King's College Hospital NHS Foundation Trust
Quality Report & Accounts 2017/18

Presented to Parliament pursuant to Schedule 7, paragraph 25(4) (a) of the National Health service Act 2006

King's College Hospital NHS
NHS Foundation Trust

Quality Report & Accounts 2017/18

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

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What is a Quality Account?

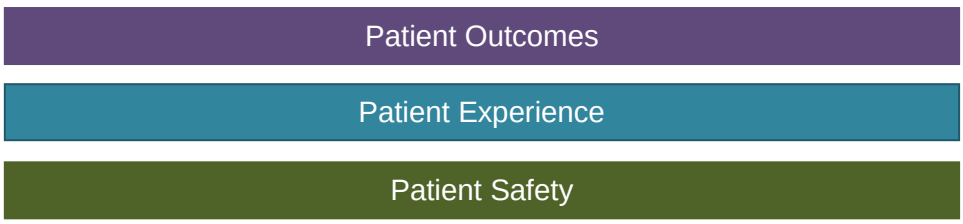
All NHS hospitals or trusts have to publish their annual financial accounts. Since 2009, as part of the drive across the NHS to be open and honest about the quality of services provided to the public, all NHS hospitals have had to publish a quality account.
You can also find information on the quality of services across NHS organisations by viewing the quality accounts on the NHS Choices website at www.nhs.uk.

The purpose of this quality account is to:

1. Summarise our performance and improvements against the quality priorities and objectives we set ourselves for 2017/18; and

2. Set out our quality priorities and objectives for 2018/19

To begin with, we will give details of how we performed in 2017/18 against the quality priorities and objectives we set ourselves under the categories of:



Where we have not met the priorities and objectives we set ourselves, we will explain why, and set out the plans we have to make sure improvements are made in the future.

Secondly, we will set out our quality priorities and objectives for 2018/19, under these same categories, we will explain how we decided upon these priorities and objectives, and how we will aim to achieve these and measure performance.

Quality accounts are useful for our board, who are responsible for the quality of our services, as they can use them in their role of assessing and leading the trust. We encourage frontline staff to use quality accounts both to compare their performance with other trusts and also to help improve their own service. For patients, carers and the public, this quality account should be easy to read and understand. It should highlight important areas of safety and effective care being provided in a caring and compassionate way, and also show how we are concentrating on improvements we can make to patient care and experience.

It is important to remember that some aspects of this quality account are compulsory. They are about significant areas, and are usually presented as numbers in a table. If there are any areas of the quality account that are difficult to read or understand, or you have any questions, please contact us through the Patient Advice and Liaison Service (PALS) by phoning the Denmark Hill team on 020 3299 3601, or the Princess Royal University Hospital and South sites team on 01689 863252 between 9am to 4.30pm, Monday to Friday (not bank holidays). Alternatively, please visit our website at https://www.kch.nhs.uk/ for further information

This quality account is divided into three sections:

Part 1	A statement on quality from the Interim Chief Executive Officer (CEO)
Part 2	
	Reviewing progress of the quality improvements in 2017/18 and choosing the new priorities for 2018/19
	Statements of assurance from the Board
	Reporting against core indicators
Part 3	Other information

Part One

Statement on quality from the chief executive of the NHS foundation trust

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS Foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Statement of Quality

King's continues to place quality, safety and the experience of patients, families and its staff at the forefront of everything that we do. This year we have seen many challenges, however, as in previous years we have also seen wonderful clinical outcomes and ground breaking research across many of our clinical areas.

Over this year we have strengthened our clinical governance processes for example launching a Trust wide SafetyNet innovation that shares the learning from clinical incidents in real time to all front line staff. We have also strengthened our inclusive approach to divisional and care group performance monitoring with monthly face to face monitoring between Executive Directors, Directors of Operations and the triumvirate leads for every care group that is: Clinical Directors, Heads of Nursing and General Managers. This approach ensures regular effective monitoring and communication between the 23 care groups and the King's Executive team.

Duty of Candour is a key objective for the Trust as it demonstrates the Trusts positive and transparent culture in response to adverse incidents. The Trust changed its reporting mechanism in April 2017 making it more robust. The Trusts Duty of Candour Guardian and Head of Patient Safety have established weekly monitoring meetings to review adverse incident and compliance with the undertaking of Duty of Candour conversations, rather than the previous reliance on quarterly spot check audits to highlight areas of non-compliance.

In September 2017 we had our unannounced CQC inspection and although the Trust remains at 'Requires Improvement' there were many areas of improvement with more services now receiving a 'Good' rating. The CQC commented on the following outstanding services:

- The iMobile outreach service was innovative and proactive. There was evidence it was producing positive outcomes for patients and the service
- A robust and well-tested major incident plan was in place
- The 'SafetyNet' communication was recognised as being a rapid means of providing staff with essential information arising from adverse events
- The Trust had set up a 'Tea Club' for patients living with dementia needs

The key areas for improvement were as follows:

- Improved staffing across particular services of the Trust
- Improved compliance with mandatory training and staff appraisals
- New Rapid Tranquilisation policy
- Discharge out of hours
- Outpatient management of medical records and prescriptions

A comprehensive CQC action plan has been developed shared with commissioners and the CQC. The actions are monitored at care group level and at the Trust monthly performance meetings and at Trust level at the two weekly Performance and Delivery Board.

Ratings for King's College Hospital

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

Ratings for Princess Royal University Hospital

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

The CQC are anticipated to re-inspect the Trust in 2018/19. A detailed action plan has been developed in response to the recommendations made following their most recent visit and this has been shared with Divisional and Care Group triumvirates for wider dissemination, to ensure clear visibility of areas requiring improvement and a focussed approach on achieving the progress required in order for the Trust to attain an overall rating of 'Good' at our next inspection. Progress against the action plan is being monitored regularly through the Trust Planning and Delivery Board.

Our staff are our most important asset and we have invested time and focus on actively engaging staff, to find out, not only what they think about working at King's, but their opinion on the changes that need to be made to ensure King's remains a wonderful place to work.
We know from our staff survey results that the percentage of King's staff experiencing harassment, bullying or abuse from staff in the last 12 months is 32% and the percentage believing that Trust provides equal opportunities for career progression or promotion for the Workforce Race Equality Standard is currently 73%.

During this year we launched our Inclusivity strategy and our BAME Network with over 180 staff attending events at the Denmark Hill and PRUH sites, we also had a very exciting finale to Black History month.
One of King's Non-Executive Directors Professor Ghulam Mufti was also appointed as Chair of the BAME steering group and is working with our Workforce Programme and Performance Manager, and colleagues across King's to ensure we make inclusivity a reality. We do not underestimate the ongoing pressure on our staff and aiming for high staff engagement, career development and compassionate leadership as everyday business is an integral part of our Workforce strategy. To this end the Workforce Development team have worked with teams throughout the organisation to launch a new appraisal strategy that is effective and

user friendly. Over 10,000 King's staff have now registered on our exciting new Learning and Development Platform (LEAP).

7-Day Service Provision

The Trust continues to make progress against the four priority clinical standards for the delivery of seven-day services.

For Standard 2 - 'Time to Consultant review', the last audit in September 2017 showed continued increase in the proportion of patents reviewed within 14 hours of admission, with a rise from 66% in September 2016 to 77% in September 2017. The Trust is currently re-auditing and is on track to achieve its target of 90% review in Q4 17/18.

Standard 5 - 'Access to diagnostics' for key diagnostic modalities within 1 hour for critical patients, 12 hours for urgent patients and 24 hours for non-urgent patients has been achieved.

Standard 6 - 'Access to Consultant-directed interventions' for timely 24 hour access seven days a week to key consultant-directed interventions has been achieved.

Standard 8 - 'On-going review' specifies that all patients with high dependency needs should be seen and reviewed by a consultant twice daily, seven days a week. Once a clear pathway of care has been established, consultant review is at least once daily unless it has been determined that this would not affect the patient's care pathway. The last audit performed in March 17 showed improvement for twice daily consultant reviews from 67% to 88% and condition-appropriate once daily reviews at 85%. Compliance has been achieved in key target specialties including Adult and Children's Critical Care, emergency vascular services and the major trauma pathway. In the Hyper Acute Stroke Unit (HASU) areas compliance is being achieved with institution of an acute neurology stroke rota at DH and PRUH, compliance is also achieved for patients within the heart attack cohort. Acute medicine patients are reviewed and assessed by consultant teams who are rostered to be in clinical areas for 12 hours per day. Roster design is being developed to provide improved cover and documentation delineating need for on-going consultant review.

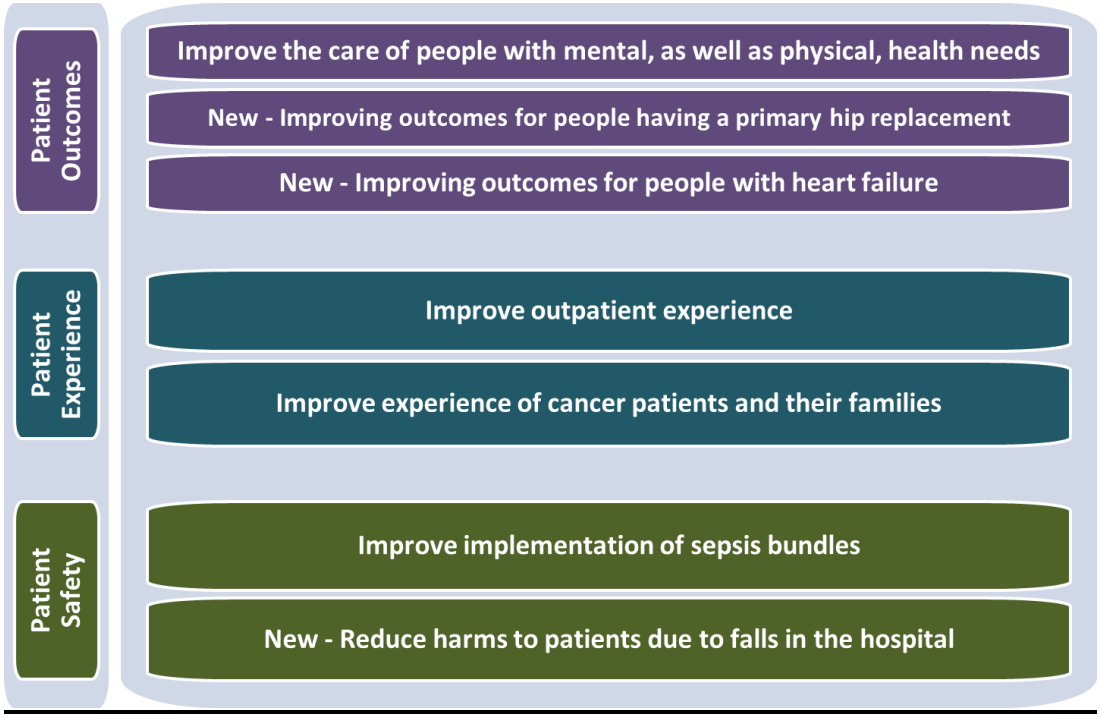
Quality Priorities

Our stakeholder engagement around the setting of quality priorities this year has been carried out across two patient catchment areas; we have had discussions with key stakeholders representing Bromley in addition to Lambeth and Southwark, and enjoyed lively public sessions with the public, patients, carers and staff from King's and KHP in selecting and refining our quality priorities for 2018/19.

In 2017/18 we chose seven very challenging quality priorities. As you will see from our Quality Account much progress has been achieved in patient outcomes and patient experience although there is still more work to do and we are committed to improve both the public health in our boroughs and care within our hospitals. This year sees an essential

focus on the person's mind and body and we are concentrating on improving the care of people with mental as well as physical health needs in a three year strategy in partnership with our colleagues at South London and Maudsley Trust and with King's Health Partners). This work has also extended to the mind and body needs of our staff with an exciting event attended by over 300 Mind and Body champions from across KHP.

Our quality and priorities for 2018/19, as devised and agreed with local stakeholder groups, staff, patients, carers are the following:



Data Quality

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

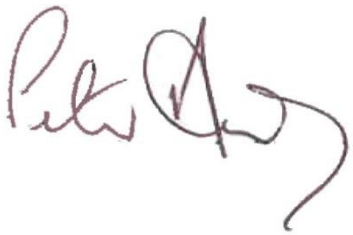
- Data are derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audit's programme of work each year.

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

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

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

The Trust and its Board have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above.
The Trust acknowledges weaknesses in the quality of internal data produced with respect to 18 Week Referral to Treatment and 4 Hour Accident and Emergency Waiting Times. This is consistent with the External Auditor's conclusion in their Qualified Opinion. The Trust is currently working on an action plan to identify areas of improvement.
Having had due regard for the contents of this statement and to the limitations as described above especially the areas of RTT and the A&E 4 hour standard to the best of my knowledge, the information contained in the following Quality Account is accurate.

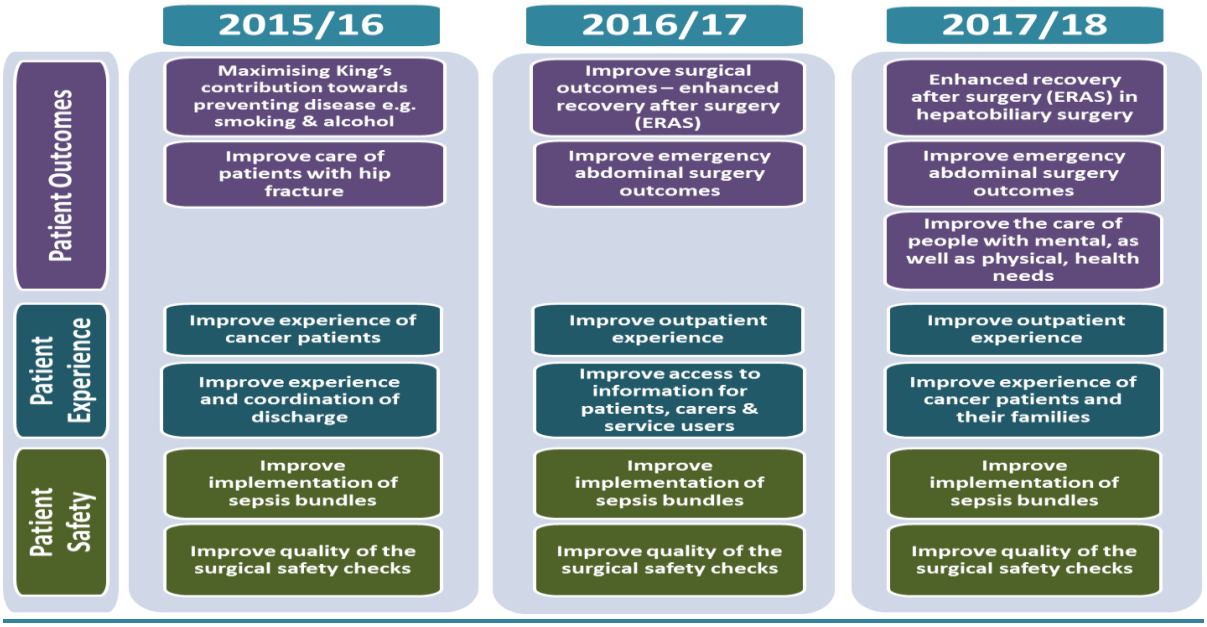
Signed: 

Peter Herring, Interim Chief Executive

Date: 14th June 2018

Part Two

Our Quality Priorities over time



Results and achievements for the 2017/18 Quality Account priorities

Summary of results and achievements for the 2017/18 Quality Account priorities		
Patient Outcomes		**Achieved/Not achieved**
Priority 1	Enhanced recovery after surgery (ERAS) in hepatobiliary surgery	**Partially achieved -** On-going work transferring to a Transformation work stream
Priority 2	Improve emergency abdominal surgery outcomes	**Partially achieved –** On-going work transferring to standard quality improvement work
Priority 3	Improving the care of people with mental, as well as physical, health needs	**Partially achieved –** Continuing 3 year priority
Patient Experience		
Priority 4	Improve outpatient experience	**Partially achieved –** Ongoing priority for 2018/19
Priority 5	Improving the experience of patients with cancer and their families	**Partially achieved –** Ongoing priority for 2018/19
Patient Safety		
Priority 6	Improve implementation of sepsis bundles	**Partially achieved –** Ongoing priority for 2018/19
Priority 7	Improve quality of the surgical safety checks	**Achieved**

Results and achievements for the 2017/18 Quality Account priorities

Improvement priority 1

Enhanced recovery after surgery (ERAS) in surgery of the liver, gallbladder, bile duct and pancreas ('hepatobiliary' (HpB) surgery).

Why was this a priority?

Enhanced recovery after surgery (ERAS) is a programme that aims to improve recovery after major planned surgery. Hepatobiliary (HpB) surgery is a specialist area for King's and we provide services for patients throughout London and the South East and beyond. Ensuring the best possible outcomes for patients undergoing HpB surgery is an ongoing King's priority.

What was our aim?

Our aim was to improve patient outcomes following HpB surgery by ensuring that care is based on the steps proven, through research, to have the greatest impact on patient outcomes.

In order to achieve this we said we would:

- Work to implement all the steps proven to benefit patient care, including:
    - Ensuring patients are as healthy as possible before their surgery.
    - Receive the best possible care during their operation.
    - Receive the best possible care while recovering.
- Enter all HpB surgery cases into the national Perioperative Quality Improvement Programme (PQIP) being run by the Royal College of Anaesthetists. This will enable us to measure our patient outcomes and compare them to other hospitals around the country.

Baseline

The baseline was considered in relation to the following categories:

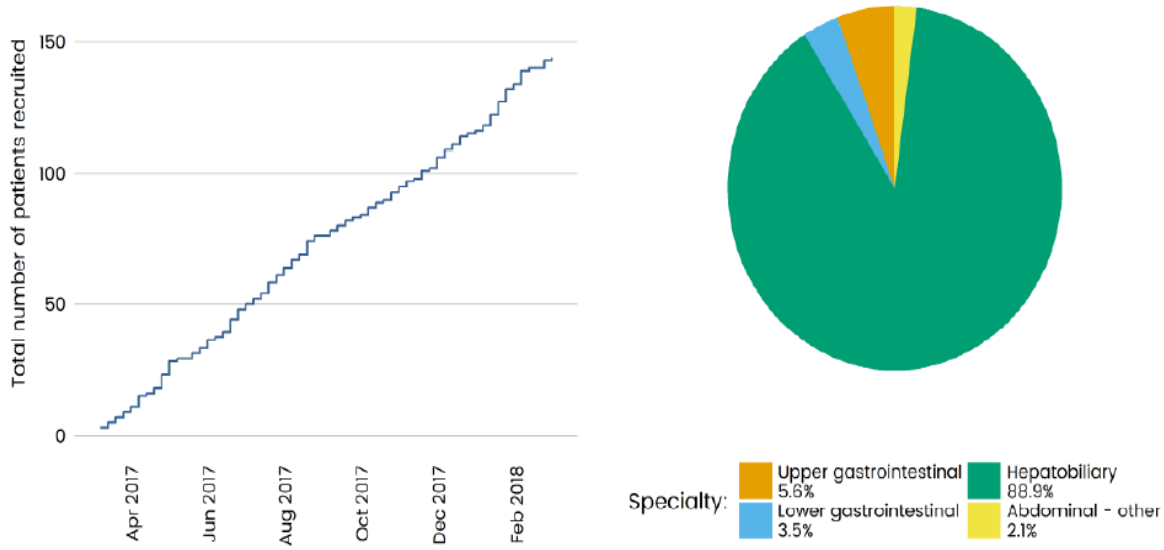
- The number of patients admitted on the day of surgery for HpB surgery in 16/17
- The length of stay in hospital for patients undergoing HpB surgery in 16/17
- The number of emergency admissions following HpB surgery in 16/17

Did we achieve this priority?

This priority was partial achieved.

We did begin our entry of HpB cases into PQIP and currently recruit 3 HpB patients per week to PQIP. Over time, this will provide us with excellent data on our patient outcomes and enable us to compare with other English hospitals.

Recruitment of patients to PQIP over time and by specialty



It became clear in-year that the ERAS programme required a more in-depth piece of organisational change than was initially anticipated. In January 2018 this work was taken on by the Trust's King's Way Transformation Team, ensuring that the required programme and operational management expertise is available to ensure significant change, including the re-development of a business case. This work is in progress and is expected to take a further 12 to 24 months.

How was progress reported?

Progress was reported through the Trust's well established quality governance framework which is described in detail within the Annual Governance Statement.

The Executive Lead for ERAS is Professor Jules Wendon, Medical Director.

Improvement priority 2

Improved outcomes following emergency abdominal surgery.

Why was this a priority?

Most people undergoing emergency abdominal surgery have life-threatening conditions and this surgery is associated with high rates of complications and deaths. Patients undergoing emergency abdominal surgery have many different diagnoses and conditions, and are therefore located within different specialties and wards across the two King's hospitals. This adds to the challenge of coordinating their care.

What was our aim?

Our aim was to continue to improve emergency abdominal surgery at Denmark Hill and PRUH.

In order to achieve this priority we said we would:

- Ensure a well-coordinated, standardised care pathway for these patients in both of our hospitals in order to achieve the best possible patient outcomes following this high risk surgery.
- Take action as required to ensure improvements against the criteria identified by the National Emergency Laparotomy (abdominal surgery) Audit project.

Did we achieve this priority?

Tables 1 and 2 below provide data from the National Emergency Laparotomy Audit to illustrate the progress that King's has made over on both sites, and provides a comparison with national average and the national target.

Denmark Hill (DH)

Improvement criteria	**2015 Report (based on data collected 2013/14)**	**2016 Report (based on data collected 2014/15)**	**2017 Report (based on data collected 2015/16)**	**National average / National target**
Consultant surgeon review within 12 hours of admission	42%	56%	* Criterion no longer included	54% / 100% (2014-15)
CT scan before surgery	4%	85%	78%	79% / 80%
Documentation of risk preoperatively	16%	42%	96%	71% / 80%
Preoperative review by consultant surgeon and consultant anaesthetists	34%	48%	73%	58% / 80%
Consultant surgeon and consultant anaesthetist present in theatre	28%	66%	62%	79% / 80%
Postoperative assessment by care of the elderly specialist in patients aged over 70	0%	50%	88%	19% / 80%
Reduced length of stay (days)	* Criterion not included	14 days	12 days	11 days (national median)

Assume: Green = above target

Amber = below target; above national average

Red = below target; below national average

Princess Royal University Hospital (PRUH)

Improvement criteria	2015 Report (based on data collected 2013/14)	2016 Report (based on data collected 2014/15)	2017 Report (based on data collected 2015/16)	National average / National target
Consultant surgeon review within 12 hours of admission	56%	57%	* Criterion no longer included	54% / 100% (2014-15)
CT scan before surgery	49%	63%	88%	79% / 80%
Documentation of risk preoperatively	29%	65%	73%	71% / 80%
Preoperative review by consultant surgeon and consultant anaesthetists	57%	79%	58%	58% / 80%
Consultant surgeon and consultant anaesthetist present in theatre	56%	83%	91%	79% / 80%
Postoperative assessment by care of the elderly specialist in patients aged over 70	0%	0%	20%	19% / 80%
Reduced length of stay (days)	* Criterion not included	13 days	10 days	11 days (national median)

Overall, results have improved across the majority of criteria on both hospital sites.

How have we improved performance?

The Trust has introduced a number of measures to support the delivery of this priority.

On the Denmark Hill site a new ten bed Surgical Assessment Unit has supported emergency laparotomy work making the process of assessing and preparing patients for surgery more efficient.

In April 2017 King's received feedback from the National Emergency Laparotomy Audit team that both PRUH and DH have been identified as being amongst the top 5 most improved hospitals in the country.

Improvement work will continue in 2018 and beyond, focusing on increasing emergency operating theatre access, surgical capacity and ward space to improve the cohorting of patients following laparotomy surgery. The PRUH site is focused on ensuring all high risk patients are admitted to intensive care following laparotomy and ensuring elderly care review. At DH we are working to improve consultant anaesthetist cover and we have instituted a weekend day time consultant (8am-8pm).

How was progress reported?

Progress was reported through the Trust's well established quality governance framework which is described in detail within the Annual Governance Statement.

The Executive Lead for improved outcomes after abdominal surgery is Professor Jules Wendon, Medical Director.

Improvement priority 3

Improving the care of people with mental, as well as physical, health needs at King's.

Why was this a priority?

We know from national studies, including the recently published report 'Treat as One' 25 (NCEPOD, 2017) that there are many obstacles to providing good mental health care in acute general hospitals such as King's Denmark Hill and PRUH. There is good research evidence that integrating the care of both mind and body leads to better patient outcomes and is cost-effective. Our aim, therefore, was to launch an ambitious 3-year programme to improve mental health care at King's.

What was our aim?

Our aim is to strive to develop truly integrated 'mind and body' services for patients in South East London (including Bromley) by:

- Identifying the mental health care needs of King's patients and tracking both mental and physical health outcomes
- Supporting our staff in providing care for mental and physical ill-health, through training and on-going supervision
- Improving joint-working with mental health services in the community and primary care to facilitate timely discharge
- Developing information technology to support us in understanding the close relationship between mental and physical health and using this information to shape clinical care
- Providing self-health resources for our patients.

This is an extremely ambitious project, but one that is supported from ward to Board and by our local commissioners. It is integrated with a wider Mind and Body Programme being undertaken across King's Health Partners (King's, Guy's & St Thomas', South London & Maudsley NHS Trusts and King's College London).

Baseline

Very little information has traditionally been collected in general hospitals about the mental health of our patients. Improving data is an integral component of the improvement work.

Did we achieve this priority?

This priority was partial achieved.

The complexity of this project means that it will be a Trust Quality Priority for at least three years.

How have we improved performance?

Huge progress has been made in the first year, including the following:

- A new Mental Health Board has been established to ensure work streams are coordinated under Executive leadership.
- 'Task and Finish Groups' of the Mental Health Board have been established, for a) emergency department, b) delirium and dementia and c) challenging behaviour.
- IMPARTS, a system for identifying and managing mental health needs in acute hospital in-patients, is now live in 28 King's clinics, and the total number of individual screenings added is now in excess of 20,000
- The launch of a new Mind and Body video animation, which has had thousands of views and has been promoted and endorsed by the Mental Health Foundation and Centre for Mental Health.
- Mind and Body content and e-learning has been embedded within trust corporate and medical inductions, reaching hundreds of new starters each month.
- Early discussion with national partners including NHS Improvement on setting up a small mental health clinical decision unit on the Denmark Hill site (detail still to be finalised).
- Joint work with the local care networks across Lambeth and Southwark to trial a new care-coordination approach for patients with more than three long-term conditions (including physical and mental health), including development of self-management tools.
- New in-reach psychological clinics (provided by Improving Access to Psychological Therapies (IAPT)) for King's services including gastroenterology, breast care and the mental health liaison team.

- Funded places for senior nurse on a specialist 5-day course (provided by IMPARTS) developing mental health skills for non-mental health professionals.

- A commitment of £500,000 by King's Health Partners to the Mind and Body Programme, bringing the total investment to almost £2 million.

How was progress reported?

Progress was reported through the Trust's well established quality governance framework which is described in detail within the Annual Governance Statement.

The Executive Lead for improving the care of people with mental health needs at King's is Dr Shelley Dolan, Chief Nurse and Chief Operating Officer.

Improvement priority 4

Improving outpatient experience.

Why was this a priority?

Patient experience of King's outpatient service continued to be less positive than it should be. This is evidenced by continued poor performance compared to our peers in the Friends and Family Test and local surveys, increased complaints and PALS contacts and significant anecdotal feedback from our patients.

Although previous improvement work has had a positive impact in some clinical areas, this has not spread Trust-wide, nor resulted in sustained improvement.

Over time we have gained an excellent insight into what makes a good outpatient experience for our patients and their relatives and carers. This evidence, and the launch of the King's Way outpatient transformation programme, provided an excellent opportunity to make far reaching changes to our processes, our communication and the way we treat and care for our patients, to achieve real and sustainable improvement.

We therefore embarked on a 3 year programme of work to transform our outpatient service so that we can provide an excellent patient experience for all our outpatients.

What was our aim?

In the first year of this programme we would:

- Listen to and involve patients, their relatives and carers to develop, test and launch a set of Patient Experience Standards for outpatients

- Set up an outpatient 'User Reference Group' to ensure that patients and our local community are involved at all stages of outpatient transformation and have a real voice in how services are developed to meet the needs of patients and their families

- Develop and test improved communication tools for patients, e.g. patient reminders

- Increase the ability to book appointments electronically in primary care and thereby offering more convenient access to patients

- Scope and pilot a range of alternatives to traditional outpatient appointments, such as virtual clinics

- Engage with patients and stakeholders in discussions about design of improved outpatient department estate

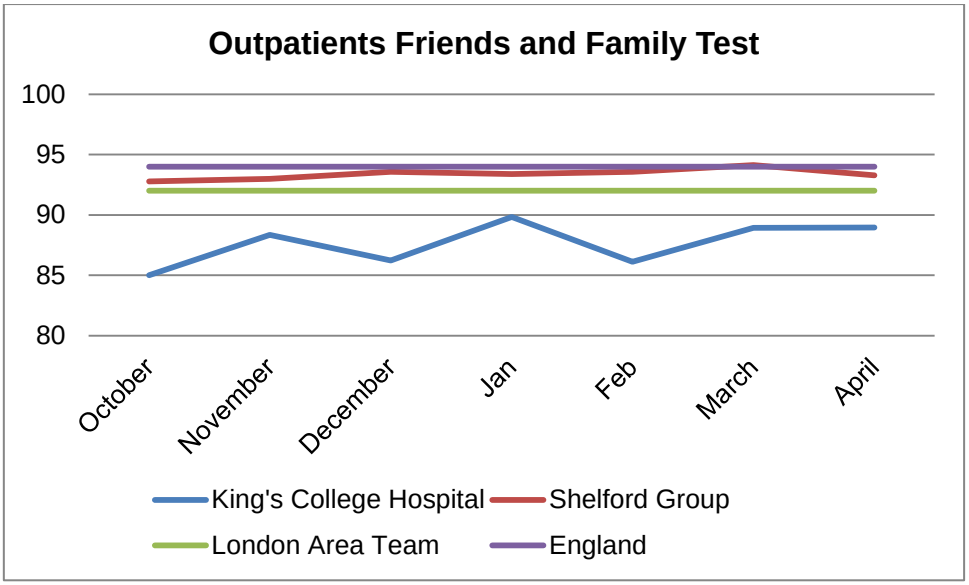
- Undertake appropriate stakeholder engagement in any service change and carry out equal impact assessments to consider how options for change impact on our more vulnerable patients and patients from all equality groups

Did we achieve this priority?

This priority was partial achieved.

Over the past year, as well as to listening to our patients to understand their experience, significant work has been done to understand where and why some aspects of outpatients are not working as well as they should. Although patient experience has not improved over the year, we are in a good position to make a real impact over the next (second) year of this three year priority.

For the Friends and Family Test, patient recommendation rates ranged from 85 – 90%, with an average over the year of 88% of patients who would recommend King's outpatient services. This puts King's patient satisfaction scores regarding outpatients below our London peers and also trusts nationally.



For our local 'How are we doing?' Outpatient Survey, the overall satisfaction score reached our target of 83% in three out of the twelve months with the average score for the year 81 out of 100. Patient experience in key areas is still well below where we would like it to be including experience of booking appointments, delays in clinic and patients not being informed about delays

How have we improved performance to date?

Launch of Outpatient Experience Standards

Based on feedback from patients and staff, we drafted a set of Outpatient Standards and tested these with patient groups, our Governors and our staff. The standards outline what our patients can expect from us through their outpatient journey. These standards will also link to a set of key performance indicators which will include patient experience measures

Recruitment and launch of 'User Reference Group'

Rather than convene a 'User Reference Group' we have conducted a series of discussion groups with patients and with staff to focus on particular areas of work. We have discussed general issues such as:

- How we can improve communication with patients through their outpatient journey including improving letters, responsiveness to telephone calls, easier access to staff if a patient needs information

- How we can best support staff to deliver excellent customer care and gather patient views on what's would make a really good experience for them

We will continue to meet with patients through the project to gather their views and to test out ideas and plans for improvement so that we deliver changes requested by patients, that will improve their experience of care

Audit of telephone responsiveness

Audits of responsiveness of our switchboard continue to show that phones are answered promptly meeting our target of 30 seconds. We will continue to measure this.

We also audit our appointment booking service at the Denmark Hill site Outpatient Appointment Centre (OPAC), where there is a target to answer 90% of calls. Although we have met this over a number of months, there were some months where our responsiveness fell below the target (see table below).

Month	**Performance – No of calls and percentage of calls answered**
April 2017	142459 (88%)
May 2017	11582 (93%)
June 2017	11047 (83%)
July 2017	11025 (89%)
August 2017	11176 (89%)
September 2017	10616 (78%)
October 2017	11595 (86%)
November 2017	10813 (86%)
December 2017	8063 (92%)
January 2018	12928 (85%)
February 2018	11642 (92%)
March 2018	11790 (91%)

Improved satisfaction with appointment booking

Over the year, patient experience in relation to booking of appointments has shown some improvement, however progress remains below target.

For the first six months of the year the average ‘How are we doing?’ survey score out of 100 for patients’ experience of booking their appointments was 72 and for the last six months of the year it rose to 77 against a target of 80.

Audit of satisfaction with virtual clinic model in pilot areas

Our transformation work this year has focussed greatly on back-office processes; for example, ensuring that we use our clinic space optimally so that we can reduce waiting times for our patients.

Although there are some services which are using alternative options to face to face, like our intensive care service that use skype to contact patients after discharge, we have not set up a new programme of 'virtual' clinics. We will be looking at alternative models for year three of this programme

Develop and test improved communication tools for patients e.g. patient reminders
We know that patients' appointment letters sometimes go astray and that this is very frustrating for patients and can also result in patients being recorded as 'did not attend' (DNAs).

In February 2017 we started piloting digital appointment letters. This offers patients the option of accessing their appointment details through a secure patient portal via a smartphone, tablet or desk top computer. There is also the capability for letters to be translated into different languages. Hospital information and appointment instructions can be easily attached and a real-time home to hospital map reduces on the day delays. For patients that do not have a mobile phone, letters will be sent by post instead.

Other improvement pilots include:

- Automatic call forward boards in our outpatient clinics which tell patients when their appointment will start and will also be able to update on waiting times/delays with appointments. This would help a key area where patients tell us that we fall short – not having information about delays in clinic

- An electronic system to assess where there are free appointment slots so that patients can be offered these vacant appointments, helping to reduce waiting times for appointments. This is being tested in April in our neurology clinic at Denmark Hill

Increase the ability to book appointments electronically in primary care and thereby offering more convenient access to patients:
In line with national policy, King's is has now completed the roll-out of the national NHS Electronic Referral Service (e-RS).

Scope and pilot a range of alternatives to traditional outpatient appointments, such as virtual clinics:
Patient feedback gathered through our listening events shows appetite for alternatives to face to face appointments including telephone consultations and video calls, as long as we provide choice for patients to suit their needs.

This year we are continuing to pilot alternatives such as Skype consultations in our diabetes service and for follow-up sessions for patients who have had an intensive care admission. We need to undertake evaluation both to assess patient satisfaction, but also the cost effectiveness of these virtual clinics.

Agree improvement targets for year:
We held two workshops at PRUH and DH to look at outpatient transformation plans going forward and a Quality Account workshop with patients, the public, HealthWatch and Governors. We also talked with our Foundation Trust Governors.

Feedback from these events has fed helped to identify our quality priorities for 2018/2019.

How was progress reported?

Progress was reported through the Trust's well established quality governance framework which is described in detail within the Annual Governance Statement.

The Executive Lead for improving outpatient experience is Lisa Hollins, Director of Transformation and ICT.

Improvement priority 5

Improving the experience of patients with cancer and their families.

Why was this a priority?

Although cancer patient experience has been improving, as measured by the National Cancer Patient Experience Survey (NCPES), there is still a long way to go. For the 2016 NCPES, although King's was the 40th most improved trust, it was still ranked 136th out of 209 cancer care providers. In addition, there is wide variation in patient experience between patients with different types of cancers.

With this in mind, King's wanted to have a much stronger, strategic focus on improving patient and family experience of cancer and we therefore chose to embark on a three year programme of improvement in order to achieve a step change in patient and family experience and one that can be sustained.

What was our aim?

We proposed this as a three year programme in order to achieve the following:

We said we would use the results of the 2015 and 2016 National Cancer Patient Experience Survey to identify focused areas for improvement. Based on 2015 data, these will include:

- Improving information for patients about all aspects of medication and treatment side effects including chemotherapy;

- Enhancing opportunities for patients and their families to talk to someone if they are worried or fearful about any aspect of their care;

- Ensuring that they have practical and accessible information about access to support, such as benefits or financial support; and,

- Further enhancing accessibility to our Clinical Nurse Specialists

In 2017/18 we also committed to:

- Undertake a review of existing data about cancer patient experience, including the King's 'How are we doing?' surveys, intelligence from cancer support groups, voluntary agencies and other trusts. This will help us to better understand the experience of cancer patients and their families and any specific target populations to inform improvement work

- Set up patient reference groups - virtual or face-to-face - for our key cancer services, such as breast and haematology. This will ensure that patients, their families and carers have a say in shaping improvements and making sure that what we do has maximum impact on patient experience

- Explore additional support for patients and their families from the King's volunteer service and peer support programmes

- Develop a suite of feedback tools to gather first-hand experience of care from our patients and their families. This will include a bespoke cancer patient 'How are we doing?' patient survey as well as regular feedback through patient stories

- Build on Macmillan Values training for staff to spread good practice in cancer care

- Share good practice between the key cancer specialties at King's to ensure that all patients receive the same level and quality of service

- Build on previous work to review and refresh our Holistic Needs Assessments and Health and Wellbeing events

- Apply to become a Level 3 Paediatric Oncology Shared Care Unit (POSCU) and scope further improvement areas for children and their families

- Set up a working group of the Trust Cancer Committee to scope a co-ordinated, Trust-wide approach to improving all aspects of cancer care and treatment, including patient experience. A key remit of the working group will be to address specific issues linked to the design of our services which, by their nature, necessitate our cancer patients being treated across a number of specialties including surgery, liver and neurosciences, as well as across different sites

Did we achieve this priority?

This priority was partial achieved.

There has been good progress over the year in getting the foundations set for a number of programmes of work to improve cancer patient experience. The work is being led by our new dedicated Head of Nursing for Cancer who came into post in May 2017. We have developed a comprehensive three year plan for improving the experience of care for our cancer patients and are making good progress in scoping these plans.

How have we improved performance?

Focus for improvement – National Cancer Patient Experience Survey (NCPES) and 'How are we doing?' survey

Following the 2016 NCPES, we carried out a detailed analysis of what patients told us including understanding the key issues that were raised in response to the survey. We also conducted detailed analysis of the patient comments from the 2015 NCPES to identify recurrent themes. The analysis was widely reported within the cancer team, including at the trust Cancer Committee in 2017 and within specific cancer teams who were asked to develop work plans to address key issues raised by patients and aligning them closely to the overall trust-wide areas for improvement.

Listening to patients and their families

Rather than setting up specific cancer user reference groups, we decided to listen to a wider group of patients through patient listening events carried out in partnership with Macmillan Cancer Support. We held one event at our Denmark Hill site and one at the PRUH. The events gave us a deeper insight into our patient's experience of care through their cancer journey, particularly their experience of the holistic needs assessment model and the recovery package. Feedback from these events, along with patient comments from the NCPES, gave us a good understanding of where we do well and where further improvement can be made.

Over the last year we have added different ways for patients to feedback their views including:

- Improved our methods of gathering cancer patient experience through addition of iPads for completion surveys electronically
- Introduced text and landline messaging in January 2018 to gather Friends and Family Test feedback for both cancer outpatients and day-case patients, for example, patients attending our chemotherapy day units. This has significantly increased the amount of feedback from our patients and will help us to target improvements
- Recruited a group of King's Foundation Trust members with an interest in patients' experience of cancer to provide ongoing advice and input into service development

- Developed a King's Cancer 'How are we doing?' survey so that we can gather cancer specific patient experience feedback on a regular basis and assess progress - rather than waiting for the annual national cancer survey

Explore additional support for patients and their families from the King's volunteer service and peer support programmes

Denmark Hill has a well-established Macmillan Information Centre, housed in the Cicely Saunders Institute. A new Centre Manager came into post in February 2018 and we are working closely together to see how we can enhance the practical support provided to our patients and their families.

We are actively working with the King's volunteer service and have agreed a new 'Chemotherapy Day Unit Volunteer' role to provide support to patients and their families receiving treatment in our Chemotherapy Day Units at both Denmark Hill and the PRUH. Volunteers will provide a range of support from traditional befriending to keep patients company, providing refreshments. Our Head of Volunteering and Head of Nursing are also exploring other ways that volunteers can support cancer patients and their families.

We have also agreed a three year collaboration with Macmillan to deliver improvements in patient experience.

Enhancing access to Clinical Nurse Specialists (CNS)

Our CNSs play a key role in supporting patients and their families through their cancer journey both through clinical support and emotional support. This year, we have undertaken work to enhance this service including:

- Launching a cancer CNS Forum to provide leadership and support
- Agreed funding for two further Clinical Nurse Specialists to support patients with Upper GI Cancers and Cancer with Unknown Primary
- We've also agreed standardised ways of working for our Cancer Clinical Nurse Specialists to ensure that all cancer patients receive the same level of service
- As part of our collaboration with Macmillan, nine of our Clinical Nurse Specialist posts have been 'adopted' by Macmillan under their Macmillan Adoption scheme. This scheme allows our CNS's to carry the Macmillan name and access the benefits available to all other Macmillan professionals. For example, our CNS's will be able to benefit from:
    - attending learning and development events and receiving coaching
    - access funding for training and development
    - access to digital information resources
    - being able to apply for grants from Macmillan to support patients with cancer who they support

We will be working with Macmillan to identify funding for additional posts to support patients.

In addition to this, support from Macmillan has also been able to support access to training though the Accountable Cancer Network to support clinical staff to gain Level 2 Psychological Skills training to support the emotional and psychological wellbeing of patients. The first cohort of staff completed their training in 2018 and further training is planned.

Review and refresh our Holistic Needs Assessments and Health and Wellbeing events

At our two listening events held at our PRUH and Denmark Hill sites, we asked patients about their understanding and experience of the different parts of the Recovery Package including Holistic Needs Assessments and wellbeing events. The feedback showed that are differences between tumour groups and hospital sites in terms of accessing the different elements of the recovery package and health and wellbeing events. This feedback will be incorporated into our improvement plan for 2018/2019.

King's is working with partners across South East London to improve equality of access for patients to having Holistic Needs Assessments and attending Health and Wellbeing events.

King's is also an active member of the South East London Living With and Beyond Cancer (LWBC) steering group which has agreed a target that 70% of patient will be able to have an HNA at the time of diagnosis and following completion of their treatment. First pilot at King's for full implementation of HNA have started September 2017 for haematology cancer.

Provide accessible information for patients

We said that we would improve the information that we give our patients and their families about the support that's available to them, for example advice on financial issues and benefits.

A new manager has joined the King's Macmillan Information Centre and we are working with them to improve accessibility of information and support to patients.

We now have dedicated financial advisors at both Denmark Hill and the PRUH who are available for two sessions per week to answer patient queries.

We also said that we would make improvements to information about specific parts of cancer treatment including information on medication side effects for chemotherapy treatment. Patient information is in available but we need to respond to patient feedback about when is best to give patients information. This will be done as part of the implementation of the Macmillan Recovery Package.

As part of our work to become a Level 3 Paediatric Oncology Shared Care Unit (POSCU), improve the experience of children with cancer and their families

This is work in progress with our partners in South East London and will continue into next year.

Set up a working group of Trust Cancer Committee to scope a co-ordinated, Trust-wide approach to improving all aspects of cancer care and treatment, including patient experience

Our comprehensive improvement action plan will address all aspects of patient experience improvement and will be overseen by the trust Cancer Board.

Baseline

Although King's was the 40th most improved trust for the 2016 National Cancer Patient Experience Survey, there is a significant way to improve on key areas where we remain statistically below the national average across the patient pathway from poor experience in outpatients and provision of information and practical support, to lack of confidence in clinical staff and care received in hospital and at home.

Progress has been made in ensuring that our staff receive the appropriate training, but we still have challenges in terms of providing cancer specific training to our staff, lack of skills to provide psychological and emotional support for patients and limited access to allied health professionals.

There remain inconsistencies in the quality of care for different cancer patients and we need to ensure that we offer patients the same level of care and treatment, whatever their cancer type. We set out to embed Holistic Needs Assessments for our patients but, again, there is variability between specialties in how this has been taken forward. We have a target of 70% of patients being provided with an HNA and our best performing specialty has reached 40%, so there is work to do here.

The 2017 National Cancer Patient Experience Survey is currently underway. We will not receive the results in time for publication of this report. When the results are published we will be able to assess whether the actions we have put in place over the last year have had a positive impact on patient experience.

For the Friends and Family Test survey which asks patients whether they would recommend the service to friends and family should they need similar care and treatment, King's patients have rated our inpatient service very highly with an average 96% (to Jan 2018) of patients saying that they would recommend the service which is above the recommendation rates for our inpatient wards overall, but remains the same as for the previous year.

Year one of this priority has established some solid foundations for improvement going forward and we are confident that, with the improvement plans in place, good progress will be made for our year two priorities.

How was progress reported?

Progress was reported through the Trust's well established quality governance framework which is described in detail within the Annual Governance Statement and progress against

the cancer improvement plan is discussed at the Trust Patient Experience Committee and has also been reported to our Commissioners.

The Executive Lead for improving the experience of patients with cancer and their families is Dr Shelley Dolan, Chief Nurse and Chief Operating Officer.

Improvement priority 6

Sepsis (improvement of its recognition, management and escalation)

Why was this a priority?

Sepsis is a life threatening condition with many mimics – nationally mortality runs at 28 % for those admitted to critical care with sepsis. At King's College Hospital NHS Foundation Trust sepsis is in its third year as a quality priority with improvements being reported. It is felt that this year would help complete and embed processes described below. Additionally the Electronic Patient Record (EPR) system is being rolled out at the PRUH which will help standardise data collection.

What was our aim?

Our aim was to improve the implementation of sepsis bundles for patients with positive blood cultures and diagnosis of sepsis as defined by EPR order set. Using "**bundles**" simplifies the complex processes of the care of patients with severe **sepsis**. A **bundle** is a selected set of elements of care that, when implemented as a group, have an effect on outcomes beyond implementing the individual elements alone.

In order to achieve this we said we would:

- Ensure sepsis screening and treatment bundles are embedded across the Emergency Department and inpatient populations
- Work to align prospective coding datasets for sepsis. Coding involves assigning a code to an illness or treatment for classification or identification. This is then used for auditing and billing purposes
- Develop a quick sepsis organ failure assessment (qSOFA) to support the identification of high risk patients. The qSOFA score is a bedside prompt that may identify patients with suspected infection who are at greater risk for a poor outcome outside the intensive care unit (ICU)
- Explore the development of sepsis dashboards

Did we achieve this priority?

This priority was partial achieved.

This will be a continuing priority for 2018/19.

Across the UK the sepsis 6 bundle is advocated for reducing the risk of mortality. It was designed by health care professionals and requires staff to firstly identify and screen a patient for potential sepsis and then to administer antibiotics within 60 minutes. The key steps required under sepsis 6 are listed below:

1. Titrate oxygen to a saturation target of 94%
2. Take blood cultures.
3. Administer empiric intravenous antibiotics.
4. Measure serum lactate and send full blood count.
5. Start intravenous fluid resuscitation.
6. Commence accurate urine output measurement

As a Trust we measure compliance with the requirement to screen and administer antibiotics/treatment as described below. The Trust reviews this in light of the Emergency Department patient cohort and inpatient patient cohort.

The electronic and case based analysis demonstrates our compliance with our aims, for Emergency Department sample sizes for screening and antibiotic compliance of 3525 and 640 respectively, and for inpatient sample sizes for screening and antibiotic compliance of 2486 and 1274 respectively.

Screening, time to antibiotics, and the sepsis 6 bundle compliance all rose to the upper quartile. In particular, audit data demonstrates antibiotic timelines, treatment and bundle compliance now are at 90 % or above in accordance with the national guidelines for those with 'bad' sepsis.

- *Successful screening of patients against those that meet criteria for screening, and treatment bundle adherence, will rise to the upper quartile.*

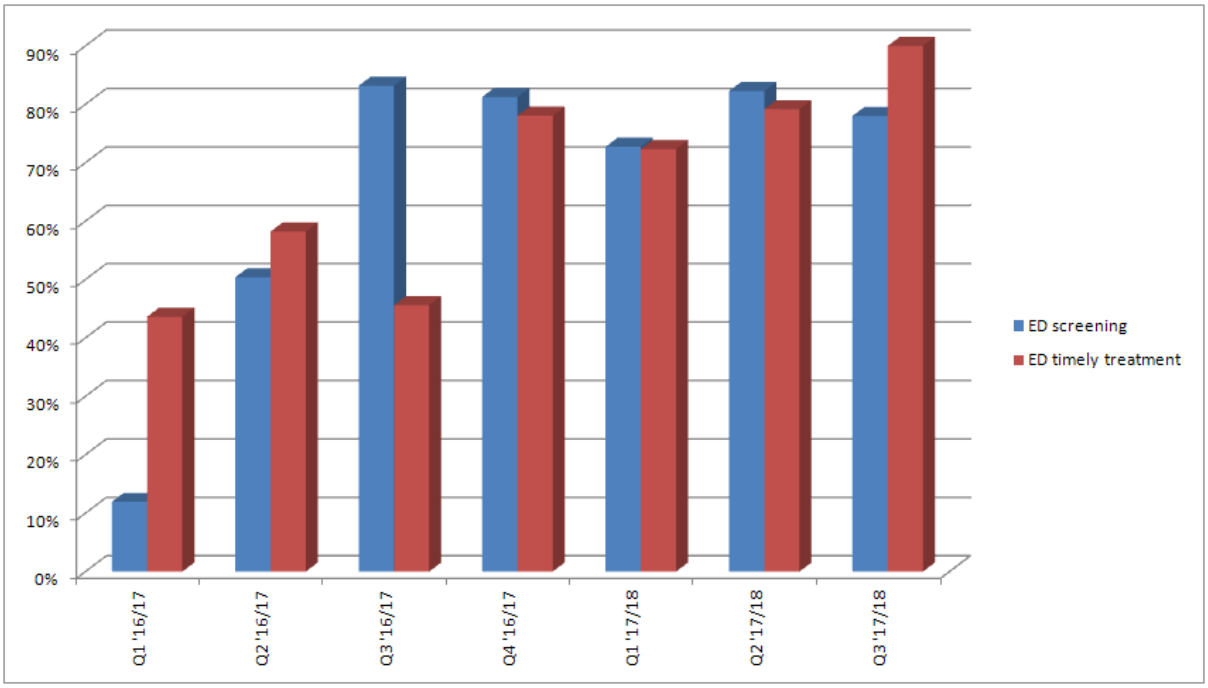
- *The number of patients appropriately coded with sepsis will rise from the baseline in 2015/16.*

- *Improve SHMI and/or Shelford group ranking (except in labour) as against the 2015/16 baseline.*

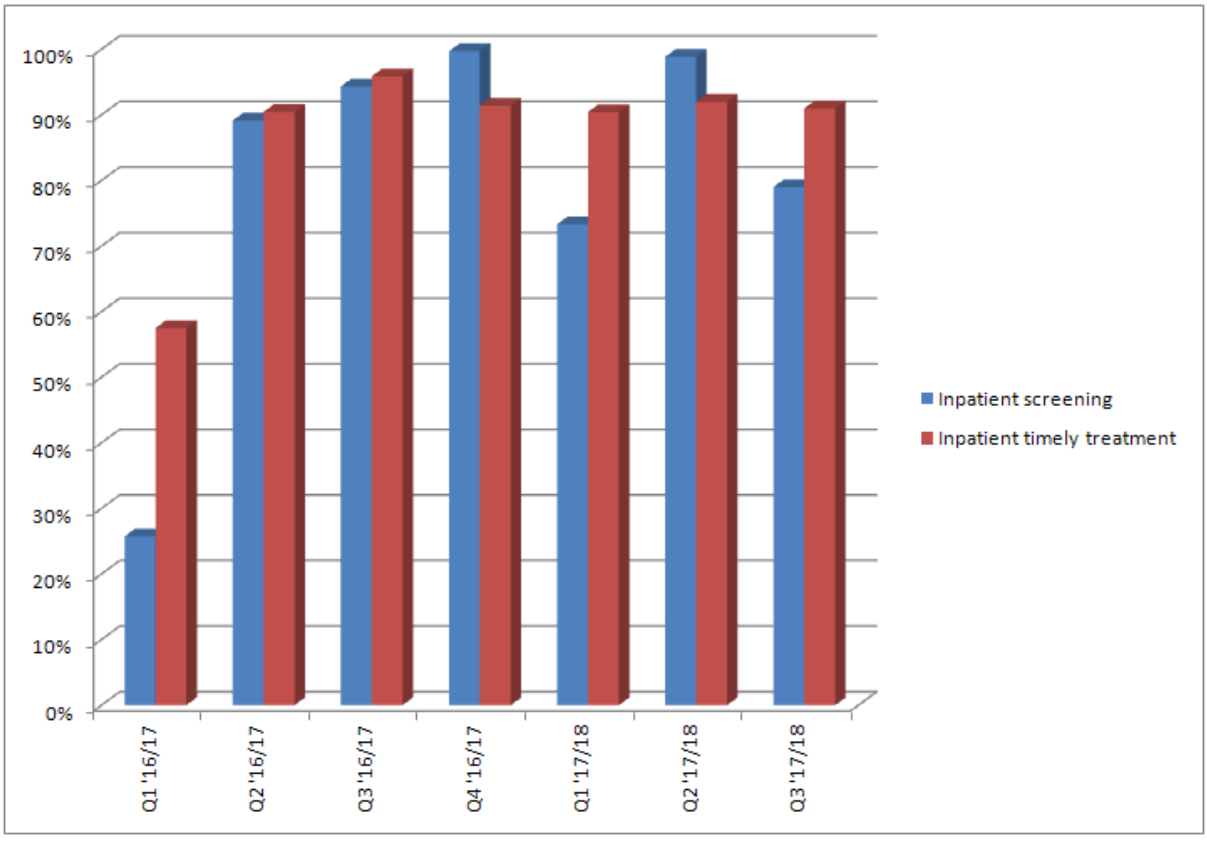
- *Reduce length of stay for patients who are coded with septicaemia (except in labour) as against the 2015/16 baseline (see table below).*

Sepsis Quarterly trends	Q1 '16/17	Q2 '16/17	Q3 '16/17	Q4 '16/17	Q1 '17/18	Q2 '17/18	Q3 '17/18
ED screening	12%	*50%*	83%	*81%*	73%	*82%*	*78%*
ED timely treatment	44%	*58%*	46%	*78%*	72%	*79%*	*90%*
Sepsis Quarterly trends	Q1 '16/17	Q2 '16/17	Q3 '16/17	Q4 '16/17	Q1 '17/18	Q2 '17/18	Q3 '17/18
Inpatient screening	26%	*89%*	94%	*100%*	73%	*99%*	*79%*
Inpatient timely treatment	58%	*90%*	96%	*91%*	90%	*92%*	*91%*

Sepsis nCQUIN quarterly returns: adult & paediatrics



Emergency Department - screening and antibiotic timeline compliance: adults and paediatrics



Inpatients - screening and antibiotic timeline compliance: adults and paediatrics

How have we improved performance?

We evolved the screening and treatment bundles throughout the hospital, undertaking regular electronic and case based audit to track our progress. The successful roll out of the electronic patient record (EPR) at the PRUH now means that a consistent approach can be used cross-site going forwards. In essence we can extract the same information and data easily across the two hospital sites which allows for easier comparison.

We had sepsis study days, link nurses for key wards and rolled out 'sepsis' boxes to support sepsis education across the trust - our approach has been to raise awareness about sepsis in order to ensure clinical grass root traction with improvements in the care of these patients.

- *Our stated measure of success in the 2016/17 Quality Account Report:*

Successful screening of patients against those that meet criteria for screening, and treatment bundle adherence, will rise to the upper quartile.

Across the two years of the sepsis quality improvement programme, and in audits across n = 1104 patients, sepsis 6 bundle adherence rose to > 90 %.

2016/17 & 2017/18	For 'bad' sepsis cases as defined by red flag sepsis, severe sepsis and septic shock	
Sepsis 6 compliance	n = 1104	
1	Oxygen given	94.42%
2	Antibiotics given	98.48%
	: in timely fasion?	93.60%
3	Intravenous fluid challenge	79.40%
4	Blood cultures	95.13%
5	Lactate meansurement	98.21%
6	Urine output monitoring	91.15%
Composite compliance across all 6 actions		93.36%

Sepsis 6 bundle compliance for 'bad' sepsis

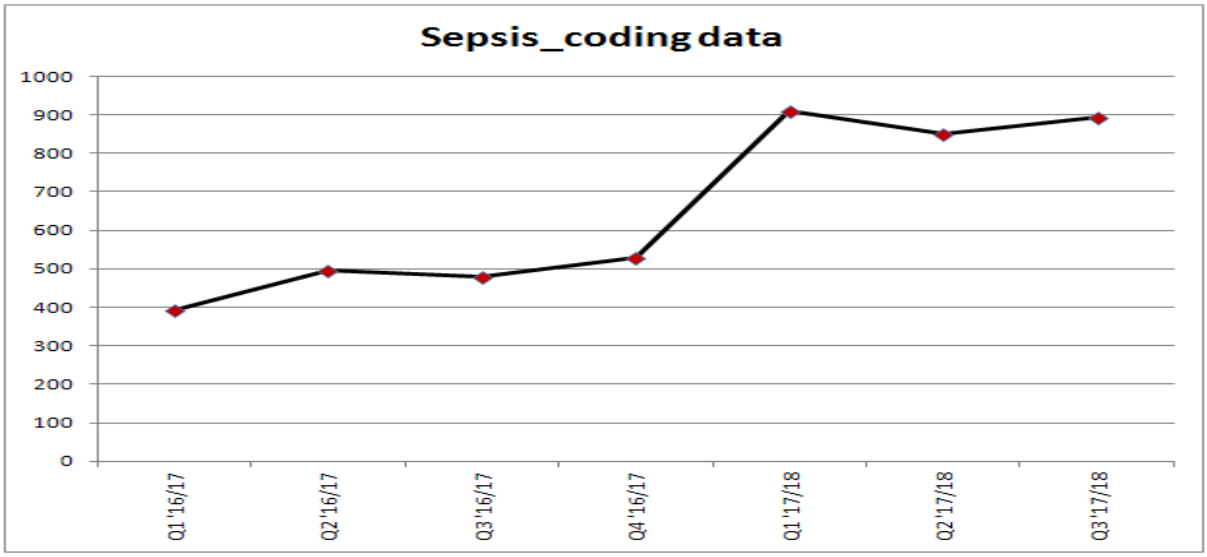
We have worked with coding and the electronic patient records (EPR) departments on correctly identifying patients with sepsis, and its coding correlates, to ensure better accuracy of our data. As part of this, we have also undertaken an NHS consultation on sepsis coding in the light of updated definitions.

Sepsis diagnostic information has been made easier to find on the electronic patient records, with automated reporting of sepsis from diagnostic information entered by clinicians, both at the front door in ED, and for inpatients. As a result, concordance between inpatient screening data and coding data has improved significantly during this time where once there was a considerable disparity, although there are still gains to be made in regard of aligning clinical and coding datasets.

Equally, it is likely for a number of reasons that we are not yet capturing all the episodes of sepsis that are admitted to, or occur within, the hospital.

- *Our stated measure of success in the 2016/17 Quality Account Report:*

The number of patients appropriately coded with sepsis will rise from the baseline in 2015/16.



Quarterly data - patients coded with sepsis

We have collated data on qSOFA, which is a marker of acuity in patients identified as having sepsis that has been suggested as an effective tool in improving outcomes for patients with sepsis.

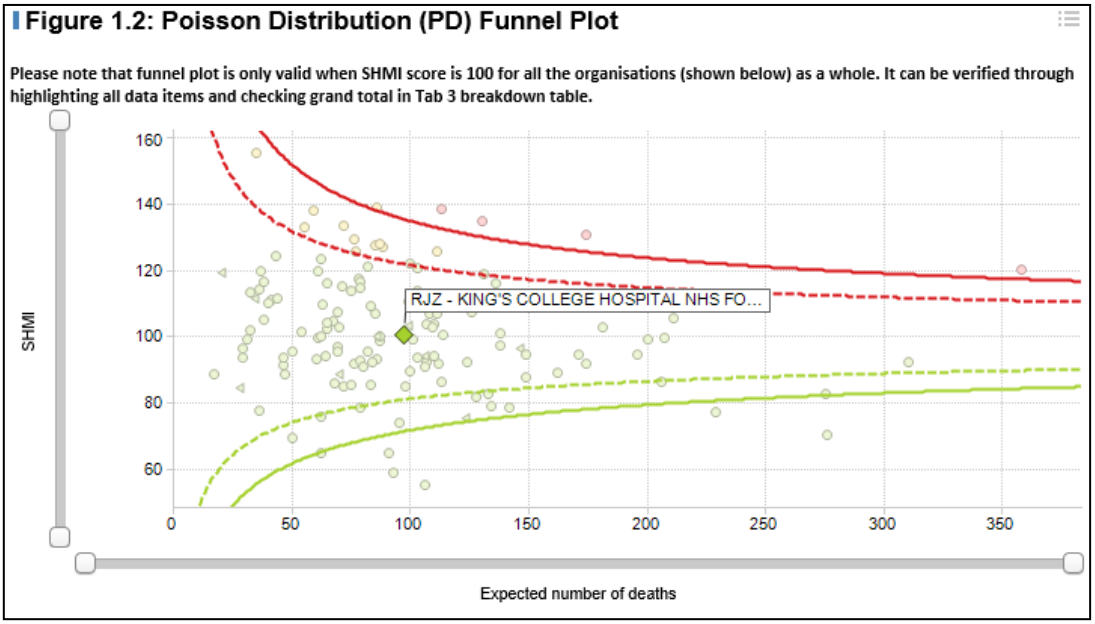
2016/17 & 2017/18				
qSOFA analysis	n = 1918			p = 0.0001
	Alive	Dead	%	Total
qSOFA - ve	905	103	10.2%	**1008**
qSOFA + ve	644	266	29.2%	**910**
Total	**1549**	**369**		**1918**

***iMobile* Critical Care Outreach sepsis screening dataset**

The iMobile outreach service (specialised intensive care staff that visit and help support unwell patients on wards that are not in intensive care) already gets automated NEWS (national early warning score) alerts directly to their service Wi-Fi telephones which they can follow up and we are looking to see whether qSOFA positive patients can be automatically flagged through the same system.

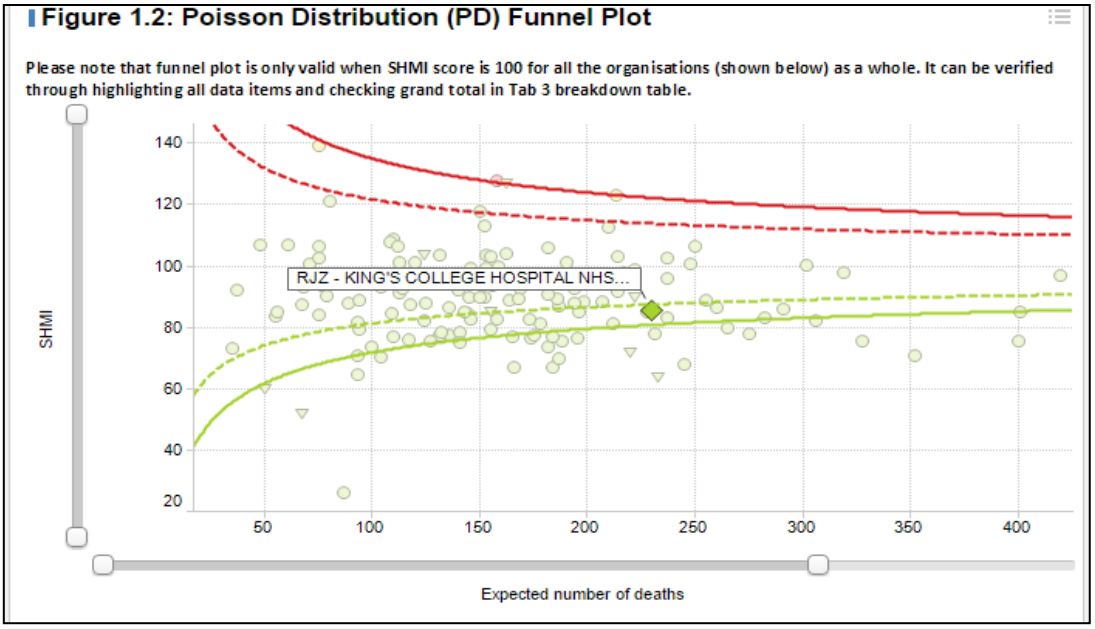
- *Our stated measure of success in the 2016/17 Quality Account Report:*

Improve Summary Hospital-level Mortality Indicator (SHMI) and/*or Shelford group ranking for septicaemia (except in labour) as against the 2015/16 baseline.*



2015/16 SHMI for Septicaemia (except in labour)

source: Healthcare Evaluation Data [HED]



2017/18 YTD SHMI for Septicaemia (except in labour)

source: Healthcare Evaluation Data [HED]

Our performance is trending in the right direction with our Shelford ranking improved from the 7th to 6th during the course of the QI programme and a significant improvement in the SHMI.

We have explored what key metrics might form part of any sepsis dashboard. We now have good data aligning key areas where septic patients are managed, as well as data on whether they required critical care admission, palliative care input, and on mortality as well as on LoS data.

For example, 6.6% had a critical care admission, 16 % had a palliative care code, emphasising again that sepsis may form part of patient's end of life illness.

Finally, in our sepsis strategy submission to NHSE in 2016, baseline mortality for those coded with sepsis in 2015/16 appeared to be 23.6 % and in 2017/18 YTD, this now stands at 18.5 % which represents a significant improvement.

Mortality comparison	Alive	Dead	*Totals*	
2015/16	1583	491	***2074***	23.67%
2017/18 Q3 YTD	2259	512	***2771***	18.48%
Totals	***3842***	***1003***	***4845***	p = 0.0001

Comparison of mortality from baseline for sepsis

- *Our stated measure of success in the 2016/17 Quality Account Report:*

Reduce length of stay for patients who are coded with septicaemia (except in labour) as against the 2015/16 baseline.

Utilising our coding dataset, we analysed 5365 patients coded with sepsis from our 2015/16 baseline through to the current 2017/18 YTD data. For patients without a palliative care code, bearing in mind that many patients now die with sepsis rather than from sepsis, average length of stay fell by over a day representing over 3000 bed days saved.

It is hard to delineate whether this is due to improved coding of patients or the quality improvement programme but it is likely multi-factorial.

Coding dataset (palliative care excluded)		
	n	LoS
2015/16	1516	18.9
2017/18 YTD	2288	17.5

Length of stay (LoS in days) data for patients coded with sepsis

How was progress reported?

Progress was reported through the Trust's well established quality governance framework which is described in detail within the Annual Governance Statement.

The Executive Lead for improving the implementation of sepsis bundles is Professor Jules Wendon, Medical Director.

Improvement priority 7

Improve quality of the surgical safety checks

Why was this a priority?

Safer Surgery was chosen as the Trust deemed it a priority to continue to reduce the number of reported Never Events at the Trust. We were particularly keen to apply safety checks in the interventional as well as surgical setting in line with the national roll out of the NatSSIPS (National Safety Standards for Invasive Procedures). While compliance with safety procedures is good at the Trust, we wanted to further assess and potentially improve the quality of such checks. Lastly we wanted to be innovative in the work that is already undertaken to ensure a safe and efficient surgical environment where staff are supported and confident in their role and team.

What was our aim?

Or aim is to improve the quality of the surgical safety checks by 10% year-on-year, as measured by the annual surgical safety checklist observational audit and quality assessment.

- Further develop processes to use electronic checklist completion data effectively to feedback to teams and for training and improvement purposes as this is largely reviewed at the SSIG currently by Theatre & Surgical Speciality and reviewed at audit mornings.

- Facilitate local training in areas where there are requirements for improvement identified through audit (including theatre staff, a human factors component & feedback on Never Events etc.)

- 'Team Brief' and 'Debrief' could not be added as a specific time slot on Galaxy which was previously planned. There would be QI project work to further embed this

- Continued audit of implementation of new invasive device insertion sticker and process (two person contemporaneous check) across all areas (including non-ICU areas) where Seldinger technique is used to embed practice

- Reinvigorate communication campaign re surgical safety to target MDT staff

- Continue with the roll-out of NatSSIPs and developing LocSSIPs (Local Safety Standards for Invasive Procedures) in areas where interventional procedures are performed and further develop recognition of risk in non-main theatre areas.

- Work with the theatre transformation team (King's Way for Theatres) to improve safety.

Did we achieve this priority?

This priority has been achieved and while we are not taking this forward as a priority through the quality accounts process, we will continue our work through the Surgical Safety Improvement programme, which reports into Executive Committees, the Board and to front-line staff.

The observational audit was also able to provide more detailed qualitative audit tool highlighting specific aspects that are working well and where improvements can be focused.

How have we improved performance?

The Trust has introduced a number of measures to support the delivery of this priority including:

- Electronic checklist completion data (broken down by speciality, theatre and surgeon) shows good compliance across all specialities reaching 100% consistently in a number of areas and enables remedial action and local training where this is not achieved. Data is cascaded across the specialities for review.

- In 2017/2018, four surgical/invasive Never Events were reported and further work is being carried out to reduce these. That is a reduction from the previous year when six surgical/invasive procedure Never Events were reported. Work focused in particular on reducing incidents relating to retained foreign bodies at the end of a procedure whereby there were elements of command/control human factors within the team. Two of the three incidents related to nursing staff knowing the count is incorrect but the surgery and discharge from the theatre continued. The 'Pause for Gauze' which allows the nursing staff safe space to perform their counts was instigated across all theatre sites.

- We were successful in further developing local surgical safety interventional procedure standards (LocSSIPs) in accordance with published national standards for all specialties that undertake invasive procedures. The oral surgery department held a number of external invents show-casing their work in this area.

- Revised intranet site re surgical safety information, used the trust-wide communications campaign SafetyNet to share lessons learned with hospital staff and are currently setting up Surgical Safety Day with national subject experts attending.

- The transformation team (King's Way for Theatres) have largely worked with staff to review operational flow and communication in theatres

- Overall quality checks increased with required improvements identified for team brief/debrief. A zero tolerance in relation to non-completion of team brief was implemented across the Trust as supported by the Executive team with exception to emergency patients. Running debrief is being trialled in the Day Surgery Setting which allows for on-going recording of staff feedback throughout surgery. The process for collating and analysing this is being developed through quality improvement work.

We are also working on:

- Collaborating with King's College London (KCL) to develop a human factors training programme
- Continue work on staff competency documents

How was progress reported?

Progress was reported through the Trust's well established quality governance framework which is described in detail within the Annual Governance Statement.

The Executive Lead for improving surgical safety is Professor Jules Wendon, Medical Director.

Choosing Priorities for 2018/19

In January 2018, NHS Improvement published the quality accounts reporting arrangements and the 'Detailed requirements for quality reports for foundation trusts 2017/18'. We chose to include the mandatory (must do) set of quality indicators for requirements for 2017/18. However, some of the indicators are not relevant to us (i.e. those that relate to ambulance trusts and mental health trusts), so we have not included them.

In February 2018, NHS Improvement issued 'Detailed requirements for external assurance for quality reports for foundation trusts 2017/18' as from 2011/2012 all acute trusts must have their Quality Accounts checked by external auditors. However, we also felt it was important to consult with our members and council of governors to incorporate their views about 'quality' into the quality account.

The process for agreeing the quality priorities for 2018/19 was as follows:

November 2017
Meeting with King's College Hospital's Quality Team to review 2017/18 priorities and determine which would be continuing priorities and which had been achieved.

December 2017
Patient, public and members engagement event held on 5th December 2017 to showcase current priorities and propose priorities for 2018/19.
Update on 2017/18 priorities and feedback from attenders at the patient, public and members event provided to Clinical Quality & Research Group (CQRG) on 12th December 2017.

February 2018
Update on continuing and new priorities presented to CQRG 27th February 2018

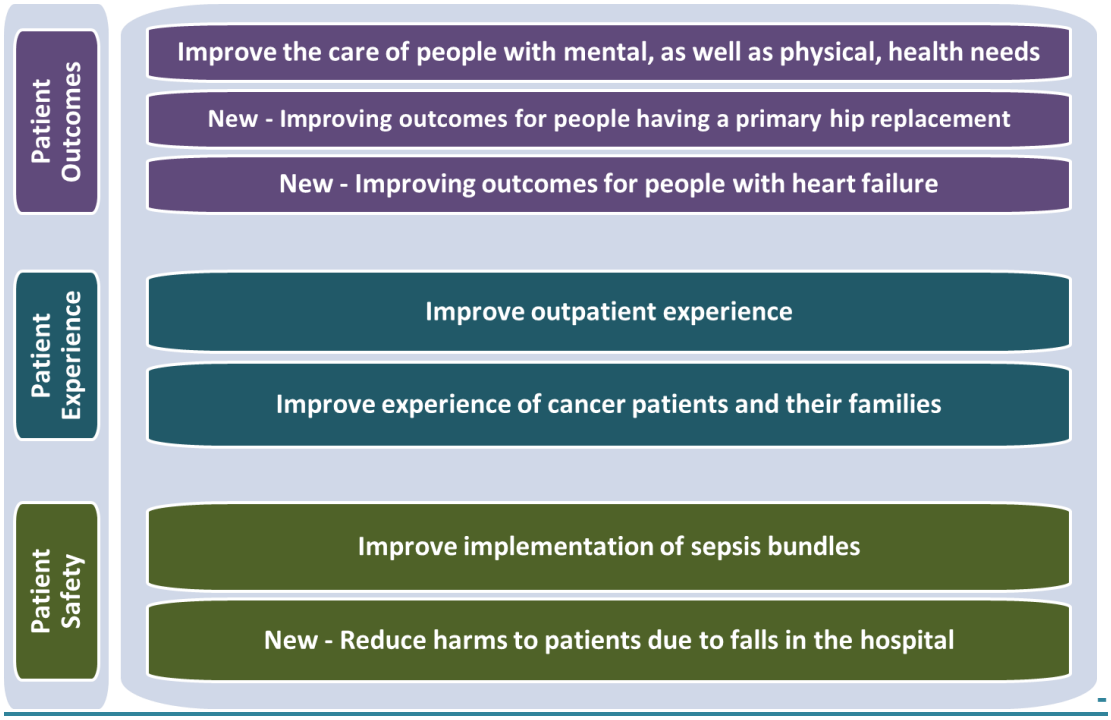
March 2018
Quality priorities discussed at Council of Governors meeting to review current proposed quality priorities for 2018/19 and discuss which would be the Governors selected priority.
Council of Governors chose a quality priority for 2018/19.

April 2018
Draft reviewed by external stakeholders for 30 days
Final draft version of the quality account completed

May 2018
Draft reviewed by the Board

Monitoring Quality Priorities

All seven quality priorities will be monitored through the divisional governance boards and then through the Executive quality Board and finally quarterly through the Board Quality, Risk and Research Committee



Improve care of people with mental, as well as physical, health needs

Why is this continuing as a priority?

As described previously, in 2017/18 we made an excellent start with our objective to improve the mental health care and outcomes of our patients. We knew, however, when we began this work that this would take more than one year and we identified this area from the outset as being a 3-year priority. To recap on why this is continuing as a quality priority for King's:

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

What is our aim for the coming year?

Next year we will:

- Increase outpatient clinics undertaking screening for mental health

- Provide self-help resources for our patients and help patients to refer themselves to psychology services

- Develop new ways to join up physical and mental health care to improve the outcomes, experience and safety of our patients

- Support staff to provide better mental health care through training and supervision.

- Work in partnership with South London & Maudsley NHS Trust, general practitioners and other local hospitals

How will we measure our success?

- Progress against these aims will be reported to the Trust's Mental Health Board and Executive Quality Board and included in the Trust's Quarterly Patient Outcomes Report

- Part of the challenge for improving patient mental health outcomes is the measurement of patient outcomes, which has not traditionally been a key element of hospital's performance measures. King's is working hard to address this and the development of standardised data on mental health outcomes is a component of our improvement work.

- As well as data on mental health outcomes, we will measure our success through the number of patients who are screened for mental health and the number of staff who have received training in mental health care.

Improving outcomes for people having primary hip replacement

Why is this a priority?

In 2016/17 approximately 750 hip replacements were undertaken at King's College Hospital NHS Trust, with most hip replacements undertaken on our Orpington Hospital site. Following surgery, patients' care is provided either at Orpington Hospital or at our Denmark Hill site.

We plan to measure the outcomes for patients at the two sites and, if we find that one site results in better outcomes, learn from this and develop the best approach for all our patients. By 'outcomes' we mean return to normal activities and quality of life after surgery.

What is our aim for the coming year?

- We aim to look at national information already gathered on patients' outcomes after surgery and compare the two services in detail

- We will then use this information to develop services that lead to the best possible patient outcomes at both hospital sites

- We will also share this information with other local hospitals. This will include improving the patient discharge process and information provided after a hospital stay

How will we measure our success?

- Our key measure of success will be detailed knowledge of the differences and similarities in patient-reported outcomes for patients following the two different post-operative pathways at King's, using the NHS Digital Patient Reported Outcomes Measures for hip replacement. This knowledge will be used to inform the future development of those pathways.

Improving outcomes for people with heart failure

Why is this a priority?

Heart failure is the most common reason for admission to hospital for patients over 65 years of age. 30–40% of patients diagnosed with heart failure die within a year. For example, 9,000 people are estimated to be living with heart failure in Southwark and Lambeth, but less than 3,000 are known to services.

We aim to help people with heart failure live longer with a better quality of life in their own homes.

What is our aim for the coming year?

We will:

- Build on work started in 2015 to ensure more patients are diagnosed and receive the treatment they need as soon as possible, and to keep people at home wherever possible.

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

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

- Ensure every patient receives information to help them live with their condition

- Ensure that care continues after the patient leaves hospital

How will we measure our success?

- A key measure of success will be an increase in the number of people with heart failure known to King's;
- The availability of an efficient and effective referral pathway for GPs;
- The availability of a 'one stop shop' service for patients;
- The availability of patient information and effective post-discharge care plans.

Improve outpatient experience

This is the second year of a three year priority linking to our King's Way Outpatient Transformation programme.

That is our aim for the coming year?

Our work over the next year will focus on five key areas:

Outpatient Standards:

- Developing Outpatient Standards was part of year one of this priority. However, although we have drafted a set of standards, we need to test these thoroughly with patients and staff. During year two we will therefore finalise the standards, launch and embed

Digital outpatients

- We will complete our pilot for digital patient letters in our musculoskeletal skeletal service at Queen Mary's. Success will be measured through patient uptake of the service and their feedback, staff feedback and also by measuring impact on did not attends (DNAs)
- We will pilot a new electronic system for updating waiting times in clinic called In Touch. This will provide information on an electronic screen and can be regularly updated. The pilot will be carried out in the outpatient clinics in Suite 3 and the Venetian Building at Denmark Hill. We will measure the success of this through our 'How are we doing?' survey which asks patients whether they were given information on waits and through patient comments.
- If the above pilots are successful, our plan is to scope how we can expand these initiatives to other areas in the Trust

Focussed improvement work in specific specialties

- We will carry out in-depth work in three key specialties: Neurology, Cardiology, and Dermatology. We aim to:
    - ensure appointments are booked with patients on a mutually agreeable date
    - reduce waiting times for appointments by providing rooms for additional clinics
    - reduce waiting times for results though additional 'results clinics'
    - provide advice to G.P's to enhance the quality of referrals and avoid inappropriate referrals
- In these areas we anticipate that we will see improvements in patient experience measured by the 'Friends and Family Test', 'How are we doing?' survey and patient comments.

King's Way for Outpatients

- This involves taking a close look at outpatient departments across our sites to make sure that they: all follow the same processes; are a pleasant place for patients to be seen and/or treated and for staff to work; and have the skills needed to be able to solve problems or issues that arise
- We are also implementing a new outpatient department accreditation scheme. This is a system which will allow us to measure all kinds of aspects of our outpatient service and environment. It will enable track how our outpatient areas are performing on a regular basis in order to be more responsive to issues such as waiting times in clinic or how clean and organised the clinic is
- This will be piloted in our Cardiology outpatient department (Suite 6) and will be rolled out to other outpatient departments during the coming year

Supporting our staff to deliver excellent patient experience

- We will support staff who work in our outpatient clinics to provide excellent customer care for our patients
- Over the coming year, we plan to run 24 coaching and mentoring workshops for outpatient administration staff across all sites to improve staff morale. We know that staff who are satisfied with their job are more likely to give a better patient experience so this is a key part of our priority

How will we measure our success?

- We will monitor patient experience in response to the launch of our Outpatient Standards
- We will successfully evaluate digital appointment letters with patients and staff expected to reduce DNAs in pilot areas
- We will successfully evaluate the In-Touch system and improve patient experience of waiting in clinic in the pilot areas
- In our specialty areas, we will measure success by improving patient experience in these outpatient areas, reducing DNAs and reducing delays in clinic
- We will gather improved patient feedback about staff in key outpatient clinics measured by our 'How are we doing?' surveys and patient comments

Improve experience of cancer patients and their families

Why is this continuing as a priority?

This is the second year of a three year priority linked to the trust's cancer improvement plan. King's has worked hard over the past five years to improve the experience of patients who come to King's for their cancer treatment. We have made real progress and this is evidenced by improved patient experience scores in the National Cancer Patient Experience Survey (NCPES) which is carried out each year. For example, we've trained many of our doctors in advanced communication skills, set up a patient help line, enhance our Clinical Nurse Specialist service and the availability of patient information through the Macmillan Information Stands in our hospitals. We have also refurbished our chemotherapy unit at the PRUH which is now a much more pleasant environment for patients.

However, satisfaction levels vary for patients depending on their cancer type. We therefore want to have a renewed focus on achieving really significant improvement for all our cancer patients and their families. We want to build on the good work that we have already done and develop new initiatives to tackle areas where we've not achieved the level of change that we need to make patient experience as good as our clinical outcomes.

The new divisional structures at King's have strengthened the focus on our cancer services and put the trust in a good position to make positive change.

What is our aim for the coming year?

For year two of this priority, we will focus on the key themes in our cancer improvement plan which are based on feedback that patients have given us through national and local surveys and in our listening events. We will continue to listen to patients and their families and to ensure that improvements address the issues that are important to them.

The main themes that we are going to focus on are:

Workforce – giving patients better access to specialist, trained staff and improved communication between patients and staff

- Communication:
  - We will ensure that all medical staff undertake communication training and will encourage medical teams to attend our Schwartz Rounds and Team Away Days to support good team working and working across teams
  - To learn from patient feedback, clinical teams will review complaints to better understand issues relating to poor communication or lack of information for patients and agree actions to make improvements

- Improve access to CNS for patients:
  - Patients to have access to a CNS at diagnosis, through their treatment and after discharge to improve the support for patients across their cancer journey
  - We will also introduce different cancer professional roles to improve wider access to professional support

- Enhancing the skills of CNS to enable better communication with patients
  - All CNSs will attend an Advanced Communication Skills Course and undergo Level 2 Psychological Assessment training during 2018

- In addition, we will encourage all administrative and care assistants' staff to attend “Sage and Thyme" training which provides clinical staff with the communication skills to: notice distress, hear the concerns that a person may have, and respond helpfully to them

- We will develop clinic template letters that clearly summarise treatments, possible side effects and when to seek help and who to contact to ensure patients and their GP are aware of what to look out for and who to contact

Accessible information for patients

- Increase the information available to patients about the impact of treatment, such as chemotherapy treatment, through our mobile Macmillan Information Units and site a new unit at the PRUH site
- Develop a new Cancer Information Pack with essential information for patients including information about different treatments, the role of the multi-disciplinary team, as well as practical information such as financial advice, benefits and free prescriptions

- Develop the role of volunteers to: signpost patients to the Macmillan Centre and to provide training to volunteers to signpost patients to information and support available in the community

- Launch training for reception staff in our outpatient clinics and in the chemotherapy day unit to signpost patients and their families to the Macmillan Centre

Improving administration of care – including outpatients and care at home

- We will hold a listening event with cancer patients to gather feedback to look at:
- alternative models for follow-up clinics, for example, telephone or Skype clinics
- how to improve outpatient clinic processes such as information on delays in clinic and how we communicate them
- getting a better understanding of feedback given in the National Cancer Patient Experience Survey (NCPES) on lack of availability of patient notes when patients visit outpatients

- Implement local actions linking to the wider King's Way for Outpatients Transformation programme

The patient Macmillan Recovery Package

King's is committed to implementing the Macmillan Recovery Package over the next year. The Recovery Package has four main interventions. Holistic Needs Assessment and Care Planning, Treatment Summary, Cancer Care Review, and Health and Wellbeing Events. These form part of an overall support and self-management package for people affected by cancer – physical activity as part of a healthy lifestyle, managing consequences of treatment, and information, financial and work support

The Recovery Package is recognised in the NHS England Five Year Forward View and the Cancer Taskforce Strategy which outlines a commitment to ensuring that '*every person with cancer has access to the elements of the Recovery Package by 2020*'. The roll out of these interventions will better support and improve the quality of life of people living with and beyond cancer

The Trust has received circa £3 million in grants from Macmillan to support out cancer improvement work and a Project Manager is being employed to work with our Cancer Lead Nurse on our improvement programme

- Phase 1 of this programme will focus on successful delivery of Holistic Needs Assessments across initially for our haematology patients during 2018. We will:

    - Recruit a project manager and Recovery Package lead
    - Train staff in the use of the HNA tool ready for roll-out
    - Implement the use of Holistic Needs Assessment as a screening tool at appropriate points along the haematology patient pathway to proactively screen patients' unmet needs
    - Introduce dedicated time and slots for staff to carry out Holistic Needs Assessments for pre and post treatment screening either face to face or by telephone with details of the HNA to be included on the patient's electronic patient record
    - Ensure that the HNA is recorded on the electronic patient record

How will we measure our success?

- For the 2017 NCPES, we want to begin to see improvements in areas where we have implemented improvements, for example in provision of information on financial support, greater access to Clinical Nurse Specialists for tumour groups where we now have staff in post including breast and urology. We would not necessarily expect to see significant improvement in 2017 on all areas as much of our improvement work will not have had time to have an impact as the survey is already underway. We would expect to see more improvement for the 2018 survey

- Audit of staff attending training to assess numbers of staff who have accessed training

- Improvement in scores for the How are we doing? survey results for outpatients linked to local improvements

- Launch of new trust wide Cancer Information Pack including evaluation by patients - planned for December 2018

- Deployment of volunteers in the Chemotherapy Day Units at DH and PRUH and evaluation of impact commencing April 2018

- Evaluation of the roll-out of Holistic Needs Assessments in haematology including patient feedback measure implementation across tumour groups assessed through electronic patient record

- Improvement in patients access to information on wider support via enhanced links with local communities and better access to financial and benefit services – to be measured by meeting the Macmillan Quality Standards for Information and Support Services (MQuISS)

- Increased use of the Macmillan Information and Support Centre by patients from all specialities measured through patient usage of the Macmillan Centre

Improve implementation of sepsis bundles

Why is this continuing as a priority?

Our aim is to extend the quality improvement programme across a third year to lessen the burden of sepsis on both our emergency department, and inpatient, populations.

What is our aim for the coming year?

- Extend and modify the EPR toolkits on screening, and treatment bundle adherence, into paediatrics and cross-site

- Ensure that diagnostic information on sepsis is readily available to clinicians and coders alike to ensure there is an accurate reflection of the burden of sepsis within the hospital which will support both timely antibiotic review and accurate coding

- Work towards automated flagging of patients who are qSOFA positive to the *iMobile* critical care outreach service, alongside the automated NEWS alerts, to help ensure timely review of patients most at risk from sepsis

How will we measure our success?

- The EPR based sepsis toolkits will be available across the whole hospital population

- The successful assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours will, on average across the quality improvement programme, exceed the thresholds set for the nCQUIN on sepsis

- At the end of our three year quality improvement programme, mortality from those coded with sepsis will be significantly different from the 2015/16 baseline

Reducing harms to patients due to falls in the hospital

Why is this a priority?

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

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

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

What is our aim?

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

- Improve on Lying & Standing BP measurement compliance in line with NICE guidelines by promotion, training and aid memoirs

- Improve adherence to standardised post-falls protocol, in particular where there was an unwitnessed fall

How will we measure success?

- Standardised documents used across all sites and 70% compliance with screening tool with continued improvement to 95% in (2019/2020)
- 95% compliance with Lying & Standing BP measurement assessments where required
- Measure of success of 95% compliance with post-falls protocol

We are also working on:

- Promoting early mobilisation and consider non-therapies assessments
- More collaboration with the Dementia and Delirium (DaD) team, build this service at the PRUH and develop joint training
- Prevent readmission of frail and elderly due to falls and ensure referral to falls clinics etc.

Where will we monitor progress of this priority?

Progress for this priority will be monitored through the Falls groups on the Denmark Hill and PRUH and South sites, the Safer Care Forum on the Denmark Hill and PRUH and South sites and then quarterly through to the Executive Quality Board and then finally six monthly to the Board Quality and Risk committee.

The observational audit was also able to provide more detailed qualitative audit tool highlighting specific aspects that are working well and where improvements can be focused.

Statements of Assurance from the Board

Mandatory declarations and assurances

Relevant health services

During 2017/18 the Trust provided and/or sub-contracted nine relevant health services – see below:

1. Assessment or medical treatment for persons detained under the 1983 Act
2. Diagnostic and screening procedures
3. Family planning services
4. Management of supply of blood and blood derived products
5. Maternity and midwifery services
6. Services for everyone
7. Surgical procedures
8. Termination of pregnancies
9. Treatment of disease, disorder or injury

The Trust has reviewed all data available to it on the quality of care in all relevant health services. The income generated by the relevant health services reviewed in 2017/18 represented 85% of the total income generated from the provision of health services for 2017/18.

The Trust receives the other 15% per cent of its income for other aspects of work for example; training and education, research and development, recharges of salaries and wages for staff working at other organisations and other direct credit and miscellaneous income.

Clinical Audits and National Confidential Enquiries

During the 2017/18 financial year, 62 national clinical audits and 6 national confidential enquiries covered relevant health services that King's College London NHS Foundation Trust provides.

During that period King's College London NHS Foundation Trust participated in 98% of the national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries in which the Trust was eligible to participate in during 2017/18 are listed in the table below on pages 47-50, in the Statement of Assurance Evidence.

The national clinical audits and national confidential enquires that the Trust participated in and for which data collection was completed during 2017/18 are also listed below on pages

47-50, 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 Clinical Audit or Confidential Enquiry	Reporting Period	Participation	Number (%) of cases submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	01/04/17 – 31/03/18	Yes	Data collection in progress
Adult Cardiac Surgery	01/04/17 – 31/03/18	Yes	Data collection in progress
BAUS Urology Audits: Nephrectomy	Data collection ongoing	Yes	Awaiting publication
Bowel Cancer (NBOCAP)	Data collection ongoing	Yes	Awaiting publication
Cardiac Rhythm Management (CRM)	Data collection ongoing	Yes	Awaiting publication
Intensive Care National Audit and Research Centre Case Mix Programme (CMP)	Data collection ongoing	Yes	Awaiting publication
Child Health Clinical Outcome Review Programme	07/03/15 – 20/03/15	Yes	Data collection in progress
Congenital Heart Disease (CHD)	Data collection ongoing	Yes	Awaiting publication
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Data collection ongoing	Yes	Awaiting publication
Diabetes (Paediatric) (NPDA)	Data collection ongoing	Yes	Awaiting publication
Elective Surgery (National PROMs Programme) – Hip replacement	Data collection ongoing	Yes	Awaiting publication
Elective Surgery (National PROMs Programme) – Knee replacement	Data collection ongoing	Yes	Awaiting publication
Elective Surgery (National PROMs Programme) – Groin hernia	Data collection ongoing	Yes	Awaiting publication
Elective Surgery (National PROMs Programme) – Varicose veins	Data collection ongoing	Yes	Awaiting publication
Endocrine and Thyroid National Audit	Data collection ongoing	Yes	Awaiting publication
Fracture Liaison Database	01/04/17 – 31/03/18	Yes	Awaiting publication
National Audit of Inpatient Falls	1/5/17 – 31/5/17	Yes	Awaiting publication

National Clinical Audit or Confidential Enquiry	Reporting Period	Participation	Number (%) of cases submitted
National Hip Fracture Database	1/1/17 – 31/12/17	Yes	Awaiting publication
Royal College of Emergency Medicine (RCEM) Fractured Neck of Femur	01/08/17 – 01/01/18	Yes	Awaiting publication
Inflammatory Bowel Disease (IBD) programme	01/04/17 – 31/03/18	Yes	Data collection in progress
Learning Disability Mortality Review Programme (LeDeR)	Data collection ongoing	Yes	Awaiting publication
Major Trauma Audit	Data collection ongoing	Yes	Awaiting publication
Maternal, Newborn and Infant Clinical Outcome Review Programme	Data collection ongoing	Yes	Awaiting publication
Medical and Surgical Clinical Outcome Review Programme	01/04/17 – 31/03/18	Yes	Awaiting publication
National Audit of Breast Cancer in Older Patients (NABCOP)	01/04/17 – 31/03/18	Yes	Data collection in progress
National Audit of Dementia	To be confirmed	Yes	Data collection not yet started
National Audit of Rheumatoid and Early Inflammatory Arthritis	To be confirmed	Yes	Data collection not yet started
National Audit of Seizures and Epilepsies in Children and Young People	To be confirmed	Yes	Data collection not yet started
National Bariatric Surgery Registry (NBSR)	Data collection ongoing	Yes	Awaiting publication
National Cardiac Arrest Audit (NCAA)	01/04/17 – 31/03/18	Yes	Data collection in progress
National Chronic Obstructive Pulmonary Disease Audit programme (COPD)	01/04/17 – 28/02/18	Yes	Data collection in progress
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	01/04/17 – 31/12/17	No	N/A
National Comparative Audit of Blood Transfusion programme	01/04/17 – 31/05/17	Yes	Awaiting publication
National Diabetes Audit - Adults	01/04/17 – 31/03/18	Yes	Data collection in progress
National Emergency Laparotomy Audit (NELA)	Data collection ongoing	Yes	Awaiting publication

National Clinical Audit or Confidential Enquiry	Reporting Period	Participation	Number (%) of cases submitted
National End of Life Care Audit	To be confirmed	Yes	Data collection not yet started
National Heart Failure Audit	Data collection ongoing	Yes	Awaiting publication
National Joint Registry (NJR)	Data collection ongoing	Yes	Awaiting publication
National Lung Cancer Audit (NLCA)	Data collection ongoing	Yes	Awaiting publication
National Maternity and Perinatal Audit	01/04/17 – 31/03/18	Yes	Data collection in progress
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Data collection ongoing	Yes	Awaiting publication
National Ophthalmology Audit	01/09/16 – 31/08/18	Yes	Awaiting publication
National Vascular Registry	Data collection ongoing	Yes	Awaiting publication
Neurosurgical National Audit Programme	01/04/17 – 31/03/18	Yes	Data collection in progress
Oesophago-gastric Cancer (NAOGC)	Data collection ongoing	Yes	Awaiting publication
Paediatric Asthma	To be confirmed	Yes	Data collection not yet started
Paediatric Intensive Care (PICANet)	Data collection ongoing	Yes	Awaiting publication
Paediatric Pneumonia	To be confirmed	Yes	Data collection not yet started
Pain in Children	01/08/17 – 31/01/18	Yes	Awaiting publication
Pleural Procedures	To be confirmed	Yes	Data collection not yet started
Procedural Sedation in Adults (care in emergency departments)	01/08/17 – 31/01/18	Yes	Awaiting publication
Prostate Cancer	Data collection ongoing	Yes	Awaiting publication
Sentinel Stroke National Audit programme (SSNAP)	01/04/17 – 31/03/18	Yes	Data collection in progress
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance scheme	Data collection ongoing	Yes	Awaiting publication
Smoking Cessation	To be confirmed	Yes	Data collection not yet started

National Clinical Audit or Confidential Enquiry	Reporting Period	Participation	Number (%) of cases submitted
UK Parkinson's Audit	01/05/17 – 31/10/17	Yes	Awaiting publication
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Non-Invasive Ventilation Study	01/02/15 – 31/03/15	Yes	8 (13%)
NCEPOD Young People's Mental Health Study	07/03/15 – 20/03/15	Yes	Report due to be published in Apr-18
NCEPOD Chronic Neurodisability Study	01/04/16 – ongoing	Yes	Report due to published in Mar-18
NCEPOD Cancer in Children, Teens and Young Adults Study	01/09/16 – 31/01/17	Yes	Report due to be published in Autumn 2018
NCEPOD Acute Heart Failure Study	01/01/16 – 31/12/16	Yes	Report due to be published in Summer 2018
NCEPOD Perioperative Diabetes Study	01/02/17 – 31/03/17	Yes	Report due to be published in Winter 2018
Adult Community Acquired Pneumonia	Not relevant to this Trust		
BAUS Urology Audits: Cystectomy			
BAUS Urology Audits: Percutaneous nephrolithotomy			
BAUS Urology Audits: Radical prostatectomy			
BAUS Urology Audits: Urethroplasty			
BAUS Urology Audits: Female stress urinary incontinence			
Head and Neck Cancer Audit (HANA)			
Mental Health Clinical Outcome Review Programme			
National Audit of Anxiety and Depression			
National Audit of Intermediate Care (NAIC)			
National Audit of Psychosis			
Prescribing Observatory for Mental Health (POMH-UK)			

The reports of 57 national clinical audits were reviewed by the provider in 2017/18 and the Trust intends to take the actions detailed on pages 52-57 to improve the quality of healthcare provided.

National Clinical Audit Projects reviewed by the Trust

National Audit Rating Key:

- Positive analysis: Outcome measures better than or within expected range; underperformance against <50% process targets with no demonstrable impact on patient outcome.
- Neutral analysis: Outcome measure within expected range; underperformance against >50% process targets with no demonstrable impact on patient outcome.
- Negative analysis: Outcome measure outside (below) expected range - negative outlier; underperformance against significant key process targets.
- Not applicable: Service not provided at this location.
- Methodological issue: Issues with the study's methods that prevent a rating, e.g. sample too small, sample not representative, results do not provide a measure of performance

National Audit Title	King's National Clinical Audit Rating		Summary of actions
	DH	PRUH	
Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme: Medical and Surgical Critical Care Unit, published Apr 17 and Jul 17			Results within expected range including the ICNARC mortality ratio – no action required.
Intensive Care/High Dependency Unit, published Mar 17 and Jun 17			
Liver Intensive Therapy Unit Report, published Apr 17 and Jul 17			
National Paediatric Diabetes Audit (NPDA), published Mar 17			There is an improving downward trend for median HbA1c results.
Myocardial Ischaemia National Audit Project (MINAP), published Jan 17			Variable performance against process indicators driven by data issues. Actions to improve data collection and transfer are in place.
National Audit of Cardiac Rhythm Management Devices (NaCRMD), published Feb 17			King's (DH and PRUH) undertakes in excess of the minimum numbers of cardiac implants as recommended by BHRS and NICE. King's has not been identified as an outlier and has reported a sufficient number of implants to satisfy the requirement for training. No action required.
National Prostate Cancer Audit, published Feb 17			No outcomes or process data supplied for King's patients and King's patients are treated by Guy's and St Thomas' Hospital (GSTT), which has not been identified as an outlier. No action required.
National Diabetes Inpatient Audit (NaDIA) England & Wales, 2016, published Mar 17			Medication, prescription, medication management and insulin errors at DH are lower than national figures and have improved since 2015. The proportion of patients admitted at DH with active foot disease seen by Multidisciplinary Diabetic Foot Team within 24 hours is higher than national figures. The number of Mild Hypoglycaemic episodes at DH is lower than national figures and has halved at PRUH since last audit. Medication management errors at PRUH have decreased significantly since 2015 and are now better than national figures. Improvement action continues, focusing on patient satisfaction, medication and insulin errors and access to diabetic foot care at PRUH.
National Diabetes Foot Care Audit, England & Wales, 2016, published Mar 17			Results appear variable but are not risk-adjusted and DH case mix (specialist diabetic foot service) has a significant impact. No specific improvement actions required.
British Association of Endocrine and Thyroid			DH and PRUH surgeons in hospital mortality rates are

National Audit Title	King's National Clinical Audit Rating		Summary of actions
	DH	PRUH	
Surgeons (BAETS) – Endocrine Surgery Surgeon Specific Outcomes, published Jan 17			below the national 0.08%. Post-operative stay, related readmissions and re-exploration for bleeding data are all below the national average and within control limits for all surgeons. No improvement actions required.
National Joint Registry – Enhanced Surgeon and Hospital Information (online), published Nov 16	Orpington		All sites are within expected range for adjusted 90 day mortality. No King's consultants were identified as being an outlier. No improvement actions required.
National Joint Registry (NJR) Annual Report, published Dec 17			All sites (DH, PRUH, and Orpington) are within the expected range for hip and knee replacements or revisions adjusted 90 day mortality. No King's Consultants were identified as an outlier. Data entry issues were identified and these are being addressed.
Perinatal Mortality Report: 2015 Births, published Jun 17			King's was awarded an overall 'green' rating and no specific improvement actions were identified.
Paediatric Asthma, published Nov 16			King's give steroids and oxygen for asthma attacks in accordance with BTS guidelines more frequently than UK average. King's offers more tertiary specialist follow-up compared to the rest of UK (a benefit of having the tertiary paediatric respiratory service on site and involved with admissions). Actions are focused on improving admissions to HDU/PICU at PRUH.
Sentinel Stroke National Audit Programme (SSNAP) Hyper Acute Stroke Unit (HASU) and Stroke Unit (SU) data, published Jun and Oct 17			The overall and team-centred scores for the HASU and SU at Denmark Hill improved, with the HASU score going from B to A. The Standardised Mortality Ratio (SMR) for DH and PRUH HASUs are within expected range. The PRUH HASU overall and team-centred SSNAP scores have maintained a level B score. 'C' ratings for PRUH SU overall SSNAP score and team-centred SSNAP score (deteriorated from 'B' last period) and 'D' rating for PRUH HASU team-centred stroke unit domain, which relates to access to HASU and is in part due to inliers from other specialties in the HASU. DH has improved from a D rating last period to a C rating. A detailed action plan is in place and was reviewed by CQC during 2017 inspection.
Neurosurgical National Audit Programme (NNAP), published May 17			King's achieved a 30 day risk-adjusted standardised mortality rate of 2.37%. The mortality rate is below expected ratio and within control limits and no specific improvement actions are required.
National Patient Reported Outcome Measures Programme (PROMS) , published May 17):			King's is within expected range for PROMs relevant to hip replacement and groin hernias, and is within control limits for both varicose veins and knee replacement (primary).
Groin hernia			• 28.6% of patients demonstrated improved symptoms for groin hernia (EQ VAS).
Hip replacement			• 98.8% of patients demonstrated improved symptoms for hip replacement (Oxford Hip Score).
Knee replacement			• 100% of patients have improved symptoms for knee replacement (Oxford Knee Score).
Varicose veins			• 70.8% of patients have improved symptoms for varicose veins (Aberdeen Varicose Vein Questionnaire).
National Lung Cancer Audit (NLCA) Annual Report, published Jan 17			78.9% of small-cell lung cancer (SCLC) patients received chemotherapy, up from 57.1% in previous audit round and better than the expected rate of 70%. 66.0% of King's patients were seen by lung cancer nurse specialist (LCNS). Although this is below the England average of 54.8%, it is better than the network average of 38.5% and an improvement from 51.1% at King's in 2014. King's performance is below expected for 8 out of 13 criteria reported. Survival at King's, 32.4% is below than the network average of 46.5%. A detailed investigation concluded that these results are driven by case mix issues (patients with high levels of

National Audit Title	King's National Clinical Audit Rating		Summary of actions
	DH	PRUH	
			comorbidity) and late presentation to King's. Work is ongoing with primary care to identify opportunities to improve early identification of lung cancer.
Annual Report on Liver Transplantation Report for 2016/17, published Sep 17 – Adult			In the period 01/04/2008 to 21/03/2012, King's achieved the highest five year risk- adjusted patient survival for both adult elective (85.2%) and super-urgent (87.2%) deceased donor first liver transplants.
Annual Report on Liver Transplantation Report for 2016/17, published Sep 17 – Children			King's College Hospital undertook the largest number of paediatric liver transplants (elective and super-urgent) nationally and King's achieved the highest five year unadjusted patient survival for paediatric elective deceased donor first liver transplants (93.5%) out of all three transplant centres (91.5% nationally).
Trauma Audit and Research Network (TARN) Online Survival Data Report, published Jul 17			More trauma patients admitted to DH and PRUH are surviving compared to the number expected based on the severity of their injury. No improvement actions identified.
TARN Clinical Report Issue 2: Core measure for all patients; Orthopaedic injuries, published Jul 17			Excess survivors standardised according to hospital case mix outcome at 30 days or discharge for DH is 1.22 and PRUH is 1.56. DH (95%) performed better than national average (62%) in completing the rehabilitation prescription for patients with ISS >8. Performance against some process indicators was below national average; however this does not appear to have an impact on patient outcome. Key improvement action relates to care of patients with open fractures and collaboration with GSTT to ensure appropriate plastic surgery cover.
TARN Clinical Report Issue 3: Core measure for all patients; Thoracic and Abdominal injuries and Patients in Shock, published Mar 17			Excess survivors standardised according to hospital case mix outcome at 30 days or discharge, for DH is 1.74 and PRUH is 3.91. The number of excess survivors has improved in both sites from last year. No specific improvement actions identified.
TARN Clinical Report III: Head & Spinal Injuries, published Nov 17			Excess survivors standardised according to hospital case mix outcome at 30 days or discharge for DH is 0.55 and PRUH is 1.03. No specific improvement actions were identified.
TARN Major Trauma Dashboard Q1, published Jul 17, Q2, published Nov 17 and Q3, published Jan 18			Rapid access to specialist MTC care in DH patients transferred to MTC within 2 days of referral request is lower than national figures and is driven by King's capacity issues – senior trust planning is in progress to address this issue and performance for this indicator has improved. DH performed lower than national figures in delivering definitive cover of open fractures within BOAST 4 guidelines, driven by the lack of plastic surgeon availability at DH. The issue has been escalated and is being addressed by the senior management team, and performance on this indicator has improved. DH performed lower than national figures in administering Tranexamic Acid within 3 hours of incident to patients that receive blood products within 6 hours of incident. This is a data interpretation issue - first dose is given at the scene or in the ambulance and a second dose is often not required.
TARN Children's Major Trauma Dashboard Jan – Jun 2017, published Aug 17			DH performed within the expected range for ten out of fourteen indicators, with above national average performance for six indicators. Improvement actions are focussed on the proportion of patients meeting NICE head injury guidelines that receive CT scan within 60 minutes of arrival at MTC.
National Clinical Audit of Biological Therapies - UK Inflammatory Bowel Disease (IBD) audit, published Sep16			DH has improved Infliximab biosimilar prescribing rate and currently more than 95% of patients are treated on the drug. There are actions underway to improve the recording of disease activity score on the biologic prescribing form.
National Paediatric Diabetes Audit (NPDA) Part2: Hospital Admissions and Complications 2012 – 2015, published Jul 17			The admission rate for King's College Hospital (DH site) in 2014 - 15 was 28.9 % (national average 23.6%) and King's DH site was not identified as an outlier and no specific

National Audit Title	King's National Clinical Audit Rating		Summary of actions
	DH	PRUH	
			improvement actions were identified.
National Emergency Laparotomy Audit Dec 2015 – Nov 2016, published Oct 2017			Adjusted 30 day mortality rate at both DH and PRUH is lower than national and both DH and PRUH have performed better than national, and better than last year, against key indicators. Improving performance for emergency laparotomy was a Trust Quality Priority this year and last year, and in September 2017 both DH and PRUH were identified by the national audit team as being amongst the five most improved sites nationally. Current improvement actions are focused on ensuring consultant anaesthetist presence in theatre for high-risk patients at DH and ensuring patients' arrival in theatre is within a time appropriate for the urgency of surgery. Theatre capacity is subject of high-level action planning.
National Audit of Percutaneous Coronary Interventions Annual Public Report 01 Jan-15 - 31 Dec-15, published: Sep 17 (BCIS Aggregate Data Report)			DH site was not identified as an outlier in the national audit report, and performed better than national average for Door-to-Balloon Time within 90 minutes.
Vascular Surgery Quality Improvement Programme (VSQIP) National Vascular Registry Surgeon Outcomes, published Aug 17			DH achieved 100% adjusted survival rate for Elective Infra-Renal Abdominal Aortic Aneurysm repair and 97.2% adjusted stroke free survival rate for Carotid Endarterectomy. No improvement actions identified.
Vascular Surgery Quality Improvement Programme (VSQIP) National Vascular Registry 2017 Annual Report, published Nov 17			The adjusted stroke and/or death rate for carotid endarterectomies was within confidence limits. Adjusted on-hospital mortality for lower limb amputation appears higher than national. This is driven by King's large tertiary referral service of very complex patients, especially diabetic cases with renal failure, with significantly higher expected and observed mortality. The King's data submitted for infra-inguinal bypasses did not include the other minor and moderate procedures that are regularly submitted by peers under the same heading. This is a data design weakness that has been discussed with GSTT colleagues in the joint consultant meeting, where it was agreed to raise this with the NVR administrators, as well as the vascular society, to make the database more meaningful for leg bypasses.
Myocardial Ischaemia National Audit Project (MINAP) Annual Public Report (2015-16 data), published Jun 17			King's experienced a problem with data submission stemming from transfer of data between databases. Actions have been taken to ensure the issue is addressed in advance of next data submission.
National Heart Failure Audit: April 2015 – March 2016, 9th Annual Report, published Aug 17			King's DH and PRUH sites achieved the requirements of the Best Practice Tariff (BPT) for its Acute Heart Failure patients and PRUH site demonstrated an overall improvement compared to 2016 report data. King's sites did not achieve national average for patients receiving input from a specialist (DH: 70.5%, PRUH: 68.8%, National: 79%) and there was an overall decline in performance demonstrated by King's DH site when compared to 2016 report data. These results were driven by bed shortages at King's, which led to fewer patients getting admitted to cardiology wards, coupled with rapid discharge from MAC/AMAU without referral to cardiology and cardiologists only seeing the patients at outpatients. Improvement actions have been taken and early indications from more recent preliminary results are that the situation is looking improved.
National Diabetes Audit Report 1: Care Processes and Treatment Targets England and Wales, 2016, published Jan 17			Performance has improved for both Type 1 and Type 2 Diabetes in comparison to 2014-15. Local data collected by the Health Innovations Network (HIN) and the preceding Diabetes Modernisation initiative shows that the offer of structured education has improved considerably in recent years in Lambeth and Southwark. The whole area of education provision in South London will be reformed and modernised on the basis of an NHS

National Audit Title	King's National Clinical Audit Rating		Summary of actions
	DH	PRUH	
			transformation project being supported by HIN with KHP clinical leadership. This will establish a hub to manage all structured education referrals across Type 1 and Type 2 diabetes and improve access to courses. This project will generate concrete data on referral and attendance rates and is likely to provide the benchmark for the NHS in this area.
National Diabetes Insulin Pump Audit, published Jul 17			31.8% of patients in DH with Type 1 Diabetes receive Insulin Pump therapy; nationally 15.3%. Patients in DH who are receiving Insulin Pump Therapy as well as those who are not receiving the therapy have a higher Treatment Target achievement rate than national figures. Improvement actions are focused on data capture in relation to the care processes.
Royal College of Emergency Medicine (RCEM) Moderate and Acute Severe Asthma, published May 17			DH performance (96%) for giving oxygen on arrival was considerably higher than national figures (19%). Both DH and PRUH performed above national figures for steroids given within 60 minutes of arrival (acute severe), within 4 hours (moderate) and for IV Magnesium 1.2 - 2g over 20 minutes given to adults with acute severe asthma who do not respond well to bronchodilators. Actions are in place to improve recording of key data and the arrival of the E-Prescribing and Medicines Administration (EPMA) system in the Emergency Department (ED) will improve recording of oxygen and medication prescription.
RCEM Consultant Sign-Off 2016-17, published May 17			DH and PRUH performed better than national figures for Consultant review of patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. Improvement actions relate to recording issues, which have been addressed by encouraging staff to complete the 'senior review' tab on the ED's IT system, a message which is now included in staff local induction.
RCEM Severe Sepsis and Septic Shock, published May 17			Improving the management of sepsis is a Trust Quality Priority and a Sepsis Working Group is leading on the implementation of trust-wide improvements. This work was reviewed in detail by CQC in its 2017 inspection.
National Audit of Dementia Care in General Hospitals, published Jul 17			DH performed better than national figures for six out of seven audit themes and was rated as best of 195 hospitals for Discharge Planning, and in the highest score group for Assessment, Staff and Carer rating of Communication and Information and the Carer rating of Patient Care. PRUH performed better than national figures on four out of the seven audit themes , and scored in the highest score group for Assessment and Discharge Planning. Improvement actions relate to the involvement of hospital leads in planning and monitoring care for people with dementia, to nutrition and to communication with carers. Additional dementia nurses have been recruited and will lead on improvement work in these areas.
National Ophthalmology Database Audit Annual Report: Year 2 Annual Report – The First Prospective Report of the National Ophthalmology Database Audit, published Jul 17			King's was not identified as an outlier for Posterior Capsular Rupture rate and no specific improvement actions were identified.
National Hip Fracture Database Report 2017 Published, Sep 2017			Performance is better than national at both sites for the proportion of patients meeting best practice criteria. Improvement actions relate to ensuring patients are admitted to orthopaedic ward within four hours, mobilised out of bed by the day after surgery and reducing hip fractures sustained as an inpatient. These areas are the subject of Trust-wide action planning and reducing in-hospital falls has been identified as a Trust Quality Priority for 2018-19.
Fracture Liaison Service Database (FLS-DB) clinical audit, published Apr 17			98.7% of patients at DH are assessed by Fracture Liaison Service (FLS) within 90 days (audit standard is 80%).

National Audit Title	King's National Clinical Audit Rating		Summary of actions
	DH	PRUH	
			There were issues with data entry leading to insufficient data being submitted for many indicators and unreliable results and a business case is under development for increased data entry support.
UK Renal Registry Annual Report, published Sep 17			Survival at King's remains good and within expected rates. More prevalent dialysis patients are managed with the home therapy dialysis than the national average. In 2015 infection episodes in our prevalent dialysis patients remain lower than the national rate. No specific improvement actions were identified.
National Neonatal Audit Programme (NNAP), 2016 Annual Report on 2016 data, published Sep 17			King's overall performance is better than national average 1.12 (0.72 – 1.53), national 1.68 (1.62 – 1.74) for proportion of babies born >34 weeks gestation having an encephalopathy within the first three full calendar days after birth. DH performed better than national average and network performance for all key evidence based process measures. The neonatal team are addressing some data entry issues.
National Cardiac Arrest Audit, published Jul 17			DH performed better than national average for survival after in-hospital cardiac arrest, for all patient groups. No specific improvement actions identified.
National Chronic Obstructive Pulmonary disease (COPD) Audit: Outcomes from the clinical audit of COPD exacerbations admitted to acute units in England 2014, published Oct 17			The published data was three years old, the results not risk-adjusted and the sample size small. The data did not prove useful for driving local improvement.
Actual and Potential Deceased Organ Donation Audit, published Oct 17			King's was noted as being '*exceptional and good for specialist Nurse presence in approaches to families'* when compared with UK performance. The total number of consented donors that became actual donors increased from 14 last year to 28 this year and the number of patients transplanted has increased from 34 last year to 61 this year. The organ donation team has a comprehensive action plan aimed at continuously improving the number of consented donors, actual donors and organs transplanted.
Paediatric Intensive Care Audit Network Annual Report 2017, published Nov 17			King's achieved excellent outcomes with an adjusted PIM3 (95% CI) mortality score of 0.85 (0.50 – 1.32). No specific improvement actions were identified.
National Pregnancy in Diabetes Audit (NPID), 2016, published Oct 2017			King's (DH) performed better than national average for the majority of key outcome indicators, but worse than national average for the key outcome indicator 'percentage of babies at DH born at/after 37 weeks admitted to a neonatal care unit for both Type 1 and Type 2 Diabetes'. King's has second highest number of pregnancies with Type 1 Diabetes in the group of London NHS trusts included in the audit and the sixth highest number of pregnancies with Type 2 Diabetes. A joint group with GSTT and primary care Lambeth & Southwark Comprehensive has formed to drive improvement actions locally, addressing pre-pregnancy counselling, pre-pregnancy planned pregnancy care, development of a pathway for women with Type 1 and Type 2 diabetes and participation in the proposed National Pregnancy in Diabetes Quality Improvement Collaborative.
National Bowel Cancer Audit (NBOCA) Annual Report, published Dec 17			DH is within expected range for adjusted 90-day mortality rate but was identified as an outlier for adjusted 2-year mortality tor patients having a major resection rate. A detailed internal investigation was undertaken and published in the appendix of the national audit report. The investigation did not identify any quality of care issues that led to the high mortality result. It did, however identify that patients presenting to King's have advance disease and are younger than the national average. Work is in progress to identify opportunities for improved screening and early identification of bowel cancer in our local community.

National Audit Title	King's National Clinical Audit Rating		Summary of actions
	DH	PRUH	
National Bowel Cancer Audit (NBOCA) Consultant Outcomes Programme Annual Report, published Dec 17			King's adjusted 90-day mortality and adjusted 30 day unplanned readmission is within control limits and no specific improvement actions were identified.
British Association of Urological Surgeons Nephrectomy, Consultant Outcomes Publication (COP), published Oct 2017			King's was not identified as an outlier, however, whilst the patients are from King's, the surgery is undertaken at Guy's and St Thomas', and the results are not a reflection of King's performance.
Serious Hazards of Transfusion Scheme (SHOT) UK National Haemovigilance Scheme, published Jul 17			There has been a significant decrease in the number of serious adverse reactions due to transfusion from 2015 to 2016. The data shows that King's reported more incidents or near miss incidents to SHOT in 2016 than the benchmark group but this is likely to be driven by good reporting practice.

Local clinical audits are managed within the Trust's Divisional management structure and approximately 300 hundreds of local clinical audits are undertaken every year. The management of these projects is appropriately led at Care Group level and the specific number of projects is not easily retrievable. Clinical audits where many of which were reviewed by CQC in its 2017 inspection and King's was found to be compliant with national requirements. Examples of trust-wide audits are provided below. Action plans are often lengthy documents and can be provided by request to the Associate Director of Governance and Assurance.

Examples of local clinical audit	Actions
Clinical record-keeping and consent trust-wide	Detailed action plans in place, including comprehensive roll out of EPR and review of feasibility of e-consent.
Availability of patient records trust-wide	Routine on-going audit with comprehensive action plan reported to Patient Records Committee monthly. Significant improvements achieved and noted by CQC in its 2017 inspection.
Infection prevention and control audits trust-wide	A comprehensive ongoing infection control audit programme is in place with results reported through the Trust's routine performance monitoring.
Maternity key indicators audits trust-wide	Comprehensive ongoing monitoring against maternity standards is integrated into the Trust's routine performance monitoring.

Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by the Trust for 2017/18 that were recruited to participate in research and approved by a research ethics committee was 16,472.

Commissioning for Quality and Innovation (CQUIN) framework

A proportion (2.5% of CCG and 2.8% of NHSE) of King's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between King's and both NHS South East Commissioning leads and NHJSE England as part of the Commissioning for Quality and Innovation (CQUIN) payment framework. This equated to a total of £16.8m. 0.5% of the CCG contract however was allocated to achieving an agreed control total value which King's has not signed up to which means a loss of income of £2m.

For 16/17 the Trust received £17,119,422 related to CQUIN related income and £986,076 related to other contracts (London Secondary Dental Care, London Breast Screening and NCAs) totalling £18,105,499.

National CQUINS

National CQUINS have been published and the following schemes apply to King's College Hospital Foundation Trust (1.5% = £6,688,400):

National CQUINS	Description	Annual Financial Value
Improving Staff Health and Wellbeing (Continuation from 16/17)	1. Improvement in staff Health and Wellbeing 2. Healthy food for staff, patients and visitors 3. Improving the Flu uptake.	£1,114,733
Reducing the impact of serious infections (Antimicrobial resistance and Sepsis) (Continuation from 16/17)	1. Timely identification of sepsis in ED and Acute Inpatient areas 2. Timely treatment of sepsis in ED and Acute Inpatient areas 3. Antibiotic review 4. Reduction in antibiotic consumption	£1,114,733
Mental Health in A&E	Improving services for people with mental health needs who present at A&E	£1,114,733
Supporting proactive and safe discharge (New)	1. Provide emergency care data set (ECDS) 2. Increase proportion of 65+ who are discharged within 7 days to their usual place of residence.	£1,114,733
Offering Advice and Guidance (New)	Increase areas offering Advice and Guidance	£1,114,733
E-Referrals (New 17/18 only)	All first outpatient appointments are to be available on e-RS	£1,114,733
Preventing ill health by risky behaviours – alcohol and smoking **(New 18/19 only)**	1. Tobacco screening 2. Tobacco brief advice 3. Tobacco referral medication 4. Alcohol screening 5. Alcohol brief advice	

Local CQUINS

CCG Contract (0.5% - £2,229,400)

Local CCG CQUINS	Description	Annual Financial Value
Health Promoting Hospital (Continuation from 16/17)	• Smoking and Alcohol screening, advice and referral • Implement review of physical activity measurement for patients • Staff training on brief advices and knowledge of Making Every Contact Count (MECC) which this CQUIN is based on • Ensuring that the organisation and staff are aware of process and what is available and is closely linked to the staff health and wellbeing CQUIN.	£1,114,700
Care Co-ordination – Lambeth and Southwark (Continuation from 16/17)	Develop and implement proactive and person-centred care coordination for people with complex needs and with long term conditions	£557,350
Integrated Care Frailty – PRUH (Continuation from 16/17)	Improving the care for patients that are frail.	£557,350

NHSE CQUINS

(2.8% - £7,306,720)

NHS England CQUINS	Description	Annual Financial Value
Hepatitis C	Improving pathways through ODN's (Continuation from 16/17)	£4,436,222
Haemoglobinopathy	Improving pathways through ODN's	£130,477

Sickle Cell	Automated exchange transfusion for Sickle Cell patients (Continuation from 16/17)	£391,431
Clinical Utilisation Review	Implementation, application and use of system to which will assist in reduction of inappropriate hospital utilisation - (Continuation from 16/17) – PRUH to be rolled out in 18/19	£1,356,962
Cancer Dose Banding IV SACT	Standardising chemo dosages - (Continuation from 16/17)	£260,954
Paediatric Networked Care	To reduce recourse to critical care distant from home.	£234,858
Spinal surgery	Networks, data and MDT oversight	£234,858
Cystic Fibrosis Patient Adherence	This scheme employs an electronic Cystic Fibrosis (CF) adherence indicator captured by an IT platform (CFHealthHub) to deliver a complex behavioural intervention that increases patient activation and adherence, thus delivering better patient outcomes and avoidance of costly escalations. Objective adherence is measured for high cost inhaled therapies collected via chipped nebulisers and displayed in CFHealthHub.	£182,668
Neuro Rehabilitation	NHS England has reviewed neuro-rehabilitation services in London and recognised that the service does not run as part of properly co-ordinated network, instead there are delays in assessment, multiple referrals for assessment, a high level of rejected referrals and poor sign-posting early in the pathway. All of this results in delay for patients accessing the right service at the right time. Additionally NHS England London found that patient experience data was not available in a routine format within units.	£78,206
Difficult to deal with Asthma	The CQUIN scheme aims to ensure assessment and investigation of children with difficult to control asthma within twelve weeks of referral, so to ensure that all eligible children have appropriate and timely assessment and investigation in order to improve asthma control, reduce hospital	£0

	admissions and avoid inappropriate escalation of therapy including the initiation of expensive monoclonal antibodies.	
Dental	Collection and submission of data on priority pathways procedures by Tier using the CQUIN dashboard. Tier 1, 2, 3 – recording of data for oral surgery and orthodontics; to include restorative when published. Understand demand and capacity issues and find solutions as 'one organisation', pooling resources where necessary and producing action plans to overcome problems.	£479,091

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

Care Quality Commission (CQC)

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

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

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

CQC Ratings

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

Key issues highlighted in the CQC report were:

- **Patient flow** in Outpatients and Emergency Departments as well as referral to treatment times at Denmark Hill and PRUH.
- **Documentation of care** (completion and availability of paper records at PRUH).
- **Environment and Capacity** in Denmark Hill's Liver and Renal outpatients, Maternity, Critical Care wards and PRUH Surgical Admission Lounge.

- **Improving Skills, Knowledge and Processes to Improve Patient Safety** Mental Capacity Act 2005 and Deprivation of Liberty Safeguards policies were reviewed and targeted training is currently implemented.

The Care Quality Commission has not taken enforcement action against King's College Hospital NHS Foundation Trust during 2017/18.

In January 2018 the Trust received the CQC's quality report from the September 2017 inspection. They found that the majority of areas were able to demonstrate improvement. However, the key areas that remained to improve were: capacity and flow issues through the Emergency Department.

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

The Trust is expecting an inspection by the CQC sometime in 2018/19 which will include the NHSI well-resourced criteria.

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

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

Records Submission

1,465,000 submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data April 2017 - January 2018 which included the patient's valid NHS number was:
:

- 98.5% for admitted patient care;
- 99.0% for outpatient (non-admitted) patient care; and
- 91.3% for accident and emergency care.

The percentage of records in the published data April 2017 - January 2018 which included the patient's valid General Medical Practice Code was:

- 99.8% for admitted patient care;
- 99.8% for outpatient (non-admitted) patient care; and
- 99.5% for accident and emergency care.

Information Governance Assessment

King's College Hospital NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 79% and was graded green / satisfactory.

Payments by Results (PbR)

The Trust was not identified as necessary for a Payment by Results (PbR) clinical coding audit in 2017/18.

Summary Hospital Mortality Index (SHMI)

April 16 – March 17 have been published and the SHMI is 92.31% for last year
July 16 – June 17 is the latest SHMI published in Dec-17 and is 90.97% for the 12-month period

Patients deaths with palliative care coded at either diagnosis or speciality level:

- 48.6% for the same 2 published periods above so no change in the figure

Learning from Deaths

During 2017/18 at King's College hospital NHS Foundation Trust 2447 patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 561 in the first quarter;
- 550 in the second quarter;
- 641 in the third quarter;
- 695 in the fourth quarter.

By 31 March 2018, 299 case record reviews and 61 investigations have been carried out in relation to 360 of the 2447 deaths included above.

In 22 cases a death was subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 69 in the first quarter;
- 110 in the second quarter;
- 142 in the third quarter;
- Fourth quarter results will be available end June 2018.

10 representing 3.1% of the patient deaths reviewed during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter this consisted of:

- 2 representing 2.9% for the first quarter;
- 6 representing 5.5% for the second quarter;
- 2 representing 1.4% for the third quarter;
- Fourth quarter results will be available end June 2018.

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

Case record reviews indicated possible contributions to death from issues relating to monitoring, use of investigations and medication, and in discharge planning. All cases have been subject to established Trust investigation processes and/or Coronial Inquest with involvement of families and in accordance to Duty of Candour polices.

At King's we aim to ensure that learning from these deaths and other safety incidents are shared widely and become embedded in clinical practice though a variety of internal communication mechanisms, including the new SafetyNet initiative. This includes sharing of summaries of individual incidents and the themes identified from their analysis. For these cases this has included review and modification of results reporting and acknowledgement processes, and training of staff in specific aspects of care that have identified as being of importance.

Aggregated data is not available for case record reviews or investigations completed in relation to deaths which took place before the start of the reporting period, as this is the first reporting period requiring this information.

Action to Improve Data Quality

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

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

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

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

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

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

The Trust acknowledges weaknesses in the quality of internal data produced with respect to 18 Week Referral to Treatment and 4 Hour Accident and Emergency Waiting Times. This is

consistent with the External Auditor's conclusion in their Qualified Opinion. The Trust is currently working on an action plan to identify areas of improvement.

Reporting against core indicators

Performance Measures						Foundation Trusts Comparable Value (Shelford Group)				
Indicator	**Measure**	**Current Period**	**Value**	**Previous Period**	**Value**	**Highest**	**Lowest**	**National Average**	**Source**	**Regulatory Statement**
Hospital Mortality Index (SHMI)	Observed mortality is lower than expected mortality	1 Dec 2016 – 30 Nov 2017	88 (95% Confidence Interval 85, 92)	1 Dec 2015 – 30 Nov 2016	93 (95% Confidence Interval 90, 96)	70 (95% Confidence Interval 67, 74)	113 (95% Confidence Interval 105, 123)	100	Hospital Episode Statistics via HED	*The King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons:* • *The Trust prioritises the delivery of excellent patient outcomes and has excellent mortality monitoring processes in place.* *The King's College Hospital NHS Foundation Trust intends to take/has taken the following actions to improve the SHMI, and so the quality of its services, by:* • *Continuing to invest in routine monitoring of mortality and detailed investigation of any issues identified.*

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable** Foundation Trust	Lowest Value Comparable** Foundation Trust	National Average	Data Source	Regulatory Statement
Patient Reported Outcomes Measures - groin hernia surgery	EQ-5D Index: 21 modelled records	Apr 15 - Mar 16	Adjusted average health gain: *	Apr 14 - Mar 15	Adjusted average health gain: *	0.106 (Oxford University Hospitals NHS Foundation Trust)	0.080 (Sheffield Teaching Hospitals NHS Foundation Trust)	0.088	HSCIC 'Select 10' table, April 2015-March 2016, published August 2017)	*King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons - our participation rate was too low. King's College Hospital NHS Foundation Trust intends to take the following actions - this national PROM ceased to be mandatory In October 2017 and, as the routine monitoring of this PROMS has not supported our commitment to ongoing improvement of patient care and outcomes, King's College Hospital NHS Foundation took the decision to cease our participation.*
	EQ VAS: 48 modelled records		Adjusted average health gain: -1.395		Adjusted average health gain: -08.42	0.770 (Oxford University Hospitals NHS Foundation Trust)	-2.690 (Guy's and St Thomas' NHS Foundation Trust)	-0.817		

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable** Foundation Trust	Lowest Value Comparable** Foundation Trust	National Average	Data Source	Regulatory Statement
Patient Reported Outcomes Measures - varicose vein surgery	EQ-5D Index: 60 modelled records	Apr 15 - Mar 16	Adjusted average health gain: 0.076	Apr 14 - Mar 15	Adjusted average health gain: *	0.104 (University Hospitals Birmingham NHS Foundation Trust)	0.038 (Imperial College Healthcare NHS Trust)	0.096		*King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons - our participation rate was too low. King's College Hospital NHS Foundation Trust intends to take the following actions - this national PROM ceased to be mandatory In October 2017 and, as the routine monitoring of this PROMS has not supported our commitment to ongoing improvement of patient care and outcomes, King's College Hospital NHS Foundation took the decision to cease our participation.*
	EQ VAS: 60 modelled records		Adjusted average health gain: -0.960		Adjusted average health gain: *	-1.135 (University College London Hospitals NHS Foundation Trust)	-3.524 (Oxford University Hospitals NHS Foundation Trust)	-0.430		
	Aberdeen Varicose Vein Questionnaire: 61 modelled records		Adjusted average health gain: -8.200		Adjusted average health gain: *	2.980 (Oxford University Hospitals NHS Foundation Trust)	-9.553 (Sheffield Teaching Hospitals NHS Foundation Trust)	-8.626		

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable** Foundation Trust	Lowest Value Comparable** Foundation Trust	National Average	Data Source	Regulatory Statement
Patient Reported Outcomes Measures - hip replacement surgery	EQ-5D Index: 234 modelled records	Apr 15 - Mar 16	Adjusted average health gain: 0.445	Apr 14 - Mar 15	Adjusted average health gain: 0.441	0.480 (Imperial College Healthcare NHS Trust)	0.418 (Sheffield Teaching Hospitals NHS Foundation Trust)	0.438		*King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons - our performance is in line with Shelford Group peers. King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by continuing to provide excellent elective orthopaedic services.*
	EQ VAS: 235 modelled records		Adjusted average health gain: 15.006		Adjusted average health gain: 12.835	15.940 (Imperial College Healthcare NHS Trust)	10.520 (Sheffield Teaching Hospitals NHS Foundation Trust)	12.404		
	Oxford Hip Score: 256 modelled records		Adjusted average health gain: 22.002		Adjusted average health gain: 22.200	24.617 (Imperial College Healthcare NHS Trust)	18.548 (Central Manchester University Hospitals NHS Foundation Trust)	21.607		
Patient Reported Outcomes Measures - knee replacement surgery	EQ-5D Index: 320 modelled records	Apr 15-Mar 16	Adjusted average health gain: 0.294	Apr 14 - Mar 15	Adjusted average health gain: 0.283	0.259 (Oxford University Hospitals NHS Foundation Trust)	0.309 (Guy's and St Thomas' NHS Foundation Trust)	0.320		*King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons - our performance is in line with Shelford Group peers. King's College Hospital NHS Foundation*
	EQ VAS: 304 modelled records		Adjusted average health gain: 5.823		Adjusted average health gain: 4.651	8.090 (Cambridge University Hospitals NHS Foundation Trust)	3.734 (Sheffield Teaching Hospitals NHS Foundation Trust)	15.752		

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable** Foundation Trust	Lowest Value Comparable** Foundation Trust	National Average	Data Source	Regulatory Statement
	Oxford Knee Score: 341 modelled records		Adjusted average health gain: 14.641		Adjusted average health gain: 14.7	16.728 (Central Manchester University Hospitals NHS Foundation Trust)	13.375 (Imperial College Healthcare NHS Trust)	16.365		*Trust intends to take the following actions to improve this score, and so the quality of its services, by continuing to provide excellent elective orthopaedic services.*
* Figure suppressed by HSCIC to protect patient confidentiality.										
** Shelford Group trusts used as comparator										

Percentage of patients readmitted within 28 days of being discharged during the 2017/18 reporting period

Patients aged 0-15 (emergency) readmitted within 28 days of being discharged April 2017- March 2018 = 1.25%
Patients aged 16+ (emergency) readmitted within 28 days of being discharged April 2017- March 2018 = 6.97%
N.B. the above data is linked to our Patient Activity System (PAS) and is supplied by our Business Intelligence Unit.

Kings is keen to reduce readmissions and has ongoing programmes across childrens and adult services linking care across the whole system.

Percentage of patients admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period

Admitted patients who were risk assess for venous thromboembolism April 2017- March 2018 = 96.7%.

N.B. N.B. the above data is linked to our Patient Activity System (PAS) and is supplied by our Business Intelligence Unit. The data is also linked through to our electronic prescribing system. Kings has been the national exemplar site for VTE prevention for over 10 years.

There is a comprehensive system of education and preparation to improve VTE assessment.

Rate per 1000 bed days of cases of C.difficile infection reported amongst patients aged 2 or over during the reporting period

Cases of C difficile infection reported for patients aged 2 or over – April 2017-March 2018 – reportable cases rate/100,000 bed days = (88 cases) 15.28per 100,000 cases

N.B. Our dedicated Alert organism surveillance team monitor all alert organisms and ensure accuracy of information throughout the Trust.

There is a regular programme of CDT reduction led by the DIPC, Consultant Microbiologists and IPC Team.

The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.

Two relevant questions posed by the 2017 staff survey:	% who agreed/strongly agreed
If a friend/relative needed treatment I would be happy with the standard of care provided by the organisation	71%
Care of patients/service users is a top priority for the organisation	74%

N.B. The Trust uses an external provider to monitor the Staff FFT. The workforce directorate have a comprehensive programme to improve staff engagement and well being.

Quality of Care Indicators - Responsiveness to Personal Needs

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest	Lowest	National Average	Data Source	Regulatory Statement
Were you involved as much as you wanted to be in decisions about your care and treatment?	Score out of 10	2016 National Inpatient Survey	7.1	2015 National Inpatient Survey	7.4	8.8	6.3		CQC	The data presented for these indicators is from the national inpatient survey which is commissioned and validated by the CQC who provide quality assurance of the survey process and produce the results nationally and for each Trust. For each question we are provided with a score using a nationally agreed formula. On this basis, we are assured of the validity of the data. The Trust is tasking its clinical divisions to develop patient, family and carer experience action plans to improve patient experience.
Did you find someone on the hospital staff to talk to about your worries and fears?	Score out of 10 trust-wide	2016 National Inpatient Survey	5.5	2015 National Inpatient Survey	5.8	8.0	4.5		CQC	
Were you given enough privacy when discussing your condition or treatment?	Score out of 10 trust-wide	2016 National Inpatient Survey	8.7	2015 National Inpatient Survey	8.5	9.4	7.9		CQC	
Did a member of staff tell you about medication side effects to watch for when you went home?	Score out of 10 trust-	2016 National Inpatient Survey	4.2	2015 National Inpatient Survey	4.2	7.7	3.5		CQC	

Did hospital tell you who to contact if you were worried about your condition or treatment after you left hospital?	Score out of 10 trust-	2016 National Inpatient Survey	6.9	2015 National Inpatient Survey	7.5	9.7	6.4		CQC	

Patient Safety Incidents 2017/18

Metric	
Number of Patient Safety Incidents 2017/18	24,971
Patient Safety Incidents/1000 Bed days	47.81
(Bed days taken as 522,331 inpatient bed days Business Intelligence Unit application data 30/4/18)	
Number of incidents contributing to death of patient	18
Percentage where contributing to death of patient	0.07
Number of incident contributing to serious harm (not including death)	96
Percentage where contributing to serious harm (not including death)	0.38

Notes

1. Patient Safety Incidents are only those reported to NHSI via the NRLS reporting system, using their definitions. (e.g. staff related incidents not included if no effect on the patient).

2. Figures as at 30/04/2018 – This includes un-reviewed incidents and incidents subject to investigation so therefore the degree or harm attributed or the validity of the incident may be clarified which would result in changes to these figures.

Part Three

Other information

Performance against the relevant indicators and performance thresholds set out below:

2016/17

Single Oversight Framework	Kings College Hospital NHS Foundation Trust												
	Target	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Total 2016/17
RTT Incomplete Performance	92.0%	80.7%	80.9%	81.3%	82.0%	82.2%	80.8%	79.1%	78.3%	77.1%	77.3%	76.9%	76.1%	79.4%
Cancer 62 day referral to treatment - GP Referral	85.0%	87.3%	80.8%	89.8%	77.3%	91.1%	84.6%	90.6%	83.7%	86.8%	86.4%	79.5%	83.3%	85.1%
Cancer 62 day referral to treatment - Screening	90.0%	93.9%	88.5%	89.1%	78.7%	95.4%	97.2%	91.8%	89.5%	94.0%	79.1%	94.1%	87.5%	89.9%
Diagnostic Waiting Times Performance < 6 Wks	<1%	5.9%	8.1%	9.4%	6.8%	2.0%	1.0%	0.8%	0.9%	1.0%	1.2%	0.9%	2.4%	3.4%
A&E 4 hour performance (All Types)	95.0%	83.5%	85.1%	83.8%	83.5%	88.2%	82.0%	81.3%	79.9%	75.5%	78.2%	81.4%	82.6%	82.1%
Summary Hospital-level Mortality Indicator	<100	97.7	96.9	95.7	94.3	94.3	92.9	93.4	93.2	94.2	95.2	95.0	93.5	94.4
VTE Risk Assessment	95.0%	97.2%	97.1%	97.4%	97.0%	96.5%	96.9%	96.9%	97.3%	97.2%	97.2%	97.4%	97.3%	97.1%
Clostridium difficile rates	60	5	5	4	7	6	9	4	10	9	4	3	3	69

Access to services

This year, 2017/18, has been a challenging year for both emergency and elective access standards with increases in the numbers of people attending our emergency department (ED), non-elective admissions and outpatient referrals. We are seeing more patients attending hospital who are elderly and have a range of healthcare need when they are admitted, increasing the length of time they require hospital services. This growth has pressure on the capacity of the Trust across beds, clinics and diagnostics. King's College Hospital has one of the highest levels of bed occupancy (beds that are full at any point in time), limiting its ability to respond when demand increases above expected levels.

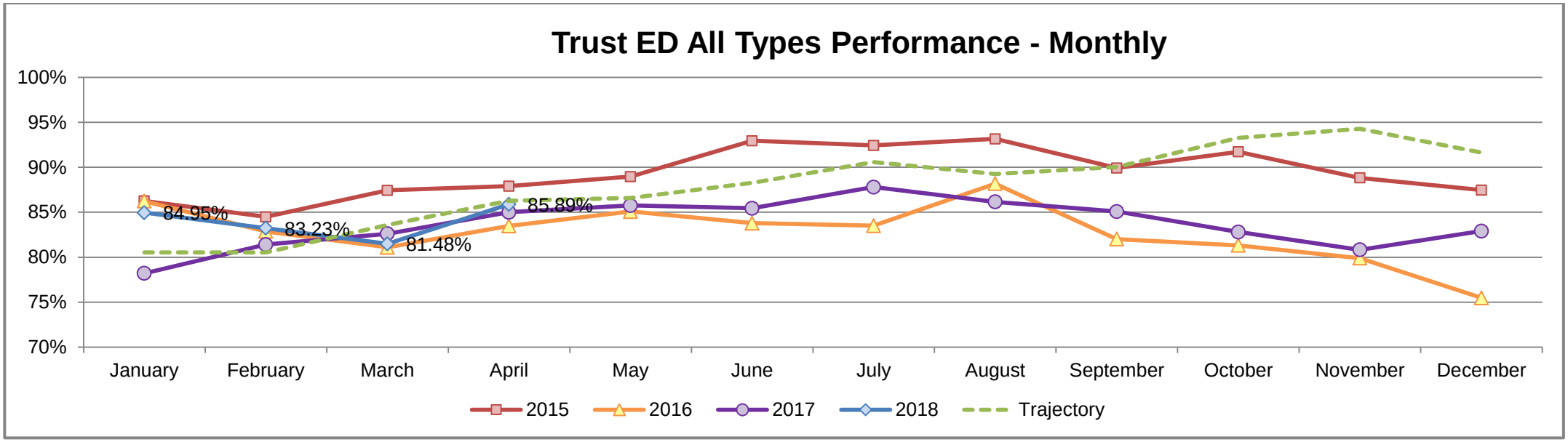
2017/18

Single Oversight Framework	Kings College Hospital NHS Foundation Trust													England	
	Target	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total 2017/18	Highest	Lowest
RTT Incomplete Performance	92.0%	74.9%	76.5%	77.1%	77.5%	77.5%	77.6%	78.6%	79.5%	79.0%	80.3%	81.0%	80.5%	78.2%	100.0%	69.4%
Cancer 62 day referral to treatment - GP Referral	85.0%	86.6%	75.9%	82.7%	81.3%	86.8%	85.6%	83.8%	84.9%	85.9%	85.8%	77.1%	87.5%	83.8%	100.0%	63.0%
Cancer 62 day referral to treatment - Screening	90.0%	84.6%	100.0%	94.3%	88.9%	96.7%	100.0%	84.9%	80.0%	94.7%	87.0%	75.0%	87.5%	90.0%	100.0%	33.3%
Diagnostic Waiting Times Performance < 6	> 99%	95.4%	98.4%	98.5%	98.9%	99.2%	99.1%	99.0%	99.1%	98.5%	98.3%	98.1%	97.5%	98.3%	100.0%	50.0%
A&E 4 hour performance (All Types)	95.0%	85.0%	85.8%	85.5%	87.8%	86.2%	85.1%	83.7%	80.7%	82.9%	85.0%	83.1%	81.5%	84.2%	99.0%	69.1%
Summary Hospital-level Mortality Indicator	< 100	92.7	92.5	91.1	90.7	89.9	90.8	90.2	90.5	90.9				90.9	128.0	72.6
VTE Risk Assessment	95.0%	97.6%	98.0%	97.9%	97.5%	97.5%	97.8%	97.7%	97.3%	93.6%	94.6%	94.8%	96.2%	96.7%	100.0%	76.0%
Clostridium difficile rates	72	5	6	10	10	8	4	3	7	11	10	7	7	88	164	0

Emergency Department performance over time

A&E Compliance by Attendance		Kings College Hospital NHS Foundation Trust												
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2016-17	Type 1 A&E Attendances	16688	17656	17247	17404	16316	16771	16936	16842	17326	16752	15070	17810	202818
	Total Attendance	24080	25566	24677	24998	23341	23863	24082	23743	24306	23510	21142	24959	288267
	Type 1 Compliance	78.4%	80.1%	78.4%	78.1%	84.2%	75.9%	74.9%	72.9%	67.2%	70.8%	75.1%	76.7%	76.1%
	Total Compliance	83.48%	85.1%	83.8%	83.5%	88.2%	82.0%	81.3%	79.9%	75.5%	78.2%	81.4%	82.6%	82.1%
2017-18	Type 1 A&E Attendances	16681	17830	17358	17817	16300	16887	18331	17770	17524	16668	14353	16452	203971
	Total Attendance	23168	24945	24529	24736	22714	23571	25437	24827	30457	34866	32547	36798	328595
	Type 1 Compliance	80.4%	81.1%	80.7%	84.3%	81.3%	80.3%	77.4%	75.0%	72.4%	70.4%	64.5%	61.8%	76.0%
	Total Compliance	85.0%	85.8%	85.5%	87.8%	86.2%	85.1%	82.8%	80.8%	82.9%	85.0%	83.2%	81.5%	84.1%

The Trust's ED type 1 attendances performance based on monthly ED Sitrep return submissions is 76.0% for 2017/18 overall. To support the external audit into our ED performance compliance, the auditors were provided with a patient-level attendance dataset based on the latest ED system data available, as this level of data is not available from month-end snapshot data. Performance compliance for 2017/18 based on the datasets provided for audit is lower at 75.2%.


Trust ED All Types Performance - Monthly
100%
95%
90%
85%
80%
75%
70%
January
February
March
April
May
June
July
August
September
October
November
December
84.95%
83.23%
81.48%
85.89%
2015
2016
2017
2018
Trajectory

Emergency department four-hour standard

The emergency department four hour standard has been a significant challenge nationally and continues to be a key priority for the Trust.

A compressive programme of work has been put in place to improve the emergency pathway, and this overseen by a dedicated weekly oversight Board, inclusive of senior commissioner partners and on-site support from NHSI. This programme provides focus on key areas impacting A&E waiting times, such as; the specific management of frail elderly admissions; innovations in staffing to offset recruitment challenges; balancing planned elective surgery to meet expected emergency bed pressures; maximising the effective flow of patients through the hospital system; and ensuring patents are discharged as soon as they no longer require hospital care, inclusive of those with complex discharge needs (requirements for social care support for example).

Emergency Department (ED) 4-hour Emergency Standard audit findings

Background

Our external auditors looked at the way in which we check whether patients have been seen, treated and transferred within four hours of arriving at the Emergency Department. This is the 'four-hour' standard for emergency care.

They were concerned that the Emergency Departments at Denmark Hill and the Princess Royal University Hospital might operate a 'ten-minute grace' approach, where patients who left the Department just after four hours were not always recorded as breaches. We found that there was evidence that this was the case, with patients leaving the Department between 4hr 01min and 4hr 10min being taken off by the IT team that records four-hour performance.

The clinical teams in the Emergency Departments on both sites carry out 'live validation'. This means they look at patients who leave the Department at around the four hour mark, but who are not always taken off the Department's computer system immediately. This is called a 'late click off' and refers to a patient who may have left at 3hr55min, but where the doctor or nurse did not update the system until later while they were busy with another patient. This can be a relatively common event in a busy Emergency Department.

As a result, it is not possible to know how many patients were taken off as a result of clinical 'late click offs' and how many have been taken off by the IT team.

We checked our policy for managing the four-hour access standard. The current version, updated in August 2015, does not mention the 'ten-minute grace' rule. All patients who leave the Department after 4hrs should be counted as a breach, unless they were a late click off.

Key Findings and actions

We wanted to check that this 'ten-minute grace' approach had not distorted our published performance. We could not do this with old data, so instead we carried out a live audit of patients falling into the period from 4hr 01min to 4hr 10min over several days.

Before doing this, we spoke to Deloitte's to make sure they agreed with our approach.

During the audit, each patient who would have fallen into the 'grace' period was reviewed by a senior member of either our nursing or operations teams. We assumed that anyone over 4hrs was to be reported as a breach unless we found clear evidence otherwise.

The results of the audit are below:

Case	**Unvalidated time in department**	**Narrative**	**Breach?**
1	241 minutes	Patient arrived at 08:00, and click off process from Symphony began at 11:59	**No**
2	243 minutes	Patient arrived at 10:16; last obs before transferring to the ward at 14:05, but not taken off Symphony in timely manner	**No**
3	241 minutes	Patient arrived at 13:22; CDU form completed at 16:50 and transferred to CDU but not taken off Symphony in timely manner	**No**
4	246 minutes	Patient arrived at 16:29; last obs at 18:04 and blood results back at 18:06 (was waiting for bloods); started click off at 20:32	**No**
5	241 minutes	Patient arrived at 17:11; blood results back at 19:54 and DVT proforma completed at 19:35 which indicated patient for discharge but not taken off Symphony in timely manner	**No**
6	241 minutes	Patient arrived at 21:02; last obs recorded at 23:50 but not taken off Symphony in timely manner	**No**
7	249 minutes	Breach reason of late click off was recorded by the clinical team in real time	**No**
8	242 minutes	Patient arrived at 16:57; click off process from Symphony began at 20:36	**No**
9	242 minutes	Patient arrived at 19:36; according to clinical notes, patient seen and discharged at 22:00, but not taken off of Symphony in timely manner	**No**
10	242 minutes	Patient arrived at 14:08; last set of obs recorded at 17:45, but not taken off Symphony in timely manner	**No**
11	247 minutes	Patient arrived at 08:01; patient seen and all results back by 10:55 – for discharge, but not taken off Symphony in timely manner	**No**
12	242 minutes	Patient arrived at 13:17; patient seen and all results back by 16:30 – for discharge, but not taken off Symphony in timely manner	**No**

None of these patients should have been reported as breaches. The patients in the 4hr 01min to 4hr 10min period were in two categories:

1. **Over four hours because of the time it takes to take them off the system**
   In interviews with our nursing team, we found that it takes 42 separate clicks in the computer system to confirm that a patient has left the Department. Nine different boxes of information need to be completed, including where the patient has gone, what our diagnosis was, which treatment they received, which doctor saw them, and so on. The most experienced members of staff can do this in under two minutes, but in a busy Department when patients sometimes move very close to four hours this can make a material difference.

2. **Time of moving confirmed by another process**
   In some of these cases, the correct time at which the patient moved was confirmed by looking at other sources of information (e.g. an admission form from another ward). These sources of evidence helped us remove some breaches.

In conclusion, the audit of patients who would have been covered by the ’10-minute grace’ rule would have been taken off appropriately; each of the cases had clear evidence that the patient departed prior to four hours and was not a reportable breach.

Impact on Reporting

The independent auditor has concluded that while there are errors in the sample and performance period reported, they are unable to quantify the effect on reported four-hour performance in 2017/18. The results of our live audit have suggested this would have little or no material impact on reporting during 2017/18.

Audit Recommendations
With immediate effect, any blanket ’10 minute grace’ amendments will cease. The ED IT team have been instructed to include every patient who is in the department for four hours or longer (>239 minutes) on the daily breach report that is validated by the senior operational, nursing and medical team. This will ensure that all patients who leave the department after four hours are validated by the senior team.

Referral to Treatment (RTT) – 18 weeks

Referral to Treatment, or so called 18 Weeks, has been a historic challenge for the Trust. Working together with our regulators, and the organisations that commission service from us, we have in place challenging plans to improve RTT compliance. These plans have allowed us to maximise the use of our day case theatres and outpatient clinics in parts of the week we have traditionally been unable to maximise, particularly at the weekend.

Through these plans we have seen month on month reduction in the total number of patients waiting for elective treatment and, more importantly, the number of patients waiting greater than 18 weeks. This has translated into improved compliance at a time when most NHS Trust are seeing 18 week compliance decline, and is set against an increasing need to prioritise of capacity for emergency and cancer pathways.

18 Week RTT – Incomplete Pathways

Audit Findings and Recommendations

Finding 1:
Enhance training and guidance provided to staff involved
From our sample of 20 pathways selected, we identified 4 cases with an incorrect clock start

- In 2 cases this was due to errors by staff inputting the information into the system
- In one case a patient who did not attend (DNA) an appointment had their appointment removed, rather than being rebooked. Therefore the system defaulted to the last event recorded, restarting the clock from this date
- In the final case, we were unable to confirm why an incorrect start date had been entered, but it appears to have been due to input error by staff.

In one case we were unable to confirm the clock start as the referral had not been date stamped

We also identified 4 cases with an incorrect clock stop:

- In one case the clock stop event was linked to another pathway for the same patient, and therefore the clock continued
- In two cases there had been errors by Trust staff in inputting the date or in completing the clinic outcome forms
- In the final case we were unable to identify an underlying cause

Correcting for the errors identified above, there would be no change in the overall breach status. However, as a result of the errors, in six cases, pathways had been misreported, or not reported at all for at least one month.

Recommendation 1:
As per our prior year recommendation, we recommend that training and guidance should be provided to all staff, including key guidance around the recording of clock starts and stops, and the retention of evidence (e.g. date stamping referral letters) to support the dates used. Regular themes and underlying causes for errors should be identified through the Trust's existing data validation processes and communicated across the Trust.

We also recommend that the Trust introduce "RTT Champions" in each Division, and encouraging staff who are unsure, to consult with them.

Management Response: The Trust agrees with the recommendation of introducing 'RTT Champions' to address RTT and DQ issues within the PTL. This would need to be agreed with the divisions and could be a joint responsibility of 'Patient Pathway Coordinators' currently working within Divisions
Timeframe: Two months
Responsibility: Caroline Jared, Performance Manager for Referral to Treatment/Divisional General Managers

Finding 2:
Duplicate referrals
From our sample of 20 tested, we identified two cases that were duplicate referrals.

Recommendation 2
We recommend that management investigate the underlying causes due to which some referrals appear twice in the waiting list population. If a control system(s) can be introduced to address this,

then these should be implemented. Alternatively, duplicate referrals in the population should be identified and validated by the validation team.

Management Response: We have created a duplicate referral report alongside the PTL. The current validation team are working towards removing all duplicates over 18 weeks within 1-2 months, to complete this piece of work will depend on the establishment of a data quality (DQ) team to take overall responsibility of this and other DQ issues within the patient tracker list (PTL).

Timeframe: Initial clean-up of duplicate referrals over 18 weeks 1-2 months – completion of remaining duplicates within the PTL – up to six months pending approval of the establishment of a dedicated DQ team.
Responsibility: Caroline Jared, Performance Manager for Referral to Treatment

Cancer Treatment within 62 Days

Referral demand for Cancer service has increased dramatically in recent years, and 2017/18 has seen that trend continue. To allow us to meet this ever increasing demand we have implanted a number of innovations, including one stop diagnostic clinics in challenged services in which we seek to do all clinical testing required to detect cancer in a single visit to hospital for patients with suspected malignancy.

Alongside, we continue to develop ways of working that eliminate the need for a hospital visit at all via “Virtual Clinics” in which teams of specialist clinicians review patients that GPs and other health professionals may require initial discussion and advice on. This helps us to ensure patients have the right treatment pathway agreed as early as possible, and often avoids the need for a direct referral to hospital, freeing up capacity for those patients with a higher likelihood of requiring treatment for Cancer.

Diagnostic Test within 6 Weeks

Our ability to sustain compliance of greater than 99% has been significantly impacted by the pressures of our beds. In periods where emergency demand exceeds the available beds within our wards we are often forced to admit patients to planned escalation areas such as our Endoscopy Suite overnight. This has a significant impact on our ability provide our endoscopy services as we plan to, leading to unavoidable waits of longer than 6 weeks.

Our teams are working continuously to find solutions to these types of pressures on delivery, and starting in late February 2018 we will be able to access additional endoscopy capacity in Croydon having worked with local health provider partners with the support of the Cancer Network.

Progress of Prior Year Recommendations

Recommendation	17/18 Update	Evidence to Support 17/18 Update (If recommendation has progressed)
All Indicators **As per prior year recommendation, enhance training and guidance provided to staff involved** Training and guidance provided to staff needs to be enhanced to reinforce the key areas such as: •Recording correct clock start dates in line with the RTT guidance •Ensuring there is appropriate evidence of treatment being provided before recording clock stop dates Staff should be made aware of the consequences for inaccurate data recording, with regular offenders identified through the Trust's existing data validation processes being provided additional training.	The Trust has an established RTT training team within the central RTT validation team, which is responsible for the documentation of agreed RTT-related data collection procedures and for the relevant training to staff.	All RTT training modules include sections on recording correct clock starts in Trust systems and to ensure that all clock stops are correctly recorded (either for treatment or other clock stop reasons - non treatment. RTT training also indicates the consequences of recording inaccurate data i.e. could cause treatment delays for patients which could result in harm; patients may be booked out of sequence as well as making it extremely difficult for services to manage pathways with poor data quality. Staff should be monitored locally to ensure that they are adhering to the Trust processes for data quality and should be managed accordingly. The RTT Tracking team will speak to individual staff that they discover are not adhering to best practice for DQ these staff may also be flagged to team leaders or managers if they do not improve.
A&E 4hr Waits indicator **Data validation** Investigate whether the current system can be upgraded to include a field that identifies when validation has taken place and allows validation comments to be included.	The ED 'Symphony' system has a field to enable the recording of the main reason for breach, and also includes a free text field to record details of any root cause analysis.	This action has been implemented in-year, and breaches are updated on the following day where they have not been recorded in real-time.

Patient safety indicators:

The following table of information is sourced from the Datix adverse incident reporting system regarding DoC compliance, Galaxy Theatre system records for Surgical Safety checklist compliance and NHSI published data.

Indicators	Reason for selection	Trust Performance 2017/18	Trust Performance 2016/17	Peer Performance (Shelford Group Trusts) 2017/18
Duty of Candour	Duty of Candour was chosen as high performance is a key objective for the Trust as it demonstrates its positive and transparent culture. The Trust changed its reporting mechanism in April 2017 making it more robust, measuring full compliance rather than spot check audits. The higher the compliance % the better.	**>90%**	**Not available**	**Not available**
WHO Surgical Safety compliance	Even though the Trust has not listed Surgical Safety as a quality priority for 18/19 it remains a key objective and work stream at the Trust. Since the beginning of 2017 the Trust has been able to electronically monitor compliance with the WHO checklist. The higher the compliance % the better.	**93%**	**Not available**	**Not available**
Total number of never events	Outside of Surgical Safety, the Trust has a number of work streams that aim to reduce the number of Never Events.	**8**	**8**	Information available at: https://improvement.nhs.uk/resources/never-events-data/

Clinical effectiveness indicators:

The following table of information is sourced from the Hospital Episode Statistics data via Healthcare Evaluation Database (HED)

Indicators	Reason for selection	Trust Performance Dec 2016 to Nov 2017[1]	Trust Performance Dec 2015 to Nov 2016	Peer performance (Shelford Group Trusts) Dec 2016 to Nov 2017
SHMI Elective admissions	Key patient outcomes performance indicator, addressing Trust objective 'to deliver excellent patient outcomes'.	**79.0 (95% CI 64.7, 95.5)**	**80.4 (95% CI 65.6, 97.5)**	**95.0 (95% CI 89.7, 100.5)**
SHMI Non-elective admissions	Key patient outcomes performance indicator, addressing Trust objective 'to deliver excellent patient outcomes'.	**88.8 (95% CI 85.7, 92.1)**	**93.6 (95% CI 90.3, 97.1)**	**85.8 (95% CI 84.6, 86.9)**
SHMI Weekend admissions	Key patient outcomes performance indicator, addressing Trust objective 'to deliver excellent patient outcomes'.	**93.3 (95% CI 87.0, 99.9)**	**98.6 (95% CI 91.8, 105.8)**	**94.7 (95% CI 90.3, 95.2)**

[1] Hospital Episode Statistics (HES) data is compiled from a variety of data sources and is subject to rigorous validation and data cleaning, resulting in a lag time of several months before publication.

Patient experience indicators:

Patient Friends & Family Tests – Emergency Department							Comparable Foundation Trust Value				
Indicator	**Measure**	**Current Period**	**Value**	**Previous Period**	**Value**	**King's Score**	**Highest**	**Lowest**	**National Average January 2018**	**Data Source**	**Regulatory Statement**
Patients discharged from Accident & Emergency (types 1/2) who would recommend the Trust as a provider of care to their family or friends?	%	Sept 2017 - March 2018 (latest available data)	81%	Sept 2016 - March 2017	78%	82% Jan 2018	100% Jan 2018	66% Jan 2018	86% Jan 2018	NHS England	*King's College Hospital considers that this data is as described. The Trust is tasking its clinical divisions to develop patient, family and carer experience action plans to improve patient experience. Work is also underway to transform the emergency pathway through the King's Way Trust Transformation programme and this includes patient experience*

Patient Friends & Family Tests - Inpatients						Comparable Foundation Trust Value				
Indicator	**Measure**	**Current Period**	**Value**	**Previous Period**	**Value**	**Highest**	**Lowest**	**National Average January 2018**	**Data Source**	**Regulatory Statement**
Inpatients the Trust as a provider of care to their family or friends?	%	Sept 17 - March 2018 (latest available data)	94%	Sept 16 - March 2017	94%	100% Jan 2018	75% Jan 2018	95% Jan 2018	NHS England	*King's College Hospital considers that this data is as described. The Trust is tasking its clinical divisions to develop patient, family and carer experience action plans to improve patient experience.*

Patient Friends & Family Tests - Outpatients						Comparable Foundation Trust Value				
Indicator	**Measure**	**Current Period**	**Value**	**Previous Period**	**Value**	**Highest**	**Lowest**	**National Average January 2018**	**Data Source**	**Regulatory Statement**
Would Outpatients recommend the Trust as a provider of care to their family or friends?	%	Sept 17 - March 2018 (latest available data)	88%	Sept 16 - March 2017	87%	100% Jan 2018	75% Jan 2018	93% Jan 2018	NHS England	*King's College Hospital considers that this data is as described. The Trust is tasking its clinical divisions to develop patient, family and carer experience action plans to improve patient experience.*

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

Local Clinical Commissioning Group's response to King's College Hospital NHS Foundation Quality Account for 2017/2018

Thank you giving commissioners the opportunity to comment on the draft quality account for 2017/18. We do appreciate the on-going collaboration and continued open dialogue with Trust's senior clinicians at the monthly Clinical Quality Review Group, and in the other quality meetings commissioners are invited to attend. And we congratulate the Trust on the positive work you are doing to drive quality improvements and lead innovation at what we acknowledge is a very challenging time.

We note the significant amount of work that was undertaken last year towards achieving your priorities; the improvements in safer surgery and the National Emergency Abdominal Surgery Audit for instance where – the Trust were amongst the top 5 most improved hospitals in the country in this area. We also note good progress in improving experience for cancer patients. The focus on the role of the CNS and providing accessible information for patients has been an important part of this achievement and we note the Trust's comments regarding a continued focus in this area. Bromley CCG is especially keen to work with the PRUH site on cancer patient experience and by combining the CCG's approach with primary care to the Trust's work we hope to resolve many of the interface issues between GP and the hospital which patients have identified. We are also aware of the significant engagement work in order to understand the issues and concerns relating to the experience of outpatients, however, I'm sure you would agree that progress towards achieving a better patient experience has been slow. We look forward to seeing tangible outcomes from this work in 2018/19. Bromley CCG would wish to see a pilot or implementation of In Touch on the PRUH site as soon as possible and would like the Trust to consider the use of tele-dermatology as part the dermatology outpatient improvement programme follow a soft launch of this in Bromley.

We support the prioritisation for improving the care of people with mental health needs in A&E and beyond. The Trust has made good progress at Denmark Hill in this area however the work has focussed on an interface with SLAM and similar work at PRUH with other local mental health providers especially Oxleas is encouraged.

Bromley CCG welcomes the introduction of EPR on the PRUH site and looks forward to seeing real quality improvements as a result of this, for example in sepsis recording on the PRUH site.

Overall we agree with the priorities for next year, being a mix of new and continuing areas. We note your comments that the work for some priorities chosen last year became bigger than was anticipated and so caution that adequate scoping and project management be given at the start of each initiative. Similarly, progress on some priorities will include working with partners and we would encourage early contact to maximise the opportunities of system-wide input and learning.

Commissioners welcome the innovation and leadership around quality which is part of the King's culture and will continue to push for innovation and resource to be spread across all Trust's sites.

Submitted by:

Dr Noel Baxter
Chair of KCH CQRG, May 2018

Healthwatch Lambeth's response to King's College Hospital NHS Foundation Quality Account for 2017/2018

General comments

We commend King's College Hospital for the accomplishments in all seven priority areas under the three main headings: patient's outcomes, experience, and safety. The report is easy to read and the tone is accessible to ordinary people who are not familiar with clinical terms. We however feel that further work has to be done on the following:

1) **Establishing baseline -** It can be noticed that all of the seven but one were 'partially achieved'. It can be appreciated that the 'partially achieved' aims are meant for a three-year implementation. The report does not give justice to the good work and progress made in most of the areas. We suggest specifying the sub-objectives and tasks in each year and measure accomplishments against specific targets.

2) **Taking stock –** It can be noticed that there was very little reflection or analysis of risks and challenges and how KCH mitigated those. A more in-depth analysis will not only guide future planning but also set context as to why some areas are not achieved.

3) **Listening to patients -** Although the achievement was good, KCH is still below other London hospitals in engaging and listening to patients. More work can be done on this. There is a strong engagement goal but the engagement team needs to be resourced at least in the first two years until engagement and listening to patients is embedded in all KCH's culture. We noted that there are 'champions' who can be further trained to help in engaging with patients. However, we strongly feel that engagement should be embedded in the culture so it can be sustained.

4) **Mind and Body –** It can be appreciated that this this is a long term goal. There was very little mention of what models worked or previous research studies already conducted in this area. We suggest that further investigation is done to inform the approach to use and determine achievable, realistic outcomes and how long it will take to achieve those outcomes.

5) **Data presentation –** Overall, there is adequate amount of data, mostly in graphs and tables. We suggest that an explanation/analysis is provided. Data can be interpreted differently and so the report should help the readers understand them and the whole report.

Additional comments:

Some things that had not been said in the report that we would like to highlight are the following:

KCH's volunteer programme

KCH volunteers programme was given an exceptional Lammy Award by Lambeth NHS CCG last year in recognition of their tireless work with the victims of Grenfell Tower who had been brought into the Denmark Hill site. The Lammy Awards were launched by Lambeth CCG in 2015 to recognise NHS and council staff, health and care teams, and individuals who live and work in the borough who go the extra mile to support the health and care of others.

We recognise KCH for going over and beyond their daily duty and encouraging volunteerism to help traumatised children and adults to feel safe and secure. In addition, King's – as one of the Capital's four Major Trauma Centres - also treated patients from the Westminster Bridge attack, London Bridge and Borough attacks.

Robust engagement and partnership with HWL

We also appreciate the work of KCH's engagement team and the continuous work with Healthwatch Lambeth to understand patients' experiences. We commend their work with us on Right 4 Everyone programme. This programme empowers adults with learning disabilities and their carers to participate in projects, and to assess how accessible and kind KCH services are for people. The R4E volunteers feel well respected and recognised by the Trust, and want to continue working with the Trust.

We also appreciate the quarterly meeting between KCH and HW offices (Lambeth, Lewisham and Southwark) which shows the intention to work collaboratively with us.

What HWL can commit

As the consumers' champion, we would like to offer our support to KCH and to continuing our good working relationship to facilitate genuine engagement of patients, their families, and carers. We hope to collaborate in your work for children and young people, older people, people with learning disabilities, and in mental health and wellbeing.

Submitted by:
Healthwatch Lambeth, May 2018

Healthwatch Southwark's response to King's College Hospital NHS Foundation Quality Account for 2017/2018

Overall, we are pleased to see a strong commitment to quality, including a clear emphasis on implementing measurable and sustainable solutions and cultural change. We were particularly encouraged to see the ongoing commitments to staff training and process simplification.

Healthwatch Southwark was overall supportive of the priorities that were set for the 2017/18 year and the initiatives in progress. Given patient feedback, we are particularly pleased that the care of people with mental health needs and improved outpatient experience continue to be priorities.

Presentation-wise, the explanation of the approach to reporting is clear, as are the objectives, priorities set and progress achieved. However, the volume of information has resulted in a very large report, which is not accessible to a lay reader. We suggest more use of annexes if possible.

The 'Results and achievements for the 2017/18 Quality Account priorities' table could benefit from an additional column being added that shows how many years each priority has existed for (this is not entirely clear in the 'Our Quality Priorities over time' table presented above).

The latter part of the section entitled 'Mandatory declarations and assurances' could benefit from some simple narrative that explains terms such as 'EQ-5D' and 'EQ VAS', and the significance of a 95% confidence interval.

Priorities ended or transferred to other programmes

- **Improve quality of the surgical safety checks (patient safety)**

  After three years of prioritising, we note that the number of surgical/invasive Never Events reported during 2017/18 was 4 (down from 6 in the previous year). It is commendable that the priority has yielded results in line with expectations. However, we would like to understand the basis for this decision not to continue to prioritise this, given that success has been based on a 10% year-on-year improvement, but no national targets have been provided.

- **Enhanced recovery in surgery (ERAS) after hepatobiliary surgery (patient outcomes)**
  We note the role that DH plays in delivering specialist hepatobiliary surgery and therefore support the focus being given to this via the King's Way Transformation Team.

- **Improve emergency abdominal surgery outcomes (patient outcomes)**
  Progress in meeting/exceeding national averages and, in some cases, targets is positive to see. It is noted that the presence of a consultant surgeon and consultant anaesthetist in surgery at Denmark Hill (DH) is still below the national target, as is the post-operative assessment by a care of the elderly specialist. We note that the programme of initiatives will now fall within the standard quality improvement work programme.

Priorities retained or broadened

- **Improve the care of people with mental, as well as physical, health needs (patient outcomes)**
  Healthwatch Southwark, on the basis of public feedback, continues to prioritise mental health (and particularly care in a mental health crisis, including at A&E). We are therefore pleased that KCH has chosen this priority and launched an ambitious 3-year programme. We will monitor the progress of the broader King's Health Partners Mind and Body Programme with interest.

- **Improve outpatient experience (patient experience)**

Feedback to Healthwatch Southwark corroborates the areas that continue to be problematic, including appointment booking, delays in clinic and patients not being informed about delays. It is encouraging to see that a suite of Outpatient Experience Standards has been developed and will likely form the KPI basis. It would be helpful to see what the national averages and targets look like.

It is interesting to note the effort being put into automating appointment booking and running the actual appointments themselves. Healthwatch Southwark hopes that these options will be offered in addition to, rather than as a substitute for direct patient contact.

- **Improve experience of cancer patients and their families (patient experience)**
  Healthwatch Southwark has received a number of signposting queries and concerns from cancer patients and their relatives. As such, a focus on standardising the overall approach to patient support and increasing access to clinical nursing specialist support is welcome.

  Whilst KCH has been rated the 40th most improved trust, as measured by the National Cancer Patient Survey (NCPS), it was still ranked 136th out of 209 cancer care providers. We would like to understand KCH's ambition for the three-year improvement programme.

- **Improve implementation of sepsis bundles (patient safety)**
  The reader will welcome an explanation of what the UK 'sepsis 6 bundle' entails and what is meant by a 'Shelford ranking'. We would appreciate an explanation of the challenges posed by timely administration of intravenous fluid.

New priorities introduced

- **Improving outcomes for people having primary hip replacement**
  Particularly in the context of long-term discussions about arrangements for orthopaedic surgery in South East London it makes sense to share learning and optimise practices across the different sites. If outcomes measures do not already exist then we support the need to establish them.

- **Improving outcomes for people with heart failure**
  Given the prevalence of and harm caused by heart failure we must support this priority. We particularly support the patient-focused measures around a 'one-stop-shop' service and information provision, and better coordination with non-hospital services such as GP practices and post-hospital care. However, further measures in this area (including patient feedback) might help to ensure quality and that these measures have the desired effect.

- **Reducing harm to patients due to falls in the hospital**
  In light of the audit mentioned and the patient demographic, this priority is sensible. It would be useful to see the baseline figures for falls and falls with harm, compliance with screening, blood pressure assessments and post-falls protocol. We are not sure what is meant by 'non-therapies assessments' and the 'DAD' team.

Submitted by:
Healthwatch Southwark, May 2018

Healthwatch Bromley's response to King's College Hospital NHS Foundation Trust Quality Account for 2017-2018

Healthwatch Bromley thanks you for the opportunity to comment on King's NHS Foundation Trust Quality Account for 2017-2018. In the London Borough of Bromley, local residents access services across several King's sites, including: Denmark Hill, (DH); the Princess Royal University Hospital (PRUH); and Orpington Hospital.

Healthwatch Bromley welcomes the focus on improving care for mental health, as well as physical health, and notes the initiatives and systems put into place across the trust to achieve this, such as closer working with SLaM. Healthwatch supports the continuation of this as a priority, as well as the work being done to increase the number of outpatients being screened for mental health. Healthwatch is also pleased to see outpatients and cancer experience continuing as priorities.

Healthwatch Bromley has established close working relations with King's, in particular at the PRUH site, and we look forward to working with you in partnership on your priorities for 2018/2019.

Submitted by:
Healthwatch Bromley, May 2018

Overview Scrutiny Committee's (OSC) response to King's College Hospital NHS Foundation Trust Quality Account for 2017-2018

Unfortunately, this year, we were unable to formally consult with the Overview and Scrutiny Committees (OSCs) because we had fallen into a period of purdah and all council committees had been dissolved pending the outcome of local elections.

The OSCs are re-established post-election and a full council meeting will be held where committee chairs and committee members are elected.

Full council meetings for King's local boroughs will be taking place in late May – early June and OSC meetings will resume in June.

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

The quality report must include a statement of directors' responsibilities, in the following form of words:

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- *the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance*

- *the content of the Quality Report is not inconsistent with internal and external sources of information including:*

    - *board minutes and papers for the period April 2017 to 6th June 2018*
    - *papers relating to quality reported to the board over the period April 2017 to 6th June 2018*
    - *feedback from commissioners dated May 2018*
    - *feedback from governors dated May 2018*
    - *the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/05/2018*
    - *the national patient surveys published in 2015/16 as well as the latest friends and family survey (published end March 2018)*
    - *the 2017 national staff survey 06/03/2018*
    - *the Head of Internal Audit's annual opinion of the trust's control environment dated 08/05/2018*
    - *CQC inspection report dated 31/01/2018*

- *the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered*

- *the performance information reported in the Quality Report is reliable and accurate*

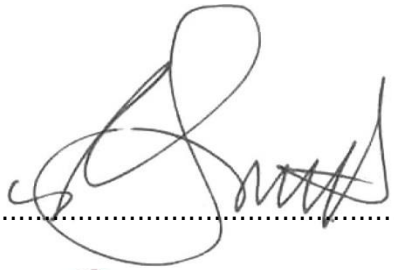
- *there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice*

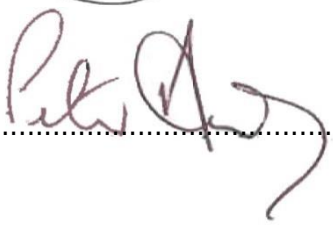
- *the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and*

- *the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.*

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

By order of the board

June 14, 2018 .....Date.....  .....Chairman

14th June 2018 .....Date.....  .....Interim Chief Executive

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

Independent auditor's report to the council of governors of King's College Hospital NHS Foundation Trust on the quality report

We have been engaged by the council of governors of King's College Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of King's College Hospital NHS Foundation Trust's quality report for the year ended 31 March 2018 (the 'quality report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of King's College Hospital NHS Foundation Trust as a body, to assist the council of governors in reporting King's College Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and King's College Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- referral to treatment within 18 weeks for patients on incomplete pathways; and
- 4 hour A&E waiting times.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in the guidance; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the specified documents in the detailed guidance.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures on monthly and departmental data;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Basis for qualified conclusion

Percentage of patients with total time in A&E of four hours or less from arrival to admission, transfer or discharge

The "percentage of patients with total time in A&E of four hours or less from arrival to admission, transfer or discharge" indicator requires that the NHS Foundation Trust accurately record the start and end times of each patient's wait in A&E, in accordance with detailed requirements set out in the national guidance. This is calculated as a percentage of the total number of unplanned attendances at A&E for which patients' total time in A&E from arrival is four hours or less until admission, transfer or discharge as an inpatient.

Our procedures included testing a risk based sample of 22 items, and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

We identified the following errors:

- In 3 cases of our sample of patients' records tested, the start or end time of treatment was not accurately recorded affecting the calculation of the published indicator;
- In 6 cases of our sample of patients' records tested, the start or end time of treatment was not accurately recorded, but did affect the calculation of the published indicator; and
- In 7 cases of our sample of patients' records tested, we were unable to obtain sufficient supporting evidence to confirm the details necessary to test the calculation of the published indicator.

As a result of the issues identified, we have concluded that there are errors in the calculation of the "percentage of patients with total time in A&E of four hours or less from arrival to admission, transfer or discharge" indicator for the year ended 31 March 2018. We are unable to quantify the effect of these errors on the reported indicator.

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

The "percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period" indicator requires that the NHS Foundation Trust accurately record the start and end dates of each patient's treatment pathway, in accordance with detailed requirements set out in the national guidance. This is calculated as an average based on the percentage of incomplete pathways which are incomplete at each month end, where the patient has been waiting less than the 18 week target.

Our procedures included testing a risk based sample of 20 items, and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

We identified the following errors:

- In 2 cases of our sample of patients' records tested, the pathway fell outside the indicator definition and should not have been included in the calculation of the published indicator;
- In 8 cases of our sample of patients' records tested, the pathway was incorrectly recorded (including start or end date of treatment not accurately recorded), but did not affect the calculation of the published indicator; and
- In 1 case of our sample of patients' records tested, we were unable to obtain sufficient supporting evidence to confirm the details necessary to test the calculation of the published indicator.

As a result of the issues identified, we have concluded that there are errors in the calculation of the "percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period" indicator for the year ended 31 March 2018. We are unable to quantify the effect of these errors on the reported indicator.

The "Action to Improve Data Quality" section of the NHS Foundation Trust's Quality Report details the actions that the NHS Foundation Trust is taking to resolve the issues identified in its processes.

Qualified Conclusion

Based on the results of our procedures, except for the matters set out in the 'Basis for qualified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in the detailed guidance; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.

Deloitte LLP

St Albans

13 June 2018

Glossary

ACRONYM/WORD	MEANING – To be updated
A&E	Accident & Emergency
ACC	Accredited Clinical Coder
AHP	Allied Health Professionals i.e. Physiotherapists, Occupational Therapists, Speech & Language Therapists etc.
AHSC	Academic Health Science Centre
ANS	Association of Neurophysiological Scientists Standards
BCIS	Bone Cement Implantation Syndrome
BHRS	British Heart Rhythm Society
BME	Black and Minority Ethnic
BREEAM	Building Research Establishment Environmental Assessment Method
BSCN	British Society for Clinical Neurophysiology
BSI	The British Standards Institution
BSS	Breathlessness Support Service
CCG	Clinical Commissioning Groups (previously Primary Care Trusts)
CCS	Crown Commercial Service
CCUTB	Critical Care Unit over Theatre Block
C-difficile	Clostridium difficile
CDU	Clinical Decisions Unit
CEM	Royal College of Emergency Medicine
CHD	Congenital Heart Disease
CHR – UK	Child Health Clinical Outcome Review Programme (UK)
CLAHRC	Collaboration for Leadership in Applied Research and Care
CLINIWEB	The Trust's internal web-based information resource for sharing clinical guidelines and statements.
CLL	Chronic Lymphocytic Leukaemia
CLRN	Comprehensive Local Research Network
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
COPD	Chronic Obstructive Pulmonary Disease
COSD	Cancer Outcomes and Services Dataset
COSHH	Control of Substances Hazardous to Health
CPPD	Continuing Professional and Personal Development
CQC	Care Quality Commission
CQRG	Clinical Quality Review Group (organised by local commissioners)
CQUIN	Commissioning for Quality and Innovation
CRF	Clinical Research Facility
CRISP	Community for Research Involvement and Support for People with Parkinson's
CT	Computerised Tomography
DAHNO	National Head & Neck Cancer Audit
DH	Denmark Hill. The Trust acute hospital based at Denmark Hill
DNAR	Do Not Attempt Cardiopulmonary Resuscitation
DoH	Department of Health
DTOC	Delayed Transfer of Care
ED	Emergency Department
EDS	Equality Delivery System
EMS	Environmental Management System
EPC	Energy Performance Contract
EPMA	Electron Probe Micro-Analysis
EPR	Electronic Patient Record
ERR	Enhanced Rapid Response
ESCO	Energy Service Company
EUROPAR	European Network for Parkinson's Disease Research Organization
EWS	Early Warning Score
FFT	Staff Friends & Family Test
FY	Financial Year

GCS	Glasgow Coma Scale
GP	General Practitioner
GSTS Pathology	Venture between King's, Guy's and St Thomas' and Serco plc
GSTT	Guy's St Thomas' NHS Foundation Trust
H&S	Health & Safety
HASU	Hyper Acute Stroke Unit
HAT	Hospital Acquired Thrombosis
HAU	Health and Aging Units
HCAI	Healthcare Acquired Infections
HCAs	Health Care Assistants
HESL	Health Education South London
HF	Heart Failure
HIV	Human Immunodeficiency Virus
HNA	Holistic Needs Assessment
HQIP	Healthcare Quality Improvement Partnership
HRWD	'How are we doing?' King's Patient/User Survey
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HTA	Human Tissue Authority
IAPT	Improving Access to Psychological Therapies
IBD	Inflammatory Bowel Disease
ICAEW	Institute of Chartered Accountants in England and Wales Code of Ethics
ICCA	IntelliSpace for Critical Care and Anaesthesia
ICNARC	Intensive Care National Audit & Research Centre
ICO	Information Commissioner's Office
ICT	Information and Communications Technology
ICU	Intensive Care Unit
IG Toolkit	Information Governance Toolkit
IGSG	Information Governance Steering Group
IGT	Information Governance Toolkit
IHDT	Integrated Hospital Discharge Team
iMOBILE	Specialist critical care outreach team
IPC	Integrated Personal Commissioning
ISO	International Organization for Standardization
ISS	Injury Severity Score
JCC	Joint Consultation Committee
KAD	King's Appraisal & Development System
KCH, KING's, TRUST	King's College Hospital NHS Foundation Trust
KCL	King's College London – King's University Partner
KHP	King's Health Partners
KHP Online	King's Health Partners Online
KPIs	Key Performance Indicators
KPMG LLP	King's Internal Auditor
KPP	King's Performance and Potential
KWIKI	The Trust's internal web-based information resource. Used for sharing trust-wide polices, guidance and information. Accessible by all staff and authorised users.
LCA	London Cancer Alliance
LCN	Local Care Networks
LIPs	Local Incentive Premiums
LITU	Liver Intensive Therapy Unit
LUCR	Local Unified Care Record
MACCE	Major Adverse Cardiac and Cerebrovascular Event
MBRRACE-UK	Maternal, Newborn and Infant Clinical Outcome Review Programme
MDMs	Multidisciplinary Meeting
MDS	Myelodysplastic Syndromes
MDTs	Multidisciplinary Team
MEOWS	Modified Early Obstetric Warning Score
MHRA	Medicine Health Regulatory Authority

MINAP	The Myocardial Ischaemia National Audit Project
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant staphylococcus aureus
MTC	Major Trauma Services
NAC	N-acetylcysteine
NADIA	National Diabetes Inpatient Audit
NAOGC	National Audit of Oesophageal & Gastric Cancers
NASH	National Audit of Seizure Management
NBOCAP	National Bowel Cancer Audit Programme
NCEPOD	National Confidential Enquiry into Patient Outcome & Death Studies
NCISH	National Confidential Inquiry into Suicide & Homicide for People with Mental Illness
NCPES	National Cancer Patient Experience Survey
NDA	National Diabetes Audit
NEDs	Non-Executive Directors
NEST	National Employment Savings Trust
NEWS	National Early Warning System
NHFD	National Hip Fracture Database
NHS	National Health Service
NHS Safety Thermometer	A NHS local system for measuring, monitoring, & analysing patient harms and 'harm-free' care
NHSBT	NHS Blood and Transplant
NICE	National Institute for Health & Excellence
NICU	Neonatal Intensive Care Unit
NIHR	National Institute for Health Research
NJR	National Joint Registry
NNAP	National Neonatal Audit Programme
NPDA	National Paediatric Diabetes Audit
NPID	Pregnancy Care in Women with Diabetes
NPSA	National Patient Safety Agency
NRAD	National Review of Asthma Deaths
NRLS	National Reporting and Learning Service
NSCLC	Non-Small Lung Cancer
OH/ORPINGTON HOSPITAL	The Trust acquired services at this hospital site on 01 October 2013
OSC	King's Organizational Safety Committee
PALS	Patient Advocacy & Liaison Service
PbR	Payment by Results
PICANet	Paediatric Intensive Care Audit Network
PiMS	Patient Administration System
PLACE	Patient Led Assessments of the Care Environment
POMH	Prescribing Observatory for Mental Health
POTTS	Physiological Observation Track & Trigger System
PROMS	Patient Reported Outcome Measures
PRUH	Princess Royal University Hospital. The Trust acquired this acute hospital site on 01 October 2013
PUCAI	Paediatric Ulcerative Colitis Activity Index
PwC	PricewaterhouseCoopers
QMH	Queen Mary's Hospital
RCPCH	Royal College of Paediatric and Child Health
RIDDOR	Reporting of Injuries, Dangerous Diseases and Dangerous Occurrences Regulations
ROP	Retinopathy of Prematurity
RRT	Renal Replacement Therapy
RTT	Referral to Treatment
SBAR	Situation, Background, Assessment & Recognition factors for prompt & effective communication amongst staff
SCG	Specialist Commissioning Group (NHS England)
SEL	South East London

SEQOHS	Safe Effective Quality Occupational Health Service
SHMI	Standardised Hospital Mortality Index. This measures all deaths of patients admitted to hospital and those that occur up to 30 days after discharge from hospital.
SIRO	Senior Information Risk Owner
SLAM	South London & Maudsley NHS Foundation Trust
SLHT	South London Health Care Trust. SLHT dissolved on 01 October 2013 having being entered into the administration process in July 2012.
SLIC	Southwark & Lambeth Integrated Care Programme
SSC	Surgical Safety Checklist
SSIG	Surgical safety Improvement Group
SSNAP	Sentinel Stroke National Audit Programme
SUS	Secondary Uses Service
SW	Social Worker
TARN	Trauma Audit & Research Network
TTAs	Tablets to take away
TUPE	Transfer of Undertakings (Protection of Employment) Regulations
UAE	United Arab Emirates
UNE	Ulnar Neuropathy at Elbow
VTE	Venous-Thromboembolism
WHO	World Health Organisation
WTE	Whole Time Equivalent