King's College Hospital NHS
NHS Foundation Trust

# Quality Account 2009-10


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# King's College Hospital NHS Foundation Trust

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*Presented as part of the*
*"Annual Report and Accounts 2009-10"*
*to Parliament pursuant to*
*the National Health Service (Quality Accounts)*
*Regulations 2010 and Schedule 7, paragraph 25(4)*
*of the National Health Service Act 2006*

**Contents** **Page**

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

| LIST OF ABBREVIATIONS | |
|---|---|
| NHS | National Health Service |
| NIAP | National Infarct Angioplasty Project |
| NIHR | National Institute for Health Research |
| NJR | National Joint Registry |
| NPSA | National Patient Safety Agency |
| nSTEMI | non-ST Segment Myocardial Infarction |
| OSC | Overview and Scrutiny Committee |
| PCI | Percutaneous coronary intervention |
| PCT | Primary Care Trust |
| PICA Net | Paediatric Intensive Care Audit Network |
| PICU | Paediatric Intensive Care Unit |
| POTTS | Physiological Observation Track and Trigger System |
| PROMS | Patient Reported Outcomes |
| PSSQ | Patient Safety & Service Quality Research Centre |
| QA | Quality Account |
| RCP | Royal College of Physicians |
| R&D | Research & Development |
| SitReps | Situation reports |
| SLaM | South London and Maudsley NHS Foundation Trust |
| STEMI | ST Segment Elevation Myocardial Infarction |
| TARN | Trauma and Audit Research Network |
| SUIs | Serious Untoward Incidents |
| SUS | Secondary Users Service |
| VRE | Vancomycin-resistant Enterococcus |
| VSSGBI | Vascular Society of Great Britain and Ireland |
| VTE | Venous-thromboembolism |
| WHO | World Health Organisation |

**Who we are**

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

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

KCH is part of King's Health Partners (KHP) Academic Health Science Centre (AHSC), a pioneering collaboration between King's College London (KCL), Guy's and St Thomas' NHS Foundation Trust (GSTT), KCH and South London and Maudsley NHS Foundation Trust (SLaM).

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

KCH works closely with other healthcare organisations, such as local Primary Care Trusts (PCTs) and neighbouring hospitals, in delivering strong networks of healthcare locally.

For more information, visit www.kingshealthpartners.org

## Part 1. Statement on quality from the Chief Executive

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

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

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

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

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

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

**Timothy Smart**
Chief Executive
King's College Hospital NHS Foundation Trust

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

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

### 2.1 Progress on quality priorities for improvement in 2009/10

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

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

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

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

#### 2.1.2 Quality Priority 2 - enhance mortality performance

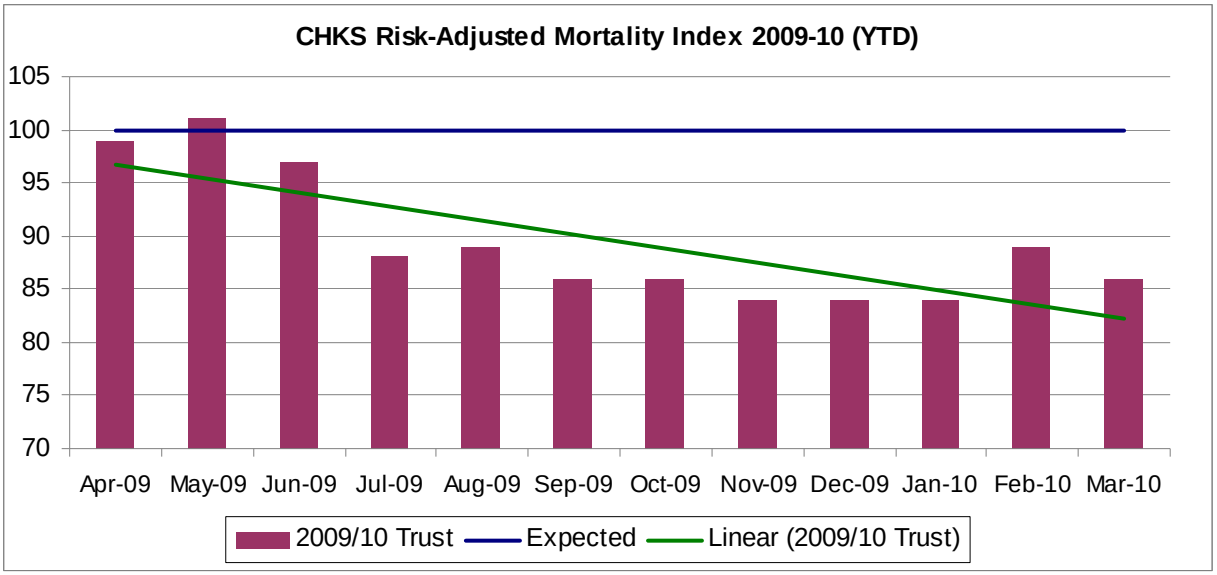
For the first time at KCH, mortality rate is monitored monthly at Trust, Division and specialty level. Governance structures, processes and systems have been strengthened as follows to ensure actions are being taken to continuously improve clinical outcomes in all clinical services at KCH:

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

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

[3]The six Never Events that apply to KCH are: 1). Wrong site surgery; 2) Retained instrument post-operation; 3). Wrong route administration of chemotherapy; 4). Misplaced naso or orogastric tube not detected prior to use; 5). In-hospital maternal death from post-partum haemorrhage after elective caesarean section; 6). Intravenous administration of mis-selected concentrated potassium chloride.
[4] Patient Safety & Service Quality Research Centre (PSSQ) is a partnership between KCH and KCL. It is funded by the National Institute for Health Research (NIHR). It was established to drive improvements in the safety, quality and effectiveness of the services the NHS provides to its patients and the public.
[5] A risk adjusted mortality ratio of 100 means the number of observed deaths equals the number of expected deaths, allowing for variations in cases treated. A ratio of 86 means that there were 14 per cent fewer deaths than were expected.

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




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

2.1.3 Quality Priority 3 - reduce infection

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

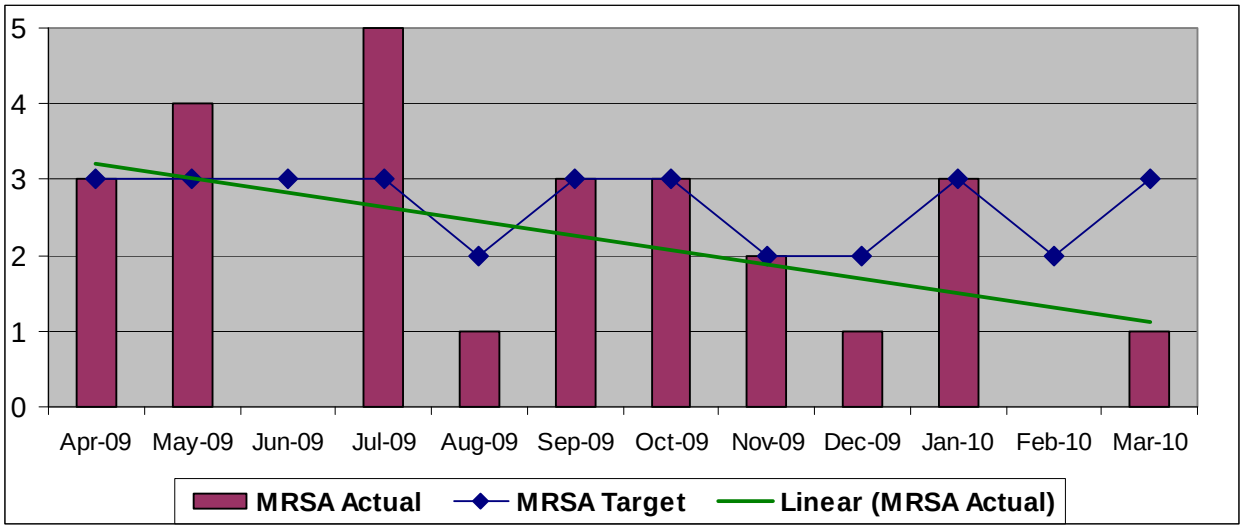
- A major review of infection control governance structures was conducted and new arrangements are now in place;
- MRSA screening for emergency cases started in February 2010;
- C. diff ward rounds were commenced to ensure actions from root cause analysis are followed up;
- An intravenous line team was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

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

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

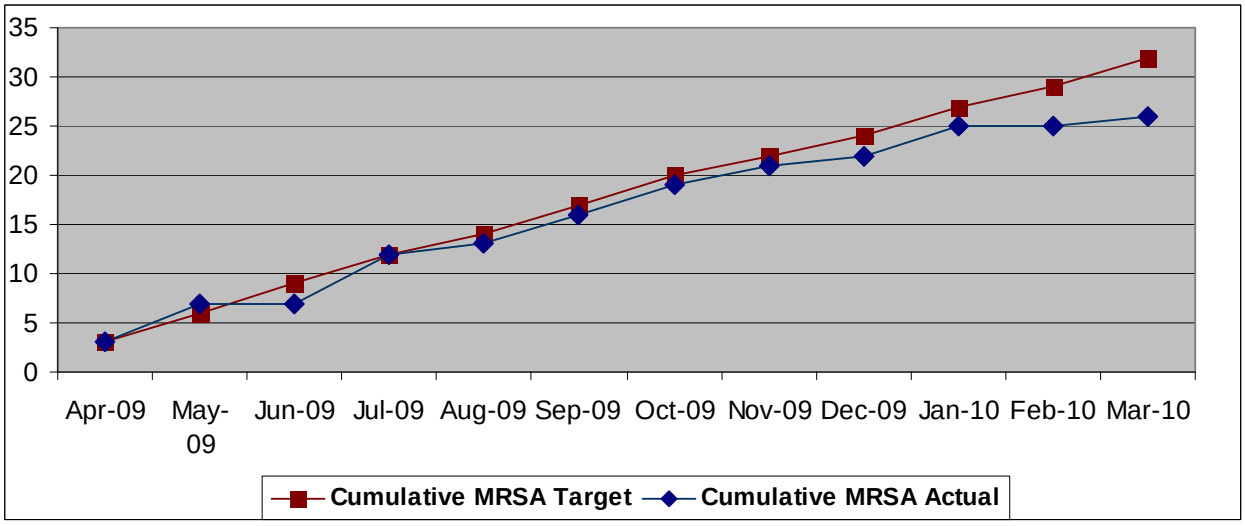
Table 2-1: MRSA and C. diff figures at KCH in 2009/10 and 2008/09

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




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

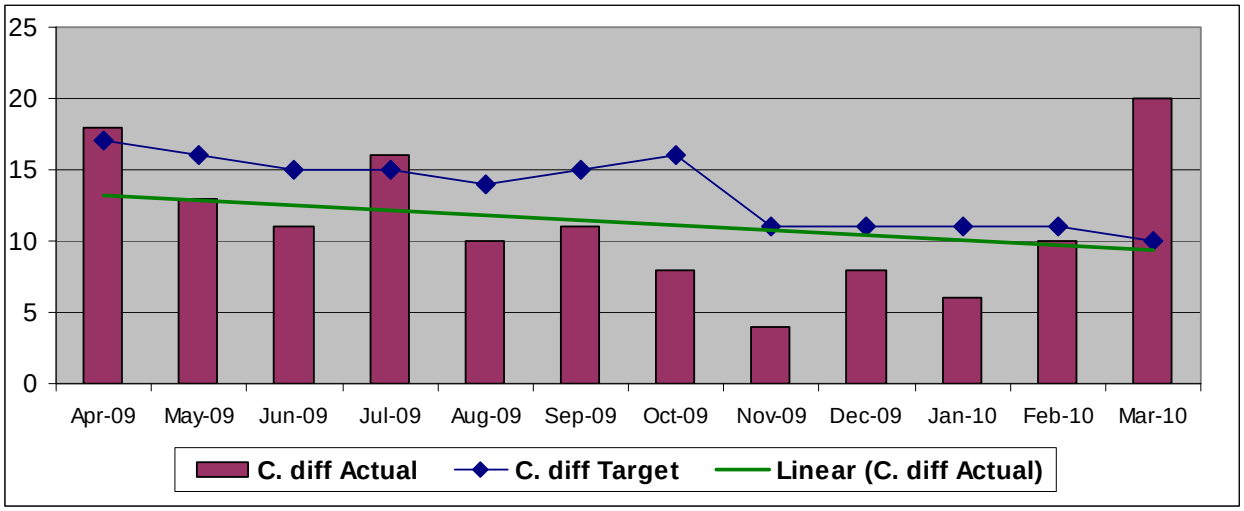
Please refer to Graph 2-3 below for details of KCH's cumulative MRSA trend in 2009/10:




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

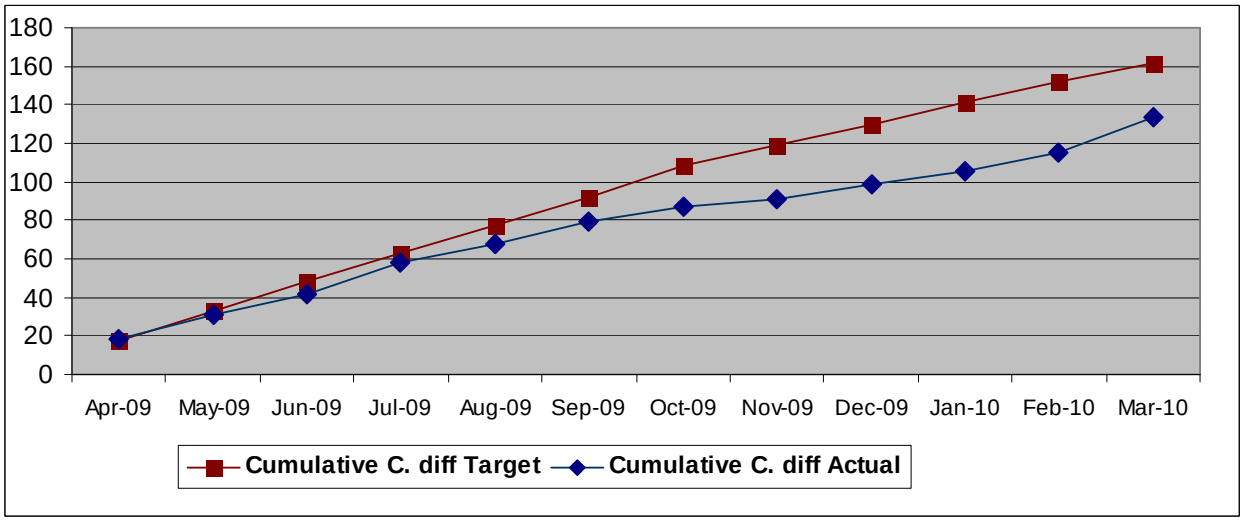
[6]The target of 32 MRSA cases is a stretch target agreed between KCH and the commissioners in 2009/10. The national target is 43 for KCH in 2009/10.
[7]The target of 162 C. diff cases is an internal stretch target at KCH. The national target for KCH is 202 in 2009/10 and 162 in 2010/11.

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




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

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




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

2.1.4 Quality Priority 4 - improve patient experience

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

- Dignity Month was launched in January 2010 to raise awareness and improve dignity of care. The joint winners at the Trust dignity event were:
  - the Health and Ageing Unit on using patient stories to learn more about patient experience and promote person-centred care.
  - Specialist Medicine on having an adolescent room with entertainment system for teenage cancer patients, having lightboxes to provide a more natural light and a two way bedside intercom system to improve communication between staff and patients who are immuno-compromised and therefore barrier nursed

- Board 'Go & See' programme was re-launched in February 2010 to include questions on patient experience and staff experience.
- Governors are involved in some of the 'Quality Ward Rounds' which promote a quality improvement culture at KCH.
- King's Values were launched in November 2009 and plans are being implemented to further embed King's Values. It is important to engage and motivate staff in order to ensure continuous quality improvement. In line with national staff survey results, KCH has developed comprehensive action plans to improve staff satisfaction in a number of areas.
- Admission and discharge processes are being reviewed in all Divisions to develop seamless pathways for all patients.
- The opening of the Medical Assessment Unit (MAU) has improved the pathway for medical emergency patients and enhanced patient experience.
- Patient feedback in outpatient services was successfully piloted in Suite 3 General Medicine. The roll out to all outpatient areas and the Emergency Department began in February 2010.
- The number of formal complaints dropped by 23% in 2009/10 compared to the previous year.
- As part of the "Contacting King's" project, standardised outpatient appointment letters were piloted and are now being rolled out trust-wide. An indicator on unanswered calls was introduced on the monthly Divisional performance scorecard to improve communication with patients and relatives. This has led to some improvement although there is further to go.

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

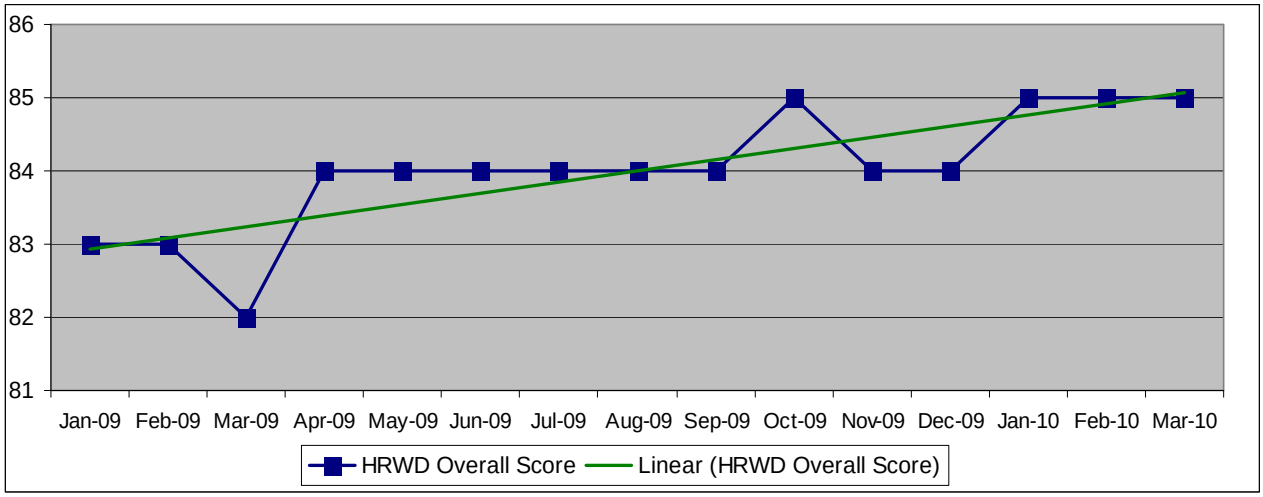
[8]The benchmark scores of the 2009 National Outpatient Survey are calculated by converting responses to particular questions into scores. For each question in the survey, the individual responses were scored on a scale of 0 to 100. A score of 100 represents the best possible response. Therefore, the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

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

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

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

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




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

## 2.2 Priorities for improvement

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

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

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

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

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

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

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

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

## 2.3 Statements of assurance from the Board of Directors

### 2.3.1 Information on the review of services

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

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

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

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

### 2.3.2 Information on participation in clinical audits and national confidential enquiries

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

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

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

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

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

### 2.3.3 Information on participation in clinical research

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

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

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

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

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

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

### 2.3.4 Information on the use of the CQUIN framework

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

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

Table 2-5: KCH CQUIN scheme 2009/10

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

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

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

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

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

## 2.4 Information on the quality of data

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

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

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

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

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

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

## Part 3. Other information

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

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

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

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

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

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

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

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

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

### 3.2 Performance against key national priorities and National Core Standards

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

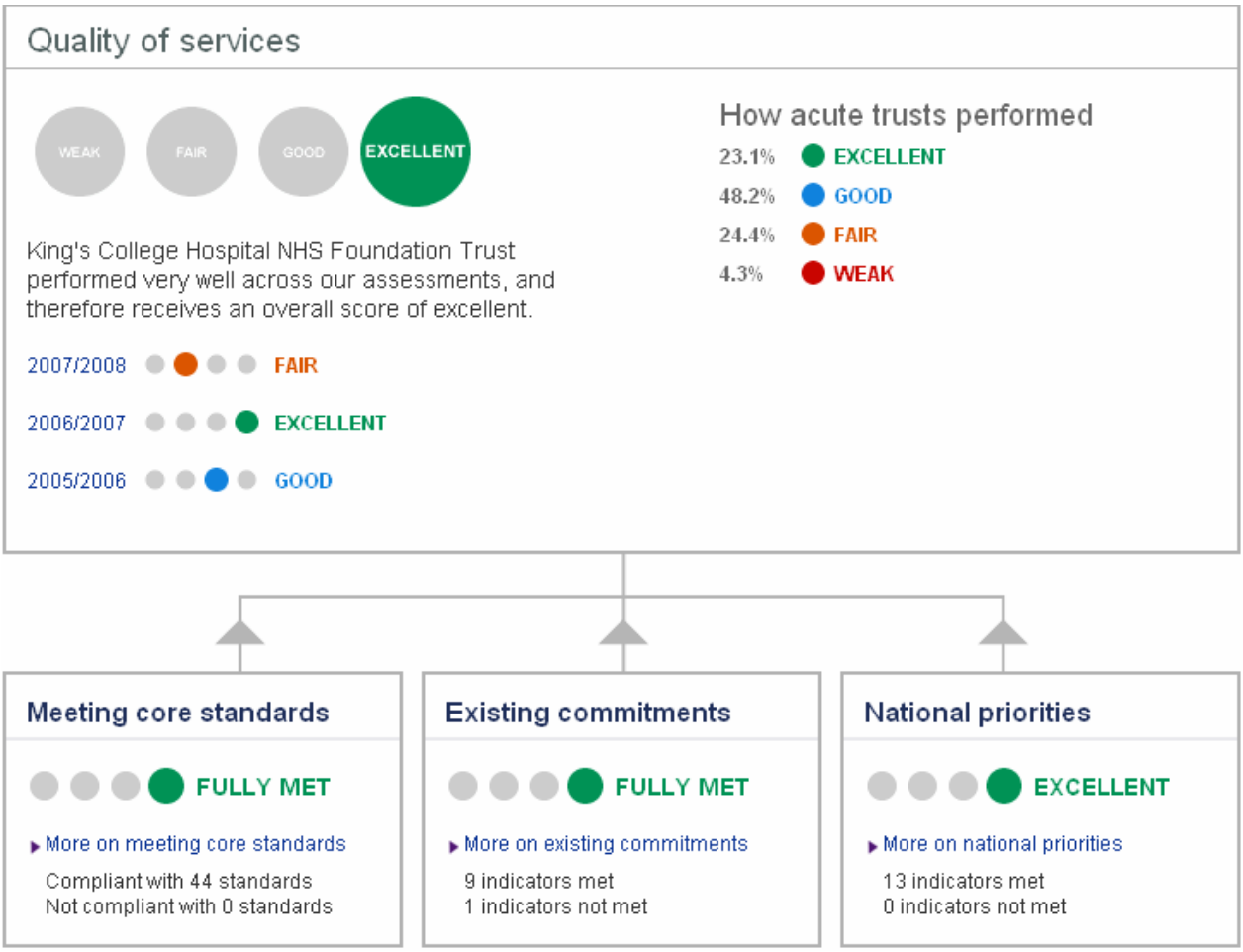



Table 3-2: KCH Annual Check results on Quality of Services

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

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

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

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

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

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

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

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

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

Table 3-5: KCH performance against all national priorities

Table 3-5 continued

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

Table 3-5 continued

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

## Part 4: Annex - Statements from PCTs, LINks, OSCs and KCH

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

### Annex 1: Statement from NHS Southwark[19]

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

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

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

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

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

- There have been no 'Never Events' (serious largely preventable patient safety incidents that should not occur of preventable measures by healthcare providers. KCH has taken action to prevent Never Events from happening;
- Enhanced mortality performance through monthly monitoring via the monthly Mortality Monitoring Committee and strengthened governance structures, processes and systems, Physiological Observation Track and Trigger system (POTTs) and strengthened coding system resulting in a 19% improvement in 2009/10 compared to 2008/09;

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

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

**Annex 2: Statement from NHS Lambeth**[20]

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

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

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

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

**Annex 3: Statement from Southwark LINk**[21]

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

**Annex 4: Statement from Lambeth LINk**[22]

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

This report is of a high standard, like its subject matter, but it is a pity that we were only given 13 days (9 working days) to consider it and respond by 17 May as KCH requested. In spite of several requests by us to KCH, after Quality Reports had been

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

received from other Trusts in Lambeth, we only received KCH's draft on 4th May. We hope that this response time is increased next year, which will enable us to comment upon the report more fully.[24]

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

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

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

We hope that in future years some clarification will be given to every sentence included in the appendices to the report, e.g. "KCH's average waiting time for MRI is under 4 weeks for weekends (national average = 32%) and weekends (national average = 20%)" (page 24 of the draft Quality Report) does not convey a clear meaning. "Patients receiving primary angioplasty at KCH was "(sic)"_98%" (national average = 49%) of what? is neither grammatical nor mathematically clear.[27]

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

## Annex 5: Statement from Southwark OSC[28]

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

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

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

time in which the sub-committee could review the QA, agree and prepare a response.

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

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

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

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

**Annex 6: Statement from Lambeth OSC**[29]

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

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

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

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

- Added the audit results for WHO Surgical Safety Checklist on page 8.
- Included names of London Trusts on the 2009 Outpatient Survey results. Please see Table 2-2 on page 13.
- Added explanation for the 2009 National Outpatient Survey scores. Please refer to footnote 8 on page 12.
- Added a summary of KCH's 2009 National Inpatient Survey results on the last paragraph of page 13.

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

- Added a summary of KCH's quality priorities in 2010/11 in Section 2.2 on page 14.
- Updated the objectives for quality priorities 2010/11 in line with KCH's Annual Plan. Please see Table 2-3 on page 15.
- Added the arrangements in place with LSL on quality monitoring in 2010/11 on the second paragraph of page 16.
- Added the exact wording instead of a summary of Mr Michael English's statement on behalf of Lambeth LINk on page 29-30.
- Grouped national audits under key headings and added additional national audits in Appendix 1.

## Appendices to the Quality Report

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

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

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

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

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

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

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

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

| National Audit | Headline results and actions taken |
|---|---|
| National Bowel Cancer Project | In the National Bowel Cancer Audit Report 2009, KCH's scored 100%, or near 100%, against national standards in several areas:<br>• Patients seen by specialist nurse: KCH: 97.6% (national average: 51%)<br>• Patients requiring surgical treatment had a CT scan: KCH: 100% (national average: 62%)<br>• Patients requiring surgical treatment had an MRI scan: KCH: 100% (national average: 52.3%)<br>• Patients had pre-operative radiotherapy: KCH: 100% (national average: 32%)<br>There are some key areas in the national audit report that do not reflect KCH's actual practice and the bowel cancer team have worked hard over the past year to improve the data returns to the national audit. |
| Adult cardiac surgery: CABG and valvular surgery | Results for 2004-08 were of activity and did not include recommendations or quality of care information for local implementation or action. |
| Myocardial Ischaemia National Audit Project (MINAP) | MINAP results 2008/9 show that:<br>• 98% of patients suffering from Myocardial Ischaemia at KCH received primary angioplasty (nationally 47%)<br>• 82% of non-ST Segment Myocardial Infarction (nSTEMI) patients were seen by a cardiologist at KCH (nationally: 80%)<br>• Patients discharged on the appropriate secondary prevention drugs:<br>- Aspirin: KCH's score was 100% (national average: 99%)<br>- Beta blockers: KCH's score was 97% (national average: 93%)<br>- Statins: KCH's score was 100% (national average: 97%)<br>- ACE inhibitor: KCH's score was 80% (national average: 92%)<br>- Clopidogrel: KCH's score was 99% (national average: 94%)<br>KCH is working to improve the number of patients discharged on an ACE inhibitor. |
| NHFD: hip fracture | A number of measures have been instituted as a result of the 08/09 report including:<br>• extra trauma lists to reduce waiting times to surgery<br>• reduced waits in A&E<br>• improved ward rounds with Care of the Elderly.<br>These have resulted in improved mortality rates this year. KCH has internally audited several of the 6 main guideline outcome measures at least twice this year, with improved results on last year. |
| TARN: severe trauma | TARN data 2006-09 demonstrates that KCH achieved:<br>• 2.8 additional survivors out of every 100 patients, i.e. for every 100 patients, nearly 3 patients survived who, due to their injuries, were not expected to survive<br>• This amounts to a total of 33 people, who were not expected to survive, survived at KCH<br>• The median time for head injury patients to have a CT scan at KCH was 1.27 hours (national average: 1.32 hours). |
| National Kidney Care Audit (2 days): Patient Transport | The results for KCH reported in 2010 (survey undertaken in 2008) show that waiting times for renal patients for hospital transport are very similar to the national average:<br>• % patients who are picked up from home within 30 minutes: KCH scored 72% (national average: 74%)<br>• % patients who wait 30 minutes or less after completing dialysis before commencing journey home: KCH scored 63% (national average: 62%). |

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

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

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

| Clinical Audit | Actions to improve quality of care |
|---|---|
| Consent | New post-mortem consent form and pilot of paperless post-mortem consent on Electronic Patient Record (EPR). New 'paperless' consent form being prepared for pilot on EPR. To undertake a trust-wide audit of consent and implement improvements as appropriate. |
| JACIE Accreditation for Bone Marrow Transplant service | Ongoing audits to be done in accordance with JACIE accreditation requirements (79 audits on total). |
| Directors' Go See/patient safety' inspections | Local action plans created and being followed up. |
| Colposcopy peer review | Action plans to address Did Not Attend (DNA) rate and waiting times in place. Working collaboratively with colleagues at Guy's & St Thomas's on joint peer review process. |
| Telemetry audit | Telemetry audit highlighted a number of concerns, action plans being developed to bring about improvements. |
| Blood transfusion | Work on-going to reduce wastage. |

## Appendix 4: Draft KCH CQUIN Scheme 2010/11

National CQUIN

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

Regional CQUIN

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

**Appendix 4 continued**

Local CQUIN

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

Specialist Commissioning Services – CQUIN

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

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



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

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

#### Geraldine Walters, Director of Nursing

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

#### Rachael Wood, Matron in Gynaecology

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

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

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

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

**Tim Smart, Chief Executive of King's College Hospital**

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

**Roland Sinker, Director of Operations**

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

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