff to focus on our response to the COVID-19 pandemic. Nevertheless, the Trust has seen many achievements against the objectives set out, and we remain committed to delivering on these priorities over the course of 2021.

Aims and progress made in 2020-21

Achieved: Aim 1 - Complete listening workshops with staff across the Trust.
We held approximately 40 listening events (almost 500 members of staff) and gained insight into peoples' experience of violence and aggression in the course of their work. We were very impressed by the insight and understanding staff showed into the causes of violence and aggression, often recognising that we can sometimes cause frustration to patients through our own Trust processes, protocols, environment and behaviours. Staff displayed great empathy for patients and relatives who may be in pain, anxious, confused or suffering from a condition that may affect their behaviour. They expressed the desire to learn more about conflict resolution and mental and physical conditions that affect patient behaviour.

It was also clear from the listening events that staff were concerned about the behaviour of some patients and members of the public who were openly aggressive regardless of how teams and individuals tried to help them.

Achieved: Aim 2 - Engage with staff to identify and try ideas for improvement.
Following the listening events, we identified the main topics that staff think contribute to violence and aggression. These were stratified into themes and we have mapped the improvement ideas that people have suggested to these themes. The areas that we are working on include

- Education for staff on recognition of escalating agitation and aggression, de-escalation, conflict resolution, customer care, Dementia, Mental Health;
- Better support systems for staff during and after a violent or aggressive incident. A staff charter has been agreed with selected groups of staff. This charter will be piloted in hot spot areas and developed before roll out across the Trust. A shift reflection tool has been piloted on five wards across the Trust's three inpatient sites. Review is underway and the Trust anticipates rolling this out across all wards pending results of the pilot;

- Improvements to the environment and patient entertainment – a programme of work is underway to improve Wi-Fi connectivity in all areas. The Trust is also in the process of procuring better entertainment solutions for patients at the bedside. Tenders have been received and are under consideration;
- Review of some of our pathways and processes (e.g. nicotine replacement, alcohol/drug withdrawal, visiting, etc.) so that we can support patients and relatives better. The substance misuse project has been restarted and improvements agreed with staff include earlier identification of withdrawal and rapid treatment with replacement therapy or medication;
- The Trust's visiting policy has been rewritten and includes sections on compassionate visiting, particularly for patients who have special needs, mental health conditions (including Dementia) and are at the end of their lives;
- Innovations in caring for patients with dementia;
- Standardised processes to help us to engage or disengage consistently with patients/the public who behave violently or aggressively – the process for behavioural contracts, warning and/or banning patients is under review.

Partially Achieved: Aim 3 - Provide robust training for staff to prevent and manage violence and aggression.

Due to the COVID-19 restrictions, the Trust has not been able to provide regular face-to-face conflict resolution training (CRT). However, all new staff are now offered online CRT through the Trust's learning and development platform (LEAP). The Trust also provides access to externally provided (IKON) online training for staff working in areas where violence and aggression is more frequent, e.g. the emergency department.

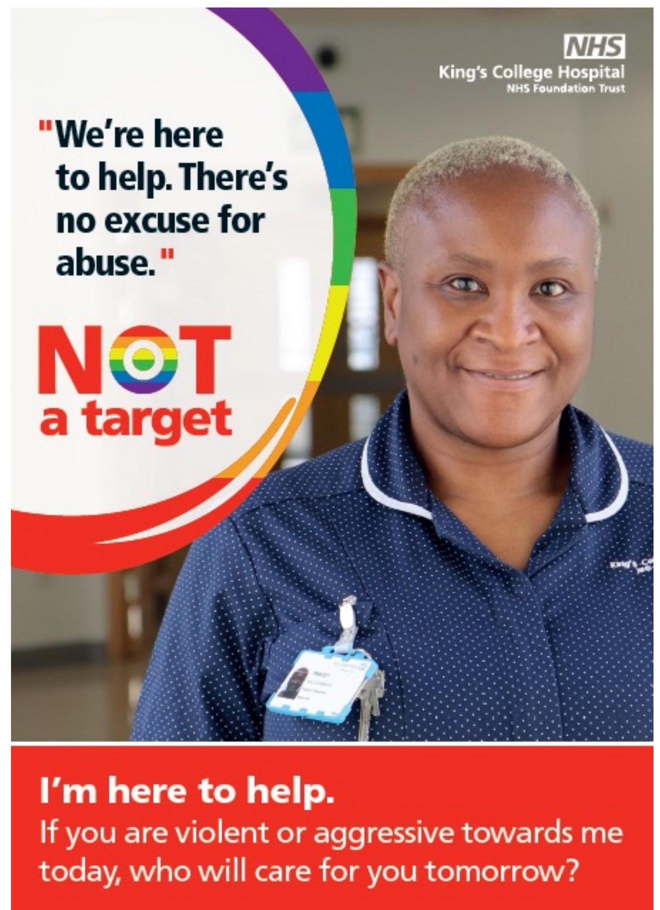
The Trust has continued to provide "bite sized" face-to-face training in "hot spot" areas identified through learning from our incident reports, so that staff are supported in recognition of escalating situations, de-escalation and break away.

We modelled how training will be provided going forwards. This includes:

1. An online package for staff who do not have contact with patients or the public in their work
2. CRT training for all frontline staff (either virtually or face-to-face)
3. Face-to-face training for staff in "hot spot" areas.

A training needs analysis (TNA) for Mental Health and Dementia training has been agreed and will be rolled out over the course of 2021/22.

Additional work undertaken includes updating the Trust's Intranet (Kwiki) for staff and the new "Not a Target" posters were designed, agreed and are now in place across the Trust. In addition, we held a webinar for all staff on 9 December 2020 to update staff on work done to date and to listen to any comments and suggestions.



2020-21 Quality Priority 3: Improving patient experience for inpatients, outpatients, emergency departments, maternity services and cancer services

Why was this a priority?

Patient feedback from the 2019 National Cancer Patient Experience Survey has shown a significant improvement from the last survey with the Trust moving from 137 out of 143 Trusts, to 107 out of 143, with 47 survey questions within the expected range and 5 below the expected. Patient feedback from National Inpatient, Emergency Department and Cancer Surveys clearly highlights there were ways in which we could make the experience of care for our patients better. The results of the national surveys align with internal Friends and Family Test (FFT); 'How are We Doing' data; and also with feedback from Trust Governors, Healthwatch, the Care Quality Commission. We want to ensure all our patients accessing our services have a good experience of their care; and we identified that we needed to do more in these areas.

Aims and progress made in 2020-21

Achieved: Aim 1 – Establish and deliver the Connected Leadership Programme for 24 wards.
It is well recognised that there are links between staff experience and patient engagement. In order to support all of our staff to deliver the best possible experience for patients, we need to ensure that we are also working hard to ensure that our staff are well supported, well developed and well-led. This is why we have connected our quality priority on improving patient experience with the Connected Leadership programme for ward leaders. The Connected Leadership programme for Ward Leaders aims to bring together Ward Leaders from across the organisation for networking and professional development as a group of peers in a safe space for learning, reflection and sharing. The programme incorporates assessment of leadership skills and styles, shadowing of the Ward Leaders in practice and coaching based on their developmental needs and objectives/goals identified. The programme also includes a series of leadership masterclasses to empower the leaders, each masterclass has a different focus to improve day-to-day troubleshooting, management of complex issues and the ability to escalate with a focus on professionalism, effective communication and values and behaviours.

The Connected Leadership programme has now successfully been developed and launched. The table below (Table 2) sets out some of the key milestones and achievements over the last year. Progress has been slowed somewhat, rightly, when our organisational priorities shifted to pandemic support. We continue to work to evaluate and embed this programme.

Table 2: Overview of progress made with the Connected Leadership Programme in 2021-21

24x Ward Leaders (Cohort 1)	Programme completed and cohort now working with the King's Way team in their ward areas
	Feedback gathered highlighted various strengths of the programme
24x Ward Leaders (Cohort 2)	Programme completed
	Staff from ITU, Theatres, Maternity and Emergency Depts. Feedback gathered highlighted various strengths of the programme
	Programme on-going, currently finishing leadership masterclasses with some dates postponed due to COVID-19
Coaching course	Attended by King's Way team Feedback gathered highlighted various strengths of the programme
24 Matrons (Cohort 1)	Programme on-going
	Dates postponed due to COVID-19 and content delivered online rather than face-to-face. Will gather feedback during, post the programme, and share Trust wide.
24 Matrons (Cohort 2)	Programme on-going
	Dates postponed due to COVID-19 and content delivered online rather than face-to-face. Will gather feedback during and post the programme and share Trust wide

Achieved: Aim 2 – Support provided to all the wards from the central corporate teams such as Patient Experience, King's Way Team and Quality Improvement Team.

The central corporate teams play a critical role in improving patient experience and their input has massively contributed to achieving the Quality Account priorities. In addition to projects mentioned elsewhere in the quality account, the fooling teams have provided the following additional support to the wards:

1) The King's Way Continuous Improvement Team provided support to 18 wards across the DH, PRUH and Orpington sites through the Outstanding Care programme. The project includes analysis of patient experience related issues and setting up ward based quality improvement projects to address the issues. Support will continue into 2021/22.
2) In addition to the supporting wards with the nutrition and hydration and patient property project detailed in aim 4, the Continuous Quality Improvement Team provide the following additional support to the wards:
   - Supporting the End of Life Care (EoLC) Clinical Lead with the implementation of the EOLC strategy including improving Advanced Care Planning for patients and their relatives
   - Supporting the set-up of a new Pre-Operative Assessment facility in the Day Surgery Unit at DH
   - Supporting the Skull Base Surgery team to make improvements to the patient pathway and experience
   - Improving patient experience at the bedside through implementation a new bedside entertainment system for patients, which will be accessible from any Wi-Fi, enabled device with a web browser. Patients will be able to use their own smart phone or tablet or use one of the 500 tablets that will be provided to the Trust as part of this contract. The platform will be suitable for our paediatric patients and is adaptable for use by patients with visual or hearing difficulties.

Partially Achieved: Aim 3 – Involvement of patient representatives for feedback and progress.

We are pleased to report that substantial progress has been made in the last year to improve he involvement of patient representatives.

- **Involvement Register:** Over 90 patients and members of the public recruited to Involvement Register.

- Over 200 patients who took part in COVID-19 interviews expressed an interest in further involvement.
- **Foundation Trust Associate Members** have over 64 organisations from the voluntary and community sector.
- **Virtual patient reference groups** established for

outpatients, Emergency Department and specific workstreams including 'Accessibility', improved patient nutrition and hydration.
- Further successful development of the **Cancer Voice group** which has increased its membership, established core workstreams and has two members attending the Trust Cancer Board.
- **Mental Health:** Scoping underway for **mental health service users** to support work streams led by the Trust Mental Health Board. Patient involvement is being scoped for all workstreams in the mental health strategy as agreed by the new mental health delivery group. Also scoping involvement of Governors and patient representatives from the Mind and Body Advisory Group. Initial scoping work completed with most of the workstreams to review existing feedback from service users to inform the development of their programmes and to identify existing groups/networks of service users who could advise the programme. 4 service users and the local Healthwatch are represented on the mental health delivery group, informing the development of a new Emergency Department psychiatric liaison survey.
- **Children and Young People:** Currently scoping plans for online listening events with parents/young people and the establishment of a parent/young people's advisory network to inform the Child health Board.

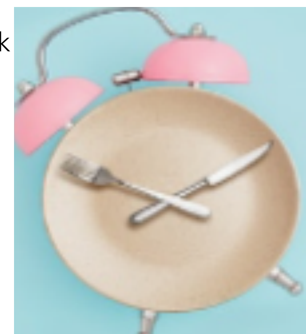
We consider that we have only partially achieved this priority aim, as we had planned to develop Care Group Patient Reference Groups aligned to the new organisational structure. The re-structure took place in October 2020, but the development of the associated patient reference groups has been impacted by COVID-19 pressures.

Partially Achieved: Aim 4 – Identification of 4-5 core themes to work on based on the survey results and other feedback that will have the greatest impact on improved patient experience for inpatient area, outpatients, maternity, cancer services and emergency departments.

The following core themes have been identified:

(1) For inpatient services, improvement projects focussed on:

- **nutrition and hydration for inpatients**, specifically providing enough help from staff for patients to eat their meals and ensuring that patients have enough to drink. An Improvement Action Plan was agreed through Patient Food Service Group with the following actions achieved in 2020/2021:
  - o Nutrition and Hydration Charter developed and piloted
  - o Series of mealtime audits carried out at Denmark Hill to inform improvement actions going forward. These include: reinstating of protected mealtimes and work with clinical colleagues to avoid diagnostic appointments during this time;
  - o Introduction of large mugs and new washable water cups on all wards to ensure they are easy to handle for patients and are a more sustainable choice for the Trust
  - o Introduction of squash as an alternative to water to encourage hydration – now routinely on hostess trolley and offered to patients at each beverage round
  - o New pictorial menu developed, positively evaluated and rolled out to ensure we communicate our food options to our diverse communities in a language that they can understand
  - o Training for hostesses now includes feedback from patients relating to mealtimes, communication and bedside manner, to improve interactions with patients.



  - o In February 2021 we launched a new Nutrition and Hydration Improvement programme launched with support from Trust's continuous improvement team to focus on: protected mealtimes, patient screening, staff training, information, policies and processes.
- **Providing enough emotional support** for patients. This work is being led by the Trust Chaplaincy Team. An initial pilot was undertaken on five wards trialling additional support for patients from chaplaincy team, information leaflets and sessions for staff, reflective sessions with staff.
- **Improving the management of patient property** through a new Patient property policy. This has been completed and is currently being implemented across the Trust. This includes the provision of colour coded patient property bags and an electronic property form on the electronic patient record that follows the patient during their journey in the Trust. We hope that this will help to reduce the incidence of patient property being forgotten/lost if the patient moves wards.
- Clear **admission and discharge** booklet for wards have been developed and launched and being rolled out trust wide.
- **Increasing volunteer presence** on the wards is thing which we know can have a really beneficial impact on patient experience. However, during the pandemic it was right that we scaled back this support to ensure that we protected the safety of our volunteers, our patients and staff. Overall we saw a decrease in the number of volunteers and the volunteer hours contributed to the hospital. Between April 2020 and February 2021, we had 353 volunteers contribute 18,281 hours, a reduction from 587 volunteers, contributing 29,387 hours between April 2019 to February 2020.

During the first and second COVID-19 waves, volunteers supported in the following key areas:

- Staff Wellbeing Hubs,
- Front of House,

- Packing and Distributing of staff and patient packs,
- COVID-19 vaccination clinics
- distribution of lateral flow testing
- fit testing
- distribution of facemasks
- assisting in patient communication and administration of visitor passports

In the period between the waves, volunteers returned to wards and were supporting as patient befrienders, providing company and conversation, supporting at mealtimes, engaging through activities. In the week leading up to Christmas, volunteers dropped off cards and presents to over 500 patients. The volunteers also created Eid activity packs for patients which were very well received.

As the results of the 2020 CQC National Adult Inpatient Survey are not available at the time of writing to quantify improvements, detailed results will be reported in Quality Account 2021/2022

(2) In our **Emergency Departments**, a patient experience improvement plan has been put together based on detailed analysis of national and internal patient feedback at Denmark Hill. Achievements to date include:
- A new system to text patients in ED waiting for to collect medication from the pharmacy has been introduced to avoid patients waiting outside or in the pharmacy queue
- New patient information leaflet produced to explain paediatric ED department tested with young people
- System in place for nursing and medical staff to receive positive named feedback about their care from patients
- New cleaning schedule introduced to address patient feedback about cleanliness
- Audits of pain management to understand areas that we can improve
- Food and drink trolley reinstated in adult ED
- Improved adult mental health facilities developed in consultation with the ED patient user group.

Other parts of the plan are ongoing including a task and finish group to develop solutions to explaining waiting times; revision of the food and drink policy, further patient information, customer care training for admin staff.

(3) **Continue with the Cancer Improvement programme and target specialties flagging on the survey feedback.**

In 2020-21, we aimed to deliver work against 9 priority areas identified as requiring improvements in the National Cancer Patients Experience Survey (NCPES). Our achievements and progress include:
- 100% of patients starting new cycles of chemotherapy are offered pre-chemotherapy consultations with high satisfaction.
- Cancer patient involvement group was set up in March 2020 and successfully imbedded during 2020-21. Patients are present in all workstreams, participating in interviews; development of patient information and available in advisory capacity for projects; surveys and service co design. Patient representatives are also part of the Cancer Board.
- Continuing professional development of the cancer Clinical Nurse Specialist workforce delivered with staff training in level 2 psychology holistic needs assessment and Sage and Thyme communication training.

We are starting to see the impact of these initiatives in the reported experience of our patients, which is very welcome. The 2019 National Cancer Patient Experience survey highlighted that the Trust had improved. Fourteen questions showed an improvement based on the baseline in 2018 and overall the Trust has moved up 30 places in the national league table. It is recognised that there is more to do, but it is reassuring to see that our work on these priority areas is making the experience better for our patients.

(4) **Continue with the Outpatient improvement programme.**

The Outpatient Transformation through a digitalised platform has continued to progress through the COVID-19 pandemic and, once complete, will improve the experience and effectiveness for patients accessing our outpatient services. The following innovations are well underway and implementation will continue during 2020/2021;
- Live chat service using chat bots to answer patient questions and enquiries while visiting the Trust website. Patient questions and chat bot answers are tracked to ensure accuracy of responses.

- Video consultation clinics
- Use of text reminders to patient mobiles at 1 week and 2 days prior to their appointments.
- Patient access to view their electronic clinic letters via a patient portal which is accessible on mobiles and tablets.
- Touch screen check-in for all outpatient units with waiting times displayed
- Electronic remote pre-assessment
- Video technology to remotely conduct clinical consultation, video consultations, and assess patients (i.e. view skin conditions). The Trust will be moving to a new platform, e-clinic which offers improved functionality.

2020-21 Quality Priority 4: Improving outcomes for people with Chronic Obstructive Pulmonary Disease (COPD)

Why was this a priority?

The NHS Long Term Plan identifies respiratory conditions as one of the top five causes of early death for the people of England. It affects one in five people and is the third biggest cause of death. Hospital admissions for lung disease have risen over the past seven years at three times the rate of all admissions generally and remain a major factor in the winter pressures faced by the NHS. Incidence and mortality rates for those with respiratory disease are higher in disadvantaged groups and areas of social deprivation, such as the populations local to KCH.

At KCH, we have long recognised the impact of COPD on quality of life and premature deaths. We are fortunate to have an integrated respiratory team, which works across hospital and community and with our local GPs to deliver excellent care to our patients.

We set out to improve the information we have on the outcomes that we achieve for our patients. By 'outcomes' we mean a change in health and/or wellbeing status, i.e. how well do we achieve what we set out to achieve. We initially planned for this to be a two-year quality priority but, as explained in the next section, our priorities changed due to the COVID-19 pandemic, which clearly had a significant impact on the work of our respiratory team.

Aims and progress made in 2020-21

Partially Achieved: Aim 1 - Identify the outcomes that are most important to our patients. We will work with the British Lung Foundation to get feedback from people with COPD on their experience of living with the condition, the things that matter most to them and the things that make the greatest difference to their quality of life.

- We undertook a detailed literature review on patient-defined outcomes. This concluded that patient-defined outcomes can be very different to clinically-defined outcomes. In collaboration with the British Lung Foundation (BLF), we set out to talk to COPD patients about the outcomes that matter most to them.
- The furloughing of BLF staff and the need for shielding for key project staff at KCH led to delays in identifying patients for interview. We believe that the pandemic also resulted in fewer patients coming forward than anticipated. Despite these difficulties, the British Lung Foundation identified a group of engaged patients and thirteen in-depth interviews took place online between September and November 2020.

- Although the sample was small, two themes could be identified in relation to outcomes that are most important to COPD patients:
  - o Return to previous physical activity abilities.
  - o Reduced time spent in hospital/clinical settings.

In addition, patients told us that they would like to see their wishes and/or hopes for treatment to be more central to communication and clinical decision-making. The intention was to use this feedback to inform indicators which would then be measured with feedback from a sample of KCH patients. This stage of the project has had to be put on hold due to COVID-19.

Partially Achieved: Aim 2 – Identify the key clinical outcomes. We will work with the integrated respiratory team to define the outcomes measures that provide clinicians with the best indication of an improvement in health status.

- A prototype set of clinical outcomes indicators was developed and, in the summer of 2020, the clinical team undertook in-depth reviews of patients' hospital records to collect pilot data and test the indicators. Although the project had to be paused in September 2020, useful learning in relation to the methodology was obtained and this has been recorded for use once the project is able to recommence.

Not Achieved: Aim 3 - Measure outcomes. We will develop the feedback from our patients and clinicians into clear measures and we will gather data against these to give us a clear picture of the outcomes we achieve for people with COPD at King's.

- This work could not be undertaken due to the COVID-19 response.

Not Achieved: Aim 4 - Obtain qualitative feedback. We will present this information to our clinical teams and understand how this data might influence their practice. We intend to include general practitioners in this work.

- This work could not be undertaken due to the COVID-19 response.

Not Achieved: Aim 5 - Embed outcomes measurement. We will refine our measures and then work with the Trust's support teams to incorporate into our clinical systems, as well as into our performance and governance frameworks, as the most important measure of our performance and care quality.

- This work could not be undertaken due to the COVID-19 response.

Not Achieved: Aim 6 – Identify key changes that will lead to an improvement in our provision of care to our patients.

- This work could not be undertaken due to the COVID-19 response.

Next steps:

The respiratory team is leading the development of new services in relation to COVID-19 rehabilitation and this will be the focus of operational work, and the Trust's quality priority for patient outcomes, during 2021-22. The Patient Outcomes Committee will consider the learning from the patient interviews with a view to developing further outcomes indicators in relation to time spent in healthcare and greater involvement of patients in decision making.

Choosing priorities for 2021-22

Choosing Priorities for 2021-22

The following improvement schemes have been agreed by the King's Executives and the Board for 2021-22. These will be reported in full in the 2021-22 Quality Account with quarterly reporting to the Quality, People and Performance Committee.

Each priority has been aligned to a quality domain (patient safety, patient experience, and clinical effectiveness). The trust made the decision to continue with three of the 2019/20 priorities as we were unable to complete due to pandemic pressures in 2020/21.

The priorities were shared and our approach discussed with the Trust Governors, Healthwatch and our Commissioners. Whilst working on the delivery of each priority we will use patient and or governor representatives as part of the working groups and seek patient or staff feedback at set points in the plans.

Our aims for each are set out below.

2021-22 Quality Priority 1: Reducing harm to deteriorating patients

Why was this a priority?

In 2020-21, we made a commitment to reduce harm to deteriorating patients, improving patient safety and outcomes. In 2021-22, reducing harm to deteriorating patients will continue to be a quality priority across the Trust.

Reducing harm to deteriorating patients is one of the quality priorities for King's because detailed analysis has shown that we have opportunities to improve how we recognise, record, manage and escalate deteriorating patients.

We know, through learning from our incidents and complaints, that patient harm has been caused through delays in identifying and escalating patients who have deteriorated. We recognise that these incidents could be avoided if vital signs are taken at appropriate intervals, recorded, triggered on the National Early Warning Scoring System (NEWS 2) so that the iMobile Team (Critical Care Outreach) can be contacted to provide additional clinical support.

Between 2017 and 2019, we saw sustained improvement in both recognition and escalation of unwell patients. However, we recognise there is still work to do to keep our patients safe particularly in relation to escalating the frequency of observations in response to patient need. There were significant changes to our patient dynamics in 2020/21 as we dealt with large volumes of COVID-19 patients through wave 1 and wave 2, that make data comparisons more complex.

What are our aims for the coming year?

In 2021-22, we will:

- Implement the Deteriorating patient training needs analysis(TNA)
- Deliver on the Live dashboard to monitor compliance on observations
- Improve the completion of timely observations and escalation
- Ensure the correct observation equipment is purchased and in place on wards.

How will we monitor and measure our progress?

Progress against these aims will be reviewed by the Deteriorating patient working group and reported to, and monitored by the Patient Safety Committee and the Quality, People and Performance Committee in the Trust's Quarterly Quality Priorities Report.

Measures of success will include the following:

- Monitor % compliance against the Deteriorating patient training needs analysis
- Delivery of the live dashboard with key metrics including
  - o NEWS score ≥ 5 and percentage (%) compliance in repeating observations within one hour on Electronic Patient Record (EPR).
  - o Documentation with Fi)2>40% or 10 Litres
  - o Previous 24 hours observation compliance
  - o Role completing observations
- Identification of themes and associated improvement plans from analysis of the reasons documented by staff as to why observations are not recorded within one hour
- Reduction in unplanned admissions to Intensive Care Unit (ICU)
- Trust-wide equipment audit in quarter 2 reviewing if the of correct observation equipment is purchased and in place on wards.

2021-22 Quality Priority 2: Improving outcomes for people with long term effects of COVID-19 ('long COVID' or Post COVID Syndrome)

Why was this a priority?

Some people experience symptoms that last weeks or months after the COVID-19 infection has gone. These long term effects have become known as 'long COVID'. Symptoms are wide-ranging and include, among many others, fatigue, shortness of breath, chest pain/tightness, 'brain fog' and depression and anxiety. The full range of long-term effects has not yet been defined.

Over the past 12 months, King's has cared for over 3,500 inpatients with COVID-19, making it one of the busiest Trusts nationally. We were one of the first Trusts to establish COVID-19 follow-up clinics and the research undertaken in these clinics has informed the NICE guidelines on managing the long-term effects of COVID-19.

King's will continue to set up new clinical services to support people with long COVID over the next year, and to be involved in ground-breaking research to understand long COVID so that we, and others, can develop effective treatments and support. This will be a clinical priority for King's over the next year.

It is appropriate, therefore, that the Trust's Quality Priorities support this clinical priority.

What are our aims for the coming year?

This quality priority brings together several aspects of quality improvement – service provision, measuring outcomes including patients' experience to inform service development, and research and innovation.

In 2021-22, we intend to:

- **Set up new clinical services** to support people with long COVID, including (working collaboratively with colleagues in Guys and St Thomas') the specialist post COVID-19 syndrome assessment clinics for the South East London Integrated Care System.

- **Measure the outcomes of these services** including the outcomes that are most important to patients, so that we can use data to inform the development of services and shared decision-making between patients and clinicians.

- **Collaborate and innovate**
We will continue to undertake and to collaborate in research on long COVID, to inform the development of our clinical services. This will include collaboration in the national Post-hospitalisation COVID-19 study (PHOSP-COVID). This is a consortium of leading researchers and clinicians from across the UK who are working together to understand and improve long-term health outcomes for patients who have been in hospital with confirmed or suspected COVID-19.

How will we monitor and measure our progress?

Measures of success will include:

- We will aim to see more than 1000 patients in the long covid assessment clinic in 2021-22
- We will aim to collect 3 month and 6 month outcome data from more than 50% of patients who attend the long covid assessment clinics within 2021-22.
- We will aim to publish the outcomes of our research collaborations in a high impact journal

Progress against our aims and using these measures will be reported to the Quality Improvement and Prioritisation Committee and included in the Trust's Quarterly Quality Priorities Report.

2021-22 Quality Priority 3: Improving patient experience for inpatients.

Why was this a priority?

Patient feedback from the 2019 National Cancer Patient Experience Survey has shown a significant improvement from the last survey with the Trust moving from 137 out of 143 Trusts, to 107 out of 143, with 47 survey questions within the expected range and 5 below the expected. Patient feedback from National Inpatient, Emergency Department and Cancer Surveys clearly highlights there were ways in which we could make the experience of care for our patients better. The results of the national surveys align with internal Friends and Family Test (FFT); 'How are We Doing' data; and also with feedback from Trust Governors, Healthwatch, the Care Quality Commission. We want to ensure all our patients accessing our services have a good experience of their care; and we identified that we needed to do more in these areas. Over 2020/21, we have made good progress with our patient experience improvement plan and want to continue to build on this.

What are our aims for the coming year?

- To continue delivering the Connected Leadership Programme for nursing and midwifery leaders
- To improve nutrition and hydration for inpatients
- To deliver an emotional support improvement programme that has been co-designed with our patients
- To embed, assess and improve our admission and discharge information based on feedback from patients and relatives
- To roll out a new patient entertainment system, which includes access to streaming services, television, print, film, web access and messaging/video calling functionality. We are planning to purchase an additional 500 tablets over the next 5 years.
- To improve communication between patients and healthcare professionals on the wards.

How will we monitor and measure our progress?

Progress against these aims will be reported to, and monitored by the Quality, People and Performance Committee in the Trust's Quarterly Quality Priorities Report.

Measures of success will include:

- By December 2021, to achieve 96% Friends and Family Test recommendation rate across all inpatient services
- By March 2022, to sustain 96% Friends and Family Test recommendation rate across all inpatient services
- By March 2022, to increase Friends and Family Test response rate to 20%
- To achieve the following improvements in the National CQC Inpatient Survey Results:
    - 7.2 score for patients reporting receiving help with feeding
    - 9.2 score for patients reporting having enough to drink whilst in hospital
    - 6.8 score for patients reporting receiving enough emotional support from hospital staff, if needed
- Completion of patient entertainment system roll out across all sites, including:
    - Full business case developed and signed off at King's Executive / Investment Board
    - Specification developed with - and agreed by – relevant internal teams (e.g. Procurement, ICT, Estates, Finance, etc.)
    - Procurement and implementation of the system.

2021-22 Quality Priority 4: Reducing violence and aggression to staff and increasing patient safety

Why was this a priority?

The national staff survey (2018/19 and 2019/20) made it clear that King's College Hospital that our staff are experiencing some of the highest levels of violence and aggression in the workplace. The Trust's incident reports also reflects the day-to-day challenges our staff face in trying to deliver high quality care to our patient population. These incidents are detrimental to our peoples' health and wellbeing, which in turn, may impact on patient care. In the 2020, NHS staff survey the trust results showed in an improved position against the national picture comparative to other hospitals. However, the percentage of staff experiencing violence and aggression at King's has remained broadly similar, with a 1.4% reduction in the number of times staff reported experiencing physical violence at work from patients and members of the public.

The Trust has implemented a range of measures over the last decade based on learning from our incident reports. Although incidents have started to reduce in 2020/21 it is not clear if this is because of the number of related restrictions such as reduced visiting and the positive messaging around NHS staff and the response to the pandemic.

The Trust remains committed to preventing and dealing robustly with violence against our staff. We also recognise that we can help to build staff resilience and their ability to de-escalate volatile situations and resolve conflict.

Violence and Aggression programme work was suspended twice during 2020/21 to allow all staff to focus on our response to the COVID-19 pandemic. Nevertheless, the Trust has seen many achievements against the objectives set out, and we remain committed to delivering on these priorities over the course of 2021.

What are our aims for the coming year?

- Clearly define the Trust approach to conflict resolution training
- Roll out comprehensive training package to improve staff confidence in managing complex patients
- Complete Trust assessment on NHS Violence prevention and reduction standard
- Roll out patient entertainment system (see priority 3)
- Develop and embed a comprehensive mechanism for staff support following incidents.

How will we monitor and measure our progress?

- Develop a series of monitoring measures to assess progress internally.
- Improvement in national staff survey results.

2.2 Statements of Assurance from the Board

1. During 2020-21, the King's College Hospital NHS Foundation Trust provided eight relevant health services.
- Assessment or medical treatment for persons detained under the 1983 Act
- Diagnostic and screening procedures
- Family planning services
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury.

1.1 The Trust has reviewed all data available to it on the quality of care in these services.

1.2 The income generated by the relevant health services reviewed in 2020-21 represents 90.0% of the total income generated from the provision of health services by the King's College Hospital NHS Foundation Trust for 2020-21.

Clinical Audits and National Confidential Enquiries

2. During 2020-21, 70 national clinical audits and 13 national confidential enquiries covered relevant health services that King's College Hospital NHS Foundation Trust provides.

2.1 During that period, King's College Hospital NHS Foundation Trust participated in 100% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate.

2.2 The national clinical audits and national confidential enquiries in which King's College Hospital NHS Foundation Trust was eligible to participate during 2020-21are as follows (see Table 3).

2.3 The national clinical audits and national confidential enquires in which King's College Hospital NHS Foundation Trust participated during 2020-21 are as follows (see Table 3).

2.4 The national clinical audits and national confidential enquiries in which King's College Hospital NHS Foundation Trust participated, and for which data collection was completed during 2020-21, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry (see Table 3).

Table 3: Participation in national clinical audits and confidential enquiries

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
BAUS Urology Audits- Nephrectomy	Yes	Awaiting publication
BAUS Urology Audits- Bladder Outflow Obstruction Audit	Yes	Awaiting publication
BAUS Urology Audits- Cytoreductive Radical Nephrectomy Audit	Yes	Awaiting publication
BAUS Urology Audits- Renal Colic Audit	Yes	Awaiting publication
British Spine Registry	Yes	Data collection in progress
Intensive Care National Audit and Research Centre Case Mix Programme	Yes	Data collection in progress
Child Health Clinical Outcomes Review Programme- Young People's Mental Health	Yes	Not provided
Child Health Clinical Outcomes Review Programme- Long-term ventilation in children, young people and young adults	Yes	Not provided
Cleft Registry and Audit Network (CRANE)	Yes	Data collection in progress
Emergency Medicine Quality Improvement Projects (QIPs) - Assessing Cognitive Impairment in Older People/Care in Emergency Departments	Yes	Awaiting publication

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
Emergency Medicine QIPs- Care of Children in emergency departments	Yes	Awaiting publication
Emergency Medicine QIPs- Fractured Neck of Femur (care in emergency departments)	Yes	Data collection in progress
Emergency Medicine QIPs- Infection Control	Yes	Data collection in progress
Emergency Medicine QIPs- Mental Health	Yes	Awaiting publication
Emergency Medicine QIPs- Pain in Children	Yes	Data collection in progress
Falls and Fragility Programme (FFFAP)- Fracture Liaison Service Database	Yes	Awaiting publication
Falls and Fragility Programme (FFFAP)- Fracture Liaison Service Database/Vertebral Fracture Sprint Audit	Yes	Data collection in progress
Falls and Fragility Programme (FFFAP)- National Audit of Inpatient Falls	Yes	Awaiting publication
Falls and Fragility Programme (FFFAP)- National Hip Fracture Database	Yes	Data collection in progress
Inflammatory Bowel Disease (IBD) Programme (IBD registry)	Yes	Data collection in progress
Learning Disability Mortality Review Programme (LeDeR)	Yes	Not available
Liver Transplantation	Yes	Not available
Mandatory Surveillance of Health Care Associated Infections	Yes	Data collection in progress
Maternal, Newborn and Infant Clinical Outcome Review Programme – Perinatal Mortality Surveillance	Yes	Data collection in progress
Maternal, Newborn and Infant Clinical Outcome Review Programme – Saving Lives, Improving Mothers' Care	Yes	Data collection in progress
Maternal, Newborn and Infant Clinical Outcome Review Programme – Perinatal mortality and morbidity confidential enquiries	Yes	Data collection in progress
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)- Dysphagia in Parkinson's Disease	Yes	Data collection in progress
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – Acute Heart Failure	Yes	57%
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – Cancer in Children, Teens and Young Adults	Yes	Not available
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – Perioperative diabetes	Yes	83%
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – Pulmonary Embolism	Yes	80%
Medical and Surgical Clinical Outcomes Review Programme (NCEPOD) – Acute Bowel Obstruction	Yes	33%
Medical and Surgical Clinical Outcomes Review Programme (NCEPOD) – In-Hospital Management of Out-of-Hospital Cardiac Arrest	Yes	35%
National Asthma and COPD Audit Programme (NACAP)- Paediatric Asthma Secondary Care	Yes	Awaiting publication
National Asthma and COPD Audit Programme (NACAP)- Adult Asthma Secondary Care	Yes	Data collection in progress
National Asthma and COPD Audit Programme (NACAP)- COPD Secondary Care	Yes	Data collection in progress
National Asthma and COPD Audit Programme (NACAP)- Pulmonary Rehabilitation	Yes	Data collection in progress
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Data collection in progress
National Audit of Cardiac Rehabilitation	Yes	Data collection in progress
National Audit of Care at the End of Life (NACEL)	Yes	Data collection in progress
National Audit of Dementia (NAD)	Yes	Data collection in progress
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	Data collection in progress
National Bariatric Surgery Registry	Yes	Data collection in progress
National Cardiac Arrest Audit (NCAA)	Yes	Data collection in progress
National Cardiac Audit Programme (NCAP)- National Audit of Cardiac Rhythm Management (CRM)	Yes	Data collection in progress

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
National Cardiac Audit Programme (NCAP)- Myocardial Ischaemia National Project (MINAP)	Yes	Data collection in progress
National Cardiac Audit Programme (NCAP)- National Adult Cardiac Surgery	Yes	Data collection in progress
National Cardiac Audit Programme (NCAP): National Audit of Percutaneous Coronary Interventional Procedures (PCI) (Coronary Angioplasty)	Yes	Data collection in progress
National Cardiac Audit Programme (NCAP): National Heart Failure Audit	Yes	Data collection in progress
National Comparative Audit of Blood Transfusion programme: 2019 Re-audit of the Medical Use of Blood	Yes	Data collection in progress
National Comparative Audit of Blood Transfusion programme: 2020 Audit of the Perioperative Management of Anaemia in Children Undergoing Elective Surgery	Yes	Data collection in progress
National Diabetes Audit (ADULTS)- National Diabetes Foot Care Audit	Yes	Data collection in progress
National Diabetes Audit (ADULTS)- National Diabetes Inpatient Audit (NADIA)	Yes	Data collection in progress
National Diabetes Audit (ADULTS)- National Diabetes Inpatient Audit (NADIA)- Harms	Yes	Data collection in progress
National Diabetes Audit (ADULTS)- Core Audit	Yes	Data collection in progress
National Diabetes Audit (ADULTS)- National Pregnancy in Diabetes (NPID)	Yes	Awaiting publication
National Early Inflammatory Arthritis Audit (NEIA)	Yes	Not given
National Emergency Laparotomy Audit (NELA)	Yes	Data collection in progress
National Gastro-intestinal Cancer Programme- National Oesophago-Gastric Cancer (NOGCA)	Yes	Data collection in progress
National Gastro-intestinal Cancer Programme- National Bowel Cancer Audit (NBOCA)	Yes	Data collection in progress
National Joint Registry (NJR)	Yes	Awaiting publication
National Lung Cancer Audit (NLCA)	Yes	Awaiting publication
National Maternity and Perinatal Audit (NMPA)	Yes	Data collection in progress
National Neonatal Audit Programme (NNAP)	Yes	Awaiting publication
National Ophthalmology Database Audit	Yes	Data collection in progress
National Paediatric Diabetes Audit (NPDA)	Yes	Data collection in progress
National Prostate Cancer Audit (NPCA)	Yes	Data collection in progress
Vascular Services Quality Improvement Programme (VSQIP)-National Vascular Registry (NVR)	Yes	Data collection in progress
Neurosurgical National Audit Programme (NNAP)	Yes	Data collection in progress
Paediatric Intensive Care Audit Network (PICANet)	Yes	Awaiting publication
Perioperative Quality Improvement Programme (PQIP)	Yes	Data collection in progress
Prescribing Observatory for Mental Health (POMH-UK)- Monitoring of Patients Prescribed Lithium	Yes	Data collection in progress
Prescribing Observatory for Mental Health (POMH-UK)- Antipsychotic Prescribing in People with a Learning Disability	Yes	Data collection in progress
Potential Donor Audit	Yes	Data collection in progress
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Data collection in progress
Serious Hazards of Transfusion (SHOT)	Yes	Data collection in progress
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	Awaiting publication
Surgical Site Infection Surveillance Service	Yes	Data collection in progress
Trauma Audit & Research Network (TARN)	Yes	Data collection in progress
UK Cystic Fibrosis Registry	Yes	Awaiting publication
UK Registry of Endocrine and Thyroid Surgery	Yes	Awaiting publication
UK Parkinson's Audit	Yes	Awaiting publication
UK Renal Registry	Yes	Awaiting publication

2.5 The reports of 24 national clinical audits were reviewed by the provider in 2020-21.

2.6 King's College Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Table 4).

Table 4: Improvement actions taken as a result of national clinical audits reviewed

National Audit title	Improvement actions to date
Pulmonary Rehabilitation Clinical and Organisational Audits 2019 (published Dec 20)	The pulmonary rehabilitation service will undergo a detailed review as part of the COVID-19 recovery work.
National Oesophago-Gastric Cancer Audit (published Dec 20)	Participation in public health campaigns aim to improve earlier identification of oesophago-gastric cancer.
National Cardiac Arrest Audit Q2 (published Dec-20)	To improve data quality, a new case submission system was introduced in August 2020.
National Neonatal Audit Programme (NNAP) (published Nov 20)	• A quality improvement project called "hot on cold babies" aiming to achieve normothermia in all babies admitted to the Neonatal Units at KCH and PRUH. • The use of non-invasive ventilation and LISA (Less Invasive Surfactant Administration) as appropriate, to address bronchopulmonary dysplasia. • Action to improve magnesium sulphate administration including continuous neonatology liaison with obstetrics team at the perinatal meetings and provision of advice about the importance of administrating magnesium sulphate to mothers who fulfil the NNAP criteria.
Royal College of Emergency Medicine – Care of Children in the Emergency Department (ED) (published Jan 21)	A Did Not Wait (DNW) pathway has been launched in Paediatric ED, designed by the Paediatric Emergency Medicine Modern Matron, to improve capture of information on all vulnerable children and young people. A presentation of children's safeguarding data (a comparison of data in lockdown compared to data from a similar time period and months pre-lockdown) was provided at the RCEM 2021 conference by Dr Lala Asim, and shortlisted for a prize.
National Heart Failure Audit (published Dec-20)	Data capture issues will be reviewed as part of the roll-out of the planned new Electronic Health Record programme. Collaboration between KCH heart failure specialists and acute medicine to ensure that the care pathway in relation to follow-up review works effectively for all patients.
National hip fracture database	Quality of data submitted in relation to in-hospital hip fractures has improved.

2.7 The reports of over 96 local clinical audits were reviewed by the Trust in 2020-21. In addition, the Trust has a comprehensive programme of clinical audits known as Perfect Ward, an assurance framework for ward managers to inspect their wards against evidenced based criteria. This is a tool developed to give assurance around the following areas:

- Treatment and welfare
- Medicine Management
- Environment
- Documentation and confidentiality
- Staffing
- Equipment, Supplies & Devices
- Quality
- Hand Hygiene
- Outpatients
- Infection Prevention and Control.

2.8 King's College Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided, through implementing the structured quality and continuous improvement programme. Its core components are outlined below:

- **Pathway redesign across clinical settings** – the Trust's structured approach to project management and service redesign is D5. This straightforward methodology takes teams through five phases of project management using a range of lean tools and techniques and comprehensive project management. Lean philosophy (which is typically described as a methodology that increases value to the customer/ patient, reduces waste and supports continuous improvement), is used as a basis for our quality improvement work. It maps well to the IHI Model for Improvement and these methodologies are seen as complementary ways of improving quality.

- **The King's Academy Continuous Improvement Training** – this is a capability building programme developed to equip our people with the skills, confidence and tools they need to deliver service redesign and continuous improvement. While the COVID-19 pandemic has interrupted our face-to-face training, we have converted our White Belt training to a virtual course and an e-learning package has been developed for roll out in 2021. Since our training programme started, over 4,100 people have received training. While the bulk of this training is White Belt), King's has also trained 325 Yellow and Green Belts.

- o Yellow and Green Belt improvement projects have been completed across a range of departments and services. To date, these projects have largely been chosen by individual students based on their personal preferences. Future projects will be prioritised and linked to support the Trust's quality priorities outlined above.
- o Educational supervisors and doctors in training have access to continuous improvement training and are encouraged to undertake QI projects during their time at KCH.

- **Continuous improvement on a daily basis through the application of lean philosophy and techniques** - The Outstanding Care programme which is led by the Executive Nursing team is being implemented on our wards. It is linked to a ward accreditation scheme, which in turn, has been built around the CQC domains of Safe, Effective, Caring, Responsive and Well-Led. The approach has undergone continuous improvement over the last year and has been developed in conjunction with a ward manager leadership programme. The Outstanding Care programme is designed to address culture and behaviours in addition to making practical changes so that the Trust runs its services in the most efficient and effective way. Frontline teams are equipped with tools that enable them to see and measure how they are doing, solve problems and make improvements every day.

The Quality and Continuous Improvement team are supporting the programmes outlined in the table 5 below during 2020-21:

Table 5: Quality and Continues Improvement programmes for 2021-22

Name of Programme	Brief description of work
Reducing violence and aggression towards staff	See Quality Priority Section
Improved recognition of the deteriorating patient	See Quality Priority Section
Patient Safety	Harm free care – implement improvements in the capture, recording and sharing of patient safety data
Patient Safety	Portering – implement improvements in flow to reduce delays in patient diagnostics
Patient Safety	Support the set-up and governance of the Patient Safety Committee
Patient Safety	Support the implementation of new risk and incident management processes
Patient Experience	Nutrition and Hydration - support the six workstreams of this programme
Patient Experience	Procure and implement a new patient entertainment system at the bedside
Patient Experience	Accessibility - Support the six workstreams of this programme
Patient Experience	Support the implementation of the End of Life Care strategy through the four pillars of Care of the Patient, Care of the Relative, Care of Staff and Care after Dying.
Patient Experience	Skull surgery - Together with the MDT define and implement improvements that will improve the experience of patients with brain tumours.
Continuous Improvement training and support	This programme has a critical role in supporting the Trust to adapt its culture to one of continuous quality improvement. The following support is provided; **In house training** - The CI training programme (White, Yellow and Green Belt) is based on lean thinking and incorporates elements of the IHI Model for Improvement. The courses support staff to become familiar with improvement tools and comfortable with implementing their own improvement projects. **Flow Coaching Academy** - Following a rigorous application and interview process the Trust was accepted as one of only three hospitals to become a flow-coaching academy in 2020 in collaboration with the Health Foundation and Sheffield Microsystems Academy. This programme did not start in 2020 due to COVID-19. We will commence this work in April 2021. **Life QI** – this is a web platform that allows us to keep a record of all quality improvement projects underway in the Trust, it provides template improvement tools to help people describe and measure their improvement projects and it supports communication and engagement between people who are undertaking improvement work. We support any member of staff undertaking improvement work to access this website and QI tools.

Information on participation in clinical research

3. The number of patients receiving relevant health services provided or subcontracted by King's College Hospital NHS Foundation Trust in 2020-21 that were recruited during that period to participate in research approved by a research ethics committee was 20,999. This is comparable to the numbers recruited in the previous year and a illustration of the hospital's commitment to research.

Commissioning for Quality and Innovation (CQUIN) framework

Due to the ongoing COVID-19 pandemic, all Trusts were instructed to operate under monthly block contracts, of a value dictated by NHSE. CQUINs were also suspended, throughout 2020/21 with the following instruction:

> ***providers do not need to implement CQUIN requirements, carry out CQUIN audits nor submit CQUIN performance data. For Trusts, an allowance for CQUIN will continue to be built into nationally-set block payments.***

NB: the normal value of CQUINs is currently 1.25% of the Trusts contracted income.

(This direction remains the same for, at least, the first part of 2021/22).

Initial CQUIN guidance, published in early 2020 (before the pandemic), included the continuation of some CQUINs undertaken in 2019/20. Recognising the importance of continuing the work focusing on the Quality of care provided to our patients, the Trust supported a number of fixed term posts to ensure this work was able to continue.

Care Quality Commission (CQC)

4. King's College Hospital NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'Requires Improvement'. King's College NHS Foundation Trust does not have any conditions on registration. The Care Quality Commission has not taken enforcement action against King's College Hospital NHS Foundation Trust during 2020-21. The tables 6 and 7 below show the overall ratings by site.

Table 6: Overall CQC rating, King's College Hospital, published Jun-19

Ratings for King's College Hospital

	Safe	Effective	Caring	Responsive	Wel-led	Overall
Urgent and emergency services	Requires improvement ↓ May 2019	Good →← May 2019	Good →← May 2019	Requires improvement →← May 2019	Requires improvement ↓ May 2019	Requires improvement ↓ May 2019
Medical care (including older people's care)	Good ↑ Sept 2017	Good →← Sept 2017	Good →← Sept 2017	Good →← Sept 2017	Good →← Sept 2017	Good →← Sept 2017
Surgery	Requires improvement ↓ May 2019	Requires improvement →← May 2019	Good →← May 2019	Requires improvement →← May 2019	Requires improvement ↓ May 2019	Requires improvement →← May 2019
Critical care	Requires improvement →← Sept 2017	Good →← Sept 2017	Good →← Sept 2017	Good ↑ Sept 2017	Good ↑ 2017	Good ↑ Sept 2017
Maternity	Requires improvement →← May 2019	Good →← May 2019	Good →← May 2019	Good ↑ May 2019	Good ↑ May 2019	Good ↑ May 2019
Services for children and young people	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
End of life care	Good ↑ May 2019	Good ↑ May 2019	Good →← May 2019	Good ↑ May 2019	Good ↑ May 2019	Good ↑ May 2019
Outpatients	Requires improvement May 2019	N/A	Good May 2019	Requires improvement May 2019	Good May 2019	Requires improvement May 2019
Overall*	Requires improvement →← May 2019	Good ↑ May 2019	Good →← May 2019	Requires improvement →← May 2019	Good ↑ May 2019	Requires improvement →← May 2019

Table 7: Overall CQC rating, Princess Royal University Hospital, published Jun-19

Ratings for Princess Royal University Hospital

	Safe	Effective	Caring	Responsive	Wel-led	Overall
Urgent and emergency services	Inadequate ↓ May 2019	Requires improvement →← May 2019	Requires improvement ↓ May 2019	Inadequate ↓↓ May 2019	Inadequate ↓ May 2019	Inadequate ↓ May 2019
Medical care (including older people's care)	Good ↑ Sept 2017	Good ↑ Sept 2017	Good →← Sept 2017	Good ↑ Sept 2017	Requires improvement ↓ Sept 2017	Good ↑ Sept 2017
Surgery	Requires improvement →← May 2019	Good →← May 2019	Good →← May 2019	Requires improvement →← May 2019	Good →← May 2019	Good →← May 2019
Critical care	Good ↑ Sept 2017	Good →← Sept 2017	Good →← Sept 2017	Requires improvement →← Sept 2017	Good ↑ Sept 2017	Good ↑ Sept 2017
Maternity	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Services for children and young people	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Outstanding Sept 2015	Good Sept 2015	Good Sept 2015
End of life care	Requires improvement →← May 2019	Requires improvement →← May 2019	Good →← May 2019	Good ↑ May 2019	Good ↑ May 2019	Requires improvement →← May 2019
Outpatients	Requires improvement Apr 2019	N/A	Good Apr 2019	Requires improvement Apr 2019	Requires improvement Apr 2019	Requires improvement Apr 2019
HIV and sexual health services						
Overall*	Requires improvement →← May 2019	Requires improvement ↓ May 2019	Good →← May 2019	Requires improvement →← May 2019	Requires improvement →← May 2019	Requires improvement →← May 2019

5. King's College Hospital NHS Foundation Trust has established a quality improvement framework outlining key priorities with measureable outcomes for each core services.

6. King's has also recently developed a self-assessment quality toolkit based on the CQC Key Lines of Enquiry, which is currently being rolled out. This will enable them to know where to focus and provides us with an overview of compliance and areas of weakness. We are presenting this as a quality assessment to embed in normal practice rather than a specific CQC exercise. We have undertaken work to review compliance with the CQC well-led domain, identifying the key areas for improvement.

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

Records Submission

8. King's College Hospital NHS Foundation Trust submitted 1,765,295 records during 2020-21 M1-12 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data April 2020 – March 2021, which included the patient's valid NHS number, was:

- 99.4% for admitted patient care;
- 99.4% for outpatient (non-admitted) patient care; and
- 95.2% for accident and emergency care.

The percentage of records in the published data April 2019 – March 2021, which included the patient's valid General Medical Practice Code, was:

- 100.0% for admitted patient care;
- 99.8% for outpatient (non-admitted) patient care; and
- 99.6% for accident and emergency care.

Information Governance Assessment

9. King's College Hospital NHS Foundation Trust's 2020/21 submission of the Data Security and Protection Toolkit reports an overall assessment of Standards Not Met (Approved Improvement Plan in place). The key area not met was staff annual Data Security and Protection Training.

Payments by Results (PbR)

10. King's College Hospital NHS Foundation Trust was not subject to the Payment by Results (PbR) clinical coding audit during 2020-21 by the Audit Commission.

Data Quality

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

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

- A large number of teams collect data across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflect clinical judgement about individual cases, where another clinician might reasonably have classified a case differently.

- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.

- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to re-analyse historic data.

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

The requirement for external audit has been removed from the Quality Accounts due to national NHS response to managing the COVID-19 pandemic. The Trust had asked our internal auditors, KPMG, to conduct a data quality review and they have specifically tested diagnostic waiting time indicators. A final report into their findings and supporting management actions has been approved by the Trust.

Learning from Deaths

During 2020-21, 2521 King's College Hospital NHS Foundation Trust patients died. This comprised the following number of deaths, which occurred in each quarter of that reporting period:
- 709 in the first quarter (April to June 2020);
- 443 in the second quarter (July to September 2020);
- 521 in the third quarter (October to December 2020);
- 848 in the fourth quarter (January to March 2021).

By 31 March 2021, 152 case record reviews and 22 investigations have been carried out in relation to 174 of the 2521 deaths included above.

In 9 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:
- 67 in the first quarter;
- 48 in the second quarter;
- 56 in the third quarter;
- 41 in the fourth quarter.

1 patient death (0.04% of the deaths in the relevant period) during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:
- 1 representing 1.5% for the first quarter;
- 0 representing 0 % for the second quarter;
- 0 representing 0% for the third quarter;
- 0 representing 0% for the fourth quarter.

These numbers have been estimated using the locally adapted version of the structured judgment review method of case record review.

No death in this period was judged to be probably avoidable (i.e. more than 50:50 likelihood of being avoidable).

The usual mortality review processes were put on hold during 2020-21 due to the COVID-19 response. Trend analyses continued and detailed analyses of COVID-19 deaths were undertaken and reported to the Trust Board throughout the year. A total of 448 structured judgement reviews of COVID-19 deaths were undertaken.

Summary of learning from case record reviews and investigations

Cases of hospital onset COVID-19 were identified and rates were benchmarked against other trusts. A programme of response and Duty of Candour for the bereaved was initiated. Monitoring of areas with high levels of mortality led to the rapid identification of 'wards under pressure' and this led to the provision of real-time support and pastoral care for staff. Data on the Trust-level outcomes for COVID-19 has been fed back to staff in all disciplines to recognise their exceptional care and commitment during this challenging year.

A description of the actions which King's College Hospital NHS Foundation Trust has taken in the reporting period, and proposes to take in the next period, in relation to Learning from Deaths

The standardised reporting process has been re-instituted following COVID-19 and work is in progress to integrate with the working of the new medical examiner system.

Previous reporting period

- 64 case record reviews and 1 investigation were completed after 31 March 2020, which related to deaths, which took place before the start of the reporting period.

- One representing 0.04% of the patient deaths before the latest reporting period was judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been estimated using the locally adapted version of the structured judgment review method of case record review.

2.3
Reporting Against Core Indicators

The following set of nationally performance core indicators are required to be reported using data made available to the trust by NHS Digital.

Table 8: Reporting against core indicators

Indicator	Measure	Current Period	Value[3]	Previous Period	Value[3]	Highest Value Comparable[2,3] Foundation Trust	Lowest Value Comparable[1,3] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
Summary Hospital-level Mortality Indicator (SHMI)	Ratio of observed mortality as a proportion of expected mortality	01/09/2019 to 31/08/2020	0.9508 (95% Over-dispersion control limit 0.8904, 1.1231)	01/09/2018 to 31/08/2019	0.9507 (95% Over-dispersion control limit 0.8868, 1.1277)	0.9984 (95% Over-dispersion control limit 0.8909, 1.1224) – better than expected	0.6946 (95% Over-dispersion control limit 0.8865, 1.1280) – better than expected	1.0	NHS Digital	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons: it is based on data submitted to NHS Digital and the Trust takes all reasonable steps and exercises appropriate due diligence to ensure the accuracy of data reported. King's College Hospital NHS Foundation Trust intends to take/ has taken the following actions to improve the SHMI, and so the quality of its services, by continuing to invest in routine monitoring of mortality and detailed investigation of any issues identified, including data quality as well as quality of care.
	Percentage of patient deaths with palliative care coded at diagnosis	01/09/2019 to 31/08/2020	52%	01/09/2018 to 31/08/2019	51%	57%	28%	36%	NHS Digital	

[2] Shelford Group
[3] Displayed by NHS Digital

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory Statement
Patient Reported Outcomes Measures - hip replacement surgery	EQ-5D Index:118 modelled records	Apr 19 - Mar 20	Adjusted average health gain: 0.452	Apr 18 - Mar 19	Adjusted average health gain: 0.482	0.462	0.392	0.453	NHS Digital	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons - our performance is in line with Shelford Group peers. King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services: • Improve PROMS data collection through the implementation of a new IT system from April 2021.
	EQ VAS: 120 modelled record		Adjusted average health gain: 12.922		Adjusted average health gain: 14.534	15.558	12.199	13.966		
	Oxford Hip Score: 121 modelled records		Adjusted average health gain: 22.549		Adjusted average health gain: 22.457	23.176	20.042	22.315		
Patient Reported Outcomes Measures - knee replacement surgery	EQ-5D Index:167 modelled records	Apr 19 - Mar 20	Adjusted average health gain: 0.340	Apr 18 - Mar 19	Adjusted average health gain: 0.328	0.359	0.289	0.334		
	EQ VAS: 165 modelled records		Adjusted average health gain: 6.164		Adjusted average health gain: 8.213	10.530	2.955	7.805		
	Oxford Knee Score: 179 modelled records		Adjusted average health gain: 16.707		Adjusted average health gain: 15.773	17.333	15.212	17.356		

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory Statement
Percentage of patients readmitted within 28 days of being discharged	Patients aged 0-14 - %	Apr-20 to Feb-21	1.22%	Apr-19 to Mar-20	1.20%	Data not comparable due to differences in local reporting.	Data not comparable due to differences in local reporting.	N/A	PiMS	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons – readmissions data forms part of the divisional Best Quality of Care scorecard reports, which are produced and reviewed by divisional management teams, and forms part of the monthly-integrated performance review with the executive team. King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by rolling out a 7 day occupational therapy and physiotherapy service across medicine to support early identification, acute treatment and onward referral to for rehabilitation and discharge planning needs; proactive referrals to community health, social care and voluntary sector services for those who need support to enable seamless transfer and delivery of onward care on discharge.
	Patients aged 15+ - %		7.96%		6.63%	Data not comparable due to differences in local reporting.	Data not comparable due to differences in local reporting.	N/A		
Trust's responsiveness to the personal needs of its patients: • Were you involved as much as you wanted to be in decisions about your care and treatment?	Score out of 10 trust-wide	2019 National Inpatient Survey	7.1	2018 National Inpatient Survey	7.1	8.8	6.5		CQC	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons as CQC national patient surveys are a validated tool for assessing patient experience and in line with local survey results. King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by launching regular Care Group patient experience reviews with key actions for improvement. National Inpatient Action Plan in place.

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory Statement
• Did you find someone on the hospital staff to talk to about your worries and fears?	Score out of 10 trust-wide	2019 National Inpatient Survey	4.4	2018 National Inpatient Survey	5.3	7.7	4.3		CQC	King's College Hospital NHS Foundation Trust considers that this data is as described as CQC national patient surveys are a validated tool for assessing patient experience. King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by launching regular Care Group patient experience reviews with key actions for improvement. National Inpatient Action Plan in place.
• Were you given enough privacy when discussing your condition or treatment?	Score out of 10 trust-wide	2019 National Inpatient Survey	8.6	2018 National Inpatient Survey	8.3	9.5	7.9		CQC	
• Did a member of staff tell you about medication side effects to watch for when you went home?	Score out of 10 trust-wide	2019 National Inpatient Survey	4.3	2018 National Inpatient Survey	4.5	7.4	3.5		CQC	

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory Statement
• Did hospital tell you whom to contact if you were worried about your condition or treatment after you left hospital?	Score out of 10	2019 National Inpatient Survey	6.5	2018 National Inpatient Survey	7.4	9.7	6.5		CQC	King's College Hospital NHS Foundation Trust considers that this data is as described as CQC national patient surveys are a validated tool for assessing patient experience King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by launching regular Care Group patient experience reviews with key actions for improvement. National Inpatient Action Plan in place
Staff employed by, or under contract to the Trust who would recommend the Trust as a provider of care to their family or friends.	%	Q1 2019-20 Q2 2019-20 Q3 2019-20 Q4 2019-20	No data (COVID-19) 72% 79%	Q1 2019-20 Q2 2019-20 Q3 2019-20 Q4 2019-20	76% 76% 67% 77%	No comparable data available at time of writing accounts	No comparable data available at time of writing accounts	No comparable data available at time of writing accounts	NHS England staff family and friends test data	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons – This is taken from NHS England national staff family and friends test website. King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by: Improving staff morale and engagement through specific engagement work streams and introducing a new culture programme

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory Statement
The percentage of patients who were admitted to hospital and who were risk-assessed for venous thromboembolism during the reporting period	%	Q1-4 2020-21	97.6%	Apr-19 to Mar-20	97.2%	Bart's Health NHS Trust 99.1%	Sheffield Teaching Hospital NHS Foundation Trust 95.0 %	95.5%	NHS Improvement	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons: This data was collected electronically. Ward audits are completed every month and they reflect similar compliance scores. King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by: Optimising use of electronic solutions to enhance surveillance of VTE risk assessment rates. VTE CNSs will work closely with areas not meeting the National target for VTE risk assessment of 95% and develop action plans to address this. Use GIRFT VTE survey data to highlight areas for improvement.

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory Statement
The rate per 100,000 bed days of cases of C. *difficile* infection reported within the Trust among patients aged 2 or over during the reporting period	rate/ 100,000 bed days	April 2020 – March 2021	92 cases	April 2019 – March 2020	98 cases	National data not available at time of finalising Quality Account	National data not available at time of finalising Quality Account	National data not available at time of finalising Quality Account	https://www.gov.uk/government/statistics/clostridium-difficile-infection-monthly-data-by-nhs-acute-trust	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons – there were 92 Trust-apportioned cases of CDI (for patients aged ≥2) in total; thus the performance target was met, and we achieved a 5% reduction (n=6 cases) compared to the previous year, 19-20. King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by: • Training of junior doctors as regards review, choice & duration of antimicrobials. • Improve compliance & engage with medical teams • Discuss scores and compliance in team meetings • Increased focus on commode and environmental cleaning. • Document assessment and bowel movements in EPR • Ensure all staff groups comply with training • Ward-based training at handover.

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory Statement
The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period	Number (rate per 1,000 bed days)	April 2020 – March 2021	18,902 total and 39.40 per 1000 bed days	April 2019 – March 2020	25,859 total and 46.61 per 1000 bed days	12-month Data not available from NRLS yet. In 6-month NRLS data, KCH reported 12787 incidents. Birmingham reported 23692 incidents in 6 months. King's was 4th highest in reporting number of incidents.	12-month Data not available from NRLS yet. In 6-month NRLS data, KCH reported 12787 incidents. Weston Health Foundation Trust reported 565 incidents in 6 months. King's was 4th highest in reporting number of incidents.	12-month Data not available from NRLS yet. In 6 month NRLS total average was 5582	NRLS reporting system	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons – 12-month national data is not yet available for benchmarking. Source is NRLS (National Reporting and Learning System) King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by: Continue positive feedback from incident reporting, continue supporting open and transparent culture, allow for anonymous reporting, automatic feedback installed on incident reporting system.

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory Statement
The number and percentage of such safety incidents that resulted in severe harm or death	Number (rate per 1,000 bed days)	April 2020 – March 2021	Death: 15 (0.03 %) Serious Harm 89 Severe Harm (0.19%)	April 2019 – March 2020	Death: 26 (0.05 %) Serious Harm 123 Severe Harm (0.22%)	12-month Data not available from NRLS yet. In 6-month NRLS data, KCH reported 8 death incidents. Guy's and St Thomas reported 22 death incidents in 6 months. KCH reported 52 serious harm incidents. Birmingham reported 72 serious harm incidents in 6 months	12-month Data not available from NRLS yet. In 6-month NRLS data, KCH reported 8 death incidents. Multiple Trusts reported 0 death incidents in 6 months. KCH reported 52 serious harm incidents. Three Trusts reported 0 serious harm incidents in 6 months	12-month Data not available from NRLS yet. In 6 month NRLS data based on figures only was 5.4 average for deaths and 13.5 average for major harm	NRLS reporting system	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons – 12-month national data is not yet available for benchmarking. Source is NRLS (National Reporting and Learning System). To note that Trusts vary in size and incident numbers. King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by: Most of the serious harm incidents relate to pressure ulcers or falls for which the Trust has steady work-streams to reduce the number of such events. After a successful pilot in 2018 seeing a reduction of such incidents in specific areas, the learning is being used across the Trust. As ever the Trust encourages reporting and has a positive culture, which allows the organisation to learn from such serious events collaboratively with staff and patients/relatives. Any themes identified have specific work-streams to address them and reduce the likelihood of reoccurrence.

Part 3: Other information

Overview of the quality of care offered by the King's College Hospital NHS Foundation Trust

Please see table 9 on page 47

Table 9: Overview of the quality of care offered by King's

Indicators	Reason for selection	Trust Performance 2020-21	Trust Performance 2019-20	Peer Performance (Shelford Group Trusts) 2020-21	Data Source
Patient Safety Indicators					
Duty of Candour	Duty of Candour was chosen as high performance is a key objective for the Trust as it demonstrates its positive and transparent culture. The Trust changed its reporting mechanism in April 2017 making it more robust, measuring full compliance rather than spot check audits. The higher the compliance % the better.	97%	>93%	Not available	Datix
WHO Surgical Safety compliance	Even though the Trust has not listed Surgical Safety as a quality priority for 2019-20 it remains a key objective and workstream at the Trust. Since the beginning of 2017, the Trust has been able to electronically monitor compliance with the WHO checklist. The higher the compliance % the better.	92.2%	96%	Not available	Local audit of data on Galaxy surgical system
Total number of never events	Outside of Surgical Safety, the Trust has a number of workstreams that aim to reduce the number of Never Events.	5	6	Information available at:	
Clinical effectiveness indicators					
SHMI Elective admissions	Summary Hospital-level Mortality Indicator (SHMI) is a key patient outcomes performance indicator, addressing Trust objective 'to deliver excellent patient outcomes'.	0.63 (95% CI 0.49, 0.79) – Better than expected	0.83 (95% CI 0.68, 1.00) – Better than expected	0.67 (95% CI 0.63, 0.71) – Better than expected	NHS Digital data via HED, period: November 2019 to October 2020
SHMI Weekend admissions		0.95 (95% CI 0.88, 1.03) – As expected	0.95 (95% CI 0.87, 1.02) – As expected	0.98 (95% CI 0.95, 1.0) – As expected	
Patient experience indicators					
Friends & Family – A&E	Patients discharged from Accident & Emergency (types 1/2) who would recommend the Trust as a provider of care to their family or friends	Not available due to suspension of reporting due to COVID-19.	74%	Not available due to suspension of reporting due to COVID-19.	NHS England national statistics
Friends & Family – inpatients	Inpatients who would recommend the Trust as a provider of care to their family or friends	Not available due to suspension of reporting due to COVID-19.	95%	Not available due to suspension of reporting due to COVID-19.	NHS England national statistics
Friends & Family - outpatients	Outpatients who would recommend the Trust as a provider of care to their family or friends	Not available due to suspension of reporting due to COVID-19.	86%	Not available due to suspension of reporting due to COVID-19.	NHS England national statistics

Performance against relevant indicators

Table 10: Performance against relevant indicators

Indicators	Trust Performance 2020-21	Trust Performance 2019-20	National average	Target
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	60.5%	78.7%	61.6%	92.0%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	83.0%	71.5%	86.9%	95.0%
All cancers: 62-day wait for first treatment from Urgent GP referral for suspected cancer	69.5%	72.2%	75.1%	85.0%
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	69.2%	86.3%	75.1%	>99%
C. *difficile*:	95 cases	97 cases	n/a	110
Maximum 6-week wait for diagnostic procedures	63.6%	91.6%	61.8%	>99%
Venous thromboembolism risk assessment	98.4%	97.8%	n/a	95.0%

Access to services

The Trust's operational response to the first wave of COVID-19 at the start of the 2020/21 financial year and the second wave from early December 2020 has had a profound impact on the achievement of elective access targets during 2020-21.

Consistent with 'Next Steps on NHS Response to COVID-19' issued by NHSE/I, the Trust limited elective inpatient admissions to urgent and life threatening cases during both the first wave and second wave, generating a 35.9% decrease in admitted elective patients seen (including day cases) and a 22.1% decrease in tertiary admissions. In parallel, the Trust implemented restrictions on e-Referral Service (eRS) so that only cancer two week wait and clinically urgent referrals were being accepted, with appointments being seen on a virtual basis where practical to do so. These actions significantly reduced the number of patients coming onto our hospital sites for elective surgery, attendance at outpatient clinics, and/or for diagnostic tests, which has greatly increased the average waiting times for key elective access targets.

We have transformed our outpatient services at pace to meet infection control standards required in response to the COVID-19 pandemic. Overall outpatient attendances have reduced by 18.8% compared to previous year due to enforced service cessation, but the number of non-face-2-face attendances has increased by 192.6% (over 132,040 appointments).

The Trust's ED four-hour performance based on monthly ED Sitrep return submissions is 83.2% for the period April to February 2020-21, which is an improvement compared to the performance level of 71.5% achieved for April - March 2019-20. Performance has improved on both the Denmark Hill and PRUH sites this year compared to 2019/20. We have seen fewer patients attending our Emergency Department (ED) and urgent care centres on both the Denmark Hill and PRUH sites this year, with a 28.3% overall reduction in patients seen at a Trust level for the period April to February 2020.

Cancer referral demand in Q1 of 2020/21 reduced to 49% of referrals received in the same period of 2019/20 due to the impact of the first COVID-19 wave. The elective activity restrictions have also meant an increase in diagnostic and treatment delays impacting our ability to meet with 31 and 62-day cancer standards.

Diagnostic and endoscopy service demand and activity was greatly reduced in the first part of the year due to COVID-19 leading to an increase in the diagnostic waiting list from 9,740 patients waiting at the end of April 2020 to an in-year high of nearly 14,000 patients

waiting by the end of October 2020. We had seen a recovery in our performance from 39.7% of patients waiting less than 6 weeks for their diagnostic test to 81.7% in November as diagnostic services were brought back on-line, however during the second COVID-19 wave subsequent activity restrictions have meant that performance worsened again with only 40% of patients waiting less than 6 week compared to the 99% target at the end of February 2021.

Referral to Treatment (18 Weeks)

Delivery against the Referral to Treatment (18 Weeks) performance standard continued to be a challenge for the Trust during 2020-21. The total RTT waiting list has reduced by over 14,100 pathways due to the demand restrictions that have been imposed by the two COVID-19 waves during the year. There are over 60,330 patients on our RTT waiting list, and based on the latest publicly published data, King's has the 11th largest waiting list in England. The volume of completed pathways for the period April to February 2021 reduced by 21.5% compared to last year.

During 2019/20 the Trust continued to work with other NHS and independent sector hospitals to provide additional capacity, specifically in bariatric surgery, elective Orthopaedics and Neurosurgery to reduce the number of over-52-week breach and longer waiting patients. There were 196 patients waiting over 52 weeks at the end of the last financial year. With the reduced elective activity that was delivered from March 2020 onwards as part of our operational response to COVID-19, the number of patients waiting over 52 weeks increased to 6,813 patients by February 2021, including over 1,800 patients waiting in both Oral Surgery and Ophthalmology.

During 2020/21 the Trust continues to work closely with local commissioners and providers to secure access to Independent Sector capacity to reduce the backlog that has developed for cancer as well as long waiting patients. These actions also link with Trust transformation programmes in outpatient re-design and digitisation, as well as theatre productivity improvement programmes to maximise the use of our day case and inpatient theatres and outpatient clinic throughput in-week. We have also implemented a new pre-operative assessment system (Synopsis) initially at the PRUH and South Sites to increase the pool of patients who are assessed as fit for surgery and to reduce the number of on-the-day cancellations.

Cancer Treatment within 62 Days

Urgent 2-week rule GP referral demand has decreased by 22.2% when comparing April 2020 to February 2021 against 2019/20, with significant reduces observed in Colorectal Surgery, Dermatology and Gynaecology. As services resumed post-COVID-19 wave one, our 2-week wait compliance improved during the year achieving the national 93% target in November and December 2020, and the Trust is currently achieving the target for March 2021.

We have not been compliant with the 62-day GP referral to treatment standard during 2020-21, where we have reported an average monthly performance of 69.4% compared to the national 85% target.

Our cancer waiting time programme has remained suspended during to the second COVID-19 wave. PRUH pathway mapping workshops were held in November 2020 to highlight new themes and areas for improvement. The root cause analysis review process was additionally re-commenced in November Trust-wide.

Increased numbers of suspected cancer patients referred are being triaged in telephone assessment clinics, and more virtual clinics introduced to reduce the proportion of patients who require a new outpatient appointment.

Diagnostic Test within 6 Weeks

The Trust has not been compliant against the 99% target since December 2017, and there are a number of diagnostic modalities where available capacity has been exceeded by demand; notably in endoscopy. There was a particular capacity gap within the PRUH endoscopy service which resulted in a significant backlog of patients on the activity diagnostic (DM01) waiting list as well as surveillance patients.

The Trust has continued to increase its use of Independent Sector endoscopy capacity particularly at BMI Chelsfield Park and Shirley Oaks, as well as at Lyca Health Care. On-site Trust capacity has been focussed on inpatient, urgent and 2 week wait suspected cancer demand.

Radiology continues to utilise additional capacity including the use of independent sector providers and mobile imaging scanners, in order to meet the changes in pathways and demands from cancer and emergency pathways. There is a significant volume of long waiters in MRI, particularly on the Denmark Hill site with capacity running at circa 60% pre-COVID-19 levels towards the end of the year. Recovery plans are being balanced alongside two major equipment replacement programmes for MRI and CT scanners.

Emergency Department four-hour standard

Achievement of the Emergency Department four-hour performance standard continues to be a significant challenge at King's despite reduced Type 1 and Type 3 attendance levels, particularly on its Denmark Hill site.

Four-hour performance at the Denmark Hill site was below 71% at the end of 2019/20 and achieved 91.8%

in July 2020 in a period where reduced numbers of patients were attending the department during wave one of COVID-19. Performance has since deteriorated to 62.2% in January 2021, but improved to 77.8% for March 2021. Attendance levels have been 69.3% of those observed in 2019/20.

As the number of COVID-19 patient attendances have reduced in Feb/March of 2021, all areas within the Emergency Department including the Medical ACU have re-opened on the Denmark Hill site. Swab turnaround times have improved since the implementation of ePlex which has been operational in the ED from 8am to 8pm. The Urgent Treatment Centre has also been re-tendered with plans to the service in place by September 2021.

On the PRUH site performance was achieving the 95% national target between May and July 2020 with a monthly average of 88.1% achieved for this financial year. Attendance levels have been 74.4% of those seen during 2019/20.

At the PRUH, a joint ED and Acute Improvement Group has been established alongside senior medical, nursing and operational leads to review scope and effectiveness of ambulatory care models in line with national guidance on same day emergency care. Focus of the group includes delivery of the ten national presenting conditions, workforce models required to support acuity and demand, and operational hours of the ambulatory units.

Investment approval has also been given for two modular buildings to be co-located with ED and allow establishment of dedicated older person's assessment unit mental health assessment unit and an extended emergency waiting room area.

Freedom to Speak Up

Fostering a culture that encourages workers to speak up, as a normal aspect of their job, produces a healthy working environment. Listening to workers, helps reduce risk, prevent harm to patients and leads to improvements. It is also essential in making workers feel valued and supported.

At King's, we firmly believe that listening to workers is everyone's business. In 2020/2021, we have taken a proactive approach to identifying hotspots of poor workplace culture and barriers to speaking up. We believe that a supportive 'speak up' culture is one where we are all able to voice concerns about any issue, knowing that it will be well received and the right action taken. Where we can share ideas, seek advice, offer feedback, challenge decisions and speak without fear of repercussions.

In our determination to embrace a 'speak up', 'listen up', 'follow up' culture at King's, we have recruited a substantive full time post holder as the Freedom to Speak Up (FTSU) Guardian. We listened to our previous Guardian, (who had a substantive full time clinical role as well) and recognised that the FTSU role required the development of a full time post.

In July 2020, the Investment Board approved a business case submitted by the previous Guardian and Executive Lead for Freedom to Speak Up, for the appointment of a substantive 8b post. There is clear evidence that trusts with a full time FTSU Guardian have higher reporting and a safer culture. The King's full time Guardian took up post on 28 September 2020. At the same time, we also approved a non-pay budget for promotional materials, communication and training strategies.

Our Guardian is supported by a full time band 4 FTSU Support Officer, who came into post on 27 January 2021. As Vice Chair of the London Regional Network of Guardians, the King's Guardian not only represents our trust, but also our region, with the National Guardians Office (NGO). Through that contact they are able to ensure wider learning and best practice is brought back to King's.

The spread of King's staff across a number of sites and our engagement with significant numbers of contractors on site means that there are still challenges to overcome in ensuring full visibility and access to the FTSU service for all 'workers', including agency, bank staff, and volunteers, not just those staff directly employed by King's.

Looking back on the last year 2019/20
COVID-19 has had an impact on everybody. We recognise that there will be long term impacts on both the personal and professional lives of NHS workers and as a consequence, speaking up is even more important.

NGO reporting categories
The NGO requires Guardians to specifically identify concerns that involve elements of bullying and harassment and/or patient safety. From 1 April 2021 'Worker safety' has been added as a category. Also, the term 'detriment' has been replaced with 'disadvantageous and/or demeaning treatment'.

Nationally - 2019/20 NGO data:
- 36% of cases reported by Guardians had an element of bullying and harassment
- 23% of cases related to patient safety issues
- 13% of cases were reported anonymously
- 3% of those raised concerns regarding detriment

King's Cases
The breakdown of concerns reported at King's for 2019/20 and 2020/21 is detailed in table 11 below. For the purpose of this report, categories have been aligned to NGO data reporting requirements.

Table 11: Breakdown of concerns reported at King's for 2019/20 and 2020/21

Quarter	Number of cases	Anonymous	Patient Safety / Quality	Bullying and Harassment	Reported detriment after speaking up
2019/20					
Q1 19/20	34	0	10	4	1
Q2 19/20	31	1	5	2	0
Q3 19/20	28	0	3	8	0
Q4 19/20	33	6	8	15	1
Total 19/20	**126**	**7**	**26**	**29**	**2**
2020/21					
Q1 20/21	41*	7	9	13	0
Q2 20/21	20	6	10	8	0
Q3 20/21	43*	0	8	15	4
Q4 20/21	45*	3	14	18	2
Total 20/21	**149**	**16**	**41**	**54**	**6**

* The COVID-19 pandemic, may be a caveat to higher case numbers as concerns regarding, vaccination, social distancing and PPE (first wave) were raised.

Analysis of King's data

(Please note, the figures for FTSU cannot reliably be analysed against the staff survey results, as FTSU is accessed by all 'workers' not just staff)

- In 2020/21, 146 concerns were raised, compared to just 126 in 2019/20. This represents an increase of 18% and of those 149 cases, 60% have been raised since 1st October, which coincides with the appointment of the full time Guardian.
- Anonymous reporting has reduced by 50% in the last 2 quarters of 20/21, compared to the same period last year. Of the anonymous concerns reported for Q4 20/21, 1 relates to PRUH, 1 Orpington and 1 at Denmark Hill (a detailed site by site breakdown will be included in the Annual Report)
- A downward trend in anonymous reporting and an increase in the number of concerns raised, implies a FTSU culture is being accepted and embedded at King's.
- Concerns involving an element of patient safety totalled 41 cases, equating to 27.5%. Overall an increase of 54% on the previous year. The rising willingness to report these issues, indicates an increased confidence in reporting, when things go wrong. Joint working with the patient safety and early resolution teams to embed a 'just culture' has contributed to this.
- The number of cases reported with an element of bullying and harassment equates to 36.2%. However, not all the cases relate to King's staff and include contract workers. Joint working with employee relations, middle managers and contract leads, is underway to effect cultural change in this particular area.
- The increase in reported 'detriment' is currently an unreliable statistic, as the definition of detriment has previously been open to interpretation. Some Guardians reported detriment in the legal context only, others reported it as disadvantageous treatment. Two of the cases of detriment reported in Q4 relate to staff working for one of our contract partners. The Executive team at King's support the Guardian with the message, 'Those who speak up, will not be disadvantaged'.
- Nursing and Midwifery remains the highest reporting group under FTSU, followed by Administrative and Clerical. However, this is to be expected as registered nurse/midwives account for 34.5% of trust staff. Administrative and clerical employees represent 19.35% of staff. A full breakdown of professional groups/level of workers raising concerns will be included in the FTSU Annual Report.

Areas of concern highlighted in the 2020/21 report, identified for improvement in 2021/22

Those facing barriers to speaking up
Many of the staff falling within this category are from ethnic minority and/or low pay working groups. To address this issue, the Guardian has established joint working with the Equality and Diversity and Inclusion teams and with the companies providing contract staff to the trust, to ensure they can access Freedom to Speak up. The Guardian is also a member of King's Able, the trust disability network

FTSU Ambassadors did not reflect the workforce
Between 1 October 2020 and 31 March 2021, 68 Ambassadors were recruited to support the FTSU culture at King's. Currently, 55 are based at Denmark Hill and 13 at the Princess Royal Hospital, Orpington. Ambassadors are supported by a supervision framework. The Guardian is in the process of delivering a bespoke training package. Ambassador ethnicity reflects the diversity of the workforce at King's, with 73% of Ambassadors from BAME or recognised disadvantaged groups
Lack of FTSU training for all staff

Training for all workers is now available on our learning platform. The Guardian has worked closely with the Organisational Development Team, to ensure training is embedded trust-wide. The NGO core training is available for all staff to complete. Training of Senior/Middle managers is strongly encouraged and disseminated through leadership programmes and meetings. The Guardian is highly visible and attends many team meetings to deliver training on FTSU. Due to COVID-19, the use of Teams for team meetings has enabled the Guardian to deliver training to all sites.

Lack of trust- wide awareness of FTSU
Since 1 October 2020, a proactive communication campaign has been in place to raise awareness and accessibility of FTSU. Joint working with employee relations, recruitment EDI, network leads, communication and wellbeing teams, has been successful in increasing knowledge. A budget provided for promotional materials, has ensured all workers have access to the FTSU confidential email address and phone number. A snapshot awareness survey, current live on the trust intranet demonstrates that 80% of King's staff know how to make contact with the FTSU Guardian and 70% of respondents answered that they felt confident to speak up.

The trust intranet has been updated to ensure FTSU information is easily accessible for all staff and workers.

A lack of a Just culture
The FTSU Guardian is working jointly with the Early Resolution team, for an approach that seeks to change and improve, rather than to blame. The FTSU Guardian is also working with the Patient Safety team and clinical leads. Listening events are carried out in areas with multiple concerns. This method has helped to establish themes and allow workers a voice in a confidential environment, leading to improvements for staff and patients.

Poor performance on Freedom to Speak Up Index
The FTSU Index allows trusts to see how any aspect of their FTSU culture compares with other organisations, so learning can be shared and improvements made. In the 2021, National Staff Survey, there will be an additional question relating specifically to access to Freedom to Speak Up.

The quarterly data submitted by the trust Guardian, is also used to inform the FTSU Index. The 2020 Index report was the second time an index had been published. In 2019 King's was one of 40 trusts which had the greatest overall decrease in the index (scoring 75%), implying that the FTSU culture at King's required improvement.

In the 2020 Index, King's score was 75.3%. The highest scoring trust achieved 86.6% and the lowest 68.3 %. Trusts with the highest index score are usually those rated good or outstanding and employ full time Guardians.

Incomplete Board Self-Review Tool / Board Assurance
In the 2019/20, Quality Accounts the trust reported that completion of the Board Self-Review Tool was outstanding. The tool allows the Board to reflect on what it perceives King's culture to be. The tool has now been made a live document and is managed by the Board Secretary.

The FTSU Guardian has direct access to the Chief Executive, Executive Lead for FTSU (Chief Nurse), Chair and Non-Executive Lead for FTSU (Nicholas Campbell-Watts). Scheduled meetings take place with the Executive Leads and CEO, on a monthly basis and include the Chair every quarter.

FTSU focus for 2021/22

The overall increase in the number of cases is a positive indicator of an improving trust culture, regarding FTSU. Going forward, the Guardian intends to build on the foundations of the last six months.

At King's, it is recognised that managers should be the first point of contact for workers raising a concern and do play a key role in fostering a culture where speaking up is valued. However, it is recognised that managers may also feel vulnerable when people speak up, particularly if the issue is personal or undermines their role. Managers need support to listen without judgement and use the information to improve and share learning. From 1 April 2021, managers and senior leaders at King's will be encouraged and supported to make a pledge to 'listen up.'

It is acknowledged that one of the reasons why workers do not speak up, is because they don't believe anything will change. Embedding a follow up culture is essential. Working with the leadership team, the Guardian will ensure concerns are followed up, lessons learned and those who speak up are thanked.

Rota gaps and the plan for improvement

Consolidated annual report on rota gaps

In 2020-21, Health Education England (HEE) were unable to provide junior doctor trainees for 139 posts and put on hold filling an additional 40 junior doctor trainee posts. This puts additional strain on Specialties to fill these gaps with local recruitment in addition to their own Trust junior doctor posts. The monthly breakdown is shown below in table 12.

Table 12: HEE rota gaps and hold gaps 2020-21

	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
HEE Rotation Gaps	13	2	3	0	34	15	20	6	10	0	26	10
HEE Hold Gaps	7	0	0	0	16	3	2	0	12	0	0	0

Plan for improvement to reduce these gaps:

- Where registrar positions are not filled additional trainees may be available from HEE to fill the gaps.
- For posts which prove difficult to appoint to, clinical fellows are appointed and locums utilised to temporarily cover positions.
- Recruitment is also undertaken in anticipation depending on skill mix within the care groups.
- Ensure schemes such as the Medical Training Initiative (MTI) are being fully utilised for International Recruitment and working closely with the Royal Colleges.
- Continue to introduce roles such as Physicians Associates to support Junior Doctor rotas.

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

Commissioners' feedback: South East London Clinical Commissioning Group Statement on King's College Hospital NHS Foundation Trust Quality Account 2020/21

South East London Clinical Commissioning Group was formed in April 2020 from a merger of the six borough based Clinical Commissioning Groups in Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark and is grateful to King's College Hospital NHS Trust for the opportunity to comment on its 2020/2021 Quality Account. The Quality Account has been produced in the most unprecedented circumstances and the South East London Clinical Commissioning Group wishes to acknowledge the enormous amount of work undertaken by King's College Hospital NHS Foundation during the pandemic and would like to thank staff for their continued endurance, compassion and commitment shown by all of the staff. Special recognition is also given to the volunteer workforce who supported the Trust throughout the year.

The South East London Clinical Commissioning Group continued to work with and support King's College Hospital NHS Trust and have attended their serious incident meetings in lieu of the Clinical Quality Review Group which were stood down during the height of the pandemic. The fact that they were awarded the Health Service Journal's Workforce Initiative of the year in March 2021 is testimony that their staff have a commitment to deliver safe care despite the trials that Covid brought with it.

The CCG recognises the work undertaken to achieve the quality priorities set in 2019/2020 and acknowledged that some were affected as a result of the pandemic.

The work undertaken to improve documentation of observations is noted as is the standardisation of education in relation to deteriorating patients and learning from incidents within this category. The work being undertaken to address and improve violence and aggression against staff is to be commended including the introduction of conflict resolution training. Other notable activities are:

- The progress made with the involvement of patient representatives.
- The identification of core themes based on the results of various surveys.
- The progression of the digitised platform for outpatients
- The ongoing work for patients who suffer from chronic obstructive pulmonary disease.

The Quality Account demonstrates that despite the pandemic a lot of work continued and was delivered to their patient population and it identifies areas where work is continuing. We commend the work undertaken to date and look forward to their continued determination in providing a quality service and endorse the new quality priorities for 2020/2021. We look forward to continuing our collaborative approach to quality improvement via attendance at their Quality, People and Performance Committee and via informal meetings with the Director of Nursing, Medical Director and Associate Director for Quality in the year ahead.

Healthwatch Bromley, Healthwatch Lambeth, and Healthwatch Southwark' comments on KCH's Quality Account 20-21

General comment:

We would like to highlight that this is the first time Healthwatch Bromley, Lambeth and Southwark are collectively providing a joint statement on King's College Quality Accounts, and we appreciate the opportunity to comment as 'critical friends' on KCH's Quality Account. Our responses are based on the experience of the public and service users which have been shared with us as we aim to promote the voice of patients to improve care.

We appreciate that the pandemic has had impact on the delivery of health services, with King's College Hospital at the forefront in responding to the needs of COVID-19 patients whilst continuing with the other non-COVID-19 related matters. Despite the challenges, the Trust has had some successes.

There is also an appreciation of the relationship that the Trust has built with the three Healthwatch. In particular, we commend the Patient Engagement and Experience Team for reaching out to us on relevant projects or accommodating us as we scoped engagement activities with King's patients.

Given the time that was given for us to respond to the report, our comments are not exhaustive. Nevertheless, we tried our best to highlight some aspects that are common to all three London boroughs. However, we would appreciate being given sufficient time and would expect this improves next year.

Specific comments:

Old priorities – all 'partially achieved'

Priority 1 - Reducing harm to deteriorating patients

We highly commend the training of staff in recognising and treating rapidly deteriorating patients, especially in the context of the pandemic. It may be worth exploring non-clinical factors of deterioration, for example patients not being listened to, and engaging patient experience on this.

- It is commendable to see the Trust engaging and listen to staff feedback, particularly in respect to having training around the role of human factors in patient deterioration and we are happy to see the patient stories are included in this training.
- We are unsure whether it is fair to claim that Aims 2 and 3 have been achieved since both projects have been suspended. We thought that 'partially achieved' may be more appropriate.
- In regard to the Harm Free Care quality improvement project, we feel that it would be a great opportunity to feed patient experience into it. This, for example, could be in the form of consulting with patients in well-managed cases and incidents to see what could be learnt and applied.
- It is good to hear that the need for improvement in the care of deteriorating patients has been prioritised, including an increased observation. We would like to see more results from those observations.
- In relation to aim 2, as it has been rightfully indicated, there are many variables to be considered when reviewing and standardising education in relation to deteriorating patients. It would be good to see evidence to show that staff training resulted in the decreased mortality of patients with COVID-19 during the second wave.

Priority 2 - Reducing violence and aggression to staff and increasing patient safety

- It is great to read about the listening events, including opportunities for staff to feedback and the inclusion of staff ideas to reduce violence. It would be good to know the numbers of staff that were able to attend.
- We are also pleased to see the support for staff in these situations especially, as highlighted in Aim 3, ensuring staff are provided with tools during the pandemic and being flexible by providing bite-sized training on preventing and managing violence.

Priority 3 - Improving patient experience for inpatients, outpatients, emergency departments, maternity services and cancer services

- It is very encouraging to see the interest and uptake with the Involvement Registry and that so many patients expressed an interest in further involvement. It would be good to know how many of the 200 people were engaged further and how many have continued to be involved.
- It would also be useful to know the demographics of those patients who are involved, and whether plans are in place to increase patient engagement amongst underrepresented groups.
- We are also glad to read about patient involvement being used to make a difference, especially the virtual patient reference group for 'Improving nutrition and hydration for inpatients. We look forward to seeing continued commitment and progress in patient and public involvement within KCH.
- It is also great to hear about the use of 'discharge booklets. The lack of information at post-discharge was a concern that people have told us about over the year. It would be good to know more about the contents of the booklets.
- Regarding the outpatient digital programme, it would be good to know whether patients' potential barrier to access - e.g., visual impairment, having no working phone or computer, low bandwidth, or data plans - have been recorded in their records, to ensure they receive the most appropriate, efficient communication.
- The 'two-week wait' cancer pathway is very good as there are separate teams to sort out any problems for the patients.
- There is also an excellent Cancer Advisory Service run jointly by KCH and Macmillan.

Priority 4 - Improving outcomes for people with Chronic Obstructive Pulmonary Disease (COPD)

- It is great that despite the challenges of the pandemic, that effort was made to directly consult with patients to define outcome metrics for Chronic Obstructive Pulmonary Disease.
- However, we feel it would be more appropriate to mark this priority as 'Not achieved' rather than 'Partially achieved' as no implementation has taken place – which we understand is related to the pressures of the pandemic.
- Currently, we are unclear if the project has been suspended indefinitely or will continue into its second year at a later stage. If it does continue, it would be good to see the plans for Aims 3 to 6.

New Priorities

Priority 1: Reducing harm to deteriorating patients

- We have heard feedback over the past year, including at King's, that patients can feel they are not being listened to because of discrimination, for example against their age or migration status. In certain cases, this has led to harm or worsened outcomes. We feel it is important to acknowledge that discrimination can underpin the lack of communication and not seriously taking patients concerns.

Priority 2: Long COVID

- We highly commend this as a priority, as a lack of support for people with Long COVID is something we have heard about this year and raised with KCH and GSTT.
- It is great to see KCH is linking with GSTT, but it would be good to see mental health acknowledged or included in the work – for example through a link with SLaM.
- It is also important to us that patient eligibility for Long COVID clinics is wider than in the past and reflects current knowledge on the range of symptoms (e.g., that have been documented on the Zoe app). Local people have raised concerns that those with Long COVID that are too ill for the GP, but do not have respiratory issues, fall through the gaps.
- There is an appreciation of making 'Long COVID' a priority.

Priority 3: Improving patient experience of inpatient's services

- It is great to see plans to improve communication between patients and health professionals, but we would like to know more about how this will be achieved. What strategies or system will be out in place and by when?
- There had been some feedback from service users that some KCH staff do not seem to communicate well with patients and whilst policies are in place to keep patients informed, it seems they are not always followed.
- The KCH telephone system, with most phones being outgoing only or never answered, is a serious problem which has presumably been made worse by COVID-19. This needs to improve for better overall patient experience.
- Patients reported that their experience of staff attitude/behaviours varied. Whilst some are extremely polite, there are a few who are rude to patients. There are also staff members who may benefit from disability awareness training to better support people with disabilities.

Priority 4: Reducing violence and aggression to staff and increasing patient safety

- We note entertainment systems and Wi-Fi are included in actions to reduce violence and aggression and are keen to know if this is based on any patient engagement or external research.

Performance against core indicators

- The decline against waiting times targets is concerning, but we understand the huge impact of COVID-19.
- It would be good to know about longer-term recovery plans to reduce waiting lists. There is some information on 2020/21, but it would be useful to know about plans for 2021/22.
- Following our qualitative report on the experiences of people waiting for hospital treatment, it would be great to see some focus on improving the experience of waiting, for example improving communication.
- During the first wave of the pandemic, some patients have had to wait until September 2021 for their surgery but the communication about this was lacking and made with very short notice. This impacted on the mental health of patients with long term health needs.
- As the use of independent sector services increases to manage waiting lists, we have concerns about record-sharing and communication between services, and with patients. Particularly in Healthwatch Southwark's report Waiting for Hospital Treatment, we heard about experiences of appointments being missed, miscommunication, and poor communication between hospitals.

Some areas that need further clarification or inclusion:

Targets VS Outcomes. We would like to see some indicators that show certain aims are achieved. Also consider including some baseline data against which you measured the achievements.

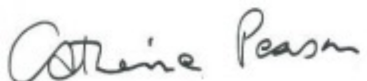
Mental health. There is currently very little mention of mental health as experienced by service users and how KCH addressed their needs, particularly maternity mental health, and young people's mental health. With the current pandemic, we would love to see mental health made a priority.

Transition of young people with mental health needs. We would like to see how KCH is supporting young people's transition to adulthood or independence, including the transition from child to adult services. In particular, please elaborate on the engagement of the Trust with primary care and community and voluntary organisations.

We are grateful that KCH has thrived during the pandemic. We hope to work with you more in the coming years as we jointly plan to improve service users' experience of health and care. We hope to continue our partnership as we recover from the pandemic and share learning from it.

Thank you very much.
Yours truly,

Marzena Zoladz
Healthwatch Bromley



Catherine Pearson
Healthwatch Lambeth

Shamsur Choudhury
Healthwatch Southwark

Overview and Scrutiny Committee, London Borough of Lambeth, feedback:

King's College Hospital NHS Foundation Trust Quality Account for 2020-2021.
Comments from Overview and Scrutiny Committee, London Borough of Lambeth.

Lambeth Council's Overview and Scrutiny Committee would like to thank King's College Hospital NHS Foundation Trust for the invitation to submit a statement on the Trust's draft Quality Account 2020/21. It has not been possible to formally consider the draft QA within the timeline requested and the Committee is not therefore submitting a response. However the Committee would wish to acknowledge that a positive working relationship exists between OSC and the Foundation Trust.

Overview and Scrutiny Committee, London Borough of Southwark, feedback:

No feedback received at time of publication

Overview and Scrutiny Committee, London Borough of Bromley, feedback:

No feedback received at time of publication

Trust Governors, feedback:

The Trust Governors provided detailed feedback. This has been collated, acted upon, incorporated within the Quality Account as appropriate, and a record held for reference.

Annex 2 - Statement of Directors' Responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2020-21 and supporting guidance, detailed requirements for quality reports 2018-19.
- the content of the Quality Report is consistent with internal and external sources of information including:
    - board minutes and papers for the period April 2020 to March 2021
    - papers relating to quality reported to the board over the period April 2020 to March 2021
    - feedback from commissioners dated 21/06/2021
    - feedback from governors dated 27/05/2021
    - feedback from Bromley, Lambeth and Southwark Healthwatch organisations dated 08/06/2021
    - feedback from Overview and Scrutiny Committee 28/05/2021 (Bromley), 27/05/2021 (Lambeth) and 28/05/2021 (Southwark)
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30/06/2021
    - the national patient survey July 2019
    - the national staff survey March 2021
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated 29/04/2021
    - CQC inspection report dated 12/06/2019 and focussed inspection on the EDs dated 18/02/2020.
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered.
- the performance information reported in the Quality Report is reliable and accurate.
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

....

Date ....

Chairman

....

Date ....

Chief Executive

Annex 3 - Independent Auditor's Report to the Council of Governors

Due to the COVID-19 pandemic, NHS providers are not expected to obtain assurance from their external auditor on their quality account / quality report for 2020/21.

King's College Hospital
NHS Foundation Trust

Quality Account 2020-21 - Published June 2021

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

Report on the Audit of the Financial Statements

Qualified opinion on the financial statements

We have audited the financial statements of King's College Hospital NHS Foundation Trust (the 'Trust') and its subsidiaries (the 'group') for the year ended 31 March 2021, which comprise the Consolidated Statement of Comprehensive Income, the Statements of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021.

In our opinion, except for the possible effects on the corresponding figures of the group of the matter described in the Basis for qualified opinion section of our report, the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2021 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for qualified opinion

Due to the operational reasons arising from the Trust's response to the Covid-19 pandemic in March 2020 it was not practicable for management to perform physical counting of inventories and as a result the predecessor auditor was not able to observe the counting of physical inventories held at 31 March 2020 or satisfy themselves by using other audit procedures concerning the inventory quantities held at that date, which had a carrying amount in the Statement of Financial Position of the group of £20 million. Consequently, the predecessor auditor was unable to determine whether any adjustment to this amount at 31 March 2020 was necessary and the predecessor auditor's opinion on the financial statements for the year ended 31 March 2020 was modified accordingly. Since opening inventories affect the determination of the surplus or deficit for the year and the income and expenditure reserve balance, our opinion on the financial statements of the group for the year ended 31 March 2021 is also modified because we were unable to determine the possible effect of this matter on the comparability of the current year's figures and the corresponding figures. In addition, were any adjustments to the group opening inventory balance to be required, the Performance Report would also need to be amended.

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the group and the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the group and the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to

draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the group or the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2020 to 2021 that the group and Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the group and Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the group and Trust and the group and Trust's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group and the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, 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 responsibilities of the Accounting Officer with respect to going concern are described in the 'Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

As described in the basis for qualified opinion section of our report, the predecessor auditor was unable to satisfy themselves concerning the inventory quantities of £20 million held by the group as at 31 March 2020. Since opening inventories affect the determination of the surplus or deficit for the year and the income and expenditure reserve balance we are unable to conclude whether or not the other information is materially misstated with respect to this matter.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS foundation trust annual reporting manual 2020/21 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust, the other information published together with the financial statements in the annual 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

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, the Chief Executive, as Accounting Officer, set out on pages 91 and 92, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2020/21, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of the services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the group and Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk

that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the group and Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021).
- We enquired of management and the Audit Committee, concerning the group and Trust’s policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the group and Trust’s financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and fraudulent income and expenditure recognition. We determined that the principal risks were in relation to:
  - journal entries posted which met a range of criteria determined during the course of the audit, in particular those posted around the reporting date which had an impact on the Consolidated Statement of Comprehensive Income
  - accounting estimates made in respect of accruals of expenditure and deferral of income around the reporting date.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on entries meeting the criteria determined by the engagement team;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and buildings valuations and accruals of income and expenditure;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. However, detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as those irregularities that result from fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and expenditure recognition, and the significant accounting estimates related to land and buildings valuations and accruals of income and expenditure.
- Assessment of the appropriateness of the collective competence and capabilities of the group and Trust’s engagement team and component auditors included consideration of the engagement team's and component auditor’s;

  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the group and Trust operates
  - understanding of the legal and regulatory requirements specific to the group and Trust including:
    - the provisions of the applicable legislation
    - NHS Improvement's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - the group and Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, financial statement consolidation processes, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - the group and Trust's control environment, including the policies and procedures implemented by the group and Trust to ensure compliance with the requirements of the financial reporting framework.
- For components at which audit procedures were performed, we requested component auditors to report to us instances of non-compliance with laws and regulations that gave rise to a risk of material misstatement of the group financial statements. No such matters were identified by the component auditors.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

Our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the Trust's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, these will be reported by exception in our Audit Completion Certificate. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2021.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of

Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for King's College Hospital NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors 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 Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Paul Dossett

Paul Dossett, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

London

29 June 2021

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

In our auditor's report issued on 29 June 2021, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2021, in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice, until we had:

- Completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2021 issued on 29 June 2021 we reported that, in our opinion, except for the possible effect of the matter described in the Basis for qualified opinions section of our report, the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2021 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

The Basis for qualified opinion section of our opinion was as follows:

- Due to the operational reasons arising from the Trust's response to the Covid-19 pandemic in March 2020 it was not practicable for management to perform physical counting of inventories and as a result the predecessor auditor was not able to observe the counting of physical inventories held at 31 March 2020 or satisfy themselves by using other audit procedures concerning the inventory quantities held at that date, which had a carrying amount in the Statement of Financial Position of the group of £20 million. Consequently, the predecessor auditor was unable to determine whether any adjustment to this amount at 31 March 2020 was necessary and the predecessor auditor's opinion on the financial statements for the year ended 31 March 2020 was modified accordingly. Since opening inventories affect the determination of the surplus or deficit for the year and the income and expenditure reserve balance, our opinion on the financial statements of the group for the year ended 31 March 2021 is also modified because we were unable to determine the possible effect of this matter on the comparability of the current year's figures and the corresponding figures. In addition, were any adjustments to the group opening inventory balance to be required, the Performance Report would also need to be amended.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

Report on other legal and regulatory requirements - the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in respect of the above matter.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of King's College Hospital NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors 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 Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Paul Dossett

Paul Dossett, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

London

16 September 2021

King's College Hospital NHS
NHS Foundation Trust

Final Annual Accounts
for the year ended 31 March 2021

FOREWORD TO THE ACCOUNTS

King's College Hospital NHS Foundation Trust

These accounts, for the year ending 31 March 2021, have been prepared by King's College Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 and comply with the guidance for NHS Foundation Trusts within the Department of Health Group Accounting Manual.

Signed:

ProfessorClive Kay
Chief Executive

Date: 29th June 2021

Statement of the Chief Executive's responsibilities as the Accounting Officer of King's College Hospital NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require King's College Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of King's College Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual)* have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis.

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

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Signed: Date**: 29th June 2021**

Professor Clive Kay
Chief Executive

Consolidated Statement of Comprehensive Income for year ended 31 March 2021

		Group	
		2020-21	2019-20
	Note	**£000**	£000
Operating income from patient care activities	2.1, 2.2	**1,262,454**	1,116,078
Other operating income	2.1	**241,819**	148,514
Total operating income from continuing operations		**1,504,273**	1,264,592
Operating expenses	3.1	**(1,528,797)**	(1,331,890)
Operating deficit from continuing operations		**(24,524)**	(67,298)
Finance income and costs			
Finance income		**30**	555
Finance expenses	5	**(27,574)**	(48,587)
Public Dividend Capital dividends payable		**(10,294)**	-
Net finance costs		**(37,838)**	(48,032)
Other (losses) / gains	7	3,642	(131)
Share of profit of associates and joint ventures	7.1	2,438	421
Corporation tax expense		(1,785)	-
Deficit from continuing operations		**(58,067)**	(115,040)
Surplus of discontinued operations and the gain on disposal of		**-**	-
Deficit for the year		**(58,067)**	(115,040)
Other comprehensive income/(expense), that will not be reclassified subsequently to income and expenditure			
Impairments	6	**(3,286)**	(511)
Revaluations	21	**23,064**	34,189
Fair value gains/(losses) on equity instruments designated at FV through OCI		**320**	269
Other recognised gains and losses		**95**	-
Share of comprehensive income from associates and joint ventures		**-**	353
Total other comprehensive income/(expenditure)		**20,193**	34,300
Total comprehensive expense for the year		**(37,874)**	(80,740)
Allocation of losses for the year			
Deficit for the year attributable to:			
(i) non-controlling interest; and		-	-
(ii) owners of the parent		**(58,067)**	(115,040)
Total		**(58,067)**	(115,040)
Total comprehensive expense for the year attributable to:			
(i) non-controlling interest; and		**-**	-
(ii) owners of the parent		**(37,874)**	(80,740)
Total		**(37,874)**	(80,740)

Consolidated Statement of Comprehensive Income for year ended 31 March 2021 (continued)

	Note	Group	
		2020-21	2019-20
Note to Statement of Comprehensive Income		**£000**	£000
Total comprehensive expense for the year		**(37,874)**	(80,740)
Add back other comprehensive expenses		**(20,193)**	(34,300)
Deficit for the year		**(58,067)**	(115,040)
Add back impairments and reversal of impairments *	3.1	**59,417**	3,231
Remove capital donations / grants I&E impact		**(1,019)**	(547)
Adjusted financial performance including PSF/FRF/MRET**		**331**	(112,356)
Remove PSF, FRF and MRET funding**		**0**	(36,956)
Adjusted financial performance surplus/(deficit)		**331**	(149,312)

** This is the total impairments and impairment reversals charged to the Consolidated Statement of Comprehensive Income in the year as disclosed in note 3.1 and note 7.*

***PSF, FRF and MRET did not exist in 2020-21.*

The adjusted financial performance is the primary view which is used by the Board of Directors to monitor the Trust's financial performance and is in line with NHS England and NHS Improvement's (NHSEI) financial performance measure.

The Group's deficit for the year was £58.1m and this figure includes asset impairments of £59.417m. This charge relates to impairments that arise from changes in market value of Land and Buildings assets. The NHSEI financial performance measures the surplus/(deficit) before impairments and the impact of donated assets.

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The unconsolidated deficit relating to the Foundation Trust for the year ended 31 March 2021 is £69.5m (2020: £118.7m) and total operating income for the year is £1,503.4m (2020: £1,271.8m).

Statements of Financial Position as at 31 March 2021

		Group		Trust	
		31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	Note	**£000**	£000	**£000**	£000
Non-current assets					
Intangible assets	8	**9,007**	9,278	**8,492**	**8,523**
Property, plant and equipment	9	**661,663**	643,009	**661,663**	**643,009**
Investment in associates, joint ventures and subsidiaries	10.1,10.2	**4,135**	4,949	**250**	**250**
Other investments	10.4	**2,614**	2,294	**335**	**335**
Receivables	12	**10,053**	7,409	**65,314**	**56,172**
Total non-current assets		**687,472**	666,939	**736,054**	**708,289**
Current assets					
Inventories	11	**22,375**	20,162	**7,984**	**7,844**
Receivables	12	**87,766**	143,214	**89,904**	**146,558**
Cash and cash equivalents	13	**143,867**	59,871	**122,219**	**50,586**
Total current assets		**254,008**	223,247	**220,107**	**204,988**
Total assets		**941,480**	890,186	**956,161**	**913,277**
Current liabilities					
Trade and other payables	14	**(222,714)**	(183,394)	**(193,412)**	**(181,497)**
Borrowings	16	**(9,972)**	(749,473)	**(17,666)**	**(752,855)**
Provisions	18	**(2,114)**	(9,469)	**(2,114)**	**(9,469)**
Other liabilities	15	**(13,317)**	(14,439)	**(13,053)**	**(14,414)**
Total current liabilities		**(248,117)**	(956,775)	**(226,245)**	**(958,235)**
Net current liabilities		**5,891**	(733,528)	**(6,138)**	**(753,247)**
Total assets less current liabilities		**693,363**	(66,589)	**729,916**	**(44,958)**
Non-current liabilities					
Borrowings	16	**(183,663)**	(187,544)	**(235,558)**	**(212,651)**
Provisions	18	**(3,823)**	(3,760)	**(3,823)**	**(3,760)**
Total non-current liabilities		**(187,486)**	(191,304)	**(239,381)**	**(216,411)**
Total liabilities employed		**505,877**	(257,893)	**490,535**	**(261,369)**
Financed by:					
Taxpayers' equity					
Public Dividend Capital		**1,034,027**	232,384	**1,034,027**	**232,384**
Revaluation reserve	21	**157,756**	142,846	**157,756**	**142,846**
Financial assets at FV through Other Comprehensive Income reserve		**1,933**	1,613	**-**	**-**
Income and expenditure reserve		**(687,839)**	(634,735)	**(701,248)**	**(636,599)**
Total taxpayers' equity		**505,877**	(257,892)	**490,535**	**(261,369)**

The notes on pages 10 to 55 form part of these accounts.

The financial statements on pages 4 to 9 were approved by the Board on 29th June 2021 and signed on its behalf by

Signed: **Date:** **29th June 2021**

Prof Clive Kay
Chief Executive

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2021

Group	Note	**Public Dividend Capital £000**	**Revaluation reserve £000**	**Financial assets at FV through Other Comprehensive Income reserve £000**	**Income and expenditure reserve £000**	**Total reserves £000**
Taxpayers' and others' equity at 1 April 2020 - brought forward		232,384	142,846	1,613	(634,735)	**(257,892)**
Deficit for the year		-	-	-	(58,067)	**(58,067)**
Impairments	21	-	(3,286)	-	-	**(3,286)**
Revaluations - property, plant and equipment	21	-	23,064	-	-	**23,064**
Transfer to retained earnings on disposal of assets	21	-	(4,868)	-	4,868	**-**
Fair value gains on equity instruments designated at FV through OCI		-	-	320	-	**320**
Share of comprehensive income from associates and joint ventures		-	-	-	-	**-**
Public Dividend Capital received		801,643	-	-	-	**801,643**
Other reserve movements		-	-	-	95	**95**
Taxpayers' and others' equity at 31 March 2021		**1,034,027**	**157,756**	**1,933**	**(687,839)**	**505,877**
Taxpayers' and others' equity at 1 April 2019 - brought forward		230,136	109,168	1,344	(520,048)	(179,400)
Deficit for the year		-	-	-	(115,040)	(115,040)
Impairments	21	-	(511)	-	-	(511)
Revaluations - property, plant and equipment	21	-	34,189	-	-	34,189
Fair value gains on equity instruments designated at FV through OCI		-	-	269	-	269
Share of comprehensive income from associates and joint ventures		-	-	-	353	353
Public Dividend Capital received		2,248	-	-	-	2,248
Taxpayers' and others' equity at 31 March 2020		232,384	142,846	1,613	(634,735)	(257,892)

Trust	Note	**Public Dividend Capital £000**	**Revaluation reserve £000**	**Financial assets at FV through Other Comprehensive Income reserve £000**	**Income and expenditure reserve £000**	**Total reserves £000**
Taxpayers' and others' equity at 1 April 2020 - brought forward		**232,384**	**142,846**	**-**	**(636,599)**	**(261,369)**
Deficit for the year		-	-	-	(69,517)	**(69,517)**
Impairments	21	-	(3,286)	-	-	**(3,286)**
Revaluations - property, plant and equipment	21	-	23,064	-	-	**23,064**
Transfer to retained earnings on disposal of assets	21	-	(4,868)	-	4,868	**-**
Public Dividend Capital received		801,643	-	-	-	**801,643**
Taxpayers' and others' equity at 31 March 2021		**1,034,027**	**157,756**	**-**	**(701,248)**	**490,535**
Taxpayers' and others' equity at 1 April 2019 - brought forward		230,136	109,168	-	(517,882)	(178,578)
Deficit for the year		-	-	-	(118,717)	(118,717)
Impairments	21	-	(511)	-	-	(511)
Revaluations - property, plant and equipment	21	-	34,189	-	-	34,189
Public Dividend Capital received		2,248		-	-	2,248
Taxpayers' and others' equity at 31 March 2020		232,384	142,846	-	(636,599)	(261,369)

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2021 (continued)

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Financial assets at FV through Other Comprehensive Income reserve
This reserve holds the valuation gain in respect of the PIK note held by the group.

Statement of Cash Flows for the year ended 31 March 2021

		Group		Trust	
		2020-21	2019-20	**2020-21**	2019-20
	Note	**£000**	£000	**£000**	£000
Cash flows from operating activities					
Operating deficit from continuing operations		**(24,524)**	(67,298)	**(33,311)**	(71,236)
Non-cash income and expense					
Depreciation and amortisation	3	**31,881**	26,256	**31,834**	26,013
Net Impairments / (reversal)	3	**63,926**	3,231	**63,926**	3,231
Income recognised in respect of capital donations		**(2,127)**	(1,446)	**(2,127)**	(1,446)
(Increase)/Decrease in trade and other receivables		**64,802**	(27,148)	**47,512**	(7,905)
(Increase)/Decrease in inventories		**(2,213)**	(1,860)	**(140)**	(857)
Increase/(Decrease) in trade and other payables		**33,036**	20,239	**11,915**	(13,671)
Increase in other liabilities		**(1,122)**	898	**(1,361)**	873
Increase/(Decrease) in provisions		**(7,267)**	6,339	**(7,292)**	6,355
Other movements in operating cash flows		**(245)**	(567)	**208**	(481)
Net cash used in operations		**156,147**	(41,356)	**111,164**	(59,124)
Cash flows used in investing activities					
Interest received		**30**	555	**1,253**	1,290
Purchase of financial assets		**(5,500)**	-	**-**	
Purchase of intangible assets	8	**(1,584)**	(2,002)	**(1,753)**	(1,217)
Purchase of property, plant and equipment	9	**(85,113)**	(30,450)	**(51,739)**	(15,428)
Sales of property, plant and equipment		**289**	-	**289**	-
Receipt of cash donation to purchase asset		**697**	1,446	**697**	1,446
Cash flows investments other		**3,500**	-	**-**	-
Net cash used in investing activities		**(87,681)**	(30,451)	**(51,253)**	(13,909)
Cash flows from financing activities					
Public Dividend Capital received		**801,643**	2,248	**801,641**	2,248
Movement in loans from the Department of Health and Social Care		**(738,730)**	136,316	**(738,730)**	136,316
Movement in other loans		**3,566**	(298)	**3,844**	-
Capital element of finance lease repayments		**(591)**	(590)	**(4,593)**	(2,389)
Capital element of PFI and other service concession	22	**(4,872)**	(4,198)	**(4,872)**	(4,198)
Interest on DHSC loans		**(6,151)**	(21,795)	**(6,151)**	(21,795)
Interest on other loans		**(18)**	(54)	**-**	-
Interest element of finance lease		**(7)**	(7)	**(107)**	(66)
Interest element of PFI and other service concession obligations		**(25,848)**	(25,714)	**(25,848)**	(25,714)
Public Dividend Capital dividend refunded/(paid)		**(13,462)**	-	**(13,462)**	-
Net cash from financing activities		**15,530**	85,908	**11,722**	84,402
Increase / (decrease) in cash and cash equivalents		**83,996**	14,100	**71,633**	11,369
Cash and cash equivalents at 1 April		**59,871**	45,771	**50,586**	39,217
Cash and cash equivalents at 31 March		**143,867**	59,871	**122,219**	50,586

Notes to the accounts

1. Accounting policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going concern

The Trust has prepared its annual report and accounts on a going concern basis.

Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. The Trust has confirmed that this is applicable to its own services.

1.2 Accounting convention

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

Consolidated Accounts

1.3 Basis of Consolidation

Charitable funds
The King's College Hospital Charity and Friends of King's are independent charities and are not under the control of the Foundation Trust. Therefore, these charities have not been consolidated within these accounts.

1.3.1 Subsidiaries
Subsidiary entities are those over which the Foundation Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

The amounts consolidated are drawn from the draft financial statements of the subsidiaries for the year. Where subsidiaries' accounting policies are not aligned with those of the Foundation Trust then the amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

The Foundation Trust has a wholly owned subsidiary company, KCH Commercial Services Ltd, which wholly owns KCH Management Ltd. The accounts for these companies have been consolidated into the group accounts.

In 2016/17, the Foundation Trust formed King's Interventional Facilities Management LLP in partnership with Kings Commercial Services Ltd. The accounts for this partnership have been consolidated into the Trust's annual accounts.

The primary statements and notes to the accounts have been presented with separate 'Group' and 'Trust' columns. Where the difference between the 'Group' and 'Trust' figures is considered immaterial, the 'Trust' version of the note has been omitted.

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust’s deficit for the period was (£69.5m) (2019/20: (£118.7m)).

1. Accounting Policies (continued)

1.3.2 Associates
Associate entities are those over which the Foundation Trust has power to exercise a significant influence. Associate entities are recognised in the Foundation Trust's financial statements using the equity method of accounting. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Foundation Trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant or equipment) following acquisition. It is also reduced when any distribution (e.g. share dividends) are received by the Foundation Trust from the associate.

1.3.3 Joint ventures
Joint ventures are arrangements in which the Foundation Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

1.3.4 Joint operations
Joint operations are arrangements in which the Foundation Trust has joint control with one or more other parties, and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Foundation Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust’s accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

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.

1.4.1 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the NHS foundation trust’s accounting policies and that have the most significant effect on the amounts recognised in the financial statements:
The following is the judgement made in applying the accounting policy on recognition of property, plant and equipment assets (Note 1.11.1) , apart from those involving estimations (see Note 1.25) that management has made in the process of applying the Trust's accounting policies and that has the most significant effect on the amounts recognised in the financial statements:

The Trust has made a judgement in assessing the time at which the new Critical Care Unit (CCU) was considered to be fully operational and ready to be moved from assets under construction to building assets in the absence of some of the usual transition checkpoints and milestones, and with the complication of emergency arrangements due to the Covid-19 pandemic. At the time of recognition as an operational asset under IAS 16 the asset was revalued in line with Modern Equivalent Asset (MEA) principles outlined in the DHSC GAM and which are applicable to all of the Trust’s operational clinical buildings. This valuation process resulted in an impairment loss of around £50m for the asset.

While the building was in use in the early part of the 20-21 financial year, as part of the Trust’s emergency response to the Covid pandemic (Wave 1), it was not judged to be a fully operational asset at this time, as this was a temporary situation, and it was known that remedial works to the building were still required. As such the asset remained within assets under construction at this time. The building was subsequently closed to patients during most of the year to allow these remedial works to be carried out.

1. Accounting Policies (continued)

During Wave 2 of Covid (in Q4 of the 20-21 financial year), the Trust experienced a high intake of Covid patients and this resulted in the CCU being reopened for patient use. Although initially a temporary measure, it was identified that the further remedial works to be completed could be done without closing the unit. Once this was clear, it was judged that at this point, the unit should be considered to be an operational asset delivering service benefit to the Trust, and as such, the unit should be transferred to completed assets and follow accounting requirements for that asset category.

1.4.2 Sources of estimation uncertainty

The following are assumptions about sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Estimate - Revaluation of Land and Buildings

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

Non-specialised buildings and Land – market value for existing use

Land (Denmark Hill Site) – alternative site basis, based on patient postcode analysis

Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

The Trust seeks professional advice from its valuers' annually in determining the value of its land and buildings. The values in the valuer's report have been used to inform the measurement of property assets at valuation in these financial statements. The RICS qualified valuer exercised their professional judgement in providing the valuation and it remains the best information available to the Trust. However, the valuer uses informed assumptions regarding obsolescence, rebuild rates and the area of the sites required to accommodate modern equivalent assets with the same service potential which could change and have a material impact on the valuation.

Consequences of Change in Estimate

The net book value at 31 March 2021 of the Trust's Property Plant & Equipment valued by professional valuers and reflected in these financial statements is £534m.

A change in the estimated values would result in changes to the Revaluation Reserve and / or a loss or gain recorded as appropriate in the Statement of Comprehensive Income. If the value of land and buildings were to reduce by 5% this would be a change of around £27m.

A 5% variance in the value of land and buildings would lead to a £27m difference in the total value of these assets disclosed, with a corresponding charge to revaluation reserve or expenditure position.

Estimate - Future Unitary Charge Commitment (PFI)

The Trust has three PFI schemes in operation using financial models in place since 2010 and provided by experts. The models are updated annually to reflect actual charges and RPI. Future years' service costs are estimated based on the latest actual charges and forecast RPI rates. The annual RPI rate used in the model for remaining life of the contracts is 2.5%.

Interest and finance lease liability charges are unaffected by changes in RPI.

Consequences of Change in Estimate

The total future unitary charge commitment disclosed is £1,600m including £1,308m for service charges and contingent rent charged to income and expenditure.

1. Accounting Policies (continued)

A reduction in the forecast RPI rates of 0.25% per annum used in each of the three models would reduce the future unitary charge commitments by £29m over the remaining years of the contracts - i.e. operating expenditure (service charges and contingent rent) would reduce by £29m over the remaining years.

An increase in the forecast RPI rate of 0.25% per annum used in each of the three models would increase the future unitary charge commitments by £30m over the remaining years of the contracts - i.e. operating expenditure (service charges and contingent rent) would increase by £30m over the remaining years.
The Trust makes a number of other estimates in its financial accounts, which are not considered to be at risk of material incertainty.

The Trust makes a number of other estimates in its financial accounts, which are not considered to be at risk of material incertainty.

1.5 Operating segments

The Foundation Trust has a number of business divisions which are aggregated under one reportable segment being the provision of healthcare. The Foundation Trust provides Private Patient, Research and Development and Training and Education services within this healthcare sector, but as they do not have a material impact they are aggregated under this one reportable segment. Note 2 entitled "Operating Income" includes the relevant income figures for these services.
The subsidiary figures have not been disclosed separately in this note as separate Group and Trust only accounts have been provided. The subsidiaries support the Trust in the overall provision of healthcare.

1.6 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust’s entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts
The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

<u>2020/21</u>
The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust’s income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a [Integrated Care System/Sustainability and Transformation Partnership] level. The related performance obligation is the delivery of healthcare and related services during the period, with the trust’s entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

1. Accounting Policies (continued)

Comparative period (2019/20)

In the comparative period (2019/20), the trust's contracts with NHS commissioners included those where the trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.
In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.7 Other Forms of Income

1.7.1 Revenue grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

1.7.2 Apprenticeship Service Income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1. Accounting policies (continued)

1.8 Expenditure on employee benefits

1.8.1 Short-term employee benefits
Salaries, wages and employment-related payments, such as social security costs and the apprenticeship levy, are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.8.2 Pension Costs
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both Schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as a defined contribution scheme; the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as 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.

1.9 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.

1.9.1 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.

1.10 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 2020/21 as the Foundation Trust did not generate any taxable income. Corporation Tax is payable on profits made in the Trust's trading subsidiary companies.

1. Accounting policies (continued)

1.11 Property, plant and equipment

1.11.1 Recognition

Property, plant and equipment is capitalised where:

it is held for use in delivering services or for administrative purposes;
it is probable that future economic benefits will flow to, or service potential 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 either
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.

1.11.2 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.

1.11.3 Measurement and 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.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

Land and non-specialised buildings – market value for existing use; and
Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.
For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

1. Accounting policies (continued)

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation – Global Standards (effective from 31st January 2020).
Land and buildings are revalued by full site inspection every three years, with desktop valuations on interim years The last asset valuations were undertaken as at 31 March 2021 by a RICS Registered Valuer from Avison Young on a desktop inspection basis.

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 and Social Care 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.

Only that plant and machinery forming part of the building services installations has been included. Total external works for each site 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. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

1.12 Intangible assets

1.12.1 Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of being sold separately from the rest of the Foundation Trust’s business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably.

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

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer, lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

1.12.2 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.

1. Accounting policies (continued)

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 where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

1.13 Depreciation, amortisation and impairments

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 on a straight line basis over the estimated remaining life of the asset as advised by the valuer. Leaseholds are depreciated over the primary lease term.

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

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The major categories and their useful economic lives are:

furniture - 7 - 10 years;
office and IT equipment - 5 - 8 years;
soft furnishings - 7 - 10 years;
medical and other equipment - 5 - 15 years.

Useful economic lives of building assets are provided through the annual independent valuation process. Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The Trust amortise intangibles over the following useful lives range:

software license, 3 - 10 years;
development cost, 5 - 10 years.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that had previously been recognised in operating expenses, in which case they are recognised as operating expenditure.
Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter charged to operating expenses.

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

1. Accounting policies (continued)

Impairments
In accordance with the DHSC GAM, impairments that arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (I) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as ‘Held for Sale’ once all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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

1.14 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.

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.15.1 The Foundation Trust as lessee
Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

1. Accounting policies (continued)

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.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.15.2 The Foundation Trust as lessor
Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.16 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 HM Treasury's FREM, the underlying assets are recognised as property, plant and equipment at their fair value, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

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

1.16.2 Lifecycle Replacement
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.

1. Accounting policies (continued)

1.16.3 Assets contributed by the Trust to the operator for use in the scheme

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.

1.17 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.

1.18 Cash and cash equivalents

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Foundation Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.19 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 HM Treasury's discount rates effective for 31 March 2021.

	Rate
Short-term	Minus 0.02%
Medium-term	0.18%
Long-term	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2021:

	Inflation rate
Year 1	1.2%
Year 2	1.6%
Into perpetuity	2.0%

Early retirement provisions and and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

1.19.1 Clinical negligence costs

NHS Resolution operates a risk-pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Foundation Trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the Foundation Trust is disclosed in note 19 but is not recognised in the Foundation Trust's accounts.

1. Accounting policies (continued)

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

1.20 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 20 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 20, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.21 Financial assets and financial liabilities

Recognition
Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

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

Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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

Financial assets are classified as subsequently measured at amortised cost.
Financial liabilities are classified as subsequently measured at amortised cost.

1.21.1 Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

1. Accounting policies (continued)

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

1.21.2 Financial assets measured at fair value through other comprehensive income
A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

On initial recognition of an equity investment that is not held for trading, the Trust may irrevocably elect to present subsequent changes in the investment's fair value in other comprehensive income. This election is made on an investment-by-investment basis.

1.21.3 Financial assets and financial liabilities at fair value through income and expenditure
Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

1.21.4 Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

The carrying amount of the trade receivable is reduced when the outstanding debt is greater than one year and payment has not been agreed with the respective debtor. Overseas visitor's debts less than one year are provided for based on historical recoverability. Private Patient debts and salary overpayments are provided for based on management estimation of the percentage of recoverability. The Foundation Trust applies the percentage provided by the Department of Health to gross debts for injury costs recovery (RTA).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset’s gross carrying amount and the present value of estimated future cash flows discounted at the financial asset’s original effective interest rate. Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

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

1. Accounting policies (continued)

1.22 Public dividend capital

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

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

donated and grant funded assets,
average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility and;
any PDC dividend balance receivable or payable;
In accordance with the requirements laid down by the Department of Health and Social Care (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 calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.23 Foreign exchange

The functional and presentational currency of the Foundation Trust is sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. The Foundation Trust does not have material foreign currency transactions. Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise. Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.24 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, third party assets are disclosed in Note 25 to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.25 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis. 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. Accounting policies (continued)

1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020-21.

1.27 Standards, amendments and interpretations in issue but not yet effective or adopted

The following list presents a list of recently issued IFRS Standards and amendments that have not yet been adopted within the FReM, and are therefore not applicable to DHSC group accounts in 2020-21.

Standards issued or amended but not yet adopted in FReM

IFRS 16 Leases
IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.
IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.
For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.
It is not currently possible for the Trust to provide an estimate of the impact of IFRS 16.

IFRS 17 Insurance Contracts
Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. Operating income

2.1 Income from activities by classification

	Group	
	2020-21	2019-20*
	£000	£000
Income from patient care activities		
Block contract / system envelope income*	**1,184,456**	913,396 *
High cost drugs income from commissioners	**6,754**	127,642
Other NHS clinical income**	**10,403**	16,820 *
Additional income for delivery of healthcare services		
Private Patient income	**6,294**	18,899
Additional pension contribution central funding***	**29,145**	27,192
Other clinical income	**25,401**	12,129
Total income from activities ****	**1,262,453**	1,116,078
Other operating income recognised in accordance with IFRS 15		
Research and development	**6,539**	6,789
Education and training	**44,399**	43,397
Non-patient care services to other bodies	**3,925**	20,215
Provider sustainability fund / Sustainability and transformation fund income	**-**	36,956
Reimbursement and top-up funding	**127,199**	-
Income in respect of employee benefits accounted on a gross basis	**8,530**	8,162
Other*****	**21,354**	20,061
Total other operating income (IFRS 15)	**211,946**	135,580
Other operating income recognised in accordance with other standards		
Research and development	**12,453**	9,659
Education and training - notional income from apprenticeship fund	**522**	442
Receipt of capital grants and donations	**697**	1,446
Charitable and other contributions to expenditure	**160**	157
Donated equipment from DHSC for COVID response (non-cash)	**1,430**	-
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	**13,366**	-
Rental revenue from operating leases	**1,245**	1,230
Total other operating income (Non-IFRS 15)	**29,873**	12,934
Total operating Income	**1,504,273**	1,264,592

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

** Other NHS clinical income includes HIV/AIDS funding, NSCG funding for liver services, bone marrow transplant funding, critical care funding from CCGs, CQUIN funding, off-tariff drugs and devices, renal dialysis, direct access, community midwifery, community dental services, national screening programmes, RTA funding and IVF services.

***The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

**** Income from patient care activity is recognised in accordance with IFRS 15.

***** Other income includes PFI transitional support, clinical excellence awards, staff nursery, car parking, accommodation and commercial rents.

2.2 Income from activities by type

	Group	
	2020-21	2019-20
	£000	£000
NHS Foundation Trusts	**2,156**	1,200
NHS Trusts	**1,481**	945
Clinical Commissioning Groups and NHS England *	**1,236,004**	1,077,991
Department of Health and Social Care	**42**	-
NHS Other (including Public Health England and Prop Co)	**32**	2,172
Non-NHS		
Local Authorities	**2,716**	3,455
Private patients	**6,294**	18,899
Overseas patients (non-reciprocal)	**5,633**	4,849
Injury costs recovery	**3,629**	3,980
Other **	**4,467**	2,587
Total income from activities	**1,262,454**	1,116,078

* Includes £29.145m (2019-20: £27.192m) notional income for pension contributions paid by NHS England on behalf of the Trust

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

2.3 Overseas visitors

	Group	
	2020-21	2019-20
	£000	£000
Income recognised this year	**5,633**	4,849
Cash payments received in-year	**520**	2,286
Additions to provision for impairment of receivables	**1,041**	3,289
Amounts written off in-year	**3,801**	3,191

2.4 Additional information on contract revenue (IFRS 15) recognised in the period

	2020-21	2019-20
	£000	**£000**
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	14,439	12,477
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

2.5 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	**31 March 2021**	31 March 2020
	£000	**£000**
within one year	13,317	13,037
after one year, not later than five years	0	0
after five years	0	0
Total revenue allocated to remaining performance obligations	13,317	13,037

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

2.6 Income from activities arising from commissioner requested and non-commissioner requested services

Under the terms of its Provider License, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Group	
	2020-21	2019-20
	£000	£000
Commissioner requested services	**1,336,709**	1,050,799
Non-commissioner requested services	**167,564**	213,793
Total	**1,504,273**	1,264,592

2.7 Fees and charges - aggregate of all schemes that, individually, have a cost exceeding £1m

	Group	
	2020-21	2019-20
	£000	£000
Income	**6,294**	18,899
Full cost	**(5,866)**	(18,944)
Deficit	**428**	(45)

2.8 Operating lease income

	Group	
	2020-21	2019-20
	£000	£000
Rental revenue from operating leases	**1,245**	1,230
	31 March 2021	31 March 2020
	£000	£000
Future minimum lease receipts due on leases of buildings expiring		
- not later than one year	**1,245**	1,230
- between one and five years	**2,490**	3,690
Total	**3,735**	4,920

The above note discloses income generated in operating lease agreements where King's College Hospital NHS Foundation Trust is the lessor. The operating leases relate to the lease of space and buildings owned by the Trust.

3. Operating expenses

3.1 Operating expenses by type

	Group	
	2020-21	2019-20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	**15,000**	12,305
Purchase of healthcare from non-NHS and non-DHSC bodies	**53,456**	62,470
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	**175,898**	150,430
Supplies and services - clinical (excluding drugs costs)	**101,087**	105,811
Supplies and services - general	**13,155**	19,387
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	**13,366**	-
Inventories written down (net including drugs)	**1,327**	-
Staff and executive directors costs	**857,257**	767,712
Remuneration of non-executive directors	**140**	150
Establishment	**11,331**	7,217
Transport (including patient travel)	**11,523**	10,145
Premises	**31,123**	29,770
Rentals under operating leases - minimum lease payments	**7,543**	7,709
PFI service costs	**65,646**	61,888
Clinical negligence	**43,701**	37,674
Depreciation on property, plant and equipment	**30,004**	24,570
Amortisation on intangible assets	**1,877**	1,686
Net impairments / (reversal)	**63,926**	3,231
Movement in credit loss allowance: contract receivables / contract assets	**4,650**	3,863
Consultancy costs	**3,078**	2,715
Audit fees payable to the external auditor		
Statutory audit	**303**	314
Internal audit costs	**258**	167
Other *	**23,148**	22,676
Total operating expenses	**1,528,797**	1,331,890

* Other operating expenses include expenditure relating to training, legal fees, storage costs, work permits and infection control costs. Other expenses also include Audit fees of £41k charged in year relating to the previous financial year.

The audit fee for the current year is £247k. No other remuneration was paid to the Trust's external auditors in 2020-21 (2019-20 : Nil)

Research and development expenditure is included in other operating expenditure, clinical and general supplies and services, premises and establishment expenses as well as in staff costs.

3.2 Operating leases

Rentals under operating leases include the following:	Group	
	2020-21	2019-20
	£000	£000
Operating lease expense		
Minimum lease payments	**7,543**	7,709
Total	**7,543**	7,709

Future minimum lease payments fall due as follows:		
	2020-21	2019-20
	£000	£000
Hire of plant and machinery		
- not later than one year	**708**	2,133
- between one and five years	**1,657**	4,521
- later than five years	**200**	200
Total hire of plant and machinery	**2,565**	6,854
Rental of buildings		
- not later than one year	**4,601**	4,948
- between one and five years	**14,586**	17,163
- later than five years	**22,948**	33,927
Total rental of buildings	**42,135**	56,038
Total	**44,700**	62,892

This note discloses costs and commitments incurred under non-cancellable operating lease arrangements where King's College Hospital NHS FT is the lessee.
Significant lease commitments relate to the rental of certain Trust hospital sites including Beckenham Beacon and a number of satellite renal and dental sites.

3.3 Late Payment of Commercial Debts (Interest) Act 1998

	2020-21	2019-20
	£000	£000
Compensation paid to cover debt recovery costs under this legislation	**5**	12

3.4 Limitation on Auditor's Liability

The limitation on auditor's liability in 2020/21 was £5m (2019/20: no limit).

4 Employee benefits

4.1 Employee benefits

	Group	
	2020-21	2019-20
	Total	Total
	£000	£000
Salaries and wages	**609,820**	552,335
Social security costs	**60,390**	55,464
Apprenticeship levy	**2,870**	2,617
Employer contributions to NHS Pensions	**67,551**	63,393
Employer contributions to NHS Pensions paid by NHS England on behalf of the Trust	**29,145**	27,192
Temporary staff (including bank and agency)	**87,501**	67,017
Total gross employee benefits	**857,277**	768,018
Recoveries from other bodies in respect of staff cost netted off expenditure	**-**	-
Total employee benefits	**857,277**	768,018
Of which		
Costs capitalised as part of assets	**(20)**	(306)
Total employee benefits excluding capitalised costs	**857,257**	767,712

4.2 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 https://www.nhsbsa.nhs.uk/nhs-pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

5 Finance expenses

	Group	
	2020-21	2019-20
	£000	£000
Loans from the Department of Health and Social Care		
Capital loans	**1,289**	3,449
Revenue support / working capital loans	**-**	16,201
Revolving working capital facilities	**0**	3,145
Finance leases	**7**	7
Other Loans	**18**	55
Finance costs on PFI and other service concession arrangements		
Main finance cost	**16,124**	16,598
Contingent finance cost	**9,724**	9,115
Total interest expense	**27,162**	48,570
Unwinding of discount on provisions	**(25)**	17
Other finance costs	**437**	-
Total finance costs	**27,574**	48,587

Finance expenditure represents interest and other charges involved in the borrowing of money.

6 Impairments

	Group	
	2020-21	2019-20
	£000	£000
Changes in market price - charged to operating expenses	**59,417**	3,231
Changes in market price - charged to the revaluation reserve	**3,286**	511
Other impairments - charged to operating expenses	**4,509**	-
Total	**67,212**	3,742

Asset valuations were undertaken in 2021 as at the prospective valuation date of 31 March 2021. This was based on alternative site which included a review of the Trust's patient base, through an analysis of postcode information allocated between outpatients and inpatients.

The revaluation resulted in an overall increase of £23.6m in the value of land and buildings owned by the Trust offset by impairments to land and building values of £67.7m. This was the primarilty the result of reclassification of the Critical Care Unit from Assets Under Construction, with a valuation impairment for this asset of £50m.

As a result of the revaluation, an impairment amount of £59.417m has been taken to the Statement of Comprehensive Income and a revaluation surplus of £23.064m transferred to revaluation reserve. An impairment of £3.286m has been charged to the revaluation reserve.

7 Other gains / (losses)

	Group	
	2020-21	2019-20
	£000	£000
Gains on disposal of property, plant and equipment	**155**	-
Gains on disposal of other financial assets / investments	**3,487**	
Losses on disposal of assets	**-**	(131)
Total (losses) / gains on disposal of assets	**3,642**	(131)

7.1 Share of operating profit / (loss) in associates and joint ventures

	Group	
	2020-21	2019-20
	£000	£000
Viapath Group LLP	**2,438**	421
	2,438	421

8 Intangible non-current assets

8.1 Intangible non-current assets - current year

Group	Software licences £000	Development expenditure £000	Total £000
Cost or valuation			
At 1 April 2020	20,554	707	21,261
Additions purchased	1,584	-	1,584
Disposals	-	(707)	(707)
At 31 March 2021	22,138	-	22,138
Amortisation			
At 1 April 2020	11,276	707	11,983
Charged during the year	1,877	-	1,877
Reclassifications	(22)	-	(22)
Disposals/derecognition	-	(707)	(707)
At 31 March 2021	13,131	-	13,131
Net book value			
Purchased	7,718	-	7,718
Leased	1,289	-	1,289
Total at 31 March 2021	9,007	-	9,007
Revaluation reserve balance			
At 1 April 2020	37	-	37
Transfer to I&E Reserve	(37)	-	(37)
At 31 March 2021	-	-	-

Development expenditure represented the implementation cost of the Activity Based Costing project, which was completed in 2006-07. This software is no longer in use.

8.2 Intangible non-current assets - current year

Trust	Software licences £000	Development expenditure £000	Total £000
Cost or valuation			
At 1 April 2020	19,443	707	20,150
Additions purchased	1,753	-	1,753
Disposals/derecognition	-	(707)	(707)
At 31 March 2021	21,196	-	21,196
Amortisation			
At 1 April 2020	10,920	707	11,627
Charged during the year	1,806	-	1,806
Disposals/derecognition	-	(707)	(707)
At 31 March 2021	12,704	-	12,704
Net book value			
Purchased	7,203	-	7,203
Leased	1,289	-	1,289
Total at 31 March 2021	8,492	-	8,492
Revaluation reserve balance			
At 1 April 2020	37	-	37
Transfer to I&E Reserve	(37)	-	(37)
At 31 March 2021	-	-	-

The range of useful economic lives over which intangible assets are amortised is included in note 1.12.

For all categories of intangible assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

8 Intangible non-current assets

8.3 Intangible non-current assets - prior year

Group	Group		
	Software licences £000	Development expenditure £000	Total £000
Cost or valuation			
At 1 April 2019	18,168	707	18,875
Additions purchased	2,002	-	2,002
Reclassifications	384	-	384
At 31 March 2020	20,554	707	21,261
Amortisation			
At 1 April 2019	9,590	707	10,297
Charged during the year	1,686	-	1,686
At 31 March 2020	11,276	707	11,983
Net book value			
Purchased	7,989	-	7,289
Leased	1,289	-	1,289
Total at 31 March 2020	9,278	-	8,578
Revaluation reserve balance			
At 1 April 2019	37	-	37
At 31 March 2020	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.

8.4 Intangible non-current assets - prior year

Trust	Trust		
	Software licences £000	Development expenditure £000	Total £000
Cost or valuation			
At 1 April 2019	17,842	707	18,549
Additions purchased	1,217	-	1,217
Reclassifications	384	-	384
At 31 March 2020	19,443	707	20,150
Amortisation			
At 1 April 2019	9,477	707	10,184
Charged during the year	1,443	-	1,443
At 31 March 2020	10,920	707	11,627
Net book value			
Purchased	7,234	-	7,234
Leased	1,289	-	1,289
Total at 31 March 2020	8,523	-	8,523
Revaluation reserve balance			
At 1 April 2019	37	-	37
At 31 March 2020	37	-	37

The range of useful economic lives over which intangible assets are amortised is included in note 1.12.

For all categories of intangible assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

9 Property, plant and equipment

Group

9.1 Property, plant and equipment - current year

Group	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 2020	**72,760**	**415,104**	**1,878**	**89,270**	**99,899**	**41,630**	**2,466**	**723,008**
Additions purchased	**1,435**	**11,852**	**-**	**32,032**	**33,598**	**11,755**	**29**	**90,701**
Additions donated	**-**	**-**	**-**	**-**	**697**	**-**	**-**	**697**
Additions - equipment donated from NHSE for COVID response (non-cash)	**-**	**-**	**-**	**-**	**1,430**	**-**	**-**	**1,430**
Impairments charged to operating expenses	**-**	**(64,198)**	**-**	**(2,344)**		**-**	**-**	**(66,542)**
Impairments charged to the revaluation reserve	**-**	**(10,604)**	**(124)**	**-**	**-**	**-**	**-**	**(10,728)**
Reversal of impairments credited to operating expenses	**144**	**(570)**	**-**	**-**	**-**	**-**	**-**	**(426)**
Reversal of impairments credited to the revaluation reserve	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Revaluations	**15,968**	**1,037**	**21**	**-**	**-**	**-**	**-**	**17,026**
Reclassifications	**-**	**94,245**	**-**	**(94,255)**	**-**	**-**	**10**	**-**
Transfers to/from assets held for sale and assets in disposal groups	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Disposals	**-**	**-**	**-**	**-**	**(74)**	**-**	**-**	**(74)**
At 31 March 2021	**90,307**	**446,866**	**1,775**	**24,703**	**135,550**	**53,385**	**2,505**	**755,092**
Depreciation								
At 1 April 2020	**-**	**344**	**-**	**-**	**56,811**	**21,134**	**1,711**	**80,000**
Charged during the year	**-**	**16,601**	**90**	**-**	**7,590**	**5,585**	**138**	**30,004**
Impairments charged to operating expenses	**-**	**(2,107)**	**-**	**-**	**-**	**-**	**-**	**(2,107)**
Impairments charged to the revaluation reserve	**-**	**(7,393)**	**(49)**	**-**	**-**	**-**	**-**	**(7,442)**
Reversal of impairments credited to operating expenses	**-**	**(935)**	**-**	**-**	**-**	**-**	**-**	**(935)**
Reversal of impairments credited to the revaluation reserve	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Revaluations	**-**	**(5,997)**	**(41)**	**-**	**-**	**-**	**-**	**(6,038)**
Reclassifications	**-**	**-**	**-**	**-**	**-**	**22**	**-**	**22**
Disposals	**-**	**-**	**-**	**-**	**(74)**	**-**	**-**	**(74)**
At 31 March 2021	**-**	**513**	**-**	**-**	**64,327**	**26,741**	**1,849**	**93,430**
Net book value								
Owned - purchased	**61,307**	**240,836**	**1,587**	**24,243**	**61,489**	**26,494**	**523**	**416,480**
Owned - donated	**2,607**	**11,545**	**188**	**-**	**2,118**	**149**	**134**	**16,741**
On balance sheet PFI	**26,393**	**193,973**	**-**	**460**	**6,186**	**-**	**-**	**227,012**
Owned - equipment donated from DHSC and NHSE for COVID response	**-**	**- -**	**-**	**-**	**1,430**	**-**	**-**	**1,430**
Total at 31 March 2021	**90,307**	**446,354**	**1,775**	**24,703**	**71,223**	**26,643**	**657**	**661,663**
Revaluation reserve balance								
At 1 April 2020	**37,113**	**99,418**	**1,447**	**-**	**4,564**	**-**	**257**	**142,799**
Revaluation and indexation in year	**15,968**	**3,823**	**(13)**	**-**		**-**	**-**	**19,778**
Transfer to I&E Reserve	**-**	**-**	**-**	**-**	**(4,564)**		**(257)**	**(4,821)**
At 31 March 2021	**53,081**	**103,241**	**1,434**	**-**	**-**	**-**	**-**	**157,756**

The effective date of land and building revaluation was 31 March 2021 and the valuation was carried out by Kerry Maguire of Avison Young, a RICS registered valuer.

The range of useful economic lives over which property plant and equipment are depreciated are included in note 1.12.

For all categories of non-property assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

9 Property, plant and equipment - continued

Trust

9.2 Property, plant and equipment - current year

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation								
At 1 April 2020	72,760	415,104	1,878	89,270	83,805	41,630	2,466	706,914
Additions purchased	1,435	7,025	-	32,032	1,514	11,755	29	53,790
Additions leased		4,827			32,081			36,908
Additions donated	-	-	-	-	697	-	-	697
Additions - equipment donated from NHSE for COVID response (non-cash)					1,430			1,430
Impairments charged to operating expenses	-	(64,198)	-	(2,344)	-	-	-	(66,542)
Impairments charged to the revaluation reserve	-	(10,604)	(124)	-	-	-	-	(10,728)
Reversal of impairments credited to operating expenses	144	(570)	-	-	-	-	-	(426)
Reversal of impairments credited to the revaluation reserve	-	-	-	-	-	-	-	-
Revaluations	15,968	1,037	21	-	-	-	-	17,026
Reclassifications	-	94,245	-	(94,255)	-	-	10	-
Transfers to/from assets held for sale and assets in disposal groups	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(74)	-	-	(74)
At 31 March 2021	90,307	446,866	1,775	24,703	119,453	53,385	2,505	738,995
Depreciation								
At 1 April 2020	-	344	-	-	40,713	21,134	1,711	63,902
Charged during the year	-	16,601	90	-	7,590	5,607	138	30,026
Impairments charged to operating expenses	-	(2,107)	-	-	-	-	-	(2,107)
Impairments charged to the revaluation reserve	-	(7,393)	(49)	-	-	-	-	(7,442)
Reversal of impairments credited to operating expenses	-	(935)	-	-	-	-	-	(935)
Reversal of impairments credited to the revaluation reserve	-	-	-	-	-	-	-	-
Revaluations	-	(5,997)	(41)	-	-	-	-	(6,038)
Disposals	-	-	-	-	(74)	-	-	(74)
At 31 March 2021	-	513	-	-	48,229	26,741	1,849	77,332
Net book value								
Owned - purchased	61,308	236,022	1,587	24,243	6,186	26,494	513	356,353
Owned - donated	2,607	11,545	188	-	2,118	149	144	16,750
On balance sheet PFI & Finance Lease	26,393	198,788	-	460	61,490	-	-	287,130
Owned - equipment donated from DHSC and NHSE for COVID response	-	- -	-	-	1,430	-	-	1,430
Total at 31 March 2021	90,307	446,354	1,775	24,703	71,224	26,643	657	661,663
Revaluation reserve balance								
At 1 April 2020	37,113	99,418	1,447	-	4,564	-	257	142,799
Revaluation and indexation in year	15,968	3,823	(13)	-		-	-	19,778
Transfer to I&E Reserve	-	-	-	-	(4,564)		(257)	(4,821)
At 31 March 2021	53,081	103,241	1,434	-	-	-	-	157,756

The effective date of land and building revaluation was 31 March 2021 and the valuation was carried out by Kerry Maguire of Avison Young, a RICS registered valuer.

The range of useful economic lives over which property plant and equipment are depreciated are included in note 1.12.

For all categories of non-property assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

9 Property, plant and equipment

9.3 Property, plant and equipment - prior year

Group

Group	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 2019	66,650	399,251	1,550	88,709	83,603	33,085	2,330	675,178
Additions purchased	-	966	-	4,649	15,621	8,773	97	30,106
Additions leased	-	23	-	466	1,723	-	-	2,212
Additions donated	-	843	-	-	371	193	39	1,446
Impairments charged to operating expenses	-	(7,339)	-	-	-	-	-	(7,339)
Impairments charged to the revaluation reserve	(28)	(620)	-	-	-	-	-	(648)
Reversal of impairments credited to operating expenses	99	1,265	-	-	-	-	-	1,364
Reversal of impairments credited to the revaluation reserve	-	-	-	-	-	-	-	-
Revaluations	5,912	16,162	69	-	-	-	-	22,143
Reclassifications	-	4,553	-	(4,553)	-	(384)	-	(384)
Transfers to/from assets held for sale and assets in disposal groups	127	-	260	-	-	-	-	387
Disposals	-	-	-	-	(1,419)	(37)	-	(1,456)
At 31 March 2020	72,760	415,104	1,879	89,271	99,899	41,630	2,466	723,009
Depreciation								
At 1 April 2019	-	176	-	-	52,550	17,263	1,559	71,548
Charged during the year	-	15,012	83	-	5,415	3,909	152	24,571
Impairments charged to operating expenses	-	(484)	-	-	-	-	-	(484)
Impairments charged to the revaluation reserve	-	(136)	-	-	-	-	-	(136)
Reversal of impairments credited to operating expenses	-	(2,260)	-	-	-	-	-	(2,260)
Reversal of impairments credited to the revaluation reserve	-	-	-	-	-	-	-	-
Revaluations	-	(11,964)	(83)	-	-	-	-	(12,047)
Disposals	-	-	-	-	(1,154)	(37)	-	(1,191)
At 31 March 2020	-	344	-	-	56,811	21,135	1,711	80,001
Net book value								
Owned - purchased	48,629	204,061	1,641	87,992	35,027	20,295	594	398,239
Owned - donated	2,137	11,635	237	1,030	1,958	200	162	17,359
On balance sheet PFI	21,994	199,065	-	248	6,103	-	-	227,410
Total at 31 March 2020	72,760	414,761	1,878	89,270	43,088	20,495	756	643,008
Revaluation reserve balance								
At 1 April 2019	31,229	71,785	1,296	-	4,601	-	257	109,168
Revaluation and indexation in year	5,886	27,643	151	-	-	-	-	33,680
At 31 March 2020	37,115	99,428	1,447	-	4,601	-	257	142,848

The effective date of land and building revaluation was 31 March 2020 and the valuation was carried out by an independent valuer.

The range of useful economic lives over which property plant and equipment are depreciated are included in note 1.12.

For all categories of non-property assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

9 Property, plant and equipment - continued

9.4 Property, plant and equipment - prior year

Trust

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 2019	66,650	399,251	1,550	88,709	67,509	33,085	2,330	659,084
Additions purchased	-	966	-	4,649	599	8,773	97	15,084
Additions leased	-	23	-	466	16,745	-	-	17,234
Additions donated	-	843	-	-	371	193	39	1,446
Impairments charged to operating expenses	-	(7,339)	-	-	-	-	-	(7,339)
Impairments charged to the revaluation reserve	(28)	(620)	-	-	-	-	-	(647)
Reversal of impairments credited to operating expenses	99	1,265	-	-	-	-	-	1,364
Reversal of impairments credited to the revaluation reserve	-	-	-	-	-	-	-	-
Revaluations	5,912	16,162	69	-	-	-	-	22,142
Reclassifications	-	4,553	-	(4,553)	-	(384)	-	(384)
Transfers to/from assets held for sale and assets in disposal groups	127	-	260	-	-	-	-	387
Disposals	-	-	-	-	(1,419)	(37)	-	(1,456)
At 31 March 2020	72,760	415,104	1,878	89,270	83,805	41,630	2,466	706,914
Depreciation								
At 1 April 2019	-	176	-	-	36,452	17,263	1,559	55,450
Charged during the year	-	15,012	83	-	5,415	3,909	152	24,570
Impairments charged to operating expenses	-	(484)	-	-	-	-	-	(484)
Impairments charged to the revaluation reserve	-	(136)	-	-	-	-	-	(136)
Reversal of impairments credited to operating expenses	-	(2,260)	-	-	-	-	-	(2,260)
Reversal of impairments credited to the revaluation reserve	-	-	-	-	-	-	-	-
Revaluations	-	(11,964)	(83)	-	-	-	-	(12,047)
Disposals	-	-	-	-	(1,154)	(37)	-	(1,192)
At 31 March 2020	-	344	(0)	-	40,713	21,134	1,711	63,902
Net book value								
Owned - purchased	48,629	204,061	1,641	87,992	5,732	20,295	594	368,945
Owned - donated	2,137	11,635	237	1,030	1,958	200	162	17,359
On balance sheet PFI	21,994	199,065	-	248	35,398	-	-	256,705
Total at 31 March 2020	72,760	414,761	1,878	89,270	43,088	20,495	756	643,009
Revaluation reserve balance								
At 1 April 2019	31,229	71,785	1,296	-	4,601	-	257	109,168
Revaluation and indexation in year	5,886	27,643	151	-		-	-	33,680
At 31 March 2020	37,115	99,428	1,447	-	4,601	-	257	142,848

The effective date of land and building revaluation was 31 March 2020 and the valuation was carried out by independent valuer.

The range of useful economic lives over which property plant and equipment are depreciated are included in note 1.12.

For all categories of non-property assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

10 Investments

10 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 2021, and for the associate (Viapath), 31 December 2020.
For the associate undertaking that has a different accounting year end date, accounts for year ending 31 December 2020, have been consolidated.

The Trust holds a £250k investment in KCH Commercial Services Ltd.

	Country of Incorporation	Beneficial interest	Principal activity
Directly owned subsidiary undertakings			
KCH Commercial Services Ltd	UK	100%	Holding company
KCH Interventional Facilities Management LLP *	UK	100%	Interventional Facilities Management
Indirectly owned subsidiary undertakings			
KCH Management Ltd	UK	100%	Healthcare services
Associates			
Viapath Group LLP (Viapath)	UK	24.5%	Healthcare services
MedTech Innovations Ltd	UK	30%	Healthcare technology
Joint operations			
NIHR/Wellcome Trust Clinical Research Facility (CRF) **	UK		
Equity		35%	Research
Constructions		54%	Research
Other investments			
King's Fertility Limited	UK	10%	Healthcare services

* KCH Interventional Facilities Management LLP (KIFM) is a limited liability partnership between King's College Hospital NHS Foundation Trust (90%) and KCH Commercial Services Ltd (10%). KCH started trading on 1 July 2016 and was set up to provide an efficient transformation and procurement service to the Trust. The income, expenses, assets, liabilities, equity and reserves of KIFM have been consolidated in full into the appropriate financial statement lines.
** The Foundation Trust entered into a joint operation with King's College London and South London and Maudsley NHS Foundation Trust for the construction and use of premises known as the NIHR/Wellcome Trust Clinical Research Facility, which opened in November 2012.
The Foundation Trust has capitalised 54% of the cost of the building, and equipment assets therein based on the construction proportion. The Foundation Trust recognises 35% of revenue and expenditure generated by the facility, based on the equity proportion as stipulated in the Collaboration Agreement.

The Trust entered a new joint venture during the year, MedTech Innovations Ltd, with GSTT NHS FT and King's College London. The Trust has a 30% ownership share in this new company. MedTech Innovations Ltd

10 Carrying value of associates

Group	**2020-21**	2019-20
	£000	£000
Balance at 1 April	**4,949**	4,175
Acquisitions in year	**5,725**	
Share of profit	**2,438**	421
Impairments	**-**	
Disbursements/dividends received	**(3,500)**	
Disposals	**(5,477)**	
Share of Other Comprehensive Income recognised by joint ventures/associates	**-**	353
Balance at 31 March	**4,135**	4,949

The balance includes investment of £225k in the Trust's new Joint Venture MedTech Innovations Ltd. The remainder of the balance relates to Viapath, which provides critical pathology services to the Trust.

Investments in Viapath and MedTech Innovations are held by the Trust's subsidiary KCH Commercial Services Ltd.

10 Value of associates

	2020-21	2019-20
	Viapath	Viapath
	£000	£000
Total gross assets of the entity as at 31 March	**71,903**	61,752
Total gross liabilities of the entity as at 31 March	**(55,516)**	(49,342)
Total revenues for the year ending 31 March	**135,900**	130,457
Profit for the year ending 31 March	**6,663**	2,393

The above figures are estimates based on the Viapath annual accounts for the year ended 31 December 2020.
Figures from the Viapath year end are used as there is not expected to be a material difference in position between the two year end dates.

10 Carrying value of other investments

	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
King's Fertility Limited	**335**	335	**335**	335
Other financial assets*	**2,279**	1,959	**-**	-
	2,614	2,294	**335**	335

*Other financial assets relates to a PIK note held by KCH Management Ltd

11 Inventories

11 Inventories - current year

Group	Drugs £000	Consumables £000	Consumables donated from DHSC bodies £000	Energy £000	Total £000
At 1 April 2020	**9,015**	**11,147**	**-**	**-**	**20,162**
Additions	**177,126**	**96,907**		**-**	**274,033**
Additions donated			**13,366**		**13,366**
Inventories consumed and expensed	**(175,898)**	**(94,595)**	**(13,366)**	**-**	**(283,859)**
Write down of inventories	**(1,327)**				**(1,327)**
At 31 March 2021	**8,916**	**13,459**	**-**	**-**	**22,375**

Inventories - current year

Trust	Drugs £000	Consumables £000	Consumables donated from DHSC bodies £000	Energy £000	Total £000
At 1 April 2020	**7,414**	**430**	**-**	**-**	**7,844**
Additions	**158,754**	**17,478**	**13,366**	**-**	**189,598**
Inventories consumed and expensed	**(158,565)**	**(17,527)**	**(13,366)**	**-**	**(189,458)**
At 31 March 2021	**7,603**	**381**	**-**	**-**	**7,984**

Opening balances were qualified in the previous year as per the footnote to 11.2, as stock takes could not be performed. In the current year, all required stock takes have been undertaken, with auditors attending virtually where required.

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £13.4m of items purchased by DHSC.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income. No material balance of centrally issued stock was held by the Trust as at the balance sheet date.

11 Inventories - prior year

Group	Drugs £000	Consumables £000	Energy £000	Total £000
At 1 April 2019	6,569	11,733	-	18,302
Additions	152,876	105,316	-	258,192
Inventories consumed and expensed	(150,430)	(105,902)	-	(256,332)
At 31 March 2020	9,015	11,147	-	20,162

Inventories - prior year

Trust	Drugs £000	Consumables £000	Energy £000	Total £000
At 1 April 2019	6,569	418		6,987
Additions	151,275	14,950		166,225
Inventories consumed and expensed	(150,430)	(14,938)		(165,368)
At 31 March 2020	7,414	430	-	7,844

The restrictions on movement in the United Kingdom in March 2020 meant that the Trust was unable to perform its planned year end inventory counts, and the auditor was unable to gain sufficient audit evidence from alternative procedures. The auditor was therefore unable to complete the procedures required by auditing standards, and was required to issue a qualified opinion in respect of the stock value for 2019-20.

12 Trade and other receivables

12 Trade and other receivables

	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Current				
Contract receivables	**65,852**	131,750	**63,818**	130,077
Allowance for impaired contract receivables / assets	**(13,472)**	(13,579)	**(13,443)**	(13,560)
Deposits and advances	**429**	1,415	**429**	1,397
Prepayments (non-PFI)	**8,134**	8,079	**6,652**	6,451
PDC dividend receivable	**3,168**	-	**3,168**	-
VAT receivable	**17,388**	10,998	**14,358**	10,457
Other receivables due from subsidiaries	**-**	-	**8,662**	9,782
Other receivables	**6,268**	4,550	**6,260**	1,954
Total current receivables	**87,766**	143,213	**89,904**	146,558
Non-current				
Contract receivables	**10,053**	2,315	**1,607**	2,315
Other receivables due from subsidiaries	**-**	-	**63,707**	48,763
Other Receivables	**0**	5,094	**-**	5,094
Total non-current receivables	**10,053**	7,409	**65,314**	56,172
Total	**97,819**	150,623	**155,218**	202,730
Of which are receivable from NHS and DHSC group bodies:				
Current	**31,090**	86,615	**31,090**	86,615

The majority of trade is with NHS England and Clinical Commissioning Groups. As these bodies are funded by the UK Government to buy NHS patient care services, no credit scoring of them is considered necessary.

The largest outstanding debtor at 31 March 2021 was King's College London totalling £7.490m (2020: NHS England - £21.355m).

12 Allowances for credit losses - 2020/2021

	Group		Trust	
	Contract receivables	**All other receivables**	**Contract receivables**	**All other receivables**
	£000	**£000**	**£000**	**£000**
Allowances as at 1 Apr 2020 - brought forward	**13,579**	**-**	**13,560**	**-**
New allowances arising	6,592	-	6,582	-
Changes in existing allowances	-	-	-	-
Reversals of allowances	(1,942)	-	(1,942)	-
Utilisation of allowances (write offs)	(4,757)	-	(4,757)	-
Allowances as at 31 Mar 2021	**13,472**	**-**	**13,443**	**-**

Allowances for credit losses - 2019/2020

	Group		Trust	
	Contract receivables	**All other receivables**	**Contract receivables**	**All other receivables**
	£000	**£000**	**£000**	**£000**
Allowances as at 1 Apr 2019 - as previously stated	**13,697**	**-**	**14,880**	-
New allowances arising *	8,064	-	8,045	-
Reversals of allowances	(4,201)	-	(5,384)	-
Utilisation of allowances (write offs)	(3,981)	-	(3,981)	-
Allowances as at 31 Mar 2020	**13,579**	**-**	**13,560**	**-**

13 Cash and cash equivalents

	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Opening balance	**59,871**	45,771	**50,586**	39,217
Net change in year	**83,996**	14,100	**71,633**	11,369
Closing balance	**143,867**	59,871	**122,219**	50,586
Made up of				
Cash with Government Banking Service	**127,956**	48,819	**113,699**	41,194
Commercial banks and cash in hand	**15,911**	11,052	**8,520**	9,392
Cash and cash equivalents as in statement of financial position	**143,867**	59,871	**122,219**	50,586
Patients' money held by the Foundation Trust, not included above	**14**	14	**14**	14

14 Trade and other payables

	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Current				
Trade payables	**61,775**	40,409	**55,065**	30,297
Capital payables	**15,315**	9,031	**14,845**	9,031
Accruals	**114,350**	106,107	**94,031**	114,968
Receipts in advance	**916**	1,451	**915**	1,451
Social security costs	**9,429**	8,648	**9,430**	8,487
Other taxes payable	**9,434**	8,181	**8,759**	7,857
Other payables	**11,494**	9,567	**10,367**	9,407
Total	**222,714**	183,394	**193,412**	181,497
Of which are receivable from NHS and DHSC group bodies:				
Current	**17,398**	24,862	**17,398**	24,862

All trade and other payables are current; there are no non-current balances.

15 Other liabilities - Deferred income

	Group and Trust	
	31 March 2021	31 March 2020
	£000	£000
Current		
Deferred income	**13,317**	14,439
Total	**13,317**	14,439

All deferred income is current; there are no non-current balances.
£264k of the deferred income is held by the subsidiary, KFM.

16 Borrowings

	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
Current	**£000**	£000	**£000**	£000
Loans from DHSC				
Capital loans	**3,769**	99,021	**3,768**	99,021
Revenue support / working capital loans	**-**	555,323	**-**	555,323
Revolving working capital facilities	**-**	89,600	**-**	89,600
Other loans	**845**	208	**640**	-
Obligations under finance leases	**-**	591	**7,900**	4,181
Obligations under PFI contracts	**5,358**	4,730	**5,358**	4,730
Total current borrowings	**9,972**	749,473	**17,666**	752,855
Non-current				
Loans from DHSC				
Capital loans	**43,669**	47,086	**43,669**	47,086
Revenue support / working capital loans	**-**	-	**-**	-
Revolving working capital facilities	**-**	-	**-**	-
Other loans	**3,527**	598	**3,203**	-
Obligations under finance leases	**-**	-	**52,218**	25,704
Obligations under PFI contracts	**136,467**	139,860	**136,468**	139,860
Total non-current borrowings	**183,663**	187,544	**235,558**	212,650
Total	**193,635**	937,017	**253,224**	965,505

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 of £735m were extinguished and replaced with the issue of Public Dividend Capital (PDC).

16.1 Reconciliation of liabilities arising from financing activities

Group	**Loans from DHSC**	**Other loans**	**Finance leases**	**PFI and LIFT schemes**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
Carrying value at 1 April 2020	**791,030**	**806**	**591**	**144,590**	**937,017**
Cash movements:					
Financing cash flows - payments and receipts of principal	(738,730)	3,566	(591)	(4,872)	**(740,627)**
Financing cash flows - payments of interest	(6,151)	(18)	(7)	(16,124)	**(22,300)**
Non-cash movements:					
Additions	-	-	-	2,107	**2,107**
Interest charge arising in year	1,289	18	7	16,124	**17,438**
Carrying value at 31 March 2021	**47,438**	**4,372**	**-**	**141,825**	**193,635**

Trust	**Loans from DHSC**	**Other loans**	**Finance leases**	**PFI and LIFT schemes**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
Carrying value at 1 April 2019	**791,030**	**-**	**29,885**	**144,590**	**965,505**
Cash movements:					
Financing cash flows - payments and receipts of principal	(738,730)	3,844	30,232	(4,872)	**(709,526)**
Financing cash flows - payments of interest	(6,151)		(107)	(16,124)	**(22,382)**
Non-cash movements:					
Additions				2,107	**2,107**
Interest charge arising in year	1,289		107	16,124	**17,520**
Carrying value at 31 March 2020	**47,438**	**3,844**	**60,117**	**141,825**	**253,224**

17 Finance lease obligations

	Group 31 March 2021 £000	Group 31 March 2020 £000	Trust 31 March 2021 £000	Trust 31 March 2020 £000
Gross lease liabilities	**-**	598	**61,881**	30,625
Of which liabilities are due:				
- not later than one year	**-**	598	**8,132**	4,278
- later than one year and not later than five years	**-**	-	**35,323**	13,852
- later than five years	**-**	-	**18,173**	12,495
Total	**-**	598	**61,628**	30,625
Finance charges allocated to future periods		(7)	**(1,510)**	(740)
Net lease liabilities	**-**	591	**60,118**	29,885
Of which liabilities are due:				
- not later than one year	**-**	591	**7,900**	4,181
- later than one year and not later than five years	**-**	-	**34,495**	13,514
- later than five years	**-**	-	**17,723**	12,191
Total	**-**	591	**60,118**	29,885

The Group held a finance lease in respect of IT software licences - this ended in March 2021, so no outstanding liabilities remain. The Trust leases clinical equipment and 1 modular building from its subsidiary, KFM on a finance lease basis.

18 Provisions

18.1 Provisions - current year

Group	Total £000	Pensions: Early Departure costs £000	Pensions: Injury benefits * £000	Legal claims £000	Other £000
At 1 April 2020	**13,229**	4,252	267	150	8,560
Arising during the year	**551**	-	-	-	551
Utilised during the year - cash	**(8,562)**	(681)	-	-	(7,881)
Utilised during the year - accruals	**(50)**	-	(50)	-	-
Reversed unused	**-**	-	-	-	-
Change in discount rate	**794**	794	-	-	-
Unwinding of discount	**(25)**	(21)	(4)	-	-
At 31 March 2021	**5,937**	**4,344**	**213**	**150**	**1,230**
Expected timing of cash flows:					
No later than one year	**2,114**	680	54	150	1,230
Later than one year and not later than five years	**2,875**	2,720	155	-	-
Later than five years	**948**	944	4	-	-
Total	**5,937**	**4,344**	**213**	**150**	**1,230**

All provisions relate to the Trust.

The timing of the provisions cash flow represents our best estimate of future liabilities based on available input from NHS professionals in the respective areas.

"Other provisions" relates to provisions raised against the cost of defending and settling legal disputes

18.2 Provisions - prior year

Group	Total £000	Pensions: Early Departure £000	Pensions: Injury benefits* £000	Legal claims £000	Other £000
At 1 April 2019	6,873	4,687	322	206	1,658
Arising during the year	8,534	-	-	73	8,461
Utilised during the year - cash	(2,326)	(700)	(60)	(7)	(1,559)
Utilised during the year - accruals	-	-	-	-	-
Reversed unused	(122)	-	-	(122)	-
Change in discount rate	253	253	-	-	-
Unwinding of discount	17	12	5	-	-
At 31 March 2020	13,229	4,252	267	150	8,560
Expected timing of cash flows:					
No later than one year	9,469	700	59	150	8,560
Later than one year and not later than five years	3,008	2,800	208	-	-
Later than five years	752	752	-	-	-
Total	13,229	4,252	267	150	8,560

KCH Managment Services Ltd has included a provision of £16k which is consolidated in the group provisions within "Other provisions". This is excluded from the Trust only provision figures on the Statement of Financial Position.

The timing of the provisions cash flow represents our best estimate of future liabilities based on available input from NHS professionals in the respective areas.

18.3 Provisions - further information

Clinical negligence

£605.053m (31 March 2020: £595.780m) is included in the provisions of the NHS Resolution at 31 March 2021, in respect of the estimated clinical negligence liabilities and existing liabilities of the Foundation Trust. As such, no provision is included in the Trust's accounts. NHS Resolution took over responsibility for unsettled clinical negligence claims for 1 April 2000, financial responsibility for all other clinical negligence claims transferred on 1 April 2002.

Pensions

The measure of the Foundation Trust's pension liability for early retired staff was recalculated in 2012-13, using the Office for National Statistics life expectancy tables. Expected future cash flows have been discounted using the real discount rate of (0.50%) (2019/20: 0.50%) (set by HM Treasury) to determine the full liability.

Legal claims

The provision is based upon information provided by the NHS Resolution and refers to non-clinical claims against the Foundation Trust (e.g. public and employer's liability cases).

Other

The Foundation Trust has provided £0.756m (31 March 2020: £0.677m) for outstanding Employment Tribunal cases and associated legal fees. A further provision has been provided for the costs of defending and settling legal claims.

19 Contingencies

	Group and Trust	
	31 March 2021	31 March 2020
	£000	£000
Contingent liabilities		
Non-clinical legal claims	**(64)**	(69)

The above contingencies refer to non-clinical legal claims, dealt with by the NHS Resolution on behalf of the Foundation Trust. This represents our best estimate of future liabilities based on available input from NHS professionals in the respective areas.

The Foundation Trust has no contingent assets.

20 Contracted capital commitments

	Group and Trust	
	31 March 2021	31 March 2020
	£000	£000
Property, plant and equipment	**16,211**	18,332

Capital commitments includes £9.8m in respect of the second phase of CCU development.

21 Revaluation reserve

Group and Trust			**31 March 2021**	31 March 2020
	Intangibles	**Property, plant and equipment**	**Total**	Total
	£000	**£000**	**£000**	£000
At 1 April 2020	**37**	**142,809**	**142,846**	109,168
Net impairments	**-**	**(3,286)**	**(3,286)**	(511)
Revaluations	**-**	**23,064**	**23,064**	34,189
Transfer to I&E reserve	**(37)**	**(4,831)**	**(4,868)**	-
At 31 March 2021	**-**	**157,756**	**157,756**	142,846

22 On-SoFP PFI arrangements

22.1 The following are obligations in respect of the finance lease element of on-Statement of Financial Position PFI schemes:

	Group and Trust	
	31 March 2021 £000	31 March 2020 £000
Gross PFI liabilities	**321,066**	342,655
Of which liabilities are due:		
- not later than one year	**21,019**	20,854
- later than one year and not later than five years	**81,008**	83,222
- later than five years	**219,039**	238,579
Total	**321,066**	342,655
Finance charges allocated to future periods	**(179,241)**	(198,065)
Net PFI liabilities	**141,825**	144,590
Of which liabilities are due:		
- not later than one year	**5,358**	4,730
- later than one year and not later than five years	**17,722**	16,210
- later than five years	**118,745**	123,650
Total	**141,825**	144,590

22.2 Total on-SoFP PFI commitments
Total future obligations under these on-SoFP schemes are as follows:

	Group and Trust	
	31 March 2021 £000	31 March 2020 £000
Total future payments committed of which will fall due:		
- not later than one year	**82,916**	80,959
- later than one year and not later than five years	**348,610**	340,723
- later than five years	**1,186,338**	1,272,865
Total	**1,617,864**	1,694,547

22.3 Analysis of amounts payable to service concession operator
This note provides an analysis of the unitary payments made to the service concession operator:

	Group and Trust	
	31 March 2021 £000	31 March 2020 £000
Unitary payment payable to service concession operator (total of all schemes)	**88,738**	85,989
Consisting of:		
- Interest charge	**16,124**	16,598
- Repayment of finance lease liability	**4,872**	4,270
- Service element	**54,414**	52,588
- Revenue lifecycle maintenance	**3,604**	3,417
- Contingent rent	**9,724**	9,115
	88,738	85,989
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	**7,628**	5,883
Total	**96,366**	91,872

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 2.29% (2019/20: 2.5%).

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 iteslf has no overseas operations and therefore has low exposure to currency rate fluctuations. The Trust's subsidiary, KCH Management Ltd, is involved in some overseas activities and is exposed to exchange rate movements on a loan held. This is an immaterial risk to the KCH group position.

Interest rate risk
32% of the Foundation Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. The interest rate on cash held is 0.01%, so overall the Foundation Trust is not 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 2021 are in receivables from customers, as disclosed in the trade and other receivables note (note 13). Trade and other receivables outstanding but not past due date are considered recoverable and are not impaired. Factors determining the of impairment of trade and other receivables past due is included in note 1.22.3.

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 outside of the uncertainty in the funding regime. See note 1.1

23.2 Financial assets

	Total	Floating rate	Fixed rate	Non-interest bearing
Group	**£000**	**£000**	**£000**	**£000**
Gross financial assets				
at 31 March 2021	**215,182**	**143,867**	**-**	**71,315**
at 31 March 2020	192,295	59,871	-	132,424
Trust				
Gross financial assets				
at 31 March 2021	**253,414**	**122,219**	**-**	**131,195**
at 31 March 2020	235,596	50,586	-	185,010

The weighted average interest rate for total financial assets was 0.01% (2019/20: 0.22%).
The weighted average period for which fixed years was unlimited (2019-20: unlimited).
The non-interest bearing weighted average term years was nil (2019-20: nil).

23.3 Financial liabilities

	Total	Floating rate	Fixed rate	Non-interest bearing
Group	**£000**	**£000**	**£000**	**£000**
Gross financial liabilities				
at 31 March 2021	**402,003**	**4,372**	**194,723**	**202,908**
at 31 March 2020	1,115,360	806	949,440	165,114
Trust				
Gross financial liabilities				
at 31 March 2021	**432,996**	**3,844**	**249,381**	**179,771**
at 31 March 2020	1,142,435	**-**	978,734	163,701

The weighted average interest rate for total financial liabilities was 8.39% (2019/20: 4.32%).
The weighted average period for which fixed years was unlimited (2019-20: unlimited).
The non-interest bearing weighted average term years was nil (2019-20: nil).

23.4 Carrying values of financial assets

Group

Carrying values of financial assets as at 31 March 2021	**Held at amortised cost £000**	**Held at fair value through I&E £000**	**Held at fair value through OCI £000**	**Total book value £000**
Trade and other receivables excluding non financial assets	68,701	-	-	**68,701**
Other investments / financial assets	335	-	2,279	**2,614**
Cash and cash equivalents	143,867	-	-	**143,867**
Total at 31 March 2021	**212,903**	**-**	**2,279**	**215,182**

Carrying values of financial assets as at 31 March 2020	**Held at amortised cost £000**	**Held at fair value through I&E £000**	**Held at fair value through OCI £000**	**Total book value £000**
Trade and other receivables excluding non financial assets	130,130	-	-	**130,130**
Other investments / financial assets	335	-	1,959	**2,294**
Cash and cash equivalents	59,871	-	-	**59,871**
Total at 31 March 2020	**190,336**	**-**	**1,959**	**192,295**

Trust

Carrying values of financial assets as at 31 March 2021	**Held at amortised cost £000**	**Held at fair value through I&E £000**	**Held at fair value through OCI £000**	**Total book value £000**
Trade and other receivables excluding non financial assets	130,610	-	-	**130,610**
Other investments / financial assets	585	-	-	**585**
Cash and cash equivalents	122,219	-	-	**122,219**
Total at 31 March 2021	**253,414**	**-**	**-**	**253,414**

Carrying values of financial assets as at 31 March 2020	**Held at amortised cost £000**	**Held at fair value through I&E £000**	**Held at fair value through OCI £000**	**Total book value £000**
Trade and other receivables excluding non financial assets	184,425	-	-	**184,425**
Other investments / financial assets	585	-	-	**585**
Cash and cash equivalents	50,586	-	-	**50,586**
Total at 31 March 2020	**235,596**	**-**	**-**	**235,596**

23.5 Carrying values of financial liabilities

Group

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	47,438	-	**47,438**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concessions	141,825	-	**141,825**
Other borrowings	4,372	-	**4,372**
Trade and other payables excluding non financial liabilities	202,908	-	**202,908**
Other financial liabilities	-	-	**-**
Provisions under contract	5,460	-	**5,460**
Total at 31 March 2021	**402,003**	**-**	**402,003**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	791,030	-	**791,030**
Obligations under finance leases	591	-	**591**
Obligations under PFI, LIFT and other service concessions	144,590	-	**144,590**
Other borrowings	806	-	**806**
Trade and other payables excluding non financial liabilities	165,114	-	**165,114**
Other financial liabilities	-	-	**-**
Provisions under contract	13,229	-	**13,229**
Total at 31 March 2020	**1,115,360**	**-**	**1,115,360**

Trust

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	47,438	-	**47,438**
Obligations under finance leases	60,118	-	**60,118**
Obligations under PFI, LIFT and other service concessions	141,825	-	**141,825**
Other borrowings	3,844	-	**3,844**
Trade and other payables excluding non financial liabilities	174,311	-	**174,311**
Other financial liabilities	-	-	**-**
Provisions under contract	5,460	-	**5,460**
Total at 31 March 2021	**432,996**	**-**	**432,996**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	791,030	-	**791,030**
Obligations under finance leases	29,885	-	**29,885**
Obligations under PFI, LIFT and other service concessions	144,590	-	**144,590**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	163,701	-	**163,701**
Other financial liabilities	-	-	**-**
Provisions under contract	13,229	-	**13,229**
Total at 31 March 2020	**1,142,435**	**-**	**1,142,435**

23.6 Fair values of financial assets and liabilities

The carrying value of financial assets and liabilities is considered a reasonable approximation of their fair values.

23.7 Maturity of financial liabilities

	Group		Trust	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
In one year or less	**235,119**	945,478	**202,098**	944,040
In more than one year but not more than five years	**101,423**	101,295	**135,490**	117,245
In more than five years	**253,618**	276,778	**271,330**	290,690
Total	**590,160**	1,323,551	**608,918**	1,351,975

This analysis is based on undiscounted future cash flows i.e. gross liabilities including finance charges. The amounts of both principal and interest payments which the Trust and group are committed to make under PFI and finance lease obligations are shown in Notes 18 and 23.

24 Third party assets

At 31 March 2021, the Foundation Trust held £13,632 (31 March 2020: £14,305) 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 2021.

26 Related parties

King's College Hospital NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health. The Department of Health and Social Care is the Trust's parent department and ultimate controlling party.

During the year, none of the Board members, the Foundation Trust's governors, members of the key management staff or parties related to them have undertaken any material transactions with the Foundation Trust.

The Department of Health and Social Care (DHSC) is regarded as a related party. During the year, the Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent entity, including CCGs, NHS Trusts and NHS England, as well as the NHS Resolution and the NHS Business Services Authority (including NHS Supply Chain). These organisations are listed below.

NHS England
NHS South East London CCG
Health Education England
NHS Kent and Medway CCG
NHS South West London CCG
Guy's & St Thomas' NHS Foundation Trust
NHS Surrey Heartlands CCG
Department for Work and Pensions
NHS Blood and Transplant
NHS East Sussex CCG
NHS West Sussex CCG
NHS North Central London CCG
Lambeth London Borough Council
South London and Maudsley NHS Foundation Trust
Oxleas NHS Foundation Trust
Department of Health and Social Care
NHS Hammersmith and Fulham CCG
NHS Central London (Westminster) CCG
NHS Newham CCG
Lewisham and Greenwich NHS Trust
Community Health Partnerships
St George's University Hospitals NHS Foundation Trust
NHS Resolution
NHS Property Services
HM Revenue & Customs
NHS Pension Scheme

In addition, the Trust has significant transactions with King's College London in respect of education, training and research and

	Income £000	Expenditure £000	Receivables £000	Payables £000
Viapath Group LLP	6,311	50,834	3,244	2,997
Kings College London	6,747	13,870	7,490	3,604
Medtech	-	225	-	225

27 Losses and special payments

Group and Trust	2020-21		2019-20	
	Number	**Value £000**	Number	Value £000
Losses of cash due to:				
- overpayment of salaries	**78**	**54**	354	467
Bad debts and claims abandoned in relation to:				
- private patients	**40**	**56**	90	132
- overseas visitors	**775**	**3,801**	1,527	3,191
- other	**42**	**109**	89	145
Stores Losses	**157**	**1,327**	-	-
Damage to buildings, property etc. due to:				
- theft, fraud etc.	**8**	**8**	15	11
Total losses	**1,100**	**5,355**	2,075	3,946
Special payments due to:				
Ex-gratia payments due to:				
- loss of personal effects	**8**	**10**	7	3
Total special payments	**8**	**10**	7	3
Total losses and special payments	**1,108**	**5,365**	2,082	3,949

In 2020-21 there were nil cases where the loss or special payment exceeded £300,000 (2019-20: 0 cases).

Losses and special payments are disclosed on an accruals, rather than a cash basis, but exclude provision for future losses.