AGENDA

Meeting	Public Council Of Governors
Time of meeting	18:00 – 19:45hrs
Date of meeting	Thursday 17th October 2019
Meeting Room	Boardroom, Hambleden Wing
Site	Denmark Hill

			Encl.	Lead	Time
1.	**Standing Items** 1.1. Welcome and Apologies 1.2. Declarations of Interest 1.3. Chair's Action 1.4. Minutes of Previous Meeting – 9th May 2019 1.5. Matters Arising / Action Tracker	 FA FR	 Enc. Enc.	Chair	18:00
2.	**OSEL STP Response to the Long Term Plan**	FD	Enc	Julie Lowe	18:05
3.	**Report from the External Auditors**	FD	Enc	Jonathan Gooding	18.30
4.	**Discussion of the Board Meeting and Papers** • **Finance** • **Performance**	FD	Oral	Chair	18.50
5.	**Improving emergency care** • **PRUH** • **DH**		Enc	 N Ranger B Bluhm	19.10
6.	**Governor Elections 2019: Election Results and update**	FR	Enc.	Siobhan Coldwell	19.25
7.	**Governor Involvement & Engagement** 7.1. Governor Engagement & Involvement Activities 7.2. Patient Experience & Safety Committee (PESC) 7.3. Membership & Community Engagement Committee (MCEC) 7.4. Governor Strategy Committee – Summary of last meeting	 FR FR FR FR	 Oral Enc. Oral Oral	 Jane Allberry Victoria Silvester Penny Dale Mr Ashish Desai	19.30
8.	**For Information** 8.1. Sub-Committee – Confirmed Minutes 8.1.1. Patient Experience & Safety Committee, 11.04.2019 8.1.2. Strategy Committee, 11.04.2019	 FI FI FI	 Enc. Enc. Enc.	Chair	19.45
9.	**Any Other Business**			Chair	19.45
10.	**Date Of Next Meeting** Thursday 12th December 2019, 6:00 – 7:30pm ORTUS Centre, 82-96 Grove Lane, Camberwell, London, SE5 8SN				

Key: ***FE***: *For Endorsement;* ***FA***: *For Approval;* ***FR***: *For Report;* ***FI***: *For Information*

Sir Hugh Taylor	Trust Chair
Elected:	
Jane Clark	Bromley
Diana Coutts-Pauling	Bromley
Penny Dale	Bromley
David Jefferys	Bromley
Alfred Ekellot	Lambeth
Barbara Goodhew	Lambeth
Susan Wise	Lewisham
Paul Cosh	Patient
Emmanuel Forche	Patient
Andrea Towers	Patient
Jane Alberry	Southwark
Pam Cohen	Southwark
Stephanie Harris	Southwark
Victoria Silvester	Southwark
Mr Ashish Desai	Staff – Medical & Dental
Kevin Labode	Staff – Administration, Clerical & Management
Carol Olding	Staff – Nurses and Midwives
Claire Wilson	Staff - Allied Health Professionals, Scientific & Technical
Nominated/Partnership Organisations:	
Dr Dianne Aitken	Lambeth CCG
Cllr. Jim Dickson	Lambeth Council
Cllr Robert Evans	Bromley Council
Charlotte Hudson	South London & Maudsley NHS Foundation Trust
Richard Leeming	Southwark Council
Phidelma Lisowska	Joint Staff Committee
In attendance:	
Faith Boardman	Non-Executive Director
Prof Jonathan Cohen	Non-Executive Director
Prof Ghulam Mufti	Non-Executive Director
Alix Pryde	Non-Executive Director
Sue Slipman	Non-Executive Director
Chris Stooke	Non-Executive Director
Prof Richard Trembath	Non-Executive Director
Dr Clive Kay	Chief Executive
Bernie Bluhm	Chief Operating Officer
Beverley Bryant	Chief Digital Information Officer
Dawn Brodrick	Chief People Officer
Nicola Ranger	Chief Nurse
Prof Julia Wendon	Chief Medical Officer – Clinical Strategy
Dr Kate Langford	Chief Medical Officer – Professional Standards
Lorcan Woods	Chief Financial Officer
Caroline White	Executive Director of Integrated Governance
Sao Bui-Van	Director of Communications
Siobhan Coldwell	Trust Secretary and Head of Corporate Governance
Tara Knight	Corporate Governance Officer (Minutes)
Apologies:	
Anne-Marie Rafferty	King's College London, Nominated Governor
Chris North	Public Lambeth Governor
Circulation to: Council of Governors and Board of Directors	

Council of Governors – Public Session

Minutes

Minutes of the Council of Governors (Public Session) meeting held on Thursday 9th May 2019 at 18:00 in the Boardroom, Hambleden Wing, King's College Hospital, Denmark Hill.

Chair:

Sir Hugh Taylor	Trust Chair

Elected Governors:

Chris North	Lambeth / Lead Governor
Jane Clark	Bromley Governor
Diana Coutts-Pauling	Bromley Governor
Penny Dale	Bromley Governor
David Jefferys	Bromley Governor
Alfred Ekellot	Lambeth Governor
Barbara Goodhew	Lambeth Governor
Paul Cosh	Patient Governor
Emmanuel Forche	Patient Governor
Andrea Towers	Patient Governor
Jane Allberry	Southwark Governor
Pam Cohen	Southwark Governor
Stephanie Harris	Southwark Governor
Victoria Silvester	Southwark Governor
Kevin Labode	Staff Governor – Administration and Clerical
Carole Olding	Staff Governor – Nursing and Midwifery

Nominated/Partnership Organisation Governors:

Cllr. Jim Dickson	Nominated/Partnership Governor – Lambeth Council
Charlotte Hudson	South London & Maudsley NHS Foundation Trust
Phidelma Lisowska	Nominated/Partnership Governor – Joint Staff Committee

In Attendance:

Clive Kay	Chief Executive Officer
Bernie Bluhm	Interim Chief Operating Officer
Faith Boardman	Non-Executive Director
Dawn Brodrick	Director of Workforce Development
Siobhan Coldwell	Trust Secretary and Head of Corporate Governance
Nina Martin	Assistant Board Secretary
Dale Rustige	Corporate Governance Officer (Minutes)
Prof Julia Wendon	Medical Director
Lorcan Woods	Chief Financial Officer

Apologies:

Ashish Desai	Staff Governor – Medical & Dental
Cllr. Robert Evans	Nominated/Partnership Governor – Bromley Council
Richard Leeming	Nominated/Partnership Governor – Southwark Council
Prof Anne Marie Rafferty	Nominated/Partnership Governor – King's College London
Claire Saha	Staff Governor - Allied & Health Professionals
Derek St Clair Cattrall	Patient Governor

Item	Subject	Action
19/14	**Welcome and Apologies**	
19/15	**Declarations of Interest**	

None.

19/16 Chair's Action

The Council noted that work would be done on streamlining the delivery of the Board and Council meetings to increase the effectiveness of the governance structure. The Governors would be kept informed of all the changes in due course.

19/17 Minutes of the Previous Meeting

The minutes of the last meeting held on 6th March 2019 were approved as accurate.

19/18 Matters Arising / Action Tracker

The Council noted that there were outstanding no actions due.

19/19 Performance Update

The Committee received and noted the Operational Performance Report for Month 12.

Bernie Bluhm, Interim Chief Operating Officer, provided a verbal update and highlights from the report:

- She had been in post for approximately 12 weeks and covers the Denmark Hill site. Fiona Wheeler covers the PRUH and South Sites.
- Bernie noted that getting the Trust into a sustainable position would require long-term work and would not be a quick fix. The improvement programmes across both sites would also include cultural changes. Indicators would be monitored regularly to ensure that the improvement works are on track.
- The Trust's 52-week wait figures compared favourably to local partners. The agreed delivery target with the regulators was currently on track. It was noted that the referral to treatment (RTT) 18-week performance figures impacted directly on the 52-week performance.
- A recovery plan was in place for the endoscopy issues at the PRUH and was being monitored on a regular basis. Some of the patients on the waiting lists at the PRUH were being treated at the Denmark Hill site.

Council had discussed the work being undertaken with the commissioners and primary care in reducing the number of unnecessary patient admissions by raising awareness of the appropriate pathways.

There was also a discussion regarding the realistic performance figures expected from the plans and programmes put in place. Council was informed that there was an opportunity for the Trust to improve its performance figures and achieve over 80% over the next 8-12 months. There would be a range of issues that would need to be resolved before the Trust can get out of the 70%+ figures.

Council noted that one of the downsides to looking at performance figures alone was that these numbers do not tell the whole story and underlying causes. The Trust pushes through an ever increasing demand on its emergency department services and the number of admissions continue to rise. It was noted that there were patients that would opt to wait six hours in the urgent care centre to be seen,

Item	Subject	Action
	instead of going through the appropriate pathway and book an appointment. There were challenges in primary care that causes an impact.	

19/20 Finance Update

The Committee received and noted the Finance Report for Month 12. Lorcan Woods, Chief Operating Officer, provided a verbal update:

- The Annual Accounts 2018/19 had been completed and submitted in time.
- The current deficit figure was at £191m, excluding the alternate delivery model (ADM) plans.
- The Trust was reaching a predictable trajectory in its financials, which was a good sign that there were a clearer understanding of the finances.
- There was a 6% increase in commissioner income in 2019/20.
- KFM reported a profit of £0.5m.
- The targeted for the overall financial improvement programme for 2019/20 was £75m.

There was a discussion about an experience one of the Governors had regarding treatment options offered by their private insurer. They noted that their insurer could provide them with a better deal with a Harley Street doctor, in comparison to the cost of referring them to King's. The Council was informed that there would be future opportunities for the Trust to develop its private clinics further.

There was a discussion regarding the CIP targets and how realistic these were to achieve by the Trust and whether there would be a risk in the Trust overstating its savings. Council was informed that some of the areas where savings could be made had already been identified and that there would be further scope to identify areas where savings could be made.

19/21 Governor Elections 2019: Update and Draft Elections Timetable

The Council noted the elections timetable and the Governor seats that would be up for election.

Council was informed that governor awareness sessions would be delivered to attract nominees. The vacant seats and elections would also be advertised on the website, newspapers, social media and the staff intranet.

GOVERNOR INVOLVEMENT AND ENGAGEMENT

19/22 1. Governor Engagement & Involvement Activities

The Committee received and noted a verbal update from Chris North on the key Governors' activities during the past few months. There had been some engagement and communications between he Governors and NHS Improvement discussing the role of Governors while the Trust is under financial special measures.

There had been a King's Health Partners Governors Event on 2nd May, which brought together Governors from Guy's and St Thomas', South London and Maudsley, and King's.

Governors continued its representation and engagement at Board and Board sub-committee meetings. There are Governor representatives sat on the Quality Assurance & Research Committee, Education and Workforce Development Committee, and Finance and Performance Committee.

Item	Subject	Action

Various Governors also continue their volunteer and engagement work across the Trust.

The Council thanked the Governors for their hard work and contributions.

2. Patient Experience & Safety Committee (PESC)
The Council received and noted a summary of the PESC meeting on 11th April 2019. Victoria Silvester, Committee Chair, noted that the focus of the meeting was on the outpatient transformation work.

FOR INFORMATION

19/23 Confirmed Minutes of Governor Sub-committees

The Council noted the following minutes:
a) Patient Experience & Safety Committee (PESC), 14/02/2019
b) Strategy Committee, 07/02/2019

19/24 ANY OTHER BUSINESS

None.

19/25 Date of next meeting

Wednesday 2nd October 2019 (14:30-15:30) in the Boardroom, Hambleden Wing, King's College Hospital, Denmark Hill site.

Our Healthier South East London
Sustainability and Transformation Partnership

South east London ICS response to the NHS Long Term Plan

Update for KCH Trust Board
October 2019

A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England

Our Healthier South East London
Sustainability and Transformation Partnership

Introduction

In January 2019, the NHS Long Term Plan (LTP) was published, setting out expectations for the next 10 years to support people in starting well, living well, and ageing well. Whilst refreshing areas such as cancer, mental health and urgent and emergency care, the LTP brings renewed focus to specific major health conditions including cardiovascular disease, stroke, and respiratory disease. In outlining an improved health and care offer for our population, the LTP also emphasises the need to reduce health inequalities, enhance out-of-hospital care, and increase digitally-enabled care.

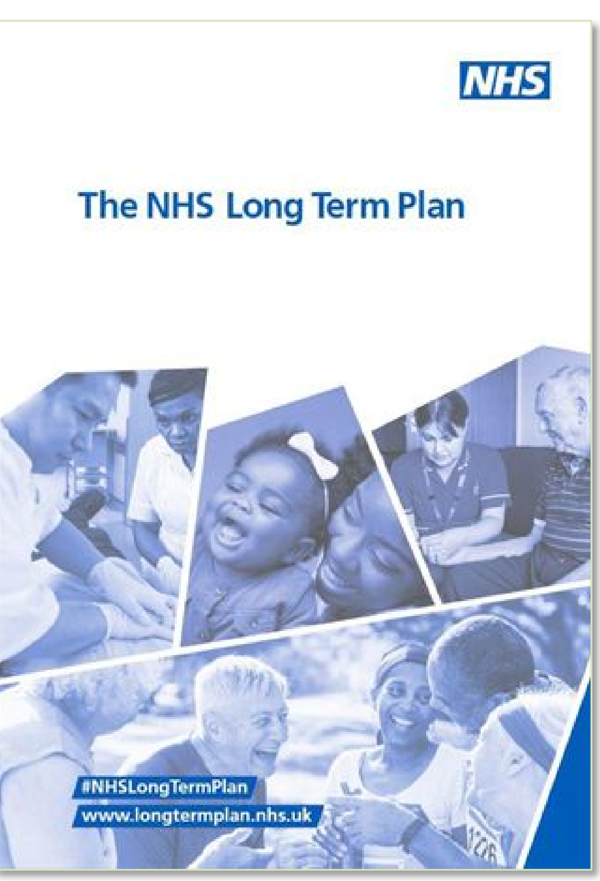
In responding to the Long Term Plan, the South East London (SEL) ICS is required to produce and submit a narrative plan for delivery between 2019/20 and 2023/24, supported by technical documents on finance, activity, workforce, and performance metrics.

Our plans need to be:

- Clinically led and locally owned
- Financially balanced
- Based on realistic workforce assumptions
- Deliver the entirety of the LTP
- Phase activity over 5 years based on local need

Background 1 of 2 – The NHS Long Term Plan (January 2019)

1. Do things **differently, through a new service model**
2. Take more action on **prevention** and **health inequalities**
3. Improve **care quality and outcomes** for major conditions
4. Ensure that **NHS staff** get the backing that they need
5. Make better use of **data** and **digital technology**
6. Ensure we get the most out of **taxpayers' investment** in the NHS



Our Healthier South East London
Sustainability and Transformation Partnership

Background 2 of 2 – OHSEL Sustainability and Transformation Plan 2016

Our challenges

1. **Demand for health and care services is increasing**
2. **There is unacceptable variation in care, quality and outcomes across SEL**
3. **Our system is fragmented resulting in duplication and confusion**
4. **The cost of delivering health and care services is increasing**

Our five priorities and areas of focus

Developing consistent and high quality community based care (CBC), primary care development and prevention	Improving quality and reducing variation across both physical and mental health	Reducing cost through provider collaboration	Developing sustainable specialised services	Changing how we work together to deliver the transformation required
• Promote self care and prevention • Improved access and coordination of care • Sustainable primary care • Co-operative structures across parts of the system • Financial investment by the system • Contracting and whole population budgets	• Integration of mental health • Reduce pressure on and simplify A&E • Implementation of standards, policies and guidelines • Collaborate to improve quality and efficiency through consolidation (e.g. the elective orthopaedic centres) • Standardise care across pathways	• Standardise and consolidate non-clinical support services • Optimise workforce • Capitalise on collective buying power • Consolidate clinical support services • Capitalise on collective estate	• Joint commissioning and delivery models • Strategic plan for south London • London Specialised Commissioning Planning Board • Managing demand across boundaries • Mental health collaboration	• Effective joint governance able to address difficult issues • Incorporation of whole commissioning spend including specialist services • Sustainable workforce strategy • Collective estates strategy and management • New models of collaboration and delivery

The impact of our plans

Priorities 1 and 2	Priority 3	Priority 4	Priority 5
• Reduction in A&E attends and non-elective admissions • Reduced length of stay • Reduced re-admissions • Early identification and intervention • Delivery of care in alternative settings (Net savings c.£116m)	Cross-organisation productivity savings from joint working, consolidation and improved efficiency (Net saving c.£225m)	• Increased collaboration • Reduced duplication • Management of flow (Need to address £190m)	• Aligned decision making resulting in faster implementation • Increased transparency and accountability

Our response – 'Core foundations' and 'prioritised commitments'

All STPs and ICSs are required to write a response that sets out how systems will deliver the commitments within the Long Term Plan. To support this a national framework for implementing the LTP was released in June; the framework confirmed key timelines and importantly identified the areas of the plan that are the **'core foundations'**, the areas that we must have clear plans for delivering on over the next five years.

The framework also outlined a number of areas – **'prioritised commitments'** – where there is more flexibility for local systems in determining how work is phased over the five year period; ultimately the national deadlines within the LTP must still be met, but systems may prioritise actions required to meet these commitments according to local need:

Core Foundations	Prioritised Commitments
• Transformed out-of-hospital care and fully integrated community-based care • Reducing pressure on emergency hospital services • Giving people more control over their own health and more personalised care • Digitally-enabling primary care and outpatient care • Improving cancer outcomes • Improving mental health services • Shorter waits for planned care • Moving to integrated care systems everywhere	• More NHS action on prevention • Maternity and neonatal services • Services for children and young people • Learning disabilities and autism • Cardiovascular disease • Stroke care • Diabetes • Respiratory disease • Research and innovation to drive future outcomes improvement • Genomics • Volunteering • Wider social impact

What our response covers:

System narrative plan	System delivery plan
1. **Our ambition for SEL residents and our service delivery vision** 2. **Understanding our population's need** 3. **Service transformation – SEL actions and priorities** *(including the London vision, the 'core foundations', prevention, and progress on care quality and outcomes)* 4. **System development – How we will deliver the transformation of our system to deliver our priorities** *(including our ICS and enablers)* 5. **Finance** *(including meeting the five tests)* 6. **Next steps**	• **Finance** • **Activity** • **Workforce**

- Draft plans have been submitted to NHSE&I (London) on **27 September**, and there will be further refinement before a final submission on **15 November**.
- Given the additional complexity of being part of the wider London system, our response will also **need to align to the London vision**.
- We have undertaken additional **public engagement** to complement the Healthwatch engagement and to ensure our response is fit for purpose.
- The content of our response will build upon previous and current plans and incorporating the outputs of engagement activities.
- In building our response we need to ensure that we are delivering the commitments within the LTP whilst also **addressing our financial challenge**.

Our System Improvement Plan commitments – ICS maturity

- In June 2019, SEL developed our System Improvement Plan.

- This made explicit the areas where SEL does not currently meet the standards for a fully mature ICS:
  - We do not consistently meet the NHS Constitutional standards, and performance in some areas is not "consistently improving";
  - We face a significant challenge in developing and delivering plans to move towards system financial balance; and
  - Further development of system leadership, architecture and partnership working is needed to drive effective collective decision making and ability to carry out decisions that are made.

- The System Improvement Plan sets out a number of actions around performance and finance, and makes a series of commitments to enhance our ICS maturity and system ways of working. The ways of working commitments are:
  1. We will set out the governance and delivery of the 'System of Systems', focussing on place-based delivery.
  2. We will redesign how we commission services in south east London.
  3. We will test hospital group model approaches.
  4. We will test integrated care approaches through the development of primary care networks at the core of our delivery model for fully integrated community-based care.
  5. We will explore delegation of specialised services commissioning to the ICS.

System financial challenge

- In order to ensure that we can deliver the aims and visions set out in our five year plan, we recognise the vital need to achieve long term financial sustainability across the South East London system. Our aim to achieve financial balance is predicated on a collective commitment from CCGs and providers to system planning and shared financial risk management, supported by a system control total and system operating plan.

- The LTP sets out the recurrent allocations for each CCG and we are required to produce a financial plan for the ICS which includes five year capital plans at a SEL level; this must demonstrate compliance with the five tests set out in the LTP:

  - Test 1: The NHS (including providers) will return to financial balance
  - Test 2: The NHS will achieve cash-releasing productivity growth of at least 1.1% per year
  - Test 3: The NHS will reduce the growth in demand for care through better integration and prevention
  - Test 4: The NHS will reduce unjustified variation in performance
  - Test 5: The NHS will make better use of capital investment and its existing assets to drive transformation

- As part of this process we will develop SEL wide principles that are agreed across our key stakeholders and which would frame the approach to financial planning and assumptions for the LTP response, building on the approach we adopted to the planning round for 2019/20.

Delivery through our integrated care system

Person

Neighbourhood c.50k

Place c. 250-500k

System c. 1m+

- Both addressing our financial challenge and delivering the commitments of the Long Term Plan can only be achieved through working across the levels within our integrated care system – neighbourhood, place and system.
- At a borough level this will require the development of place-based boards and local care partnerships to design and oversee delivery of integrated health and care for the local population.
- As part of this services will need to work together beyond the scale of the neighbourhood level. For example, primary care networks and community services will need to work together to wrap services around the needs of patients with long term conditions.
- At the same time we will need to deliver personalised care as far as possible, aiming to do is right for the individual person rather than what is easiest for the system.

Deloitte.

King's College Hospital NHS Foundation Trust

Findings and Recommendations from the 2018/19 NHS Quality Report External Assurance Review

Issue Date: 11 June 2019

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Contents

Executive Summary 3

Content and consistency findings 5

Performance indicator testing 7

Accident and Emergency 4 hour waiting times

62 day cancer waiting times

Summary Hospital Level Mortality Index (SHMI)

Appendix 1: Recommendations for improvement 19

Appendix 2: Update on our prior year recommendations 23

Appendix 3: Further detail on tested sample 27

Appendix 4: Clinically Led Review of NHS Service Standards 29

Responsibility statement 32

Executive Summary

We have completed our indicator testing and have received a satisfactory, final signed Quality Report

Status of our work

- We have completed our work, including tests on the reported indicators. In the course of our work, we reviewed three drafts of the Quality Report and made some recommendations for improvement. These have been addressed in the final iteration.
- The scope of our work is to support a "limited assurance" conclusion, which is based upon procedures specified by NHS Improvement in their "Detailed Requirements for External Assurance For Quality Reports for Foundation Trusts 2018/19".
- Based on our work, we have issued a modified conclusion in our limited assurance report for inclusion in your 2018/19 Annual Report.

The Care Quality Commission last inspected the Trust in September and October 2017, and rated the Trust "Requires Improvement" overall.

	2018/19	2017/18
Length of Quality Report	83 pages	108 pages
Quality Priorities	7	6
Future year Quality Priorities	4	7

Scope of work

We are required to:

- Review the content of the Quality Report for compliance with the requirements set out in NHS Improvement's Annual Reporting Manual ("ARM").
- Review the content of the Quality Report for consistency with various information sources specified in NHS Improvement's detailed guidance, such as Board papers, the Trust's complaints report, staff and patients surveys and Care Quality Commission reports.
- Perform sample testing of three indicators.
  - The Trust has selected A&E 4hr Waiting Time and 62-Day Cancer Waiting Time (from Urgent GP referral) as the publically reported indicators, based on NHS Improvement's specified order of preference – the alternatives were 18 Week RTT – Incomplete Pathways and 28-day readmissions.
  - For 2018/19, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. Acute providers were encouraged to select the Summary Hospital-level Mortality Indicator ("SHMI") and therefore the Trust has selected SHMI as its local indicator.
  - The scope of testing includes an evaluation of the key processes and controls for managing and reporting the indicators; and sample testing of the data used to calculate the indicator back to supporting documentation.
- Provide a signed limited assurance report, covering whether:
  - Anything has come to our attention that leads us to believe that the Quality Report has not been prepared in line with the requirements set out in the ARM; or is not consistent with the specified information sources; or
  - There is evidence to suggest that the A&E 4hr Waiting Time and 62-Day Cancer Waiting Time (from Urgent GP referral) indicators have not been reasonably stated in all material respects in accordance with the ARM requirements.
- Provide this report to the Council of Governors, setting out our findings and recommendations for improvements for the indicators tested: A&E 4hr Waiting Time, 62-Day Cancer Waiting Time (from Urgent GP referral) and SHMI.

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Executive Summary (continued)

We have modified our opinion relating to the A&E 4hr Wait and 62-Day Cancer Wait indicators.

Content and consistency review

Review content → **Document review** → **Interviews** → **Form an opinion**

We reviewed three drafts of the Quality Report and made recommendations for improvement. These have been addressed in the final iteration. We can therefore confirm that, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019 the Quality Report is not prepared in all material respects in line with the criteria set out in the ARM.

	Overall conclusion
Content Are the Quality Report contents in line with the requirements of the Annual Reporting Manual?	B
Consistency Are the contents of the Quality Report consistent with the other information sources we have reviewed (such as Internal Audit Reports and reports of regulators)?	

Performance indicator testing

Interviews → **Identify potential risk areas** → **Detailed data testing** → **Identify improvement areas**

NHS Improvement requires auditors to undertake detailed data testing on a sample basis of three mandated indicators. We perform our testing against the six dimensions of data quality that NHS Improvement specifies in its guidance.

We have identified issues in respect of A&E and 62-Day Cancer indicators. Due to the issues detailed in pages 8-15 of this report, we are unable to confirm the indicators in the Quality Report subject to limited assurance have been reasonably stated in all material respects in accordance with the ARM and the six dimensions of data quality set out in the "Detailed Requirements for External Assurance on Quality Reports for Foundation Trusts 2018/19".

	A&E 4hr Wait	62 Day Cancer	SHMI
Recommendations identified?	✓	✓	✓
Overall Conclusion	Modified conclusion	Modified conclusion	No conclusion required

The six dimensions of data quality:

Accuracy
Is data recorded correctly and is it in line with the methodology.

Validity
Has the data been produced in compliance with relevant requirements.

Reliability
Has data been collected using a stable process in a consistent manner over a period of time.

Timeliness
Is data captured as close to the associated event as possible and available for use within a reasonable time period.

Relevance
Does all data used generate the indicator meet eligibility requirements as defined by guidance.

Completeness
Is all relevant information, as specific in the methodology, included in the calculation.

No issues noted Requires improvement Satisfactory – minor issues only Significant improvement required

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Content and consistency findings

Content and consistency review findings

We have received a satisfactory, signed Quality Report

The Quality Report is intended to be a key part of how the Trust communicates with its stakeholders.

Although our work is based on reviewing content against specified criteria and considering consistency against other documentation, we have also made recommendations to management through our work to assist in preparing a high quality document. We have summarised below our overall assessment of the Quality Report.

Key questions	Assessment	Statistics
• Is the length and balance of the content of the report appropriate?	B	Length: 83 pages
• Is there an introduction to the Quality Report that provides context?	G	
• Is the number of priorities appropriate across all three domains of quality (Patient Safety, Clinical Effectiveness and Patient Experience)?	G	4 priorities across the three domains
• Has the Trust set itself SMART objectives which can be clearly assessed?	G	
• Does the Quality Report clearly present whether there has been improvement on selected priorities?	G	
• Is there appropriate use of graphics to clarify messages?	G	
• Does there appear to have been appropriate engagement with stakeholders (in both choosing priorities as well as getting feedback on the draft Quality Report)?	G	
• Does the Annual Governance Statement appropriately discuss risks to data quality?		
• Is the language used in the Quality Report at an appropriate readability level?	B	

Deloitte view

In the course of our work we reviewed three drafts of the Quality Report and found them to be better compared with other Trusts we audit. We were also pleased to see that the length of the Quality Report had reduced since last year, to bring it closer to other Trusts.

As part of our reviews we made some recommendations that needed to be addressed in order to make the Quality Report more compliant with the ARM and more useful for the average reader. Our recommendations included:

- Making the Statement from the Chief Executive more balanced; and
- Adding some statements of assurance and performance indicators required by the Quality Accounts Regulations and improving the contents of some existing assurance statements.

Management accepted our recommendations and these have been addressed in the final iteration of the Quality Report.

G No issues noted   A Requires improvement   B Satisfactory – minor issues only R Significant improvement required

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Performance and Indicator Testing

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Accident and Emergency 4 hour wait times

We have modified our opinion with respect to this indicator

	Trust reported performance	Target	Overall evaluation
2018/19	69.8%*	>95%	Modified Conclusion
2017/18	75.2%*	>95%	Modified Conclusion
2016/17	82.1%	>95%	Modified Conclusion

* These are the performance figures for the Trust's main Type 1 A&E units

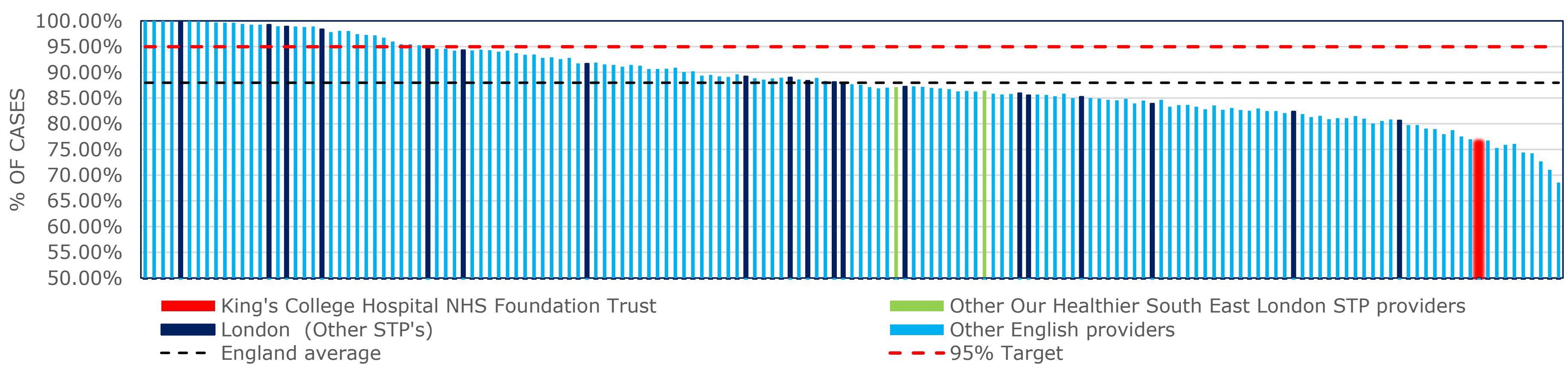
Indicator definition

Definition: "Percentage of patients who spent 4 hours or less in A & E."

Longer lengths of stay in the emergency department are associated with poorer health outcomes and patient experience as well as transport delays, treatment delays, ambulance diversion, patients leaving without being seen, and financial effects. It is critical that patients receive the care they need in a timely fashion, so that patients who require admission are placed in a bed as soon as possible, patients who need to be transferred to other healthcare providers receive transport with minimal delays, and patients who are fit to go home are discharged safely and rapidly.

National context

The chart below shows how the Trust compares to other organisations nationally for 2018/19.



Source: Deloitte analysis of NHS Digital data. Data includes category 3 units, but only includes providers with category 1 units

National context of data quality

NHS Improvement mandated the 4 hour wait times indicator for testing for the first time in 2015/16. In the first year of testing, just under 30% of Foundation Trusts tested were qualified on this indicator. In 2017/18, 18 Foundation Trusts (22% of Trusts tested nationally) were qualified, showing some progress nationally in addressing data quality and audit trail issues with this indicator. Common issues nationally relate to system constraints in data recording, retention of audit trails, and record keeping around changes to initial recording.

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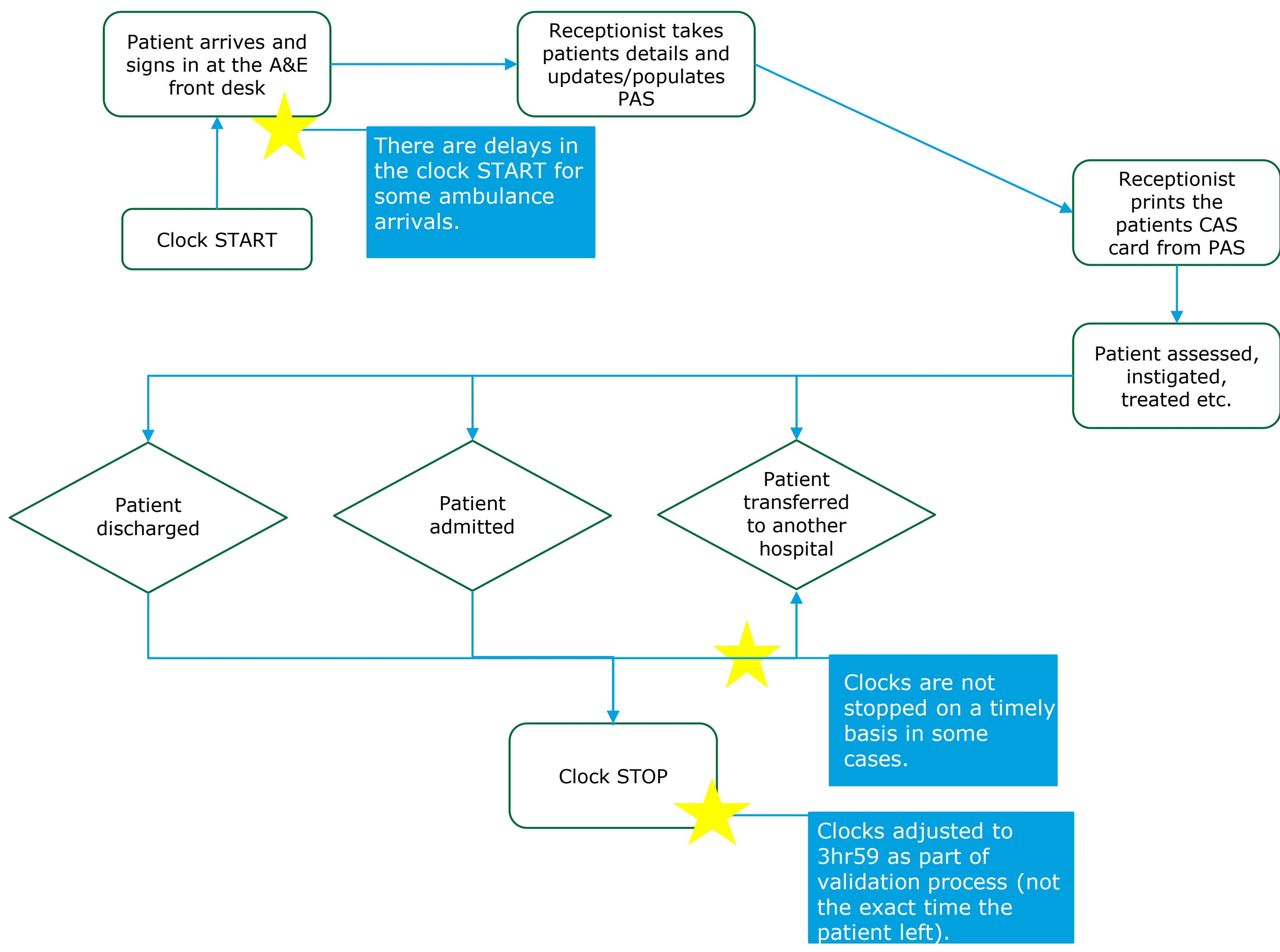
Accident and Emergency 4 hour wait times (continued)

We have identified issues in the A&E process

We have highlighted errors resulting from control weaknesses in the indicator process in the blue boxes.



Accident and Emergency 4 hour wait times (continued)

Approach

- We met with the Trust's lead for the A&E 4 hour waiting time metric to understand the process from patient referral to the result being included in the Quality Report.
- We evaluated the design and implementation of controls through the process. We discussed with management and used analytical procedures to identify whether there were any representing a greater risk that we should focus sample testing on. As a result we focused our testing on patients arriving by ambulance and those reported as waiting close to the 4hr mark.
- We analysed data to review activity, looking for anomalies, and compare the rate to other organisations we audit.
- We selected a sample of 22 attendances from 1 April 2018 to 28 February 2019, following patient records through until treatment. Due to the volume and nature of errors identified, we did not perform further testing relating to March data or relating to the completeness of the data set provided.
- We agreed our sample of 22 to supporting documentation.

Findings

Clock Starts

- NHSI guidance requires that an A&E clock is started within 15min of an ambulance's arrival, regardless of when the patient is actually entered into the hospital's systems. Of the 10 ambulance arrivals in our sample, we found two cases where the clock had started more than 15min after the ambulance's arrival and one case where we were unable to confirm the clock start as the ambulance handover card had not been retained. In addition, we found one case where although the ambulance form had been retained it did not include the ambulance's arrival time, and we were therefore unable to conclude on the clock start used.

Clock Stops

- As is common with other Trusts, we were unable find clinical notes for any of our sample that were time-stamped at exactly the time when the stop date had been applied. We therefore reviewed clinical notes to check when the last medical notes were documented, against the time that the clock was stopped. We considered that 15min should be sufficient time for a patient to collect their belongings, and leave, and therefore the clock to be stopped. We found 9 cases where the clock had been stopped more than 15min after the last medical notes.
- Finally, in a further five cases we could not conclude on the clock stop, based on the evidence available.

Correcting for the above errors, in two cases, the A&E waiting time would change from a breach to a non-breach.

Please see related recommendation in Appendix 1 (Recommendation 1)

Breach Validation

- On a daily basis, A&E attendances recorded with a length of stay (LoS) > 4 hours are reviewed against supporting documentation to check whether there is evidence to indicate the patient had left before the four hour point, and so should be recorded as a non-breach. In such cases, the clock stop is amended so that the LoS is recorded as 3hr59min, rather than the actual time that the patient left the department based on the evidence available. Please see related recommendation in Appendix 1 (Recommendation 2)

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Accident and Emergency 4 hour wait times (continued)

Deloitte View:

In 2016/17 and 2017/18, we modified our conclusion in respect of this indicator and made recommendations for improvement. We have found a lower level of error in our A&E testing, compared with last year, although some of the underlying causes still remain.

Some of our recommendations have been implemented, most notably relating to a “grace period” that was being applied for some breach cases. However, other recommendations are still in progress, and it will take time for these to become embedded and be reflected in further improved data quality.

We have made further recommendations this year and would expect an improvement in data quality once our recommendations are implemented.

In addition, there is a difference between the A&E performance calculated based on monthly SitRep returns (76%) and that calculated from data from the ED system, which was provided to us for audit (69.8%). Both figures have been disclosed in the Quality Report with an explanation for the difference.

In addition, NHSI has proposed changes to A&E waiting time targets, including the measurement of average (mean) waiting times. “Late click-offs” and the current practice of validating breaches to 3hr59min (rather than the actual time that a patient left the department) will have an adverse effect on reported performance if the proposals are confirmed.

Due to the volume and nature of errors identified in our testing this year, we have modified our conclusion in respect of this indicator.

62 day cancer wait times

We have modified our opinion with respect to this indicator

	Trust reported performance	Target	Overall evaluation
2018/19	**79.1%**	**>85%**	Modified Conclusion
2017/18	**83.8%**	**>85%**	Not selected
2016/17	**85.1%**	**>85%**	Not selected

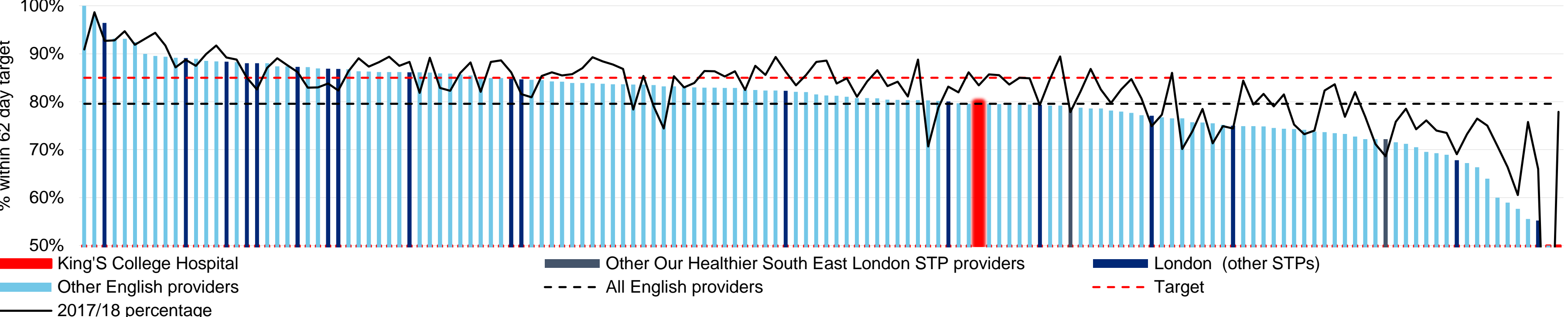
Indicator definition

Definition: "Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer."

The NHS Cancer Plan set the goal that no patient should wait longer than two months (62 days) from a GP urgent referral for suspected cancer to the beginning of treatment, except for good clinical reasons.

National context

The chart below shows how the Trust compares to other organisations nationally for the first three quarters of 2018/19, the latest national data available.



Source: Deloitte analysis of NHS Digital data

National context of data quality

NHS Improvement have selected 62 day cancer wait times for testing by acute providers ahead of 18 week Referral to Treatment waiting times for 2018/19. This is the first time that most acute providers will have this indicator tested since 2015/16. The National Cancer Breach Allocation Guidance was updated in April 2016, which changed the basis of allocation of breaches between providers based on when the referral was made. The national statistics are in the process of moving over to these new guidelines, and NHS Improvement has given providers a choice for 2018 of applying the new guidelines or using the old 50-50 breach allocation basis for the Quality Accounts. The Trust has followed the old guidelines. A number of challenges were identified in testing of some providers in implementing the revised guidance, and it is likely that some issues will be identified nationally as a result this year. Historically, 62 day cancer waiting times has had relatively few qualifications, however reflecting these challenges in 2017/18, two of the eleven providers with 62 day cancer waiting times tested were qualified.

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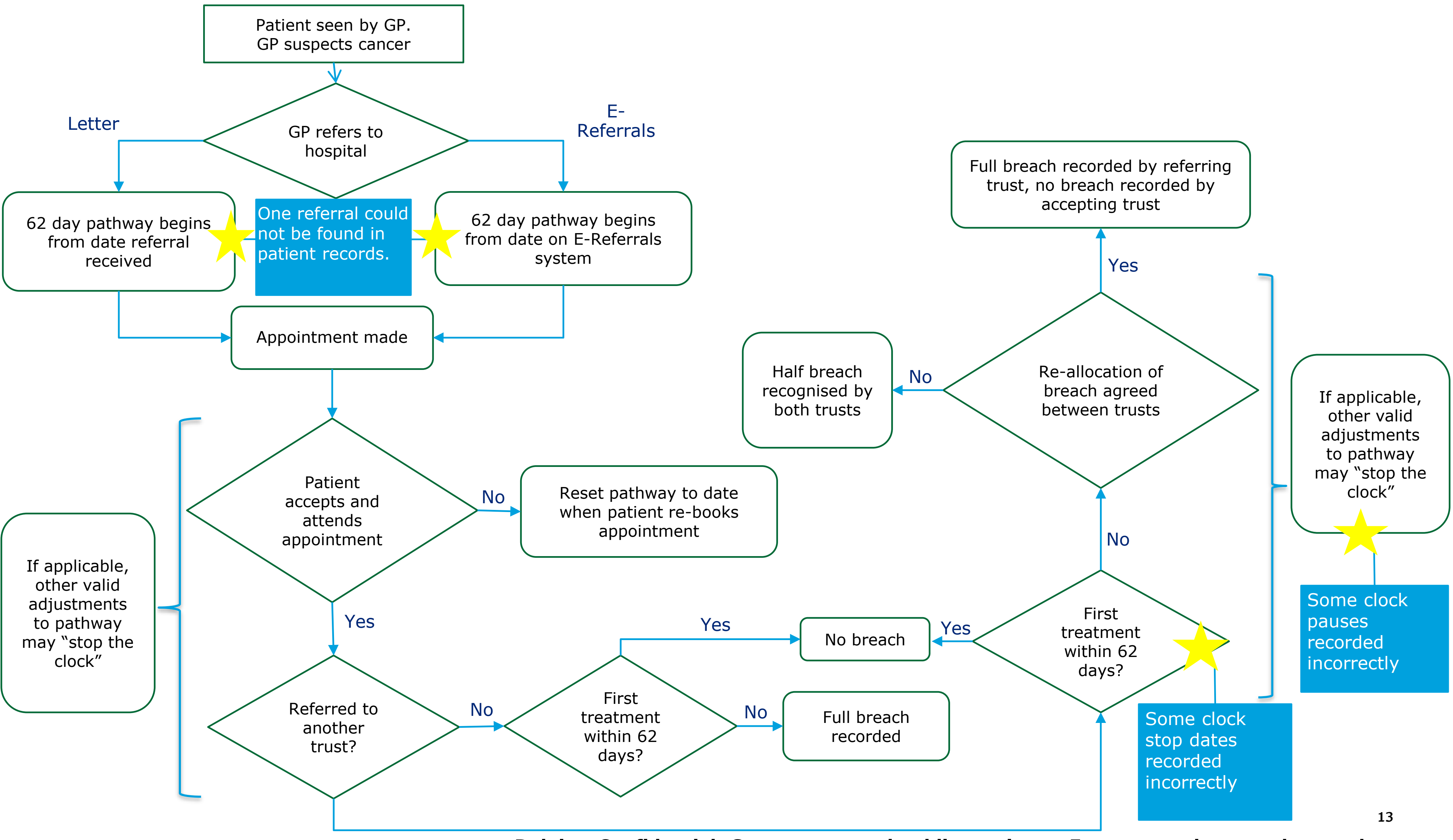
62 day cancer waiting times (continued)

We have identified issues particularly relating to clock pause adjustments

We have highlighted errors resulting from control weaknesses in the indicator process



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62 day cancer waiting times (continued)

Approach

- We met with the Trust's lead for 62 day cancer waits to understand the process from an urgent referral to the Trust to the result being included in the Quality Report.
- We considered in particular how the National Cancer Breach Allocation Guidance has been implemented and note that the Trust is still reporting in line with the "old" 50:50 breach allocation methodology.
- We evaluated the design and implementation of controls through the process. We discussed with management and used analytical procedures to focus on pathways which appear to be most at risk of error e.g. patients with manual adjustments and pathways close to the 62 day breach date.
- We selected a sample of 22 pathways from 1 April 2018 to 28 February 2019 including in our sample a mixture of cases in breach and not in breach of the target. Due the nature and volume of errors identified we did not test a further sample for March 2019, or test completeness of the indicator population.
- We agreed our sample of 22 to supporting documentation.

Findings

Clock Starts

From our sample of 22, 9 referrals related to the Denmark Hill (DH) site.

- The majority of referrals that arrive at DH do so through the e-Referrals system. There is an automatic interface between e-Referrals and Somerset (the Trust's system) which records the referral receipt and the clock start. We have therefore not confirmed the clock start date to any other supporting documentation.
- Princess Royal University Hospital (PRUH) follows a more manual process. Of the 13 referrals relating to the PRUH site, in eleven cases we were able to confirm the clock start date to date stamped referral letters held in patient files. However, in one case although the patient file was available, the referral could not be found, and in one further case we were unable to obtain patient file as it was in use at a clinic.

As a result there is a limitation of scope on our procedures.

Please see related recommendations in Appendix 1 (Recommendations 3)

Clock Stops

- Where patients are treated at another Trust, KCH tracks such patients on an internal spreadsheet which is periodically updated during weekly conference calls and with reference to NHS Digital.
- We identified two such pathways where the treatment date recorded by KCH was one day later than the date recorded in NHS Digital, and the Trust's own spreadsheet which tracks shared patients. Correcting for these would not have an effect on the breach status of either case.

Please see related recommendation in Appendix 1 (Recommendation 4)

Clock Pauses

- NHS guidance allows a clock to be paused when a patient makes themselves unavailable. The pause starts from the earliest reasonable offer of an appointment that could have been made, were the patient available, and stops when the patient makes themselves available again.
- We identified one case where a patient rescheduled an appointment from 29/10/18 to 12/11/2018. A pause was applied (although it was counted incorrectly as 12 days rather than 14). However, as this was not the patient's first appointment, in line with national guidance, no pause should have been applied; the first appointment had already been attended on 19/10/18.
- Correcting for this error, assuming the clock start date recorded was correct, would change the breach status from non-breach to breach.

62 day cancer waiting times (continued)

Findings (continued from previous page)

- We noted two further cases where we were unable to confirm the length of the clock pause on the basis of the evidence available. The annotation was not detailed enough to be able to establish when the pause should have started (ie. the date of the earliest reasonable offer that the provider would have been able to offer that patient") or stopped (ie. The date the patient became available again)

Please see related recommendation in Appendix 1 (Recommendation 5)

Deloitte View:

Our testing has demonstrated that there is scope to improve the process for the monitoring and recording of patients on the 62-day cancer pathway, particularly relating to clock pause adjustments.

We have made some recommendations which once implemented and embedded, should improve the data quality going forward. However, due to the errors identified in our testing and lack of adequate audit trail for some clock pause adjustments, we have modified our conclusion in respect of this indicator.

It should also be noted that updated guidance was issued in 2016 setting out how to deal with cancer waiting time breaches where a patient transfers between trusts, but there have been delays in implementing this in NHS Digital (the national cancer reporting system). As a result, in common with many Trusts, KCH has continued to report using the previous method of reallocating (a tertiary pathway is given a 50% weighting), and this is the basis on which the Trust has reported performance in the Quality Report.
As NHS Digital will not support national reporting in line with the updated guidance until 2019/20, this is considered an acceptable approach by NHSI.

Summary Hospital Level Mortality Indicator

This is the Trust's selected local indicator

	Trust SHMI Value	Trust SHMI Banding	Overall evaluation
Oct 17 – Sep 18	0.9589	As Expected	No Conclusion Required
Oct 16 – Sep 17	0.9096	As Expected	Not selected
Oct 15 – Sep 16	0.9177	As Expected	Not selected

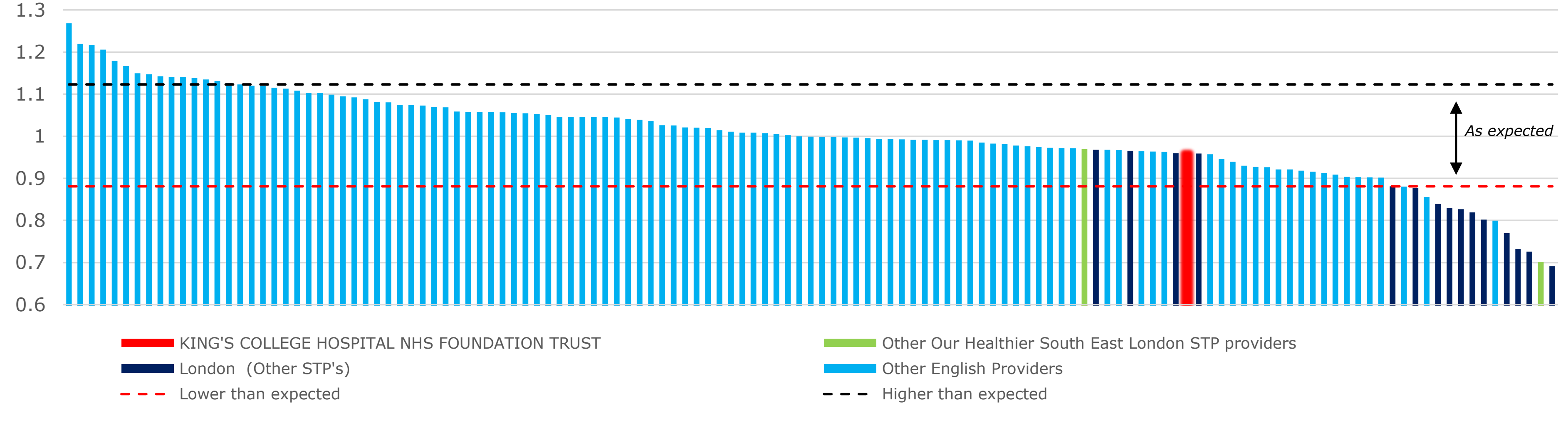
Indicator definition and process

Definition: The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

NHS Digital calculates SHMI using a statistical model, based on data provided by Trusts. As a result, there is a delay between Trust's submission of data and publication of the SHMI indicator.

National context

The chart below shows how the Trust compares to other organisations nationally for Oct-17 to Sep-18, the latest national data available.



Source: Deloitte analysis of NHS Digital data

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Summary Hospital Level Mortality Indicator (continued)

Approach

- We met with the Trust's leads to understand the process from recording of an inpatient's admission to submission of data to NHS Digital. There were no recommendations from the previous auditor's review of last year's Quality Report as this indicator was not part of the external assurance work.
- We tested the following seven fields of data recommended by NHS Digital: Admission Method, Patient Classification, Primary Diagnosis Code, Discharge Date, Discharge method, Sex and Age.
- We selected a sample of 24 inpatient spells from 1 October 2017 to 30 September 2018.
- We met with a member of clinical coding to agree our sample of 24 to the underlying information held within patient notes and other Trust Records.

Findings

From our sample of 24 spells, in two cases we could not find any notes in EPR or physical files with information relating to the spell and so could not test these. Please see related recommendation in Appendix 1 (Recommendation 3)

Of the remaining 22 samples we found:

- One case where the Admission method had been recorded as coming via A&E rather than as an elective admission. Although the patient attended UCC at another Trust, they had subsequently attended a Fracture clinic at King's who had referred the patient for surgery the following week.
- Two cases where the discharge date was recorded incorrectly. In one case it was recorded as one day earlier than it should have been, and in the other case it was recorded three days later than it should have been.
- One case where the patient was recorded as being 118 years old as the age had been recorded as unknown. We understand that when a patient's age is recorded as unknown, the system defaults the Date of Birth to 01/01/1900, reporting them as a 118 year old. There is a code in the NHS data dictionary for "unknown age" that should have been used.

Please see related recommendation in Appendix 1 (Recommendation 6)

Deloitte View:

For NHS foundation trusts providing acute services, NHSI strongly recommended that trusts selected SHMI as the local indicator. As a result, many of the Trusts that we audit have selected SHMI as their local indicator. In common with many of these other trusts, this is the first year that the SHMI indicator has been selected for testing as part of the independent limited assurance work.

As the indicator itself is calculated by NHS Digital from data submitted by the Trust, the scope of our testing was limited to tests on the data submitted by the Trust as part of monthly SUS submissions. We did not recalculate the reported indicator, and are unable to quantify the impact of data issues upon the reported metric.

Appendices

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Appendix 1: Recommendation for improvement

We have made six recommendations for improvement

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
A&E 4hr Wait	**1. Implementation of prior year recommendations and internal audit of A&E processes** We recommend that management revisit our previous year's reports, and complete the implementation and further embed our recommendations made relating to: 1) The provision of further guidance and training to A&E staff to ensure clock starts and stops are applied accurately and on a timely basis and evidence retained; 2) Introducing a process for recording clock starts of ambulance arrivals within 15min; 3) Improving the timeliness with which clock stops are applied; and 4) Improving the audit trail for transfers from A&E to wards We also recommend that while the above recommendations are implemented, more detailed internal audits of A&E processes and on at least a six monthly basis, we recommend that updates against the recommendations is provided to the Audit Committee.	We note the first recommendation, which was also made following last year's audit. We have continued to train staff and to emphasise the importance of updating Symphony in a timely manner. In a very buy department, however, it can often be challenging to update Symphony in real time. As such, in the breach validation policy, if it is unclear whether a patient moved to a ward before 4-hours, then it is assumed that the patient breached the 4-hour standard. The team have also explored having a clear log of when porters move patients to the ward. However, this solution is not possible within the current contractual arrangement with Medirest, the company that provides portering services for King's. The ED team have invited Emergency Care Intensive Support Team (ECIST) to observe the Department's ambulance handover process, and a visit is scheduled for the last week of May. We will ask for ECIST to issue recommendations regarding the best process for ensuring the accurate recording of ambulance arrival times, and will move forward with their recommendation. Please also refer to management updates on prior year recommendations for details of actions being taken under the other recommendations. **Responsible Officer:** General Manager - ED **Timeline:** Ongoing	H

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Appendix 1: Recommendation for improvement

We have made recommendations across all three indicators

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
A&E 4hr Wait	**2. Recording of End time as part of breach validation** Under the proposed changes to waiting time rules, there may be a move towards the reporting of "average (mean)" waiting times. Therefore, in order not to overstate the mean time, as part of breach validation, management should update the end time to the exact time that is supported by corroborating evidence.	The team are now recording the time patients leave, instead of 3 hours 59 minutes. However, the team also note the issues outlined above regarding the occasionally limited audit trail of the exact time a patient leaves the ED. **Responsible Officer:** General Manager - ED **Timeline:** 30 September 2019	M
62 Day Cancer and SHMI	**3. Safeguarding of patient records** As part of our indicator audits we reviewed patient files and identified we could not find records of two inpatient spells (SHMI), and one referral letter (62 Day Cancer). We recommend that the Trust investigates the underlying causes for the unavailability of patient records, and implement an action plan to resolve this issue.	A formal management response to this recommendation had not been received at the time of finalising this report.	M

Appendix 1: Recommendation for improvement

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
62 Day Cancer	**4. Improvements to validation process** We recommend that as part of the validation checks that the Trust already has in place, they should check that the clock start, clock stop, and any clock pause adjustments are supported by a clear audit trail and are accurately recorded in the system (Somerset).	It is the treating Trust's responsibility to validate clock stop and clock pause adjustments prior to uploading treatments to NHS digital, including clear audit trails. The Trust now has had a monthly reconciliation call with other Trusts in South East London (LGT and GSTT) to validate all key data items for all shared records. This includes: • Clock start dates; • DNA adjustments (if applicable); • IPT date; • Clock stop date; • Clock pause adjustment (if applicable); • Breach reason and breach comments (if applicable). Previously, KCH had identified cases where the treatment start date had changed at the treating Trust but KCH had not been informed. The implementation of the monthly reconciliation calls has addressed this issue. In addition the Trust has a weekly call with other Trusts in South East London to talk about patients on live pathways. In these calls data quality issues are also addressed where appropriate. **Responsible Officer:** Cancer Performance and Data Manager **Timeline:** The monthly call is now in place	

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Appendix 1: Recommendation for improvement

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
62 Day Cancer	**5. Training and guidance relating to clock pause adjustments** We recommend that internal guidance relating to clock pause adjustments is developed and communicated to staff involved in managing and recording of 62-day cancer pathways. We recommend that this includes: - circumstances in which a clock pause should be applied; - the need to record a clock pause on Somerset as soon as a period of absence is notified; and - the need to have an adequate audit trail (for example in the form of a tracking note) to support the clock pause start and end dates Whilst this becomes embedded, we recommend that a 100% validation check on clock pause adjustments is performed to confirm compliance with the policy and feedback provided where learning points are identified.	All clock pauses for treatment undertaken at KCH are currently validated as part of the monthly cancer management validation cycle, before data is uploaded. However we recognize the need to ensure staff are fully aware of the requirements in relation to clock pauses. Regular training already takes place (dates have been shared as part of the audit) for all staff involved with the management of the cancer PTL and cancer systems. However, revision guidance training on all aspects of clock pauses, including identifiable audit trails, will take place as part of ongoing cancer waiting time refresher training. There is the function available in Somerset to record (free text) more information on the reason for a pause and relevant dates. This will now be logged too and validated each month prior to submitting the data. **Responsible Officer:** Cancer General Manager **Timeline:** from April 2019 submission	H
SHMI	**6. Learning from errors identified** Our findings represent an error rate of 2.6%, and we have not identified any indication of a pervasive issue. However, we recommend management review the errors in further detail and check to confirm that these were isolated errors and whether there is any learning that needs to be communicated to the coding / operational teams to improve the recording of SUS data going forward. We also recommend that management consider developing logic checks that can be used to check for any similar errors in the future, as part of the validation process.	A formal management response to this recommendation had not been received at the time of finalising this report.	M

Appendix 2: Update on prior year recommendations

Management has made progress in implementing our recommendations

Indicator	Prior year Recommendation	Prior Year Management Response	Current year Management Update
RTT and A&E	**Improved guidance and training** Comprehensive guidance and training should be developed for all staff, particularly relating to the recording of clock starts and stops, and the retention of evidence.	Training and Guidance is currently being updated which will include improving standard operating procedures and systems training to ensure data quality and accuracy is improved. **Responsible Officer:** RTT and A&E Leads **Timeline:** End July 2018	RTT training updated to include 10 online modules which are utilised for new starters/or refresher training, there is also provision of classroom training sessions and bespoke clinical sessions. Data quality is a fundamental part of the RTT training packages. With regards to A&E, the senior ED team continue to provide training to staff surrounding the accurate recording of clock starts and stops. We believe the improved audit report from 2018/19 reflects that this training has been successful.
RTT	**Data validation** While the Trust has a validation process, this could be further improved through the communication of regular themes/errors to minimise repetition of issues. 'RTT Champions' should be appointed in each division, to encourage consultation with staff members who are unsure regarding application of rules.	The Trust agrees with the recommendation of introducing 'RTT Champions' to address RTT and DQ issues within the PTL. This would need to be agreed with the divisions and could be a joint responsibility of 'Patient Pathway Coordinators' currently working within Divisions **Responsible Officer:** RTT Lead and Divisional General Managers **Timeline:** End July 2018	Patient pathway coordinators have been trained and act as RTT Champions within each specialty, they also link directly to the RTT Team as a further source of support for RTT queries.
RTT	**Review of duplicate referrals** Management should review the duplicate referrals identified in our sample, identifying the underlying cause, and isolating the further population where this could be an issue. Management should consider the implementation of system control, to restrict the creation of duplicate referrals. Alternatively, duplicate referrals in the population should be identified and validated by the validation team.	We have created a duplicate referral report alongside the PTL. The current validation team are working towards removing all duplicates over 18 weeks within 1-2 months. Completion of this work will depend on the establishment of a DQ team to take overall responsibility of this and other DQ issues within the PTL **Responsible Officer:** RTT Lead and Divisional General Managers **Timeline:** Initial clean-up of duplicate referrals over 18 weeks – End July 2018 Completion of remaining duplicates within the PTL – Q3 2018/19 pending approval of the establishment of a dedicated DQ team.	DQ Team has now been established and will upon completion of training take responsibility for review of Duplicate referrals. This is currently being picked up by the validation team.

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Appendix 2: Update on prior year recommendations

Indicator	Prior year Recommendation	Prior Year Management Response	Current year Management Update
A&E	**Audit trail for transfers to ward** The Trust should maintain a full audit trail to evidence the actual time patients were transferred from Accident & Emergency to a ward.	The senior team are in the process of updated the breach validation policy, which will include guidance on the maintenance of an adequate audit trail. **Responsible Officer:** RTT Lead and Divisional General Managers **Timeline:** End-July 2018	The team acknowledge the lack of full audit trail for ward transfers. As such, in the breach validation policy, if it is unclear whether a patient moved to a ward before 4-hours, then it is assumed that the patient breached the 4-hour standard. The team have also explored having a clear log of when porters move patients to the ward. However, this solution is not possible within the current contractual arrangement with Medirest, the company that provides portering services for King's. As the 2018/19 audit demonstrates, there were no instances where it appeared that the patient left the department after the time that was recorded; instead, there were cases noted that likely did not breach the 4-hour standard, but were recorded as breaches.
A&E	**Ten minute 'grace period'** There is no allowance with NHSI regulations to allow for a 'grace period' and therefore the Trust should review all data and record any waiting time greater than four hours as a breach.	From an operational perspective, all patients who are 'clicked off' the system over 4 hours are validated by the senior team the following day. We will ensure that as part of the reporting process all breaches above 4hrs are reported. We will perform an audit at the end of May to confirm compliance. **Responsible Officer:** Trust Lead for Emergency Care Performance and Improvement **Timeline:** End-May 2018	There is no grace period applied. All patients who are in the department for more than 4 hours are validated by the team.

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Appendix 2: Update on prior year recommendations

Indicator	Prior year finding	Deloitte Recommendation	Current year Management Update
A&E	**Delay in recording clock stops in symphony** We understand that the Trust aims for click offs to be no later than 10min after departure. We recommend that A&E staff are reminded to ensure that all patients are clicked off Symphony as soon as possible after their departure, within the time limits set by the Trust.	We remind staff on a daily basis of the importance of clicking patients off in a timely manner. Additionally, the senior nursing team regularly meet with the team leaders, where they will remind the team again. **Responsible Officer:** Head of Nursing / Lead Nurse **Timeline:** End-July 2018	We have reiterated to staff the importance of accurately reflecting ambulance arrival times (please see below response for 2018/19 findings). Additionally, please see above response regarding delayed discharge times from Symphony.
A&E	**Delay in ambulance clock starts** We recommend that A&E reception staff guidance and training be updated requiring them to check the ambulance's arrival time (per LAS handover notes) against the time that the patient arrives. Where the wait has been greater than 15min, the staff should be instructed to manually adjust the clock start time	We remind the reception of the importance of reflecting the correct clock start times for all patients. We will work with the reception team to reinforce this message. **Responsible Officer:** General Manager / Head of Nursing / Service Manager **Timeline:** End-June 2018	The Trust fully acknowledges the discrepancies in ambulance handover times noted in the report. This issue is known to the senior team within ED, and the ED team regularly meet with LAS colleagues in order to improve the accuracy of data recording around ambulance arrival. However, the accuracy of this data is a shared responsibility with LAS colleagues; the ED team have escalated concerns regarding when LAS crews report they arrive in the department, and when LAS systems record them as arriving in the department. Further, as one of the discrepancies found in the Deloitte report surrounds an incomplete LAS sheet, the Trust would note that the ED team are unable to affect the completeness of LAS documentation. However, the senior ED team fully accept that in order to improve data quality, a joint approach with LAS colleagues must be undertaken. As such, the teams will continue to meet on a regular basis so as to improve the identified data quality issues

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Appendix 2: Update on prior year recommendations

Indicator	Prior year finding	Deloitte Recommendation	Current year Management Update
NELA	**Automation of Data Entry** We recommend that the data collection process be made more automated. For example, the required fields should be extracted from the various systems on a monthly basis, validated by an appropriate staff member, and then uploaded to NELA via a automated interface	The Trust agrees that data entry needs to be automated wherever possible to minimise the workload of the clinical team. The Business Intelligence Unit will liaise with the relevant stakeholders to identify how the process in relation to reporting emergency laparotomies can be made more efficient (incl. increased automation) to support the NELA submission process. **Responsible Officer:** Head of BIU **Timeline:** End September 2018	These actions being taken forward within the Getting it Right First Time (GIRFT) improvement work, which includes work to improve consultant ownership of data, improvements in PiMS data and improved coding. GIRFT actions are summarised in the attached slide set, although NELA is not specifically mentioned actions to improve data capture for NELA are embedded in the GIRFT workstreams. A successful business case has led to the recruitment of a Clinical Nurse Specialist for emergency surgery and part of her role will be to support improved data capture for NELA. She will be in place on 1/6/19. Additional resources are required to support data capture for NELA on both sites, however the financial position of the Trust means that this is unlikely in the short term. There is sustained consultant leadership, from Mr Duncan Bew and Mr Sudeendra Doddi, who provide supervision for data entry. Data entry itself continues to be managed with the use of temporary, albeit high-quality, Interns.
NELA	**Training and Guidance** We recommend that guidance is developed clearly setting out responsibilities for collection, validation and reporting of data. In addition, the guidance should include detail on which cases are to be included and the process for identifying and then reporting NELA reportable cases.	The Trust agrees that the responsibilities for collection, validation and reporting of data needs to be clarified. Sustainable support for data entry into this high profile national audit needs to be identified. Once this is in place the recommended guidance can be produced. **Responsible Officer:** Divisional General Managers **Timeline:** End-November 2018	
NELA	**Maintenance of Audit Trail** We also recommend that the Trust record all instances of Laparotomies electronically within EPR and retain an adequate audit trail of paper records	The Trust agrees that all laparotomies must be recorded on the EPR and this will be messaged to all relevant consultants by the NELA leads on both sites. The guidance (above) will include the Trust's approach to the maintenance of an audit trail. **Responsible Officer:** NELA Leads, Denmark Hill and PRUH **Timeline:** Communication to consultants – by end June 2018. Audit trail – by end November 2018	

Appendix 3: Further Detail on tested sample

Accident and Emergency 4 hour wait times

	Details per findings section of our report				
	Clock Start Findings			Clock Stop Findings	
Sample Number	Clock Started >15min after ambulance's arrival	Ambulance Handover Card not retained	Ambulance arrival time not completed	Clock Stopped >15min after the most recent notes	Insufficient Evidence to Conclude
1					
2	1				1
3				1	
4				1	
5					
6					
7					1
8				1	
9		1		1	
10					1
11					
12				1	
13				1	
14					
15					1
16					
17			1	1	
18				1	
19	1				1
20					
21				1	
22					
Total	2	1	1	9	5

Details per the Audit Opinion

2	cases of our sample of patients' records tested, the start or end time of treatment was not accurately recorded affecting the calculation of the published indicator
8	cases of our sample of patients' records tested, the start or end time of treatment was not accurately recorded, but did not affect the calculation of the published indicator
7	cases of our sample of patients' records tested, we were unable to obtain sufficient supporting evidence to confirm the details necessary to test the calculation of the published indicator

Not referred to in the Audit Opinion

1	Issues noted in our findings but not separately referred to in opinion as multiple issues on the same pathways

Appendix 3: Further Detail on tested sample (continued)

62 Day Cancer waiting times (from urgent GP referral)

	Details per findings section of our report				
	Clock Start Findings		Clock Stop Findings		Clock Pause Findings
Sample Number	Could not find referral (PRUH)	File in use at clinic	Treatment date recorded incorrectly	Pause applied incorrectly	Unable to confirm length of pause
1					
2					1
3				1	
4					1
5					
6			1		
7					
8					
9					
10					
11					
12					
13					
14			1		
15					
16					
17					
18	1				
19					
20					
21					
22		1			
Total	1	1	2	1	2

Details per the Audit Opinion

1	the duration of a clock pause was not accurately recorded affecting the calculation of the published indicator
2	the end date of the pathway was not accurately recorded, but did not affect the calculation of the published indicator
4	unable to obtain sufficient supporting evidence to confirm the details necessary to test the calculation of the published indicator

Appendix 4: Clinically-led Review of NHS Access Standards

The NHS National Medical Director has issued an interim report on recommendations for updating and supplementing current targets

Issue

In 2018 Professor Stephen Powis, NHS National Medical Director, was asked to carry out a clinical review of standards across the NHS, with the aim of determining whether patients would be well served by updating and supplementing some of the older targets currently in use.

An interim report in March 2019 made a number of recommendations across elective care, urgent care, cancer and mental health, to replace and/or add to the existing clinical access standards. The standards are designed to support:

- shorter waiting times for a wider range of clinical services;
- more emphasis on standards that improve the quality of clinical care and outcomes;
- shorter waiting times for A&E and planned surgery, by tracking the entire wait for every patient; and
- standards that will enable trusts to modernise their care without being penalised.

The new standards are planned to be field-tested during 2019/20 and then implemented during 2020/21, with field testing to consider both the practicalities of adoption and also whether they:

- promote safety and outcomes;
- drive improvement in patient experience;
- are clinically meaningful, accurate and practically achievable;
- ensure the sickest and most urgent patients are given priority;
- ensure patients get the right service in the right place;
- are simple and easy to understand for patients and the public; and
- do not worsen inequalities.

The proposed indicators are set out on the next page. Dependant upon the final changes, this may affect the scope of Quality Report testing in from 2020/21.

Deloitte View

The choice of specific targets to measure often involves trade-offs in what is captured, or not captured, by the indicators selected, and in the behaviours that are incentivised.

There have been a variety of responses to the proposals, reflecting in part the changes in what would be emphasised (and deemphasised) relative to the current targets and indicators.

The intention of the new indicators is to measure what is most important clinically and to patients. As the implementation of new standards progresses, it will be important that organisations do not focus solely upon achievement of performance against the selected metric, and that there is continued focus on the overall quality and timeliness of care provided to service users.

We highlight that the implementation of new metrics will require process and potentially system changes, and it will be important for the Trust to consider controls over data quality as part of implementing any changes.

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Appendix 4: Clinically-led Review of NHS Access Standards (continued)

The NHS National Medical Director has issued an interim report on recommendations for updating and supplementing current targets

Urgent care

The proposed standards would replace the current 4 hour wait target with a measure of the average waiting time, and a specific measure for treatment of the most critically ill patients.

- Time to initial clinical assessment in Emergency Departments and Urgent Treatment Centres (type 1 and 3 A&E departments). (The report does not include a specific target).
- Time to emergency treatment for critically ill and injured patients (complete a package of treatment in the first hour after arrival for life-threatening conditions).
- Mean waiting time in A&E (all A&E departments and mental health equivalents).
- Utilisation of Same Day Emergency Care. The aim is to complete all diagnostic tests, treatment and care that are required in a single day.
- Call response standards for 111 and 999.

Mental health

A series of new indicators are proposed for testing, which would replace the current Early Intervention in Psychosis and Improving Access to Psychological Therapies targets. These would focus on faster access for mental health crises, with slower but timely targets for other support.

- Expert assessment within hours for emergency referrals; and within 24 hours for urgent referrals in community mental health crisis services.
- Access within one hour of referral to liaison psychiatry services and children and young people's equivalent in A&E departments.
- Four-week waiting times for children and young people who need specialist mental health services.
- Four-week waiting times for adult and older adult community mental health teams.

Cancer

The proposed standards combine existing standards into simplified overall metrics:

- Faster Diagnosis Standard: Maximum 28 day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening.
- Maximum two-month (62-day) wait to first treatment from urgent GP referral (including for breast symptoms) and NHS cancer screening.
- Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

Elective care

The current 18 week RTT target may be revised, and a patient choice standard introduced.

- Maximum wait of six weeks from referral to test, for diagnostic tests (the current standard is to be retained).
- Defined number of maximum weeks wait for incomplete pathways, with a percentage threshold (current 18 week RTT threshold and maximum wait to be reviewed) **OR** Average wait target for incomplete pathways.
- 26-week patient choice offer (patients will be able to choose whether to access faster treatment elsewhere in a managed way).
- 52-week treatment guarantee.

Responsibility statement

Purpose of our report and responsibility statement

Our report is designed to help you meet your governance duties

What we report

Our report is designed to help the Council of Governors, Audit Committee, and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations to report to the Governors and Board our findings and recommendations for improvement concerning the content of the Quality Report and the mandated indicators. Our report includes:

- Results of our work on the content and consistency of the Quality Report, our testing of performance indicators, and our observations on the quality of your Quality Report.
- Our views on the effectiveness of your system of internal control relevant to risks that may affect the tested indicators.
- Other insights we have identified from our work.

What we don’t report

- As you will be aware, our limited assurance procedures are not designed to identify all matters that may be relevant to the Council of Governors or the Board.
- Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.
- Finally, the views on internal controls and business risk assessment in our final report should not be taken as comprehensive or as an opinion on effectiveness since they will be based solely on the procedures performed in performing testing of the selected performance indicators.

Other relevant communications

- Our observations are developed in the context of our limited assurance procedures on the Quality Report and our related audit of the financial statements.

We welcome the opportunity to discuss our report with you and receive your feedback.

Deloitte LLP
11 June 2019

This report is confidential and prepared solely for the purpose set out in our engagement letter and for the Board of Directors, as a body, and Council of Governors, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent. You should not, without our prior written consent, refer to or use our name on this report for any other purpose, disclose them or refer to them in any prospectus or other document, or make them available or communicate them to any other party. We agree that a copy of our report may be provided to NHS Improvement for their information in connection with this purpose, but as made clear in our engagement letter dated 15 April 2019, only the basis that we accept no duty, liability or responsibility to NHS Improvement in relation to our Deliverables.

Deloitte.

Public CoG meeting-17/10/19

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INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of King's College Hospital NHS Foundation Trust (the 'foundation trust') and its subsidiaries (the 'group'):

- **give a true and fair view of the state of the group's and foundation trust's affairs as at 31 March 2019 and of the group's and foundation trust's income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

We have audited the financial statements which comprise:

- the consolidated statement of comprehensive income;
- the group and foundation trust statements of financial position;
- the group and foundation trust statements of changes in taxpayers' equity;
- the group and foundation trust statements of cash flow; and
- the related notes 1 to 29.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Material uncertainty relating to going concern

We draw attention to note 1.27 in the financial statements, which indicates that the Group:

- Has a planned deficit before impairments and capital grants and donations of approximately £133m for 2019/20;
- Has a cost improvement plan of £60m for 2019/20;
- Has accepted its control total and has been allocated provider sustainability and financial recovery funding totaling £35m;
- Has prepared cash flow forecasts that show a minimum level of headroom of £3 million throughout 2019/20;
- Has assumed it will receive additional loans of £133 million, which have not yet been committed by the lender, to meet a revenue funding gap in 2018/19;
- Is working with NHSI to secure additional distressed capital resource of £26m; and
- Has significant existing loan arrangements falling due within the next 12 months including a term loan of £99m which falls due in November 2019 and revolving credit facility of £90m which matures in April 2020.

The foundation trust has identified that additional funding is required before the end of 2019/20 to support the foundation trust in meeting its liabilities which is yet to be formally agreed. Without additional funding, the Group will have insufficient working capital to meet its liabilities as they fall due.

In response to this, we:

- reviewed the Group's financial performance in 2018/19 including its achievement of planned cost improvements in the year;
- held discussions with management to understand the funding arrangements that have been agreed, confirming to signed loan agreements, and regarding management's expectation around further funding requirements;
- reviewed the Group's cash flow forecasts and the Group's financial plan submitted to NHS Improvement;
- challenged the key assumptions used in the cash flow forecasts by reference to NHS Improvement guidance; and
- considered the consistency and historical accuracy of the budgeting process used by the Group.

As stated in note 1.27, these events or conditions indicate that a material uncertainty exists that may cast significant doubt on the Group's and the foundation trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Summary of our audit approach

Key audit matters	The key audit matters that we identified in the current year were: • Recognition of NHS revenue; • Property valuations; • Going concern (see 'material uncertainty relating to going concern' section); • Management override of controls; and • Arrangements to secure value for money (see matters on which we are required to report by exception – use of resources section). Within this report, any new key audit matters are identified with ⊗ and any key audit matters which are the same as the prior year identified with ⊗.
Materiality	The materiality that we used for the group financial statements was £11.6m which was determined on the basis of 1% of revenue.
Scoping	Our group audit was scoped by obtaining an understanding of the group and its environment, including internal controls, and assessing the risks of material misstatement at the group level. Audit work was performed at the group's head offices in Denmark Hill directly by the audit engagement team, led by the engagement lead. We performed a fully substantive audit on the foundation trust and one of the foundation trust's subsidiaries, KCH Interventional Facilities Management LLP, which together account for over 99% of the revenue of the group.
Significant changes in our approach	We identified appropriate capitalisation of expenditure as a key audit matter for 2017/18. Due to the reduction in the size of the foundation trust's capital program which was £35m in 2018/19 compared to £55m in 2017/18, we did not identify capital expenditure as a key audit matter for 2018/19.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit

strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to the matters described in the 'material uncertainty relating to going concern' section and the 'matters on which we are required to report by exception – use of resources' section , we have determined the matters described below to be the key audit matters to be communicated in our report.

Recognition of NHS revenue

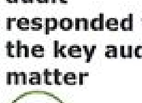
Key audit matter description

As described in note 1.7 and note 1.28, there are significant judgements in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to the judgemental nature of provisions for disputes, including in respect of outstanding overperformance and non-contracted income for quarters 3 and 4.

Details of the Group's income, including £983m of Commissioner Requested Services, are shown in note 2 to the financial statements. NHS debtors are shown in note 13 to the financial statements.

The Group earns revenue from a wide range of commissioners, increasing the complexity of agreeing a final year-end position. The settlement of income with Clinical Commissioning Groups continues to present challenges, leading to disputes and delays in the agreement of year end positions.

How the scope of our audit responded to the key audit matter



We evaluated the design and implementation of controls over recognition of NHS income.

We performed detailed substantive testing on a sample basis of the recoverability of unsettled revenue amounts, and evaluated the results of the agreement of balances exercise.

We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners.

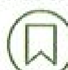
Key observations

We concluded that NHS revenue and provisions were within an acceptable range.

Our evaluation of the design and implementation of controls identified weaknesses.

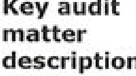
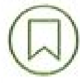
Property valuations

Key audit matter description



The Group holds property assets within Property, Plant and Equipment at a modern equivalent use valuation of £467m. The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value.

The net valuation movement on the Group's estate shown in note 10 is a

	net gain on revaluation of £16m and notes 1.12 and note 7 provide more information about the valuation basis.
How the scope of our audit responded to the key audit matter	We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the foundation trust to the valuer. We used Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Group's properties. We challenged the Group's assumption that an alternative, lower value, site could be used in calculating a Modern Equivalent Asset value by critically evaluating whether the alternatives considered would be viable given the nature of the foundation trust's activities. We have reviewed the disclosures in notes 1.12 and 7 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation. We considered the impact of uncertainties relating to the UK's exit from the EU upon property valuations in evaluating the property valuations and related disclosures. We assessed whether the valuation and the accounting treatment of the impairment were compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.
Key observations	We have concluded the Group's valuation assumptions fall within the expected range highlighted by Deloitte internal valuation specialists. Our evaluation of the design and implementation of controls identified weaknesses.
Management override of controls 	
Key audit matter description 	We consider that in the current year there continues to be a heightened risk across the NHS that management may override controls to fraudulently manipulate the financial statements or accounting judgements or estimates. This is due to the increasingly challenging financial circumstances of the NHS and close scrutiny of the reported financial performance of individual organisations. The areas of judgement which are more susceptible to management override include accruals, deferred income, accrued income, provisions, impairment allowances, property valuations, and useful economic lives of assets. Details of critical accounting judgements and key sources of estimation uncertainty are included in note 1.28.
How the scope of our audit responded to the key audit matter	**Manipulation of accounting estimates** Our work on accounting estimates included considering areas of judgement including deferred income, partially completed patient spells, bad debt provisions, property valuations, and useful economic lives of assets. We have considered both the individual judgements and their impact individually and in aggregate upon the financial statements. In testing each of the relevant accounting estimates, engagement team members were directed to consider their findings in the context of the identified fraud risk. Where relevant, the recognition and valuation criteria used were compared to the specific requirements of IFRS.

	We tested accounting estimates (including in respect of NHS revenue and provisions and property valuations discussed above), focusing on the areas of greatest judgement and value. Our procedures included comparing amounts recorded or inputs to estimates to relevant supporting information from third party sources. We evaluated the rationale for recognising or not recognising balances in the financial statements and the estimation techniques used in calculations, and considered whether these were in accordance with accounting requirements and were appropriate in the circumstances of the Group. **Manipulation of journal entries** We used data analytic techniques to select journals for testing with characteristics indicative of potential manipulation of reporting focusing in particular upon manual journals. We traced the journals to supporting documentation, considered whether they had been appropriately approved and evaluated the accounting rationale for the posting. We evaluated individually and in aggregate whether the journals tested were indicative of fraud or bias. We tested the year-end adjustments made outside of the accounting system between the general ledger and the financial statements and consolidation adjustments and journals. **Accounting for significant or unusual transactions** We considered whether any transactions identified in the year required specific consideration and did not identify any requiring additional procedures to address this key audit matter.
Key observations	We agreed with management that the treatment of the accounting estimates, journal entries and significant or unusual transactions is appropriate. Our evaluation of the design and implementation of controls identified weaknesses.

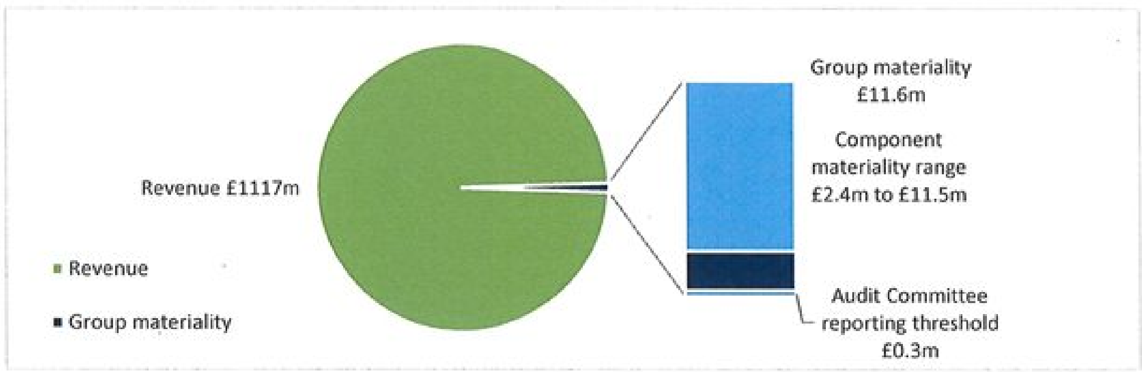
Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

	Group financial statements	Foundation trust financial statements
Materiality	£11.6 million (2018: £11.2 million)	£11.5 million (2018: £11.1 million)
Basis for determining materiality	1% of revenue (2018: 1% of revenue)	1% of revenue (2018: 1% of revenue)

Rationale for the benchmark applied	Revenue was chosen as a benchmark as the foundation trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.	Revenue was chosen as a benchmark as the foundation trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.



We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £300,000 (2018: £223,000), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our group audit was scoped by obtaining an understanding of the group and its environment, including internal controls, and assessing the risks of material misstatement at the group level. Audit work was performed at the group's head offices in Denmark Hill directly by the audit engagement team, led by the engagement lead.

We performed full scope audit procedures on the foundation trust and one of the foundation trust's subsidiaries, KCH Interventional Facilities Management LLP, which together account for over 99% of the revenue of the group.

Our audit work was executed at the level of materiality determined on an entity by entity basis, all of which were lower than group materiality.

At the group level we also tested the consolidation process and carried out analytical procedures to confirm our conclusion that there were no significant risks of material misstatement of the aggregated financial information of the remaining components not subject to audit or audit of specified account balances.

The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and information technology systems.

Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon.

We have nothing to report in respect of these matters.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

Responsibilities of accounting officer

As explained more fully in the accounting officer's responsibilities statement, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the foundation trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the group or the foundation trust or to cease operations, or has no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

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

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

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources

We are required to report to you if, in our opinion the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Basis for adverse conclusion

- There are weaknesses in the Trust's arrangements for agreeing, monitoring and recording of contracts with third parties. The Annual Governance Statement describes the action which the Trust has taken during the year to prepare a comprehensive contract register as a basis for improving management of its contracts and procurement activity. These improvements to arrangements did not operate throughout the financial year.

This issue is evidence of weaknesses in proper arrangements for commissioning services and procuring supplies effectively to support the delivery of strategic priorities.

- NHSI accepted updated enforcement undertakings from the Trust in September 2018 as it stated it had reasonable grounds for suspecting that the Trust was providing healthcare services for the purpose of the NHS in breach of its license conditions, in particular because of:
  - the Trust's financial position and performance;
  - the governance issues identified by the Care Quality Commission (CQC) in their January 2018 report and others;
  - and the Trust's performance against access standards for A&E 4 hour waits and Referral to Treatment 18 week and number of patients who had waited more than 52 weeks.

  The Trust was inspected by the CQC with its report being issued in January 2018. The report concludes that overall the Trust 'Requires improvement' and identifies weaknesses in governance arrangements.

These issues are evidence of weaknesses in proper arrangements for acting in the public interest, through demonstrating and applying the principles and values of sound governance.

- A number of significant financial reporting control weaknesses were identified through our audit of the 2018/19 financial statements of the Trust relating to the ability of the Trust to produce reliable financial reporting securely within the timetable set by NHSI.

This issue is evidence of weaknesses in the Trust's arrangements in respect of producing reliable and timely financial reporting that supports the delivery of strategic priorities.

- In our "Limited assurance report on the content of the quality report and mandated performance indicators", we issued a qualified conclusion because of errors identified in the calculation of the 62 day cancer and Accident and Emergency 4 hour wait performance indicators.
- Internal audit identified improvement requirements in relation to performance information; in particular, the Trust has not established minimum requirements which apply to all Trust systems and the quality of data within them.
- Weaknesses identified in 2017/18 in the capture, analysis and reporting of activity data used for contracting and billing purposes and in the evaluation of local pricing decisions and other contract terms have impacted on the amount of income earned by the Trust in 2018/19.

These issues are evidence of weaknesses in proper arrangements for understanding and using appropriate and reliable financial and performance information to support informed decision making and performance management.

- The Trust incurred a deficit of £178m for the year ended 31 March 2019. The Trust's deficit before impairments, capital donations and grants and provider sustainability funding was £190m. This is £44m higher than the Trust's 2018/19 plan.

- The Trust's Annual Governance Statement describes weaknesses in financial planning, budgetary control and financial recovery governance and control arrangements identified through the work of the Trust's internal auditor.
- The foundation trust's 2019/20 plan submission in March 2019 shows a forecast deficit before impairments, capital donations and grants and provider sustainability funding of £170m for 2019/20.
- In order to fund the deficit in 2018/19, the Trust received additional financial support in 2018/19 from the Department of Health and Social Care of £146m and is seeking additional revenue financial support in 2019/20 of £133m and capital financial support of £26m from the same source, as well as seeking the extension of a term loan of £99m which is due for repayment in November 2019 and revolving credit facility of £90m which matures in April 2020. There were weaknesses in financial planning and budgetary control identified through the work of the Trust's internal auditor.
- In 2016/17, an independent report was provided to the Trust that estimated the Trust's backlog maintenance costs to be approximately £200m, excluding costs in respect of equipment. The Trust now estimates this cost to be well in excess of £200m. The Trust does not have an up-to-date estates strategy and is substantially reliant on additional loan funding, agreed annually, to meet the cost of capital works. These matters expose the Trust to significant risks related to the age and condition of the estate that could impact levels of service provision.

These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

- Internal audit and other reports issued in 2017/18 and 2018/19 identified weaknesses in governance, financial control and contracting arrangements in relation to commercial activities carried out by subsidiary entities. Issues included weaknesses in arrangements for membership of the KCH Interventional Facilities Management LLP ("KIFM") Management Board, failure to update contract documentation to reflect activities carried out by KIFM and performance of regular reconciliations of all intercompany balances. Actions taken to address these weaknesses were not in place for some or all of the year.
- The Annual Governance Statement reports on the changes the Trust has made to address weaknesses in its controls over the development and scrutiny of business cases. These improvements were not in place for the full financial year.
- The opinion of the Trust's Head of Internal Audit is that only 'partial assurance with improvements required' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control and the Annual Governance Statement describes the weaknesses in control identified from his 2018/19 audit plan which have contributed to this opinion, including financial planning and budget monitoring processes, capital expenditure management, agency cap compliance, responding to GDPR, information governance self assessment, quality of performance reporting, governance and controls over financial recovery, management of capital projects and divisional risk management.

These issues provide evidence of weaknesses in proper arrangements for managing risks effectively and maintaining a sound system of internal control.

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in December 2017, we are not satisfied that, in all significant respects, King's College Hospital NHS Foundation Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

3

Annual Governance Statement and compilation of financial statements

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

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

Reports in the public interest or to the regulator

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

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of King's College Hospital NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the foundation trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Jonathan Gooding

Jonathan Gooding, FCA (Senior statutory auditor)
for and on behalf of Deloitte LLP
Statutory Auditor
St Albans, United Kingdom
11 June 2019

King's College Hospital NHS
NHS Foundation Trust

Emergency Department
Princess Royal University Hospital

Improving Our Services For Patients

Dr Sarah Frankton - Clinical Director
Chris Kerr - Head of Nursing
Hannah Jackson - General Manager
Dr Claire Gray - Clinical Lead
Nicola Wilcox - Matron
Alison Godfrey - Matron

Pioneering better health for all

Reducing Overcrowding and Improving Patient Experience

- All patients in the Acute Medical Unit are reviewed twice a day by a consultant to ensure that we maintain capacity for Emergency medical admissions
- Emergency Department safety huddles take place every 3-4 hours; capacity in the Department and across the site is reviewed
- Multi-disciplinary attendance from all care groups at flow meetings to promote early discharges
- Flow coordinator trial in place to help facilitate the smooth running of the patient journey within the Emergency Department
- The full capacity protocols are under review to ensure that they are robust and the site as a whole responds to pressures within the Emergency Department

King's

Managing The Resuscitation Area

- From March 2019, with immediate effect non clinical spaces in the resuscitation area are no longer used for patient care under any circumstances
- We have created guidance to determine which patients should be cared for in the Resuscitation area and ensured that staff are aware in order to manage capacity
- We are using monitored step-down cubicles to safely manage the flow from the resuscitation area
- We ensure that the i-mobile (critical care outreach) team are aware of patients moving from ED to the wards who are thought to be at risk of deterioration
- We have introduced the National Early Warning Score (NEWS) 2 – it is planned for electronic roll-out from October 2019
- We have submitted a Business Case for the expansion of the Emergency Department which would provide designated area / staffing for HDU step down

Providing Rapid Assessment and Treatment

- We are developing a Rapid Assessment and Treatment (RAT) model to ensure that there is no delay in starting urgent treatment and identifying patients that can be streamed directly to specialties
- We are addressing delays in specialty (medical, surgical, gynaecology, paediatrics) attendance with support from our Divisional Medical Director
- We are addressing late referrals from the Urgent Care Centre with colleagues from the CCG and Greenbrook Healthcare Provider

King's

Developing Pathways as an Alternative to The Emergency Department

- We ensure that when possible all appropriate patients are streamed directly from the Urgent Care Centre and ED triage to the Ambulatory Emergency Care Unit (medical and surgical) to avoid admission and de-congest the Emergency Department.
- We are looking at alternatives to admission with other care group colleagues including possibilities such as a Surgical Assessment Unit and a Paediatric Assessment Unit
- We have a new acute frailty consultant who is working in partnership with the acute and emergency medical teams to avoid admission or reduce length of stay in hospital for our most frail, elderly patients

King's

Improving Care for Patients with Mental Illness

- We have transformed one of our Emergency Department Consulting Rooms into a dedicated mental health room only and no longer use it for any other purpose
- Ligature points, high backed chairs and any other equipment that could put patients at risk of harming themselves have been removed
- We have ordered soft furniture for the room to further as recommended for mental health rooms.
- Improved working relationships with Oxleas colleagues
- **Mental Health Risk Assessment** Document should be completed within 30 minutes of being triaged in ED. We currently are **90% compliant** on our last audit

Providing Safe Care

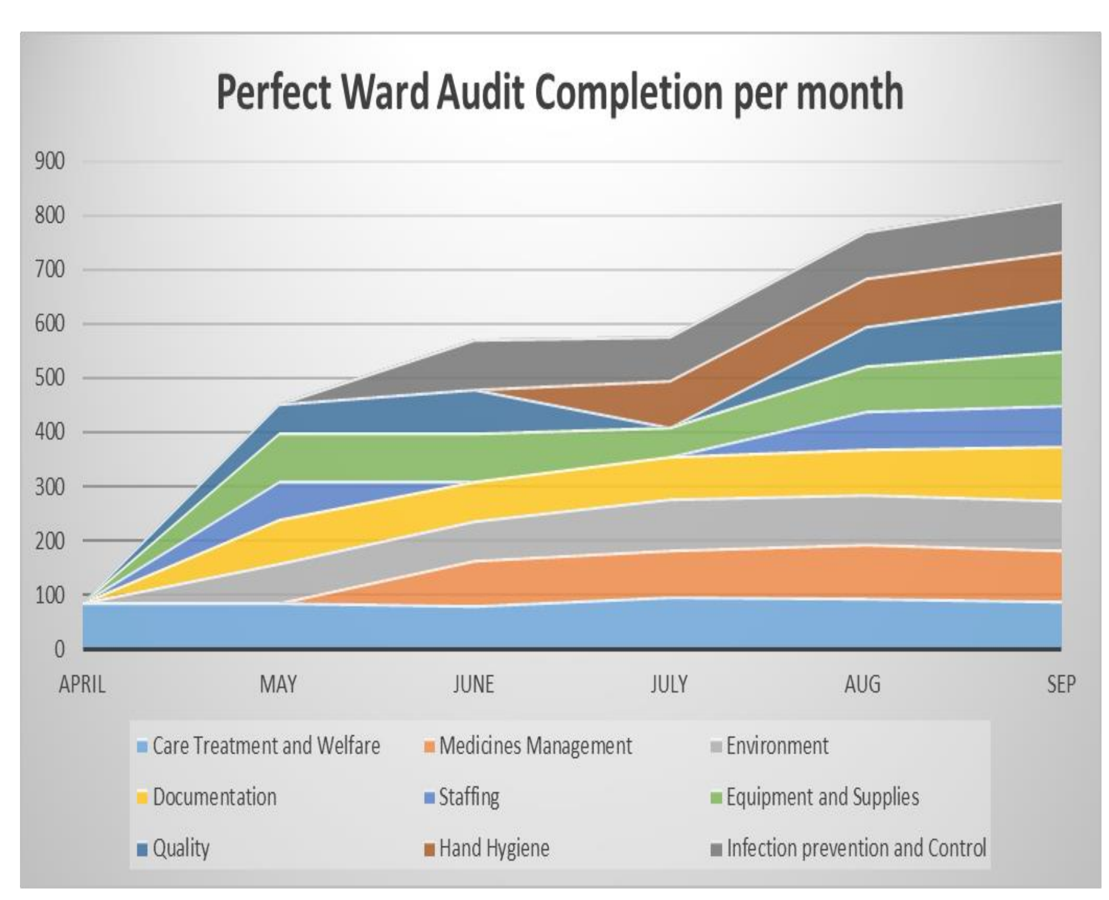
- Rounding is in the process of being introduced. This will ensure that patients are comfortable and have received refreshments and are aware of their plan
- Patient Safety checklists are in place in the nursing documentation
- Falls Risk Assessments are completed for all patients that meet the inclusion criteria and a falls work stream has been established and led by one of the ED matrons
- Falls and Pressure area risks are recorded in new nursing documentation
- Patients who are triaged and remain with ambulance crews have regular observations
- All falls with harm presented at the Safer Care forum to ensure that learning is shared

King's

Auditing Our Progress

Nursing Band 7s are now leads for individual work streams for each component of the **Perfect Ward Audits:**

- **Hand Hygiene – 95%**
- Care, treatment and welfare – 93%
- **Medicines Management – 98%**
- Environment – 100%
- **Documentation – 100%**
- Staffing – 82%
- **Equipment and Supplies – 100%**
- Quality – 95%
- **Infection Prevention and Control – 94%**



King's

Improving Our Staffing and Skill Mix

- Nursing skill mix and workforce review completed – identified by ECIST as best practice and will be used on their National platform
- Healthcare Support Workers are now fully established into roles
- Nursing vacancy has significantly reduced from **26** WTE to **4** WTE across band 4 and 5 & 6
- Recruiting into vacant JCF and FY2 posts and creating further training opportunities to attract senior doctors
- Development of flow coordinator position
- Advanced Care Practitioners' (ACP) training programme in place and recruiting ACP for "see and treat" model

King's

Improving Infection Prevention and Control

- **Hand hygiene audit** is conducted weekly. For September we have consistently achieved **above 90% compliance**
- Clinical Director is holding meeting with trainees to emphasise the importance
- **Daily cleaning check lists** performed. For September we have **achieved 94%** compliance **(11% improvement from Q1)**
- Infection control team delivering refresher training and will complete spot checks
- Updated signage is in place regarding the use of Personal Protective Equipment
- Alcohol gel has been placed on pillars outside cubicles to encourage hand hygiene before and after each patient contact
- Introduction of an intravenous antibiotics preparation room

King's

Delivering Compassionate Care

- Leadership team at all levels reinforcing and role modelling the right care for our patients.
- Hot food and snacks are now available to patients and signage is in place regarding refreshment times and availability of water fountain
- Hot drinks rounds are now in progress, mid morning and mid afternoon including in the waiting room area
- We aim to increase the number of volunteers to support the wellbeing and comfort of patients
- New signage is being discussed to support smooth functioning of the ED
- A wellbeing lead for staff is in place
- A patient feedback forum is planned supported by patient experience lead

King's

Improving Our Environment and Equipment

- Business case to be approved for additional clinical space
- Introduction of housekeeper role
- Staff and other patients removed when X rays taken, signage in place and risk assessment completed by head of ionising radiation
- Hazardous substances are locked away
- The Resuscitation trolley is checked daily
- Computer screens turn to screen saver after 1 minute of inactivity to ensure patient confidentiality
- **Consumables in date and expiry dates completed**, most recent audit in September achieved **94% compliance**. Ongoing weekly audits in place

King's

Improving Clinical Governance

- Duty of Candour to be completed– and reviewed at governance meetings – **zero outstanding DoC conversations and letters**
- Monthly Care Group Joint Governance Meetings in place
- Newsletter Designed – learning from Incidents and Complaints
- Detailed minutes to be shared with the team including junior doctors and nurses
- Themes and actions are recorded on the Governance Tracker
- All policies and guidelines are being reviewed. We are ensuring that electronic guidelines are current and up to date and policy for reviewing guidelines (Guidelines working group) to be founded

Leadership and Culture

- Establishment of weekly triumvirate meetings, monthly Multi-disciplinary meetings and away day planned
- Engagement sessions with junior medical staff (with pizza!)
- Staff drop in sessions led by the triumvirate
- Well-being Lead – Looking after our staff

King's

Improving Our Services For Patients – Our Achievements

- Friends and Family Test – **86% of our patients now say they would recommend us** – an increase of 20%
- We have been **commended by ECIST for our Nursing Recruitment Strategy**. Our vacancy rate is at the lowest it has ever been
- There is a **robust development programme** supported by PDN / CPFs and the Band 7s for nursing staff to ensure that staff have opportunities in order to retain them

Improving Our Services For Patients – Our Achievements

- Band 7s all allocated work streams to lead on with their teams to **empower all staff to take ownership**
- **Regular provision of hot and cold refreshments** to our patients and families now in place including in the waiting room
- We are **supporting four Trainee Advanced Clinical Practitioners** in the department to develop the workforce

Improving Our Services For Patients – Our Achievements

- HEE funded programme in place which has led to an **improvement in our GMC survey**
- Intravenous **antibiotic audit completed** to inform community services and avoid lengthened hospital stay
- **Draft Clinical Strategy has been written** for discussion at a care group away day
- **Operational and admin staff review completed** and all posts recruited in to

King's

Improving Our Services For Patients – Our Achievements

Some of our Positive Patient Feedback on NHS Choices August/September 2019:

- "I was advised to go to A&E immediately and was offered an ambulance which I declined as a friend took me to the PRUH. I arrived at 10pm and was assessed immediately. I saw the doctor at 10.45pm. She was excellent - thorough and reassuring. Assessed my problems - change of diet, constipation and food poisoning. Now OK thanks to medical recommendations. Please convey my thanks to the staff at the PRUH - the receptionist was excellent and the doctor was outstanding. I am 71 and have never been to A&E before and was dreading it because of media perceptions! So reassured! THANK YOU."

- "My grandad was admitted to hospital following a long stay in the ED before admission, I would just like to say a HUGE thank you to the HCA in ED, he was absolutely incredible, he got all my grandads visitors chairs, he offered us hot drinks or water and he was rushed off his feet. He was so friendly and I always saw him with a smile, he was a breath of fresh air in what was a very stressful and upsetting time for us all. Out of all the doctors, nurses and other staff this was the only member of staff who seemed to get us answers by asking more senior members of staff or checking with the nurses, nothing seemed to be too much trouble for him. He is an absolute credit to the ED and the PRUH are very, very lucky to have such a fabulous member of staff. Thank you"

- "Mum was admitted 5 weeks ago after a bad fall. They discovered she had fractured 7 ribs in A&E and also in the course of scanning her found extensive cancer. She has deteriorated now to the point of needing palliative care in a nursing home. I cannot commend the staff in A&E and Ward S5 enough for their care, patience and commitment. That care would be the last she will have remembered as she is sleeping a lot now. The palliative consultant, ward nurses and assistants have been so compassionate - I can only say a very big thank you on behalf of my Mum".

- **"I have been in and out of this ED many times over the years and the visit has completely changed my views. All the staff were great. Erika was just incredible, explained my treatment beautifully and was very prompt, engaging and caring"**
  (4th September 2019)

King's

Next steps

Perfect week planned for week of the 14th October 2019 in ED

This will allow us to test:

- Flow co-ordinator
- Daily Rapid Assessment and Treatment
- Escalation processes
- Subacute open 24/7
- Aim to test see and treat model at the front door
- Clinical Decision utilisation of beds and chairs
- Implementation of Frailty Model

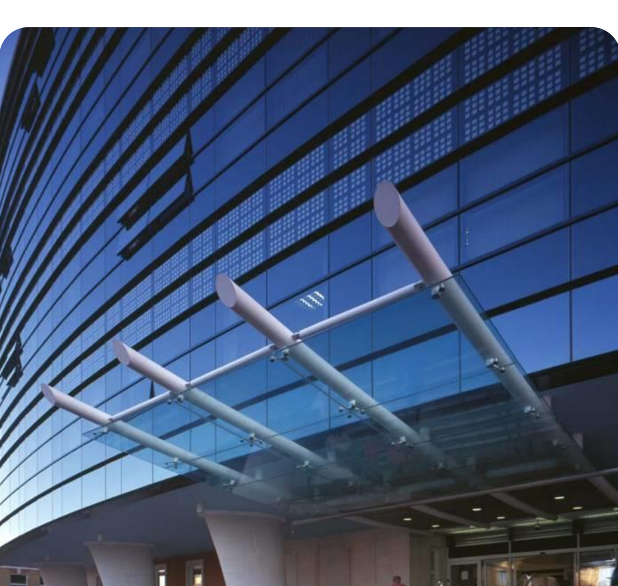
King's

Thank you for Listening

Any Questions?

Bernadette Bluhm
Chief Operating Officer

Improving Emergency Care
October 2019



An Academic Health Sciences Centre for London

Pioneering better health for all

The shop window into the soul of the organisation

NHS
King's College Hospital
NHS Foundation Trust

Performance for last 3 months

DH Weekly Performance

(last 3 months)

95%
90%
85%
80%
75%
70%
65%
60%
55%
50%

09/06/2019 16/06/2019 23/06/2019 30/06/2019 07/07/2019 14/07/2019 21/07/2019 28/07/2019 04/08/2019 11/08/2019 18/08/2019 25/08/2019 01/09/2019 08/09/2019 15/09/2019

DH Type 1 DH Type 3 DH All Types

King's

The case for change

- Listen to:
  - what our patients are telling us about their experience
  - what our staff are telling us about the care they deliver
- Understand our data – signpost to improvement opportunities
- Engage - clinical staff are key to success
- Expert help - secured to support change agenda
- Governance – established our Emergency Care Improvement Programme
- Discipline – set measurable goals and timeframes
- Commitment – deliver on our promises
- Resilience – manage energy and expectation as this will take time
- Leadership – executive oversight

Focus for improvement

- How quickly are our patients being seen when they arrive in ED? Time to first assessment!
- How can we avoid admissions?
- How do we simplify the route to specialty assessment from ED?
- How do we engage our specialty services?
  - Agree common approach
  - Cultural shift to shared ownership
- How do we reduce our length of stay and create capacity?
- How do we work better with our system partners?

Progress to date

- Creating an environment where staff have contributed to solutions and are actively seeking change
- Established regular escalation huddles
- Focus on getting the basics right – quality and safety rounds
- Emergency Department – implementation of Rapid Assessment and Treatment model August 2019
  - **Wait for first assessment in ED reduced by an average of 30 minutes following new process**
  - **Arrival to specialty referral has reduced by 30 minutes**

Progress to date

- Increasing primary care redirections

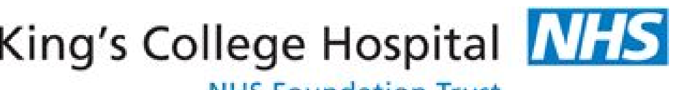
- Same Day Emergency Care for Medicine was implemented on 1st July. 8 care spaces co-located with Clinical Decision Unit in ED
  - **As of 16th September, we had seen 903 patients in this new facility**

- Reduced waiting times for speciality response
  - **General Surgery and Medicine consistently reduced specialty response times over the last 6 months to less than 60 minutes**
  - **Trauma response times also reduced to an average of 60 minutes**

Next Steps

- We must address **EXIT BLOCK** and reduce overcrowding in ED
- Further extend medical Same **D**ay Emergency Care to direct GP access
- Extension of current Frailty services to cover 7/7
- Provision of Same Day Emergency Care service for surgical specialities due to open on 30th September 2019
- Strengthen out of hours GP provision in the UCC
- Provision of Networked Care hot clinics from November starting with Cardiology to facilitate length of stay reduction
- Direct pathway to Medical Assessment unit from ED planned for December
- Continue to drive stranded patient agenda both 7 day and 21 day.

Aim High - a new shop window



Governors' Patient Experience & Safety Committee

Minutes

Minutes of the Patient Experience & Safety Committee (PESC) meeting held on Thursday 11th April 2019 at 11:00-13:00 in the Dulwich Meeting Room, King's College Hospital, Denmark Hill.

Present:

Victoria Silvester	Public Governor (Chair)
Jane Allberry	Public Governor
Penny Dale	Public Governor
Barbara Goodhew	Public Governor
Chris North	Public Governor / Lead Governor

In attendance:

Siobhan Coldwell	Trust Secretary and Head of Corporate Governance
Helen Fletcher	Associate Director of Nursing for Quality, Patient Safety & Improved Experience
Ashley Parrott	Director of Quality Governance
Dale Rustige	Corporate Governance Officer (Minutes)
Nicky Waring-Edkins	Director of Delivery and Outpatients (Part meeting)
Andy Oxby	Senior Programme Manager (Part meeting)
Rob Marlowe	Publications Manager in Communications Department (Part meeting)

8.1

Apologies:

Jessica Bush	Head of Engagement & Patient Experience
Pam Cohen	Public Governor
Diana Coutts-Pauling	Public Governor
Stephanie Harris	Public Governor
Anne-Marie Rafferty	Stakeholder Governor
Claire Saha	Staff Governor AHP
Derek St Clair Cattrall	Patient Governor

Item	Subject	Action
19/15	**Welcome and Introductions** Apologies for absence were noted.	
19/16	**Declarations of Interest** None.	
19/17	**Chair's Action** None.	
19/18	**Minutes of the Previous Meeting** The minutes of the last meeting held on 14 February 2019 were approved as an accurate record.	
19/19	**Action Tracker and Matters Arising** The Committee reviewed the action tracker and the following updates were noted: 1. 23/02/2018 (18/04): Maternity Service Action Plan – The Committee noted that the item would be deferred as Jenny Cleary (Director of Midwifery & Gynaecology) was not in attendance. **(Action deferred)**	

Item	Subject	Action

2. 14/02/2019 (19/05): Patient Information Materials – This was added as an item to the meeting agenda and a sample of several patient information materials were circulated with the papers for review by the Committee. **(Action closed)**

PATIENT EXPERIENCE

19/20 King's Quality Account 2018/19

The Committee received the Draft Quality Account 2018/19 for feedback and review.

The Committee noted the feedback and comments provided by the Governors present. They were noted by Ashley Parrott, Director of Quality Governance, and inform the final version of the document.

It was noted that a section of the Quality Account would require an agreed narrative from the Governors. The Committee noted that this would be provided through the Lead Governor.

The Committee was informed that some changes would be made to the overall presentation of the Quality Account. More infographics would be added, narrative on the Trust's achievements and challenges, and the possibility of including patient stories.

19/21 Patient Information Materials

The Committee reviewed a sample of three patient information leaflets produced by the Trust for King's at Denmark Hill.

Robert Marlow, Publications Manager from the Communications Department, was present at the meeting to provide an update on the process of producing information leaflets and to answer any queries. The Committee was informed that Care Groups and specific clinical areas were responsible for the production of the content of the leaflets. These would then be passed on to the Communications Department to review, do the design formatting, and produce print copies if needed.

The Committee was informed however that the PRUH currently uses an outsourced/external system in which they can download generic patient information materials on different clinical procedures, which would then be provided to patients. The Denmark Hill site produces its own tailored materials.

Concerns were noted about the difficulty in being able to monitor all patient information materials produced across the Trust. One of the ways this issue was being managed was to ensure that care groups are made aware that they have responsibility over patient information materials provided within their wards/areas. This would be linked up with the Trust's perfect ward initiative. Care Groups would also be asked to consult patients to inform the process of developing their patient information materials.

19/22 Outpatient Transformation

The Committee received a progress update on the transformation of the Trust's outpatients service. Nicky Waring-Edkins (Director of Delivery and Outpatients) and Andy Oxby (Senior Programme Manager) attended the meeting to provide an

Item	Subject	Action
	update.	
	The Committee was informed that plenty of work was being done to address the various improvement areas. Work was being done to improve the patient pathway and ensure that only patients who require the outpatients service were coming through. The Committee was informed that up to 45% of patients currently being referred to the Trust's outpatient service (totalling thousands of patients) did not need to be referred. There were also thousands of follow-ups being done unnecessarily. The Trust had been working with primary care to ensure more effective triaging and referrals.	
	A review of the systems and processes was also being done to ensure consistency across the service. The use of the "consultant connect system" would be further developed; this was a way for primary care to receive information from consultants, therefore potentially avoiding unnecessary referrals.	
	One of the key areas of work was the reduction of the "did not attend" (DNA) rates, in which patients missed appointments without providing notice. The Committee heard that effective communications with patients was a key factor in reducing DNA rates. This would involve calling or texting patients to remind them about their appointments.	
	Part of the next phase would be for the Trust to use digital apps for mobiles that would enable patients to book or manage their own appointments. The Committee had a discussion regarding the challenges of rolling out the digital booking system to the older demographics served by the Trust.	
	The Committee thanked the team for the report and noted the progress with the outpatient transformation work.	
	PATIENT SAFETY AND RISK MANAGEMENT	
19/23	**Quality and Performance Report**	
	The Committee received and noted the Trust's Quality & Performance Report (February 2019 data). The Committee had a question regarding the response rate figure for the Friends and Family Test and Patient Feedback for the A&E service, which appeared quite low at 4%. The Committee was informed that there were various reasons for the low figure. The Emergency Ddepartment can get very busy and challenging, which could have an impact on the level of priority given to providing service feedback. It was recognised that more work was needed to improve the response rates in this area.	
	Action: The Committee had a question on whether the Trust gathered statistics on self-discharges, including trends on the reasons behind patients discharging themselves. It was agreed that this would be looked into on the kind of data that the Trust gathers and collates on this.	**Ashley Parrott**
	GOVERNOR FEEDBACK	
19/24	**Food Service Feedback – Update**	
	Governors were concerned about the food service, particularly on David Marsden ward. Alternative meals were given to patients for no apparent reason and on one	

8.1

Item	Subject	Action
	occasion, food was unavailable due to Medirest's late delivery to Denmark Hill site.	

The Committee was informed that the issue appeared to be a miscommunication between staff. There was a problem with the delivery of food that day, therefore the usual options were not available. It was noted that steps had been taken to ensure that staff were refreshed on the appropriate escalation procedures for these type of issues.

19/25 Commissioners Quality Review Group (CQRG)

The Committee received and noted the summary of the CQRG meeting on 19/02/2019 from Jane Allberry and Barbara Goodhew.

19/26 Chair's Summary of the Quality Assurance & Research Committee (QARC) meetings

The Committee noted the meeting summaries from the QARC meetings on 26/02/2019 and & 09/04/2019.

19/27 Update from Committee Members and Governors in attendance on activities

The Committee received and noted a verbal update on governor activities relating to patient experience and safety:

Victoria Silvester
- 6 March – Board and Council meeting
- 21 March – Patient Food Service meeting and agenda setting meeting for PESC on 11 April
- 28 March – Development Day
- 3 April – Food audit on David Marsden Ward
- 9 April – Observer at QARC meeting

Stephanie Harris
- Member of interview panel to select a new Head of Nursing for Mental Health for KCHFT
- Quality Review visit
- Attendance of Trust Mental Health Board
- Member of King's Mental Health Strategy formation team
- Involvement with KCH Mind and Body Advisory Panel
- Input into Quality Account
- "Sit & See" observation of Fisk and Cheere ward

Jane Allberry
- CQRG and QARC meeting
- Attended meetings for the new Cancer Patient Experience Programme of work; Jane is a representative on the Programme Board and one of the work streams
- End of Life Care Committee

Penny Dale
- 7 March – Commendation panel Kings Stars awards
- 22 March – Met Irina, head of Cancer services to discuss services at PRUH
- 25 March – Patient Experience Committee at PRUH
- 25 March – Members Health Talks re Cancer services at PRUH
- 28 March – Governor Development Day meeting with NHSI

Item	Subject	Action
	• 4 April – Commendation Awards ceremony at DH • 5 April – End of Life Committee DH • 11 April – PESC and Strategy meetings	
19/28	**ANY OTHER BUSINESS**	
	None.	
19/29	**DATE OF NEXT MEETING**	
	Thursday 11th July 2019 (17.30-19.30) in the Dulwich Room, Hambleden Wing, Denmark Hill.	

Governors' Strategy Committee

Minutes

Minutes of the Meeting of the Governors' Strategy Committee held on Thursday 11th April 2019, 2.00-4.00pm in the Dulwich Room, Hambleden Wing, Denmark Hill

Members Present:	
Ashish Desai	Chair
Chris North	Public/Lead Governor
Carole Olding	Staff Governor
Penny Dale	Public Governor
Stephanie Harris-Plender	Public Governor
Jane Allberry	Public Governor
In Attendance:	
Nina Martin	Assistant Board Secretary (minutes)
Siobhan Coldwell	Trust Secretary
Abigail Stapleton	Director of Strategy
Heather Gilmour	Interim Deputy Director of Strategy
Peter Grummitt	Strategy Manager
Lorcan Woods	Chief Financial Officer (part)
Victoria Silvester	Public Governor
Apologies:	
Kevin Labode	Staff Governor
Claire Saha	Staff Governor

8.1

Item	Subject	Action
	STANDING ITEMS	
019/11	**Welcome and Apologies**	
	Welcome and apologies were noted.	
019/12	**Minutes of the Previous Meeting – 7 February 2019**	
	The minutes of the previous meeting were agreed as an accurate record.	
019/13	**Matters Arising and Action Tracker**	
	The Committee noted the actions.	
	HORIZON SCAN	
019/14	**Focus on NHS Long Term Plan and STP**	

The Deputy Director of Strategy updated the Committee on the external strategic developments and the potential impact for the Trust. These included the NHS Long term plan; the NHS London Region; SELSTP/OHSEL and highlighted the national and local timetable for these agendas. Key comments included:

- A focus on collaboration and joined up working in the NHS London Region plans.
- The governance around the south east London partnership was evolving as there was a recognised need to streamline the governance arrangements. The Director of Strategy highlighted the importance of the governance structure. There was the potential for an acute based care board and the need to consider King's position in this structure. Partner

Item	Subject	Action

Boards would need to take an integrated view and decide what can be delivered collectively. The value of networks, referrals management and the potential for network commissioning would need to be explored.
- The Committee also noted that STP wide working should not be a deterrent to local working.
- Ms Allberry noted the absence of certain priorities from the list presented, notably long-term conditions and the Committee was informed that the Trust corporate and clinical strategy was at present a work in progress.

  Ms Dale queried the approach to patient choice, particularly as it relates to orthopaedics. The Director of Strategy said this was under consideration and at present the priority was on reducing the 52 weeks waiting list.

Regarding the STP and collaborative working, Mr North raised the following concerns:
- Governance arrangements.
- King's commitment to collaboration as this historically had not been an area of priority and focus by the Trust.
- The feasibility of the integrated health agenda given the financial constraints and the limited appetite of partners to take on the Trust's deficit. He added that the it was important to focus the strategy and resources on what was achievable. The Strategy Director highlighted that ICS was the way forward and partnership working would support the Trust's recovery efforts.

The Chair queried the KHP/RBH institute work and whether there would be engagement with the adult services. The Committee heard that presently, the focus was on respiratory and paediatric services and the next step would be NHSE consultation.

TRUST STRATEGIC FOCUS

019/15 Trust Strategic Framework Feedback

The Committee heard that there had been good responses from the engagement on the strategic framework. There had been some doubt expressed about the achievability of the objectives. The new CEO and Trust Chair had been engaged on the strategy and further engagement with wider stakeholders had been planned. There were plans to focus on a smaller number of clear priorities.

Action: Strategy team would circulate to the Committee the outcomes they engaged on with staff.

The Chair queried the approach to estates and capital and the reference to innovative models given the limitations on capital. The Committee heard that this was a long term objective and future investment would need to be carefully planned. The Chair also queried the status of the CCU and the Trust Secretary suggested the probability of a summer handover with a view toward an autumn opening of the service.

Regarding the strategy straplines, CN advised confirming these were not in used elsewhere and offered to work with the Strategy team to develop a unique strapline.

8.1

Item	Subject	Action

019/16 Trust annual operating plan

The CFO introduced this item adding that there were three components to the plan:

- The trust's forecast outturn
- Commissioning contracts
- 19/20 plan

The Trust had signed off its contract with local commissioner and NHSI. A block contract had been signed with the CCGs and a cost and volume contract had been signed with NHSE. A system improvement plan of £10m had been signed.

The Committee heard that the Trust needed to deliver £50m worth of CIPs but there was little appetite system wide to deliver CIPs through income and so the push was towards driving out cost.

Further comments:

- Further staff engagement and ownership of the plan was needed and this would be taken forward over the next few months.
- A comprehensive capital prioritisation plan was being developed.
- The Interim COO (DH) was working to carry out service level demand and capacity modelling.
- The CFO confirmed that that shorter version of the plan was being developed to support Trust wide engagement.

The BIU team updated that they had worked with divisions to support the quantification of activities. This involved looking at capacity to develop the 19/20 activity forecast.

There was a discussion around capacity within the plan to deliver outcomes. Further to the discussion, the Committee heard that the trajectories while challenging were reasonably realistic.

There was a discussion around the Trust's confidence in achieving the planned £50m CIP as historically there had been slippage in meeting CIP targets. The Committee heard that the Trust had delivered £60m in CIPs for 18/19. The approach of the Turnaround and Transformation teams would be to design new and different ways of working. The Recovery team had so for identified £38m worth of schemes but there was no immediate assurance that this would be deliverable.

Further to a query around capacity planning for the bariatrics service as this could be a potential revenue generator, the Committee heard that bariatrics tariff had in fact decreased. The decreased tariff would mean that partners may not be keen to take on the service.

COMMITTEE BUSINESS

019/17 Terms of Reference

The Committee noted the proposed ToR. It was agreed that item 2.4 "To work with the PPE and stakeholder relations team" should be removed as part of the Committee remit as this was covered by the Membership and Community Engagement Committee.

Item	Subject	Action
019/18	**2019 Workplan** The 2019 workplan was agreed	
019/19	**ANY OTHER BUSINESS** No other business was noted.	
019/20	**DATE OF NEXT MEETING** The next meeting is scheduled for Thursday 18 July 2019, 5.30pm, Dulwich Room, Hambleden Wing.	