NHS
King's College Hospital
NHS Foundation Trust

Quality Account
2022-2023

OUR VALUES: AT KING'S WE ARE A KIND, RESPECTFUL TEAM

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Statement on Quality from the Chief Executive

Once again, I am delighted to introduce the Quality Account for King's College Hospital NHS Foundation Trust. It has been another busy year for King's, and the wider NHS, but with the support of patients, the public, and key stakeholders, we have continued to make positive progress in a number of areas.

It is now over three years since the start of the COVID-19 pandemic, but I am pleased to say that, as I write, the number of COVID-19 positive patients we are treating in our hospitals is continuing to steadily reduce. It is true to say, however, that the virus continues to impact the services we provide. Recovery and survival rates for these patients is amongst the very best nationally, for which our clinical teams deserve enormous credit.

We continue to make progress implementing our five year, Strong Roots, Global Reach strategy launched in July 2021. In April 2022, we published our Action Plan for 2022-23, which set out 20 of the key projects we planned to focus on as an organisation, with a focus on partnership working, supporting staff, and reducing waiting lists for planned operations, which - like all hospitals - had grown significantly as a result of the COVID-19 pandemic. In May 2022, we also launched our first ever Roadmap to Inclusion 2022-2024, which sets out the steps the Trust will be taking over the next two years to make King's a more inclusive place to work, and to be treated.

As important, we also made positive progress in regards to our Quality Priorities for 2022-23, which were to improve the detection of the deteriorating patient and escalating as appropriate; to improve patient experience through effective communication; to improve outcomes for patients receiving rehabilitation following a severe head injury or major trauma; and to support positive behaviour to increase staff and patient safety.

The report that follows sets out the many different plans and initiatives we have put in place to make sure these priorities are taken forward, and turned into meaningful, practical improvements for staff, as well as patients who use our services. We have made tangible, measurable improvements in a number of areas, which is positive - however, we also know there is more work to do in a number of areas, which we are continuing to work hard to address.

Some key improvements over the past year include:

- The Care Quality Commission (CQC) rating for the Trust's leadership arrangements improved to 'Good' from 'Requires Improvement'.
- Our teams have pioneered a range of innovative new procedures, including the creation of the first minimally invasive endovascular arteriovenous fistula (AVF) for patients who have chronic kidney disease and need haemodialysis.
- Hearing loops have been installed at King's College Hospital for patients and visitors who are deaf or hard of hearing.
- The endoscopy department at King's College Hospital received national recognition after retaining its Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation.
- In June 2022, a new state-of-the-art operating theatre opened in Orpington Hospital, enabling hundreds of additional operations to take place each year.
- Data from NHS Blood and Transplant shows that King's is the leading Trust in UK for organ donation, with 53 patients donating their organs after death at King's.
- Bowel cancer specialists across the Trust have been recognised by the National Bowel Cancer Audit (NBCA) for boosting survival rates for patients diagnosed with bowel cancer, with fewer patients 11% at King's College Hospital and 10% at the PRUH having urgent or emergency bowel surgery compared to the national average of 21%.
- In March 2023, we marked our one year anniversary of King's patient entertainment portal, with patients signing onto the portal 1,918,000 times.

A vital part of our approach to quality is also making sure we have a strong and positive reporting culture in place to ensure we share and learn lessons when mistakes occur which, despite the best efforts of everyone at the Trust, will and do happen from time to time. When mistakes do happen, however, it is important that we ensure they are properly investigated

and managed, and improvements made to reduce the risk of mistakes happening in the future.

In the past year we have been working to introduce a new incident reporting tool - called InPhase - which will support our teams to improve the way we report, investigate and analyse incidents. It will also help us improve how learning is embedded into clinical practice. This system enables us to report in a way aligned to the national Learning from Patient Safety Events (LFPSE) which support our delivery of the significant changes we are making to implement the Patient Safety Incident Response Framework (PSIRF).

We have also developed and initiated the roll out of a new Quality Assurance Framework for the Trust. This framework will improve our ward to board reporting, enhance our focus on getting the basics right, increase executive and non-executive director visibility and ensure that the voices of our patients, and our staff are heard.

Finally, I would like to thank our patients and local stakeholders once again for the support they give us, which includes constructively challenging our teams to constantly improve, and innovate for the benefit of patients, and the 15,000 colleagues that make up Team King's.

Professor Clive Kay
Chief Executive, King's College Hospital NHS Foundation Trust

About us and the service we provide

King's College Hospital NHS Foundation Trust (King's) is one of the country's largest and busiest teaching hospitals. King's provides a strong profile of local hospital services for people living in the boroughs of Lambeth, Southwark, Lewisham, and Bromley, and specialist services are also available to patients from further afield. King's provides nationally and internationally recognised services in liver disease and transplantation, neurosciences, haemato-oncology, and fetal medicine. King's works with many partners across South East London including the two mental health providers: South London and Maudsley NHS Foundation Trust, and Oxleas NHS Foundation Trust. King's is also part of King's Health Partners Academic Health Sciences Centre, and the South East London Acute Provider Collaborative.

King's provides many services across five sites including the following:

Local services such as:

- Two Emergency Departments - one at King's College Hospital and one at the Princess Royal University Hospital (PRUH).
- An elective Orthopaedic Centre at Orpington Hospital.
- Acute dental care at King's College Hospital.
- Sexual Health Clinics at Beckenham Beacon and King's College Hospital.
- Two Maternity Units - one at King's College Hospital and one at the PRUH.
- Outpatient services, including those at Willowfield Building, a brand new facility at King's College Hospital dedicated to outpatient services.

Community Services such as:

- A number of satellite renal dialysis units, community dental services, and a Breast Screening service for South East London.
- The Haven sexual assault referral centres at King's College Hospital and at the Royal London and St Mary's Hospitals.
- Outpatient physiotherapy and outpatient occupational therapy at Coldharbour works near King's College Hospital.
- Antenatal and community midwifery services.

Specialist services such as:

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

Research and Innovation

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

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

We have nearly 15,000 staff across five main sites King's College Hospital, Princess Royal University Hospital, Orpington Hospital, Queen Mary's Hospital Sidcup and Beckenham Beacon as well as several satellite units.

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

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

2.1 Priorities for improvement

Results and achievements for the 2022-23 Quality Account Priorities

At the time of agreeing the 2022-23 quality account priorities, King's was marking two years since the first COVID-19 patients were treated by the Trust. This was in addition to emerging from the response to the Omicron variant. Despite this, we were able to make considerable progress whilst rising to the challenge of restoring services and reducing the COVID backlogs.

In 2022-23, we produced a scorecard for each of the priorities, with the Quality, People and Performance Committee (QPPC) tracking progress against the measures of success.

Table 1 below summarises the achievements made against the targets in 2022-23 aligned to the Trust strategy, Strong Roots, Global Reach.

Table 1: Summary of results and achievements for the 2022-23 Quality Account priorities

Domain			**Target, 2022-23**
Patient Safety			
Priority 1		**To improve the detection of the deteriorating patient and escalation as appropriate**	
Objectives	1	Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation and time of clinical response recorded.	**Fully Achieved**
	2	Achieving 60% of all unplanned paediatric critical care unit admissions from noncritical care paediatric wards of children up to their 16th birthday, having a Bedside Paediatric Early Warning Score (BPEWS) score, time of escalation and time of clinical response recorded.	**Fully Achieved**
	3	Achieving 60% of all unplanned maternity critical care unit admissions from the birth centres or labour wards, having a Maternity Early Warning Score (MEWS) score, time of escalation and time of clinical response recorded.	**Partially Achieved**
Trust Strategy contribution	1	Staff will be supported and receive the appropriate training to improve detection and escalation of deteriorating patients.	**Partially Achieved**
	2	Improvement will be embedded to deliver safer care for deteriorating patients.	**Fully Achieved**
	3	A pilot of patient activated triggers will be undertaken to ensure that the diversity of patient needs will identified.	**Partially Achieved**
Health Inequalities contributions	1	On migration to Datix Cloud, can feed from PIMS, and report on safety information with regards to protected characteristics.	**Not Achieved**
	2	Identify opportunities for improvement for groups coming to disproportionate harm	**Not Achieved**
Sustainability contributions	1	Improving how we recognise and escalate the deteriorating patient could lead to less expenditure in terms of costs of escalation of care, extended stay in hospital plus potential claims costs.	**Partially Achieved**
Mental Health	1	Explore roll out of the Code 10 escalation and management pathway of patients in mental health crisis or deteriorating in use in the ED across the Trust	**Partially Achieved**

Domain			Target, 2022-23
Patient Experience			
Priority 2		**To improve patient experience through effective communication**	
Objectives	1	To improve communication skills with patients and their relatives / carers through education and training.	**Year 2 Objective**
	2	To improve responsiveness to patients and their relatives / carers through answering telephone calls.	**Fully Achieved**
	3	To improve information provision to patients and their relatives / carers.	**Year 2 Objective**
Trust Strategy contribution	1	Training and toolkit will improve communication positively impacting staff's wellbeing.	**Year 2 Objective**
	2	Effective communication will lead to a reduction of violence and aggression incidents.	**Partially Achieved**
	3	Better communication will mean greater compliance for improved health outcomes.	**Year 2 Objective**
	4	Exploring new ways of contacting King's as part of digital transformation	**Year 2 Objective**
	5	Utilizing community partnerships to co-design solutions	**Year 2 Objective**
Health Inequalities contributions	1	Analyse violence and aggression data in relation to health inequalities and protected characteristics	**Fully Achieved**
	2	Work with partners including homeless/ACT to ensure meeting the needs of higher risk populations reducing their likelihood of becoming violent or aggressive and therefore reducing health inequalities.	**Partially Achieved**
Sustainability contributions	1	Support development of sustainable environments that focus on both patient and staff experience and reduce conflict	**Partially Achieved**
Mental Health	1	Training, reducing restrictive practice and restraint.	**Partially Achieved**
	2	Increasing therapeutic interventions and activities for patients presenting with mental health needs to improve engagement and reduce violence and aggression.	**Partially Achieved**
Patient Outcomes / Clinical Effectiveness			
Priority 3		**To improve patient outcomes in neuro and major trauma rehabilitation services**	
Objectives	1	To clarify, define, measure and improve the outcomes that matter most to patients receiving rehabilitation following a severe head injury or major trauma through co-design with patients and their families / carers.	**Partially Achieved**
Mental Health	1	Mental health outcomes will be included as key outcomes measures for patients receiving rehabilitation after severe head injury and/or Major Trauma.	**Fully Achieved**
Patient Safety			
Priority 4		**Supporting Positive Behaviour to increase patient safety 'Confident, Supported, Protected'**	
Objectives	1	To reduce the incidence of violence and aggression from patients, visitors and service users towards staff.	**Partially Achieved**
	2	To provide staff with the support they require to aid recovery from incidents of violence and aggression, promoting their health, well-being and safety.	**Fully Achieved**
	3	To provide an environment where all people at King's feel confident, supported and protected	**Fully Achieved**
Trust Strategy contribution	1	Ensure our people have the training, skills and support to carry out their roles and learn from incidents.	**Fully Achieved**
	2	Increase awareness of Trauma-Informed Care.	**Fully Achieved**
	3	Use quality improvement approach to reducing incidents of violence & agression by developing preventative models alongside staff and patients.	**Fully Achieved**

Domain			Target, 2022-23
	4	Continue to build partnerships and networks within SEL (South East London) and nationally to share learning and best practice.	**Fully Achieved**
	5	Proactive in anticipating and supporting patients with complex needs such as trauma, drug/alcohol abuse.	**Fully Achieved**
Health Inequalities contributions	1	Analyse Violence and aggression data in relation to health inequalities and protected characteristics.	**Fully Achieved**
	2	Work with EDI (Equality, Diversity and Inclusion) colleagues in development of work streams.	**Fully Achieved**
Sustainability Contribution	1	Green Impact: Support development of sustainable environments that focus on both patient and staff experience and reduce conflict.	**Partially Achieved**
	2	Long-term programme sustainability: Establishment of in house training team will be able to provide ongoing training that will adapt to the organisation's needs, incidents and risk assessments.	**Partially Achieved**
Mental Health	1	Training, reducing restrictive practice and restraint.	**Partially Achieved**
	2	Increasing therapeutic interventions and activities for patients presenting with mental health needs to improve engagement and reduce violence and aggression.	**Partially Achieved**

2022-23 Quality Priority 1:

Improving the detection of the deteriorating patient and escalating as appropriate

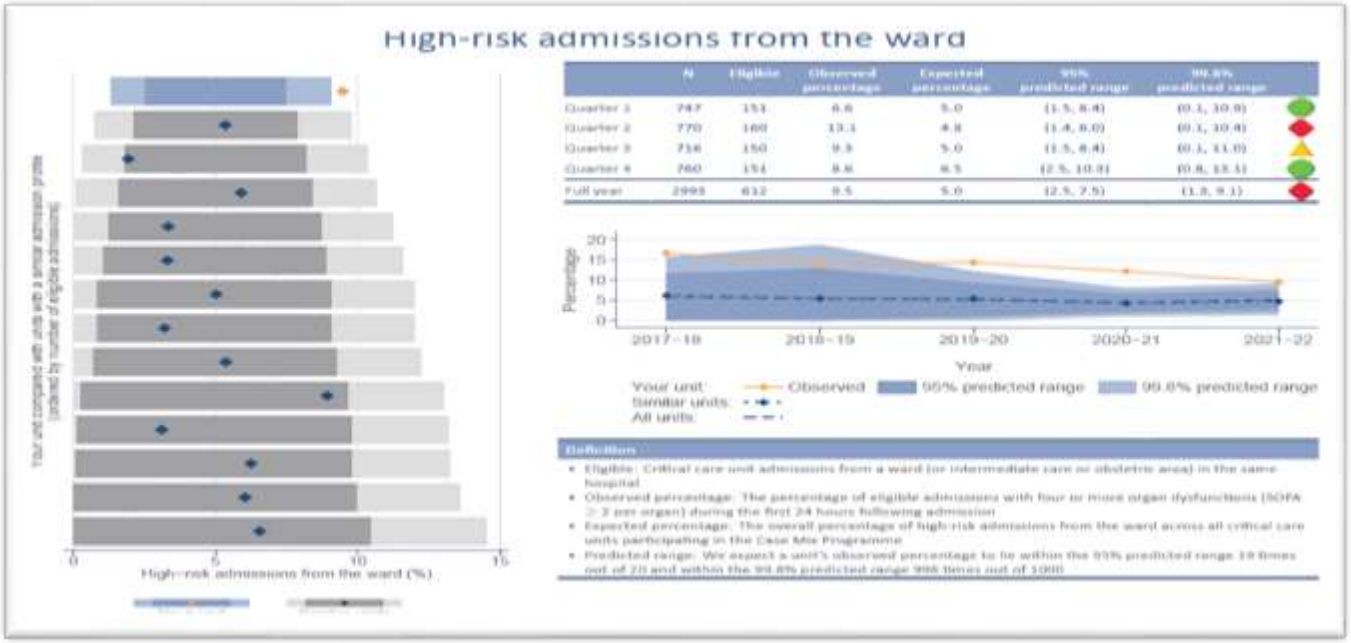
Why was this a priority?

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

It is important to note that patient deterioration in itself may be a natural progression of their condition or illness, but our aim to identify and manage that as quickly as possible to reduce, where possible, the impact on the patient and give them the best chance at a good outcome. Sometimes the appropriate treatment in that instance is making a cardiac arrest call to seek additional assistance in treating the patient, and it may also involve a transfer to intensive care in order to ensure the patient has the enhanced care they need. Neither a cardiac arrest call, nor a transfer to intensive care are therefore a clear way of tracking the impact of our quality improvement work. However, they remain important metrics for us to consider, in context.

A more nuanced measure is the Intensive Care National Audit & Research Centre (ICNARC) data. This data shows that risk adjusted survival to discharge (for patients admitted to intensive care) deteriorated from 31% in 2019 and down to 23.5% in 2021. Figure 1 below shows the percentage of high risk admissions from the wards to the intensive care unit. King's College Hospital achieved worse than national/similar units for '*high-risk admissions from the ward'*. This quality priority therefore set out to look specifically at our unplanned admissions to intensive care and to assess how well the patient's deteriorated was identified and managed prior to that point, using the relevant EWS (Early Warning Score) documentation. The documentation was used to check whether the patient was being monitored in line with their EWS, when the patient was escalated, and the effectiveness of the response to escalation. The priority also distinguishes between adults, children, maternity patients as the EWS and escalation protocols are different in each patient group. We also introduced goals for patients with deteriorating mental health conditions.

Figure 1: High risk admissions from the ward to intensive care units as reported in ICNARC Quarterly Quality Report: 1 April 2021 to 31 March 2022



Aims and progress made in 2022-23

Figure 1: Improving the detection and escalation of the deteriorating patient QAP (Quality Account Priority) scorecard

		Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	QAP Target
Quality Account Priority 1: Improving the detection of the deteriorating patient and escalating as appropriate														
	Deteriorating adult, NEWS2													
1	% unplanned critical care admissions with NEWS2 score recorded at time of escalation	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	60%
2	% unplanned critical care admissions with time and date of escalation recorded	85.0%	72.0%	89.0%	94.0%	81.0%	92.0%	91.0%	95.0%	90.0%	89.0%	92.0%	92.0%	60%
3	% unplanned critical care admissions with time and date of clinician response recorded	79.0%	97.0%	89.0%	92.0%	92.0%	95.0%	91.0%	97.0%	98.0%	100.0%	96.0%	100.0%	60%
	Deteriorating child, B/PEWS													
4	% of patients with evidence that documentation of observations occurred within 5 mins of recognition of deterioration or concerns	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	53%	*	60%
5	% of patients with evidence that documentation of escalation occurred within 60 mins of escalation	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	53%	*	60%
6	% of patients with parenteral concern documented (either no concerns or specific concerns recorded)	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	38%	*	60%
7	All escalations follow the Score Matched Care Recommendations (SMCR)	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	81%	*	60%
8	Reduction in number of amber & red incidents reported involving inpatient deterioration across child health that could have been recognised earlier	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	7	*	3
9	% staff who report that they are confident in interpreting the BPEWS score	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	74%	*	100%
10	% staff who report that they are confident in interpreting the SMCR to manage escalations	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	64%	*	100%
11	Reduction in the number of staff who report difficulties with escalating concerns regarding deterioration	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	61%	*	85%
12	Number of unplanned/unexpected children's critical care admissions from wards	*	*	*	*	*	*	*	*	*	*	*	*	tbc
13	% unplanned/unexpected PICU admissions with B/PEWS and lactate score recorded at time of escalation	*	*	*	*	*	*	*	*	60%	*	*	*	60%
14	% unplanned PICU admissions with time and date of escalation recorded	*	*	*	*	*	*	*	*	68%	*	*	*	60%
15	% unplanned PICU admissions with time and date of clinician response recorded	*	*	*	*	*	*	*	*	81%	*	*	*	60%
Process indicators using CQI D5 methodology														
16	Define phase: Define project scope & KPIs. Hold kick off meeting with stakeholders	▪▪▪	▪▪▪	▪▪▪	▪▪▪	◑	✓	✓	✓	✓	✓	✓	✓	By Aug-22
17	Describe phase: Baseline data analysis and root cause	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	◑	◑	◑	✓	✓	✓	✓	By Oct-22
18	Design phase: Rapid improvement workshop to identify and prioritise solutions and change ideas	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	◑	✓	✓	✓	By Dec-22
19	Deliver phase: Test and monitor improvement interventions (PDSAs)	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	◑	◑	◑	By Mar-23
20	Digest phase: Evaluate outcomes of PDSA. Monitor implemented interventions. Discuss/ share results and lessons learnt	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	By Jun-23
	Deteriorating woman (maternity), MEOWS													
21	% unplanned HDU/critical care admissions with MEOWS score recorded at time of escalation	*	*	*	*	*	*	*	*	*	*	*	*	100%
22	% unplanned HDU/ critical care admissions with time and date of escalation recorded	*	*	*	*	*	*	*	*	*	*	*	*	100%
23	% unplanned HDU/critical care admissions with time and date of clinician response recorded	*	*	*	*	*	*	*	*	*	*	*	*	100%
24	% non-high dependency maternity admissions and intrapartum care with MEOWS score recorded at time of escalation	*	*	*	*	*	*	*	*	65.0%	*	*	*	60%
25	% non-high dependency maternity admissions and intrapartum care with time and date of escalation recorded	*	*	*	*	*	*	*	*	43.0%	*	*	*	60%
26	% non-high dependency maternity admissions and intrapartum care with time and date of clinician response recorded	*	*	*	*	*	*	*	*	40.0%	*	*	*	60%
Process indicators using CQI D5 methodology														
27	Define phase: Define project scope & KPIs. Hold kick off meeting with stakeholders	▪▪▪	▪▪▪	▪▪▪	▪▪▪	◑	✓	✓	✓	✓	✓	✓	✓	By Aug-22
28	Describe phase: Baseline data analysis and root cause	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	◑	◑	◑	✓	✓	✓	✓	By Oct-22
29	Design phase: Rapid improvement workshop to identify and prioritise solutions and change ideas	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	◑	◑	◑	✓	✓	◑	By Feb-23
30	Deliver phase: Test and monitor improvement interventions (PDSAs)	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	By Apr-23
31	Digest phase: Evaluate outcomes of PDSA. Monitor implemented interventions. Discuss/ share results and lessons learnt	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	By Jun-23
	Life support training, BLS and PBLS													
32	% of staff compliant with Resuscitation training	80.4%	81.4%	83.1%	83.2%	83.7%	74.7%	84.10%	82.40%	81.60%	81.60%	*	*	90%
	Mental Health													
33	% of patients presenting with mental health needs who received therapeutic interventions and activities	76%	77%	81%	72%	76%	71%	73%	75%	80%	80%	78%	78%	↑%
	Process Indicators													
34	Investigation into incidents relating to identification and escalation of the deteriorating patient completed	▪▪▪	▪▪▪	◑	✓	✓	✓	✓	✓	✓	✓	✓	✓	By Jul-22
35	B/PEWS documented electronically via EPR	▪▪▪	▪▪▪	▪▪▪	◑	◑	◑	◑	✓	✓	✓	✓	✓	By Dec-22
36	Life support training needs analysis (TNA) revised and completed	◑	◑	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	By Aug-22
37	Pilot patient activated triggers to ensure that the diversity of patient needs will identified	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	◑	By Mar-23
38	Report safety information with regards to protected characteristics for the deteriorating patient	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	By Mar-23
39	Conduct financial modelling with NHS Resolution, in relation to the deteriorating patient	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	By Mar-23

Key	
▪▪▪	Pending
◑	In progress
✓	Completed
* Data not yet available	

Fully Achieved: Objective 1 -: Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation and time of clinical response recorded.

NHS England and Improvement (NHSE/I) reintroduced the national Commissioning for Quality and Innovation (CQUIN) evidence-based improvement scheme in 2022-23. Our first objective for this priority was to achieve the CQUIN goal.

This consists of recording of NEWS2 score, escalation time and response time for unplanned critical care admissions. This is designed to promote the reliable recording of the NEWS2 score, escalation and response timings, including documentation in medical records for ward inpatients, where there is a deterioration episode.

This was fully achieved with every quarterly data submission, showing sustained improvement across the Trust from April 2022 to March 2023 as seen in the deteriorating patients scorecard, indicators 1, 2 and 3 in figure 3 above.

Fully Achieved: Objective 2 -: Achieving 60% of all unplanned paediatric critical care unit admissions from non-critical care paediatric wards of children up to their 16th birthday, having a Bedside Paediatric Early Warning Score (BPEWS) score, time of escalation and time of clinical response recorded.

The paediatric element of the priority commenced in July 2022 with a formal project launch to wider stakeholders in September 2022. After September 2022, the team have now achieved the 60% target and are now looking at a stretched target of 85%. A parent representative was included in the Steering Committee to ensure consultation and to facilitate co-production where appropriate.

Process indicators were included that demonstrated adherence to the stages of the quality improvement methodology (D5 model) shown in the priority's scorecard, see figure 3 above, indicators 4 to 20. In February 2023, baseline data was collected and further data will be collected and consistent data collection is due to begin in July 2023. The team have now set a stretch target of 85%.

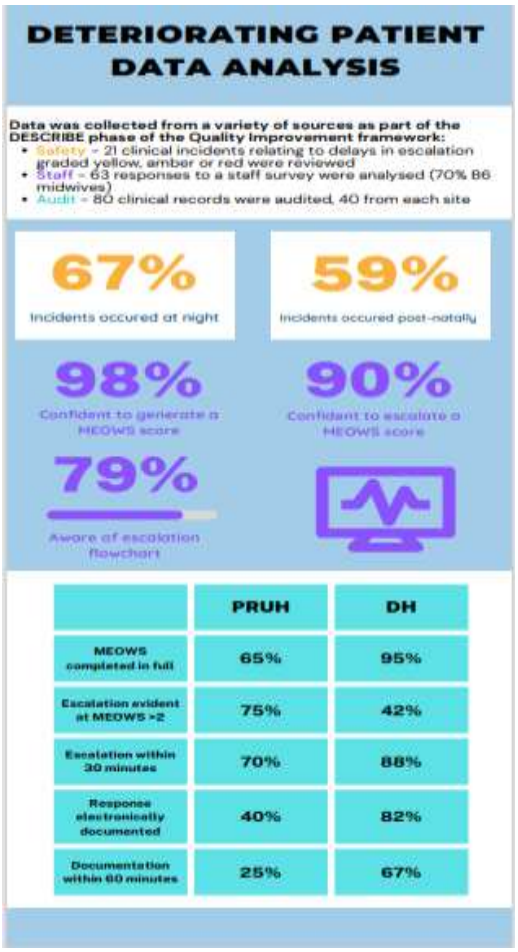
A rapid improvement workshop was held in February 2023 with 30 stakeholders from Child Health to share the quantitative and qualitative data collected, highlight sources of variation & capture challenges that were used to identify root causes and generate change ideas. The KPIs (key performance indicators) developed were also included in the scorecard on the previous page.

The project team has prioritised the solutions and has established working groups to test and support implementation. The revised timeline for project completion is July 2023.

Partially Achieved: Objective 3 -: Achieving 60% of all unplanned maternity critical care unit admissions from the birth centres or labour wards, having a Maternity Early Obstetric Warning Score (MEOWS) score, time of escalation and time of clinical response recorded.

The maternity workstream commenced in August 2022. Baseline data to measure improvement against was collected and is shown in figure 4 below.

Figure 2: Baseline data collection of MEOWS completion within the Maternity at DH and PRUH, October 2022



	PRUH	DH
MEOWS completed in full	65%	95%
Escalation evident at MEOWS >2	75%	42%
Escalation within 30 minutes	70%	88%
Response electronically documented	40%	82%
Documentation within 60 minutes	25%	67%

A Rapid Improvement Workshop for Maternity took place on 24 February 2023. The ideas generated have been prioritised and working groups are now being established to test these using Plan Do Study Act cycles.

Data will be collected to measure the impact to determine whether the success of the change. It is anticipated that the project will be complete by July 2023 with monthly data collection monitored with Maternity. Progress made is shown in the deteriorating patients scorecard, indicators 21 to 31 in figure 3 above.

Partially Achieved: Trust Strategy Contribution 1 -: Staff will be supported and receive the appropriate training to improve detection and escalation of deteriorating patients.

The Trust training needs analysis (TNA) for resuscitation training was revised aligning it to the Resuscitation Council UK's quality standard for Acute Care. This includes the use of an 'early warning scoring' system to identify the deteriorating patient, including the use of an escalation protocol to ensure early and effective treatment of patients in order to prevent cardiac arrest.

The Trust resuscitation team is now fully established with capacity to provide training to all staff in accordance with their training needs. There was a refresh of the Trust's Resuscitation training needs analysis in January 2023 so the data for February and March is not included here, as it is no longer directly comparable.

We continue to monitor the training compliance figures via the Quality Committee and as part of the priorities for 2023/24

Fully Achieved: Trust Strategy Contribution 2 -: Improvement will be embedded to deliver safer care for deteriorating patients.

The Quality Improvement (QI) team provided intensive support for the quality account priority utilising the Trust D5 approach to QI. D5 takes teams through five phases of project management:

- **Define** the problem
- **Describe** the current situation and root causes of any problems
- **Design** solutions to fix the root causes of problems
- **Deliver** the project plan
- **Digest** by evaluating whether the project has achieved its outputs and outcomes and conduct further improvement cycles.

Partially Achieved: Trust Strategy Contribution 3 -: A pilot of patient activated triggers will be undertaken to ensure that the diversity of patient needs will identified.

The Trust was successful in an application for the national NHS England and Improvement Patient Worry and Concern project and is the chosen London region pilot site. The soft launch was held on 25 January 2023 and the Trust's core implementation group meets on a fortnightly basis to plan and monitor progress with the pilot. The implementation group will be piloting the use of patient activated triggers to help identify the diversity of patient needs.

Not Achieved: Health Inequalities Contribution 1 -: On migration to Datix Cloud, can feed from PIMS, and report on safety information with regards to protected characteristics.

Not Achieved: Health Inequalities Contribution 2 -: Identify and conduct quality improvement around, groups coming to disproportionate harm due to deteriorating patients related issues.

Both objectives were agreed in February 2022 when the Trust Learning Reporting Management System (LRMS) was Datix Web. The Trust was in the process of migrating to Datix Cloud which offered the additional functionality that would allow for linking incidents to protected characteristics. Datix Cloud was not able to meet the required functionality and the Trust has now moved to InPhase which is able to meet all LRMS requirements. This has led to a delay in meeting with objective, however, this will resume in 2023/24 once PIMS has been integrated with InPhase and we will be able to report on safety information with regards to protected characteristics and groups coming to disproportionate harm.

Partially Achieved: Sustainability Contribution 1 - Improving how we recognise and escalate the deteriorating patient could lead to less expenditure in terms of costs of escalation of care, extended stay in hospital plus potential claims costs.

The new NHS Resolution claims scorecard enables organisations to see the percentage contribution of claims cost by clinical specialty area. Knowing the percentage a specialty costs as well as the volume, financial cost, cause and injury in this area will help enable improvement targets to be set as well as performance tracking. This will be a key part of data insight with the implementation of the NHS Patient Safety Incident Response Framework (PSIRF).

Partially Achieved: Mental Health Contribution 1 -: Explore roll out of the Code 10 escalation and management pathway of patients in mental health crisis or deteriorating in use in the Emergency Department across the Trust

The expansion of Code 10 to areas of the Trust outside of DH Emergency Department (ED) has not been fully achieved. We have however continued to work on a number of projects and initiatives designed to improve both the identification of the deteriorating patient and their management in relation to mental health.

Regular interface meetings have now been re-established with our local Mental Health Trusts in order to ensure oversight of Mental Health pathways. Our internal, Trust-wide Mental Health

Governance Committee is now fully established – this quarterly meeting asks care group representatives to provide bi-annual updates about specific risks within their individual areas, and allows for a forum in which Trust-wide risks in relation to mental health and learning from incidents can be shared to a wide audience.

A major roll out of Mental Capacity Act and Mental Health Act training is due to start in spring 2023. This training will be delivered on the ground in clinical areas in bite-size modules in order to support as many clinical staff to attend as possible. It will be open to all clinical disciplines and will have a particular focus on capacity assessments.

As a part of the regular monthly Medical Emergencies in Eating Disorders (MEED) working group, Trust-wide guidance has been developed outlining expectations for the care and treatment of patients admitted with confirmed or suspected eating disorder. This risk based approach to admission will mean the safer management and discharge of inpatients with an emphasis on faster and more effective Multidisciplinary Team (MDT) communication.

Suicide Prevention Guidance, developed jointly with GSTT, was launched in August 2022. In addition to providing staff with context and an overview of whole population static risk factors and dynamic considerations, the guidance provides staff with an accessible 4-part assessment tool and comprehensive set of resources, with clear instructions on how to escalate concerns if working with a patient expressing acute suicidal thoughts.

Next Steps

Improving the detection of the deteriorating patient and escalating as appropriate will continue as a quality account priority for 2023/24 with a particular focus on Sepsis. The aim of this quality account priority would be to improve the identification and management of patients with sepsis as outlined on page 30.

2022-23 Quality Priority 2:

To improve patient experience through effective communication

Why was this a priority?

Communication with patients and communication with relatives / carers is amongst the top five concerns raised by patients and relatives accessing services at King's College Hospital NHS Foundation Trust in 2021/22. The indicators in table 2 below from the Care Quality Commission (CQC) NHS Adult Inpatient Survey 2020 and 2021 show some of the areas for improvement as reported by our patients in relation to communication:

Table 2: Areas for improvement highlighted by the CQC NHS Adult Inpatient Survey 2020 and 2021 in relation to:

Questions	No. of respondents	King's score		Trust average score	Lowest score	Highest score
		2020	2021			
Q26. Did you feel able to talk to members of hospital staff about your worries and fears?	333	7.3	7.4	7.6	6.4	9.2
Q32. Beforehand, how well did hospital staff answer your questions about the operations or procedures?	237	8.6	8.7	8.9	8.2	9.7
Q33. Beforehand, how well did hospital staff explain how you might feel after you had the operations or procedures?	312	7.1	7.2	7.6	6.4	8.8
Q34. After the operations or procedures, how well did hospital staff explain how the operation or procedure had gone?	314	7.6	7.6	7.9	7.0	9.2
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	436	6.8	7.1	7.6	6.2	9.7

We continue to receive complaints raising concerns about communication with either patient or relative. Patient feedback from the Friends and Family Test (FFT) indicates that waiting negatively affects our patients experience and this is associated with lack of communication and information about waiting times and reasons for waiting.

As highlighted in the CQC survey (above) and the Trust's FFT scores, communication challenges are negatively affecting patient experience. In addition, research indicates that there are strong positive relationships between a healthcare team member's communication skills and a patient's capacity to follow through with medical recommendations, self-manage a chronic medical condition, and adopt preventive health behaviors. Studies conducted during the past three decades show that the clinician's ability to explain, listen and empathize can have a profound effect on biological and functional health outcomes as well as patient satisfaction and experience of care. We have committed to two years to make improvements necessary to achieve more effective communication.

Aims and progress made in 2022-23

Figure 3: Improving patient experience through effective communication QAP scorecard

		Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	QAP Target
Quality Account Priority 2: To improve patient experience through effective communication														
	Responsiveness to telephone calls													
1	% Patient Advice and Liaison Service's queries relating to inability to contact Ophthalmology (Unable to contact direct line or dept - no response)	*	*	*	*	*	43%	38%	8%	17%	11%	0%	17.4%	↓25% (18%)
2	Number of enquiries & concerns (per calendar month) recorded by PALS for Ophthalmology on the DH site	8	8	8	8	8	8	6	1	1	9	12	23	↓50% (4 p/cm)
3	% of negative comments received referencing communications improvements as part of FFT responses for Ophthalmology on DH site	27%	15%	19%	15%	29%	21%	9%	20%	41%	23%	24%	17.0%	↓30% (13.3%)
	Process Indicators													
5	Audit of the Accessible Information Standard (AIS) completed	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	◑	◑	◑	◑	✓	✓	✓	By Mar-23
6	Identify areas of improvement and implement quality improvement changes from AIS audit	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	◑	◑	◑	◑	◑	◑	✓	By Mar-23
7	Review and co-produce patient information in relation to waiting times in PRUH ED	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	◑	◑	◑	By Mar-23
8	Review and co-produce patient information in relation to waiting times in DH ED	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	◑	◑	◑	By Mar-23
9	Review and co-produce patient information in relation to pre- and post-surgery	▪▪▪	▪▪▪	▪▪▪	◑	◑	◑	✓	✓	✓	✓	✓	✓	By Mar-23
10	Review and co-produce patient information in relation to discharge	▪▪▪	▪▪▪	▪▪▪	◑	◑	◑	◑	✓	✓	✓	✓	✓	By Mar-23
11	Establish a patient information group	▪▪▪	▪▪▪	▪▪▪	✓	✓	✓	✓	✓	✓	✓	✓	✓	By Mar-23
12	Establish a patient group to review complaint responses to make them more accessible and compassionate	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	By Mar-24
13	Review and identify areas for implementation from NICE CG138, Patient experience in adult NHS services, in relation to communication and information, 1.5.1 to 1.5.19.	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	◑	By Mar-24

Year 2: Objective 1 -: To improving communication skills with patients and their relatives / carers through education and training.

The training package is scheduled to be delivered in Year 2 of the project. However, progress in Year 1 includes development of a bank of patient and carer stories which will form part of the training. These stories will be presented to clinical and non-clinical staff to help them better understand the impact that poor communication has on our patients and communities. Training and education will be monitored by the Patient Experience Committee.

Achieved: Objective 2 -: To improve responsiveness to patients and their relatives / carers through answering telephone calls.

In 2022-23 our efforts to improve responsiveness through answering telephones focused on our Ophthalmology services. The service supports patients with diagnosis and treatment for a wide range of eye conditions and delivers over 210,000 appointments on an annual basis.

We worked alongside our Quality Improvement team, our patients and communities to co-design solutions. This resulted in deploying additional staff, updating internal and external information, purchasing equipment and introducing new ways to communicate with the service. This led to a reduction of PALS (Patient Advice & Liaison Service) queries relating to inability to contact Ophthalmology via the telephone from 43% to 17% which is very positive progress within the year particularly in the context of increased volume of Pals queries reported over for ophthalmology over the same period (due in part to changes in the Pals logging system). There has also been a 10% decrease in the % of negative FFT comments for ophthalmology which reference communication. Whilst this did not fully achieve the target of 13.3% (17% reported in March 2023) we are pleased to report progress in a very positive direction against an ambitious stretch target.

This objective will carry on into 2023/24 as learning from the Ophthalmology will be rolled out wider.

Year 2: Objective 3 -: To improve information provision to patients and their relatives / carers.

Our work to co-design information for our patients and communities will continue. In 2023/24, we aim to double the number of patients involved in reviewing information that we provide alongside articulating our patient-led information standard and reviewing more than 30 leaflets in line with this.

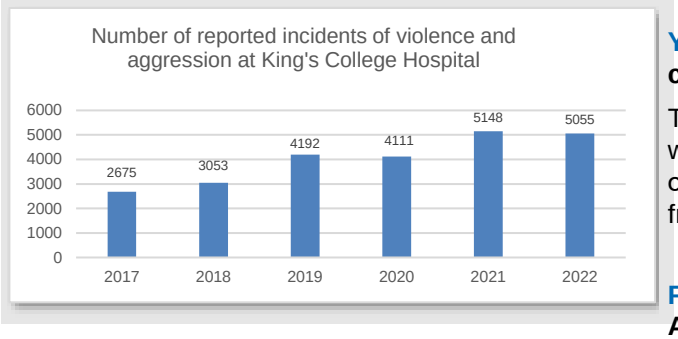
Year 2: Trust Strategy Contribution 1 -: Training and toolkit will improve communication positively impacting staff's wellbeing.

2023/24 will see us working alongside our staff and patients to co-design and deploy 'accessibility and communication kit box' to give our staff the confidence to better communicate with our diverse communities.

Year 2: Partially Achieved: Trust Strategy Contribution 2 -: Effective communication will lead to a reduction of violence and aggression incidents.

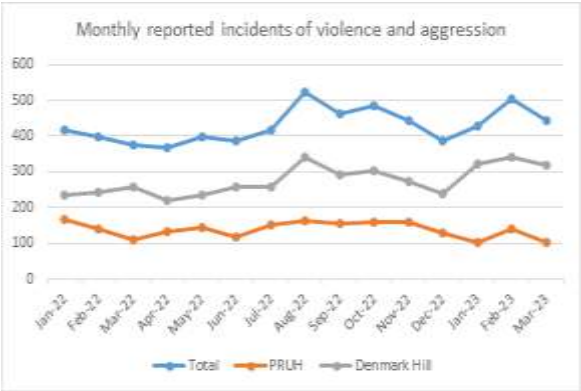
Figure 4: Number of reported incidents of violence and aggression

across the Trust



Since 2017 incidents of violence and abuse reported by staff at King's has shown an upward trend. Incidents peaked in 2021 with 5148 incidents reported that year. It is unclear whether this trend is set to continue and data will need to continue to be monitored closely to identify any consistency. Research tells us that incidents of violence and abuse are significantly under reported therefore, whilst this data should be interpreted positively, it should be done so with caution.

Figure 5: Monthly reported incidents of violence and aggression across the Trust



There remains considerable variation month on month in the violence and aggression incidents reported, with many often relating to the same patients. Incident data is monitored through the Supporting Positive Behaviour Group.

Year 2: Trust Strategy Contribution 3 -: Better communication will mean better compliance for better health outcomes • Exploring new ways of contacting King's as part of digital transformation.
Year 2: Trust Strategy Contribution 4 -: Exploring new ways of contacting King's as part of digital transformation.

In October 2023, we will launch a brand new patient record system that will also introduce MyChart, patient portal, which will enable patients to access and communicate information about their care via a simple app. Our Patient Advice and Liaison Service (PALS) will also pilot additional methods of contact.

Year 2: Trust Strategy Contribution 5 -: Utilizing community partnerships to co-design solutions.

Throughout 2023/24 we will build on the extensive links we have with our community partners and we will define our 'model for involvement' with supporting tools, framework and policies underpinning this work.

Fully Achieved: Health Inequalities Contribution 1 -: Analyse violence and aggression data in relation to health inequalities and protected characteristics.

The Trust is able to monitor staff survey WDES and WRES data. Tables 3 and 4 show the percentage of staff who have experienced at least one incident of verbal abuse from patients/service users, their relatives, or other members of the public in the previous 12 months. This data is shared with the Supporting Positive Behaviour Group for monitoring and improvement actions.

Table 3: Percentage of staff who have experienced verbal abuse in previous 12 months WDES data

	2018	2019	2020	2021	2022
Staff with a long lasting health condition or illness	36%	44%	42%	41%	41%
Staff without a long lasting health condition or illness	29%	35%	36%	35%	36%

Table 4: Percentage of staff who have experienced verbal abuse in previous 12 months WRES data

	2018	2019	2020	2021	2022
White staff	20.8%	23.0%	19.2%	20.2%	21.9%
All other ethnic groups combined	26.7%	14.8%	17.6%	21.8%	28.6%

Year 2: Achieved Health Inequalities Contribution 2 -: Work with partners including homeless/ACT to ensure meeting the needs of higher risk populations reducing their likelihood of becoming violent or aggressive and therefore reducing health inequalities.

Support to provide care for patients with complex needs is available across the Trust and the aim of multi-disciplinary decision making is to proactively anticipate patient's needs. The Alcohol Care Team, Homeless Team, Learning Disability, Safeguarding, Mental Health and Psychology teams all work collaboratively to support patients whilst under the care of King's. This has now been embedded in our daily practice.

Partially Achieved: Sustainability Contribution 1 -: Support development of sustainable environments

that focus on both patient and staff experience and reduce conflict.

It is acknowledged that the environment within high risk areas of King's are not conducive to reducing levels of violence and aggression. Additionally, when patients display challenging behaviour damage can occur to those environments that lead to poorer patient experience, staff experience and increased costs.

The paediatric Emergency Department on the Denmark Hill site has requested charity funding to install sensory lighting and speakers within their adolescent room. The aim of this is to improve patient experience, particularly for those who attend due to a mental health crisis and reduce incidents of violence and aggression.

Partially Achieved: Mental Health Contribution 1 -: Training, reducing restrictive practice and restraint.

All training in managing violence and aggression provided by The Trust has an emphasis on dealing effectively with situations in order to obviate the need for restraint.

Those who are trained to use restraint techniques receive additional training in the risks and potential psychological impact of restraint.

Incidents of significant restraint are reviewed by security, the clinical team, the Violence Reduction Matron, mental health leads and the Director of Nursing for Vulnerable Adults to establish learning and actions to further improve our restraint reduction work.

Partially Achieved: Mental Health Contribution 2 -: Increasing therapeutic interventions and activities for patients presenting with mental health needs to improve engagement and reduce violence and aggression.

The Enhanced Care policy was reviewed outlining:

- Criteria for patients requiring enhanced care
- Enhanced Care Risk Assessment Tool
- Promoting intermittent therapeutic supervision of patients and engaging the patients in activity as much as possible.

Registered Mental Health Nurses (RMNs) are now requested for patients requiring enhanced care, however, staffing remains a challenge. This work will continue into 2023/24.

Next Steps

Following successful delivery of interventions within the Ophthalmology service, resources are now being committed to scaling the pilot and sharing best practice with other services at King's College Hospital whilst the training package is being finalised and prepared for roll-out in 2023/24.

2022-23 Quality Priority 3:

Improving outcomes for patients receiving rehabilitation following a severe head injury or major trauma

Why was this a priority?

Major trauma is defined as an injury or combination of injuries that are life-threatening and could be life-changing because they may result in long-term disability (NICE, 2016). Rehabilitation of patients is a crucial component of effective healthcare delivery, supporting patients to achieve the best possible quality of life after major trauma and/or a severe head injury.

Given the impact that rehabilitation can have on people's lives, and the scale of rehabilitation services being delivered at King's, it is essential that the interventions being delivered are appropriately evaluated to ensure they achieve the maximum benefit for patients. We therefore want to find out, and then measure, the outcomes that matter most to patients. This information will help us to improve our care and services for current and future patients.

In 2021, the Patient Advisory Group of the South London Neurosciences Operational Delivery Network (ODN) in partnership with King's Health Partners (KHP) undertook a survey on the experience of patients receiving neuro-rehabilitation after a head injury. The recommendations of the report included: earlier and more rehabilitation while on acute wards; greater scope to access inpatient rehabilitation beds; more weekend rehabilitation services; improving communication and understanding of individual needs; better and speedier access to community and hospital outpatient rehabilitation services.

This quality priority is an opportunity to build on the patient survey results to define, measure and improve the outcomes for patients across the rehabilitation pathway from hospital admission to longer term care within community settings.

The South London Neurosciences Network and its patient advisory group have developed a 'well-being app' for people with a neurological condition, capturing outcomes that matter most to patients. This quality account priority provides an opportunity to explore whether this app could be used to obtain information on outcomes that matter most to patients who have had a severe head injury and/or major trauma.

A key objective to our Strong Roots, Global Reach strategy is supporting better patient outcomes by exploring new rehabilitation models across our acute sites. This is in recognition of the significant demand driven by our role as a major trauma centre and heart attack centre, alongside the needs of stroke and neuro-oncology patients. This priority addresses this Trust strategic priority. It will run over 2 years: Year 1 will focus on finding out and measuring the outcomes that matter most to patients, and Year 2 will focus on making improvements.

Aims and progress made in 2022-23

Partially Achieved: Objective 1 -: To clarify, define, measure and improve the outcomes that matter most to patients receiving rehabilitation following a severe head injury or major trauma through co-design with patients and their families / carers.

In 2022 we completed a comprehensive literature review of outcomes measurement in neuro-rehabilitation, including published and 'grey' literature that provided information about outcomes that are most important to patients. We reviewed existing Trust data and concluded that it does not help us in measuring outcomes that matter most to patients.

In the autumn of 2022, we held several focus groups with patients and their families, who generously gave their time to tell us about their health and quality of life after they or their loved ones left King's. They told us that they are incredibly supportive of King's moving towards measuring quality of life as a key outcome measure, and they advised us that we need to measure this up to two years after discharge from King's services. Patients and their families shared their experiences, the outcomes that are most important to them and gave us some ideas on areas that could be improved. The patient focus group offered to review and feedback to us on existing quality of life questionnaires, and to review our 'prototype' questionnaire. Based on their feedback, our questionnaire in its final version and we will begin to send it out to patients in March 2023 and, for the first time, gather information on

the outcomes that are most important to patients.

As well as an enormous ‘thank you’ to the patients and families who have experience our neuro-rehabilitation services, we would like to give credit to NHS Wales, who have generously supported and helped us on this journey – we look forward to ongoing collaboration with all during our next year’s work and beyond.

Fully Achieved: Mental Health Contribution 1 -: Mental health outcomes will be included as key outcomes measures for patients receiving rehabilitation after severe head injury and/or Major Trauma.

Mental health is included in the outcomes about which we are asking patients for their feedback, and outcomes data will be shared in Year 2.

Next Steps

We began sending our questionnaire to patients in March 2023. As well as feedback on the outcomes that our patients achieve, we are asking for feedback on their ideas about how services, at King’s or in the wider health community, can be improved to help future patients achieve the best possible outcome. As we get responses we will analyse the data and identify improvement actions, collaborating with colleagues within King’s and across the Integrated Care System as required.

We will also report on the other objectives set out in 2022-23 for completion in 2023-24.

2022-23 Quality Priority 4:

Supporting Positive Behaviour to increase staff and patient safety

Why was this a priority?

King's College Hospital's NHS Staff Survey Results demonstrate that our staff continue to experience some of the highest levels of violence and abuse in the workplace. Table 5 displays results between 2018 and 2022 and whilst there does appear to be an improved position since 2018 the results clearly show a significantly higher number of incidents in comparison to the national average.

Table 5: Staff experiencing verbal abuse and physical assault across the Trust from 2018 to 2022

Year	% of KCH staff who have experienced verbal abuse	SEL average	National average	% of KCH staff who have experience physical assault	SEL average	National average
2018	37.2%	-	28.2%	19.3%	-	14.1%
2019	34.4%	-	28.1%	19.2%	-	14.4%
2020	33.4%	-	26.0%	17.8%	-	14.2%
2021	33.7%	30.6%	27.4%	16.8%	15.5%	14.2%
2022	33.5%	31.6%	28.1%	17.5%	15.8%	15.0%

The Trust remains committed to preventing and dealing robustly with violence and abuse against our staff and has implemented a range of measures over the last decade based on learning from our incident reports. In 2022-23 the Trust continued its previous work on reducing incidents of violence and aggression under the Supporting Positive Behaviour programme of work. This programme of work aims to identify and understand the root causes of violence and aggression and prevent incidents occurring. It is important to acknowledge that we are unlikely to eliminate all incidents of violence and abuse therefore we need to have effective support systems in place to limit harm caused and actively learn from incidents that do occur.

Aims and progress made in 2022-23

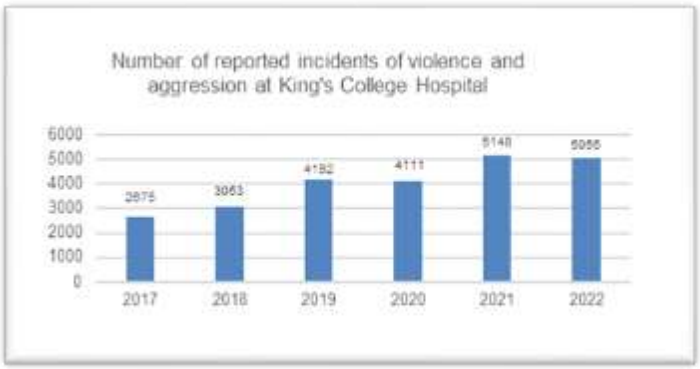
Figure 6: Improving staff and patient safety through supporting positive behavior QAP scorecard

		Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	QAP Target
Quality Account Priority 4: Supporting Positive Behaviour to increase staff and patient safety														
	Violence and aggression towards staff													
1	Number of reported incidents of verbal abuse/threats	298	315	328	341	414	380	391	329	300	360	401	352	-
2	Number of reported incidents of physical assault	70	84	56	77	109	82	95	114	77	69	112	88	↓
3	% of incidents requiring Security Team response	70%	66%	73%	64%	67%	62%	63%	62%	68%	68%	71%	66%	↓%
4	% of staff signed supporting positive behaviour staff charter	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	
	Training													
5	Total number of staff who have completed level 1 Trauma Informed Approach to Conflict Resolution training	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	↑
6	Total number of staff who have completed level 2 conflict resolution training	525	541	566	595	632	652	661	695	695	837	837	865	↑
7	Total number of staff who have completed level 3 conflict resolution and disengagement training	573	578	592	606	624	673	736	813	822	977	1021	1065	↑
8	Total number of staff who have completed management of telephone abuse training	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	16	tbc
	Mental health													
9	% of patients presenting with mental health needs who received therapeutic interventions and activities	76%	77%	81%	72%	76%	71%	73%	75%	80%	80%	78%	78%	↑%
10	% of patients requiring physical restraint during Security Team response	49%	56%	50%	46%	45%	52%	45%	45%	49%	38%	51%	48%	↓%
	Process Indicators													
11	Launched a new strategy for embedding Supportive Positive Behaviour to BOLD	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	By Dec-22
12	Produced a film exploring Conflict Resolution and Trauma Informed Care	➲	➲	➲	➲	➲	➲	➲	✓	✓	✓	✓	✓	By Dec-22
13	Developed an e-learning package for Level 1 Conflict Resolution, TIC and Customer Awareness	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	➲	➲	➲	➲	➲	By Mar-23
14	Developed, trialed and evaluated preventative models to reduce violence and aggression	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	➲	➲	➲	✓	✓	✓	By Mar-23
15	Embedded the staff charter across the organisation	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	By Mar-23
16	Standardised support structure in place to support positive behaviour	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	➲	➲	➲	➲	✓	By Mar-23

Partially Achieved: Objective 1 -: To reduce the incidents of violence and aggression from

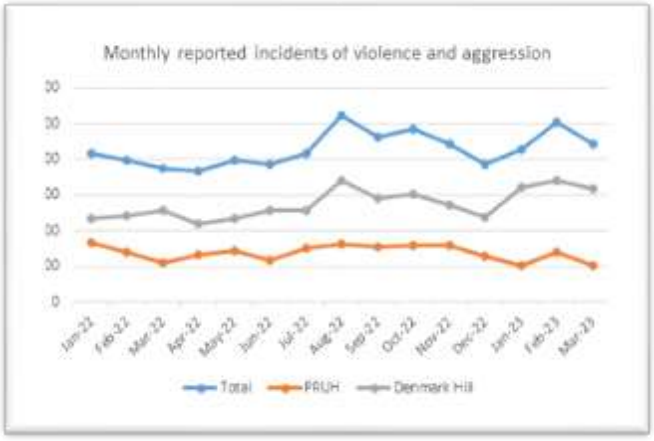
patients, visitors and service users towards staff.

Figure 7: Number of reported incidents of violence and aggression across the Trust



Since 2017 incidents of violence and abuse reported by staff at King's has shown an upward trend. Incidents peaked in 2021 with 5148 incidents reported that year. In 2022, the incidents plateaued with 5055 being reported across the organisation. It is unclear whether this trend is set to continue and data will need to continue to be monitored closely to identify any consistency. Research tells us that incidents of violence and abuse are significantly under reported therefore, whilst this data should be interpreted positively, it should be done so with caution.

Figure 8: Monthly reported incidents of violence and aggression across the Trust



Whilst reported incidents have plateaued year on year there remains considerable variation month on month. Incident data is monitored through the Supporting Positive Behaviour Group. The number of reported incidents of verbal abuse and physical assault, and those requiring Security Team response are shown in the scorecard, indicators 1 to 3 on figure 8.

Fully Achieved: Objectives 2 & 3-: To provide staff with the support they require to aid recovery from incidents of violence and aggression, promoting their health, well-being and safety. To provide an environment where all people at King's feel confident, supported and protected.

Whilst improvements have been made in the King's NHS Staff Survey results and the number of incidents reported has plateaued, our staff continue to see above acceptable levels of violence and aggression. It is acknowledged that not every incident of violence and aggression is preventable therefore robust mechanisms must be in place to ensure our staff get the support they require post an incident.

Acute Specialty Medicine, a care group with significantly high incidents of violence and aggression, carried out a quality improvement project with regards to staff support post incidents of violence and aggression. The project aimed to develop a process to ensure consistent and timely actions are in place to provide support for staff. A reflection and debriefing group of twenty staff members was set up. This group monitored adverse incident reports submitted in relation to violence and aggression and reached out to staff within 72 hours with a one week follow-up. Initial feedback from the project has been positive with staff feeling support is more focused and individualised. A formal evaluation of this project will be shared with care groups for wider implementation.

In addition to this the Trust continues to support staff through the Staff Wellbeing team. Dedicated psychologists support individuals and teams through reflective practice sessions and Critical Incident Staff Support (CISS) sessions. The provision of CISS has expanded with all members of the wellbeing team completing training and supervision allowing them to lead facilitations.

Fully Achieved: Trust Strategy Contribution 1 -: Ensure our people have the training, skills and support to carry out their roles and learn from incidents.

In 2021/22 a review of Conflict Resolution Training (CRT) was carried out and an innovative approach to CRT comprising of five levels was developed:

1. Short awareness training, delivered via film and e-learning, focusing on trauma informed care and conflict
2. Half day CRT training for staff who work in low-risk areas e.g. outpatients
3. One day CRT training for staff in 'high risk' areas which will include non-restrictive breakaway techniques.
4. Specialised training for staff in 'hot spot' areas where the use of restraint may be considered necessary.
5. Highly specialised training for the Security Team

In 2022-23 work began to establish training provision using this approach. Funding was secured from South East London Integrated Care System (ICS) to develop the level 1 e-learning package. This has been co-produced with the Trust's Violence Reduction Matron, Security Team and Patient Experience. The decision was taken to produce this package internally utilising design skills within our Learning and Organisational

Development team therefore this is now due for completion at the end of April 2023. This training package will be made available to all organisations within the ICS including primary and social care. The Violence Reduction Matron chairs a SEL-wide Task and Finish Group to establish a standardised ICS approach to CRT. This work is currently focused on developing level 2 CRT as an e-learning module to increase accessibility and improve cost effectiveness.

Whilst this training is being developed the King's Security Team are providing level 2 to 5 training on a regular basis to teams that require it. Significant progress has been made with those who have completed level 3 CRT with 1065 staff members of staff having completed the training. There is an increased provision and access to this training going forward across all sites. The number of staff that have been on the level 2 and level 3 conflict resolution training has risen steadily as seen on the scorecard above, indicators 6 and 7 in figure 8 above.

All training CRT delivered in the Trust has a focus on the risks of restraint and the need to reduce restrictive interventions.

Furthermore, funding was secured to deliver training specific to the management of telephone abuse to support PALS, complaints and administrative staff. Eight virtual sessions have been commissioned with an external provider who will deliver the training between April and November 2023. This training will be evaluated to establish whether further funding should be sought.

Fully Achieved: Trust Strategy Contribution 2 -: Increase awareness of Trauma-Informed Care.

The Trust's Violence Reduction Matron worked alongside a film production company to produce a short 15 minute film based on King's staff experiences of violence and abuse. This film, which aims to spark thought and reflection on the management of conflict using the principles of Trauma Informed Care, was launched in December 2022.

Additionally, the one hour e-learning package within the conflict resolution training framework has embedded a trauma informed approach. This e-learning package embeds the film and uses it as an education tool to raise awareness of the concept. The training will be launched in July 2023 and will be available to all staff. An evaluation of the effectiveness of this training will be carried out towards the end of 2023.

The Security Training and Violence Reduction Manager has worked alongside the Safeguarding team to trial simulation training from those working with our major trauma patients which focusses on restraint reduction and trauma informed care. After two successful trial sessions this is now available for clinical teams to access on study days and team away days.

We reviewed the governance process for restraint, aligning with the Patient Safety Incident Response Framework (PSIRF), increasing focus on understanding how incidents of restraint happen, including the factors which contribute to them and how we can learn and improve. Our MDT approach allows us to support positive behaviour.

Fully Achieved: Trust Strategy Contribution 3 -: Use quality improvement approach to reducing incidents of violence and aggression by developing preventative models alongside staff and patients.

Quality improvement projects to reduce incidents and impact of violence and aggression towards staff have been underway within various services across the organisation.

The Multi-Disciplinary Team in Acute Specialty Medicine at Denmark Hill have implemented a project called DEFUSE, aimed to support staff in the management of patients who are displaying challenging behavior. This has been shared with the Acute Medical Units at PRUH for implementation. The South East London ICS Health and Wellbeing Committee funded an in-depth data capture to establish the root causes of violence and aggression within the Neurology. This is due to be carried out in earlier 2023/24 and the findings will inform interventions for the care group going forward.

Trials of Body-Worn Video Cameras for clinical staff were carried out at Denmark Hill Emergency Department and Katherine Monk ward (trauma & surgery). Both these trials were successful and usage of the cameras have continued. Furthermore, cameras are now being introduced to support the PRUH Emergency Department.

Fully Achieved: Trust Strategy Contribution 4 -: Continue to build partnerships and networks within SEL and nationally to share learning and best practice.

King's is a member to the South East London Urgent Care Violence and Aggression network and was instrumental in forming a partnership between themselves and the University of Coventry. The Centre for Trust Peace and Social Relations at the University of Coventry is supporting the network in designing and implementing interventions to reduce violence and aggression. The areas of focus are:

- Development of a South East London wide strategy
- Review of training provision
- Focus on the recognition and professional development of Hospital Security Officers
- Review of data sharing processes between Acute Trust's, the London Ambulance

Service and Metropolitan Police.

Fully Achieved: Trust Strategy Contribution 5 -: Proactive in anticipating and supporting patients with complex needs such as trauma, drug/alcohol abuse.

Support to provide care for patients with complex needs is available across the Trust and the aim of multi-disciplinary decision making is to proactively anticipate patient's needs. The Alcohol Care Team, Homeless Team, Learning Disability, Safeguarding, Mental Health and Psychology teams all work collaboratively to support patients whilst under the care of King's.

All services are represented at the Supporting Positive Behaviour Group to ensure collaboration on work streams and actions.

Fully Achieved: Health Inequalities Contribution 1 -: Analyse violence and aggression data in relation to health inequalities and protected characteristics.

The Trust is able to monitor staff survey WDES and WRES data. Tables 6 and 7 show the percentage of staff who have experienced at least one incident of verbal abuse from patients/service users, their relatives, or other members of the public in the previous 12 months. This data is shared with the Supporting Positive Behaviour Group for monitoring and improvement actions.

Table 6: Percentage of staff who have experienced verbal abuse in previous 12 months WDES data

	2018	2019	2020	2021	2022
Staff with a long lasting health condition or illness	35.7%	43.5%	42.3%	40.5%	40.7%
Staff without a long lasting health condition or illness	28.8%	34.9%	35.8%	35.1%	35.8%

Table 7: Percentage of staff who have experienced verbal abuse in previous 12 months WRES data

	2018	2019	2020	2021	2022
White staff	20.8%	23.0%	19.2%	20.2%	21.9%
All other ethnic groups combined	26.7%	14.8%	17.6%	21.8%	28.6%

Fully Achieved: Health Inequalities Contribution 2 -: Work with Equality, Diversity and Inclusion (EDI) colleagues in development of work streams.

It is acknowledged that hate incidents have a significant impact on our workforce. A Multidisciplinary Team (MDT) working group with Equality, Diversity and Inclusion colleagues was established, led by the Chief Nurse to develop guidance in relation to managing hate incidents. This guidance has been included within the Supporting Positive Behaviour Policy and will be made available to all staff.

It was identified that incident management software coding in relation to violence and abuse did not capture whether an incident was motivated by hostility or prejudice towards a person's characteristics. A review of the coding was carried out to better capture these incidents allowing the Trust to better understand the frequency and impact of hate incidents towards our workforce.

Partially Achieved: Sustainability Contribution 1 -: Green Impact: Support development of sustainable environments that focus on both patient and staff experience and reduce conflict.

It is acknowledged that the environment within high risk areas of King's are not conducive to reducing levels of violence and aggression. Additionally, when patients display challenging behaviour damage can occur to those environments that lead to poorer patient experience, staff experience and increased costs.

The paediatric Emergency Department on the Denmark Hill site has requested charity funding to install sensory lighting and speakers within their adolescent room. The aim of this is to improve patient experience, particularly for those who attend due to a mental health crisis and reduce incidents of violence and aggression.

Partially Achieved: Sustainability Contribution 2 -: Long-term programme sustainability: Establishment of in house training team will be able to provide ongoing training that will adapt to the organisation's needs, incidents and risk assessments.

Plans for an in-house training team developed throughout 2022-23. In person Conflict Resolution Training (CRT) is provided by the Security Violence Reduction Training Manager with support from the Violence Reduction Matron and security team.

Work with SEL ICS identified that the provision of level 1 and level 2 CRT through an e-learning format improved cost effectiveness and accessibility. Therefore having the ability to be far wider reaching than previously anticipated. The level 1 e-learning package has been developed with the support of King's Learning and Organisational Development team. Due to this, it is possible to be adapted as we learn from incidents and improve our understanding of interventions.

Levels 3 to 5 of the training framework will continue to be delivered face to face and work continues to be underway as to how this will be provided going forward.

Partially Achieved: Mental Health Contribution 1 -: Training, reducing restrictive practice and restraint.

All training in managing violence and aggression provided by The Trust has an emphasis on dealing effectively with situations in order to obviate the need for restraint.

Those who are trained to use restraint techniques receive additional training in the risks and potential psychological impact of restraint.

Incidents of significant restraint are reviewed by security, the clinical team, the Violence Reduction Matron, mental health leads and the Director of Nursing for Vulnerable Adults to establish learning and actions to further improve our restraint reduction work.

Partially Achieved: Mental Health Contribution 2 -: Increasing therapeutic interventions and activities for patients presenting with mental health needs to improve engagement and reduce violence and aggression.

The Enhanced Care policy was reviewed outlining:

- Criteria for patients requiring enhanced care
- Enhanced Care Risk Assessment Tool
- Promoting intermittent therapeutic supervision of patients and engaging the patients in activity as much as possible.

Registered Mental Health Nurses (RMNs) are now requested for patients requiring enhanced care, however, staffing remains a challenge.

The Trust has started work with King's College London to explore the opportunity to learn from mental health settings in relation to reducing violence and aggression.

There is an increasing body of evidence within mental health settings in relation to successful interventions that reduce restrictive practice and levels of violence and aggression.

The initial focus of this work is with the Denmark Hill Emergency Department. The KCL team have met with senior leaders and staff within the department to try and understand their environment and the daily challenges they face. An application to secure research funding is currently being written, if this is successful the project aims to begin in early 2024.

The project will look to implement simple and sustainable interventions that work within the ED. Those interventions will be designed and developed with ED staff themselves and utilise service user experience.

Next steps

The Trust continues to work to reduce levels of violence and aggression, led by the Supporting Positive Behaviour Group and Violence Reduction Matron. The Trust will continue to learn and collaborate with NHS organisations locally and nationally to build the body of evidence into effective interventions and improve both staff and patient experience.

Choosing priorities for 2023-24

Choosing Priorities for 2023-24

The following improvement schemes have been agreed by the King's Executives and the Trust Board for 2023-24. These will be reported in full in the 2023-24 Quality Account with quarterly reporting to the Quality, People and Performance Committee.

Each quality account priority (QAP) has been aligned to a quality domain (patient safety, patient experience, and clinical effectiveness). The Trust made the decision to continue with two of the 2022-23 priorities as they were agreed as two year projects with further scope for quality improvement in 2023-24.

The Patient Experience and the Patient Outcomes QAPs selected in 2022-23 and carrying on into 2023-24 were coproduced with our external stakeholders and partners. An extensive consultation process took place during the development of the Trust BOLD strategy through workshops, surveys and discussions with 4,500 staff, patients, public and partners. The priorities identified during the strategy consultation process formed the basis of the proposed priority topics. In addition to feedback obtained via the BOLD strategy, the Trust stakeholders and partners also proposed topics. Feedback was received from:

- The Council of Governors
- Clinical Commissioning Groups
- Our Healthier South East London (OHSEL) Integrated Care System (ICS)
- Healthwatch, including an online survey and patient and public feedback group
- Overview and Scrutiny Committees
- Site Executives and Care Groups.

Recommendations were received and amalgamated by theme creating a long list of proposed quality account topics. A panel of experts met to short list and propose the final four QAPs. The panel included:

- Corporate Medical Director – Quality, Governance & Risk
- Deputy Chief Nurses
- Programme Director, Continuous Improvement
- Director of Quality Governance
- Director of Strategy
- Representative from the Council of Governors
- Healthwatch, Patient and Public Representative.

An evidence based prioritization matrix was used to guide the panel, with proposed topics ranking highest from 1 to 21. Based on the matrix and intelligence, knowledge and expertise from the panel, the priorities were chosen, with the following two selected to run over two years, continuing into 2023-24:

- To improve patient experience through effective communication
- Improving outcomes for patients receiving rehabilitation following a severe head injury or major trauma.

For 2023/24, provided that two of the QAPs, patient experience and patient outcomes, will be continued into 2023/24, we are proposing that the patient safety QAP is a continuation of the deteriorating patient priority, but with a specific focus on Sepsis. The aim of this particular quality priority would be:

- To improve the identification and management of patients with sepsis.
- To reduce the incidence of harm as a result of delays in the detection and management of sepsis and therefore improve the outcomes of patients with sepsis.

For 2024/25, we will resume our extensive consultation process.

2023-24 Quality Priority 1:

To improve the identification and management of patients with sepsis

Why is this a priority?

In 2022-23, we set out to improve the detection of the deteriorating patient and escalating as appropriate, thereby reducing harm to patients. We managed to achieve at least 90% of all unplanned critical care admissions with a NEWS2 score recorded at time of escalation, with a time and date of escalation and clinician response recorded, achieving our target of 60% for adult patients.

Staff are now trained in line with the Resuscitation Council UK's quality standard for Acute Care, with return of face to face resuscitation training.

However, work outlined in the 2022-23 quality account priority continues to improve the detection and escalation of the deteriorating child, mothers and birthing persons. We have continued with this important priority, however, with a specific focus on sepsis. The Care Quality Commission also identified the need for the Trust to have a lead clinician for sepsis.

The UK Sepsis Trust notes that although treatable in many cases, at least 48,000 deaths a year in the UK are related to sepsis. Sepsis is the body's overwhelming and life threatening response to infection that can lead to tissue damage, organ failure and death. For those who survive, many continue to suffer from physical, cognitive or psychological effects. Research suggests that black and minority ethnic groups and those with a lower socio-economic status have a higher incidence of sepsis and of severe sepsis compared to white groups. For example black maternal patients face twice the risk of severe sepsis compared to white maternal patients. Black children are 30% more likely than white children to develop sepsis.

A focus on sepsis identification and prevention, with specific regard to health inequalities aligns to our commitment to delivering Outstanding Care whilst also ensuring that Diversity, Equality and Inclusion is at the heart of everything we do.

What are our aims for the coming year?

Our aims and objectives for 2023-24 are outlined below:

Aim	To improve the identification and management of patients with sepsis
Objectives	• To reduce the incidence of harm as a result of delays in the detection and management of sepsis and therefore improve the outcomes of patients with sepsis.
Trust Strategy contribution	• The introduction of sepsis training relevant to professional groups will help to further develop our people deliver the highest standards of care. • This Trust priority stems from our lessons learned from harm caused to our patients, and reflects the Trust's commitment to being a learning organisation.
Health Inequalities Contributions	. To begin work to understand the possible health inequalities that exist in patients presenting with, and/or developing sepsis whilst in our care
Sustainability contributions	• Early identification and management of sepsis may contribute to reductions in length or stay, and the rate of re-admission following discharge.
Mental Health	• The timely identification and management of sepsis to help mitigate the impact of the condition, and therefore reduce the likelihood of ongoing mental health concerns following physical recovery.

How will we monitor and measure our progress?

Progress against these aims will be reported to, and monitored on a quarterly basis by the Trust Quality Committee.

Measures of success will include:

- A reduction in incidence of harm as a result of delays in the detection and management of sepsis.
- Monitoring the uptake of sepsis training relevant to professional groups will help to further develop our people deliver the highest standards of care.
- Production of trust level data which describes sepsis incidence within different ethnic/socioeconomic groups.

2023-24 Quality Priority 2:

To improve patient experience through effective communication

Why was this a priority?

In 2021-22, due to poor experiences reported by our patients and communities, we decided to run a two-year's long programme of work to improve patient experience through effective communication. Following the success of initiatives deployed in year one, we will continue this work in 2023-24.

What are our aims for the coming year?

Our aims and objectives for 2023-24 are outlined below:

Aim	To improve patient experience through effective communication
Objectives	• To improving communication skills with patients and their relatives / carers through education and training. • To improve responsiveness to patients and their relatives / carers through answering telephone calls. • To improve information provision to patients and their relatives / carers.
Scope	• Identifying the root cause • Monitoring metrics including complaints, Patient Advice and Liaison Service, FFT and Care Quality Commission's patient surveys here, to be agreed • Switchboard, mapping of telephone numbers • EPR (Electronic Patient Record) / PiMS, change in consultant • Education and training • Further scoping needed • Communication toolkit
Trust Strategy contribution	• Training and toolkit will improve communication positively impacting staff's wellbeing. • Effective communication will lead to a reduction of violence and aggression incidents. • Better communication will mean better compliance for better health outcomes • Exploring new ways of contacting King's as part of digital transformation • Utilising community partnerships to co-design solutions
Health Inequalities Contributions	• Analyse violence and aggression data in relation to health inequalities and protected characteristics • Work with partners including homeless/ACT to ensure meeting the needs of higher risk populations reducing their likelihood of becoming violent or aggressive and therefore reducing health inequalities.
Sustainability contributions	• Support development of sustainable environments that focus on both patient and staff experience and reduce conflict • Establishment of in house training team will be able to provide ongoing training that will adapt to the organisation's needs, incidents and risk assessments.
Mental Health	• Training, reducing restrictive practice and restraint. • Increasing therapeutic interventions and activities for patients presenting with mental health needs to improve engagement and reduce violence and aggression.

How will we monitor and measure our progress?

Progress against these aims will be reported to, and monitored on a monthly basis by the Trust Patient Experience Committee, with quarterly reports to the Quality Committee.

Measures of success will include:

- By March 2024, we will develop a customer service training package and complete the training needs analysis.

- By March 2024, we will review the process communicating to patients their named consultant from admission to discharge.
- By March 2024, we will provide communication skills for doctors.

2023-24 Quality Priority 3:

Improving outcomes for patients receiving rehabilitation following a severe head injury or major trauma

Why was this a priority?

As described previously, neurorehabilitation was identified as a quality priority last year and we knew that it would take us at least 2 years to find out about, then measure and improve, outcomes that matter most to our patients.

What are our aims for the coming year?

Our aims and objectives for 2023-24 are outlined below:

Aim	To improve patient outcomes in neuro and major trauma rehabilitation services
Objectives	• Having identified the outcomes that are most important to our patients, we will now measure these outcomes and seek feedback from patients about the things that would improve their quality of life and health outcomes after leaving King's services. • We will use this feedback to identify improvement actions within King's, and in our coloration with colleagues and services across the Integrated Care System.
Trust Strategy contribution	• Outstanding Care: This project represents a cultural shift for King's in becoming a more effective, person-centred organisation that measures the outcomes that matter most to patients and uses these to drive service improvement
Health Inequalities Contributions	• We will endeavor to explore whether there are differences in the outcomes that matter most to all of our patients, including whether there are differences between different groups within our community. And we will try to understand the differences in outcomes for different patient groups by protected characteristics, so that we can develop culturally competent care in rehabilitation services.
Sustainability contributions	• Collaborating with the ICS and Apollo programme.
Mental Health	• Mental health outcomes have been included as key outcomes measures for patients receiving rehabilitation after severe head injury and/or Major Trauma. We will feedback our result to colleagues working in King's Health Partners Mind and Body Programme, including the Integrating Mental & Physical healthcare: Research, Training & Services (IMPARTS) team, to enable them to explore the feasibility of expanding into Neuro- and Major Trauma rehabilitation clinics. We will also share our results and collaborate with South London and Maudsley NHS Foundation Trust, to enable them to explore provision of mental health Occupational Therapy • services for Neuro and Major Trauma rehabilitation patients.

How will we monitor and measure our progress?

Progress against these aims will be reported to, and monitored on a monthly basis by the Trust Quality Committee, with quarterly reports to the Patient Outcomes Committee and the Quality, People and Performance Committee. A task and finish group will also be set up with project management support from the continuous quality improvement team.

Measures of success will include:

- By April 2023, we will have begun to collect data from our patients based on the co-produced outcomes questionnaire.
- By December 2023 we will have produced the first results that will inform us about how well King's and the wider health service delivers against outcomes that matter most to patients.
- By March 2024, on roll out of Epic, we will have explored the feasibility of including the routine

collection of feedback from patients into the new Electronic Health Record system.

- By March 2024, will have begun to implement identified quality improvement initiatives in relation to improving the outcomes that matter most in relation to rehabilitation following head injury and/or major trauma.

2.2 Statements of Assurance from the Board

1 During 2022-23, the King's College Hospital NHS Foundation Trust provided eight relevant health services:

- Assessment or medical treatment for persons detained under the 1983 Act
- Diagnostic and screening procedures
- Family planning services
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury.

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

1.2 The income generated by the relevant health services reviewed in 2022-23 represents 92% of the total income generated from the provision of health services by the King's College Hospital NHS Foundation Trust for 2022-23.

Clinical Audits and National Confidential Enquiries

2 During 2022-23, 62 national clinical audits and 11 national confidential enquiries covered relevant health services that King's College Hospital NHS Foundation Trust provides.

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

2.2 The national clinical audits and national confidential enquiries in which King's College Hospital NHS Foundation Trust was eligible to participate during 2022-23 are as follows (see Table 8).

2.3 The national clinical audits and national confidential enquires in which King's College Hospital NHS Foundation Trust participated during 2022-23 are as follows (see Table 8).

2.4 The national clinical audits and national confidential enquiries in which King's College Hospital NHS Foundation Trust participated, and for which data collection was completed during 2022-23, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry (see Table 8).

Table 8: Participation in national clinical audits and confidential enquiries

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
Intensive Care National Audit and Research Centre Case Mix Programme	Yes	100%
Child Health Clinical Outcomes Review Programme – Transition from child to adult health services	Yes	Data collection in progress
Child Health Clinical Outcomes Review Programme – Testicular Torsion	Yes	Data collection in progress
Elective Surgery- National PROMS Programme- Hip Replacements	Yes	Data collection in progress
Elective Surgery- National PROMS Programme- Knee Replacements	Yes	Data collection in progress
Emergency Medicine QIPs (RCEM (Royal College of Emergency Medicine)): Pain in Children (care in emergency departments)	Yes	Data collection in progress
Emergency Medicine QIPs (RCEM): Assessing cognitive impairment in older people	Yes	Data collection in progress
Emergency Medicine QIPs (RCEM): Consultant Sign-off	Yes	Data collection in progress
Emergency Medicine QIPs (RCEM): Mental Health Self Harm	Yes	Data collection in progress
Falls and Fragility Programme - Fracture Liaison Service Database	Yes	Data collection in progress
Falls and Fragility Programme - National Audit of Inpatient Falls	Yes	Data collection in progress
Falls and Fragility Programme - National Hip Fracture Database	Yes	Data collection in progress
Inflammatory Bowel Disease (IBD) Programme (IBD registry)	No	Non participation
Learning Disability Mortality Review Programme (LeDeR)	Yes	Data collection in progress
Liver Transplantation Audit	Yes	Data collection in progress
Maternal, Newborn and Infant Clinical Outcome Review Programme – Perinatal Mortality Surveillance	Yes	Data collection in progress
Maternal, Newborn and Infant Clinical Outcome Review Programme – Saving	Yes	Data collection in progress

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
Lives, Improving Mothers' Care		
Maternal, Newborn and Infant Clinical Outcome Review Programme – Perinatal mortality and morbidity confidential enquiries	Yes	Data collection in progress
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – Community Acquired Pneumonia	Yes	Data collection in progress
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – Crohn's disease	Yes	Awaiting report publication
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – End of Life Care	Yes	Data collection not started yet
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – Endometriosis	Yes	Data collection in progress
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – Epilepsy study	Yes	20%
Muscle Invasive Bladder Cancer at Transurethral Resection of Bladder Audit (MITRE)	Yes	Data collection in progress
National Adult Diabetes Audit - National Diabetes Foot Care Audit	Yes	Data collection in progress
National Adult Diabetes Audit - National Diabetes Inpatient Safety Audit	Yes	Data collection in progress
National Adult Diabetes Audit - Core Audit	Yes	Data collection in progress
National Adult Diabetes Audit - National Pregnancy in Diabetes	Yes	Data collection in progress
National Adult Diabetes Audit – National Diabetes Audit Integrated Specialist Survey	Yes	Not reported
National Asthma and COPD Audit Programme - Paediatric Asthma Secondary Care	Yes	Data collection in progress
National Asthma and COPD Audit Programme - Adult Asthma Secondary Care	Yes	Data collection in progress
National Asthma and COPD Audit Programme - COPD Secondary Care	Yes	Data collection in progress
National Asthma and COPD Audit Programme - Pulmonary Rehabilitation	Yes	Data collection in progress
National Audit Project 7 - Perioperative Cardiac Arrest	Yes	Awaiting Report
National Audit of Breast Cancer in Older People	Yes	Data collection in progress
National Audit of Cardiac Rehabilitation	Yes	Data collection in progress
National Audit of Care at the End of Life	Yes	Data collection in progress
National Audit of Dementia (NAD) Care in general hospitals	Yes	Awaiting report
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	Data collection in progress
National Bariatric Surgery Registry	Yes	Data collection in progress
National Cardiac Arrest Audit	Yes	Data collection in progress
National Cardiac Audit Programme - National Audit of Cardiac Rhythm Management (CRM)	Yes	Data collection in progress
National Cardiac Audit Programme - Myocardial Ischaemia National Project	Yes	Data collection in progress
National Cardiac Audit Programme - National Adult Cardiac Surgery	Yes	Data collection in progress
National Cardiac Audit Programme: National Audit of Percutaneous Coronary Interventional Procedures (Coronary Angioplasty)	Yes	Data collection in progress
National Cardiac Audit Programme : National Heart Failure Audit	Yes	Data collection in progress
National Early Inflammatory Arthritis Audit	Yes	Awaiting publication
National Emergency Laparotomy Audit	Yes	Data collection in progress
National Gastro-intestinal Cancer Programme - National Oesophago-Gastric Cancer	Yes	Data collection in progress
National Gastro-intestinal Cancer Programme - National Bowel Cancer Audit	Yes	Data collection in progress
National Joint Registry	Yes	Data collection in progress
National Lung Cancer Audit (NLCA)	Yes	Awaiting report
National Maternity and Perinatal Audit	Yes	Data collection in progress
National Neonatal Audit Programme	Yes	Data collection in progress
National Ophthalmology Database Audit	Yes	Data collection in progress
National Paediatric Diabetes Audit	Yes	Data collection in progress
National Prostate Cancer Audit	Yes	Data collection in progress
Perioperative Quality Improvement Programme	Yes	Data collection in progress
Vascular Services Quality Improvement Programme - National Vascular Registry	Yes	Data collection in progress
Neurosurgical National Audit Programme	Yes	Data collection in progress
Paediatric Intensive Care Audit Network	Yes	Data collection in progress
Potential Donor Audit	Yes	Data collection in progress
Renal Audits: UK Renal Registry	Yes	Data collection in progress
Renal Audits: National Acute Kidney Injury Audit	Yes	Data collection in progress

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
Respiratory Audits: Adult Respiratory Support Audit	Yes	Data collection not started
Respiratory Audits: Smoking Cessation Audit- Maternity and Mental Health Services	Yes	Awaiting report publication
Sentinel Stroke National Audit Programme	Yes	Data collection in progress
Serious Hazards of Transfusion	Yes	Awaiting report publication
Society for Acute Medicine's Benchmarking Audit	Yes	Awaiting report publication
Trauma Audit & Research Network	Yes	Data collection in progress
UK Cystic Fibrosis Registry	Yes	Awaiting Report Publication
UK Parkinson's Audit	Yes	Awaiting Report Publication
Royal College of Emergency Medicine (RCEM): Infection Prevention and Control	Yes	Awaiting Report Publication

2.5 The reports of 73 national clinical audits were reviewed by the provider in 2022-23.

2.6 King's College Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Table 9)

Table 9: Improvement actions taken as a result of national clinical audits

National Audit title	Improvement actions to date
National Audit of Breast Cancer in Older Patients	To continue to improve on the number of patients having a triple diagnostic assessment. These were carried out in 52% of 50-69 year olds (national average 68%); and 41% of those 70 plus years old (national average 70%). Although these remain below the national average, they are an improvement on 2018 when 15% of 50-69 year olds and 24% of 70 plus years had triple diagnostic assessments.
Intensive Care National Audit and Research Centre: Case Mix Programme	1. Aseptic Non Touch Technique (ANTT) training has been reintroduced to all. 2. The following steps are being taken to improve barrier protection of lines: • Introducing antibiotic impregnated lines • Changing bio-patch to chlorhexidine impregnated dressings • Writing new blood culture guidance • A review of peripheral lines to be conducted • Once the above has taken place, the team will review the impact of changes 3. Broad review of other risk factors for blood stream infection: • Review of mouth care. • Review ventilator-associated pneumonia (VAP) and association of VAP and blood stream infections. • Working closely with microbiology – the microbiology team now submits a monthly dashboard of all blood stream infections including contaminants, and the data can be crossed referenced with the with the audit team submitting to ICNARC. 4. A data scientist has been recruited to get a better understanding of the data and better inform next steps, and an internal investigation and casenote review is in progress.
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy 12) Report	The team are in the process of introducing mental health screening tools in the epilepsy clinic. Consultant Psychologists recruited in the previous year are accessible through the DH clinic. DH is establishing a transition pathway from paediatrics to adults with a joint outpatient service next year.
Myocardial Ischaemia National Audit Project (MINAP) Annual Report	Data issues are currently being addressed. Quarterly meetings to review data submissions to the British Cardiovascular Intervention Society (BCIS) database are in place. Weekly meeting are in place to address any fields <70% complete and to highlight any discrepancies.
National Neonatal Audit Programme (NNAP) (DH and PRUH)	1. Bronchopulmonary dysplasia: Use of non-invasive ventilation (NIV) and less invasive surfactant administration (LISA). These are now in regular use for babies from 27 weeks. Ventilation settings/weaning processes and steroid use are being reviewed, including timing of administration to support further improvements. 2. Outlier alert received from NNAP in October 2022 in relation to Deferred Cord Clamping. Improvement actions included: a. Cross-site guideline written b. Weekly cross-site, multi-disciplinary review c. Training for all neonatal trainees

	d. Clinical equipment ordered. 3. Infection: Last year there was an outbreak of Staphylococcus capitis (S.capitis) infection on the unit. The team has actively engaged with the trust infection control team and Medirest services and been part of the UK Health Security Agency national S.capitis task and finish group. Vancomycin policy has changed. S.capitis colonisation and blood stream infection rates have reduced significantly.
National Asthma and COPD Audit Programme – Adult Asthma	At DH an updated asthma pathway is in place and will be audited in summer 2023. At the PRUH the Respiratory Team will collaborate with the emergency department team to improve administration of steroids and provide support where required.
Sentinel Stroke National Audit Programme (SSNAP)	Capacity issue in DH and PRUH HASU beds affect the HASU overall team-centred rating score for key stroke unit indicator. The risk is known to both teams and has been included on their risk register and escalated to Quality, People & Performance Committee.

2.7 The reports of over 1,400 local clinical audits were reviewed by King's College Hospital NHS Foundation Trust in 2022-23. This is part of the Trust' comprehensive programme of clinical audits that are recorded on the MEG auditing system and aligned with the Trust's Quality Assurance Framework. This system enables ward managers to inspect their wards against evidenced based criteria. This is a tool developed to give assurance around the following areas:

- Hand Hygiene
- Infection Preventions & Control
- I.V Lines
- Uniform & Dress Code
- Medicines Management
- Outstanding Care A (Safety)
- Outstanding Care B (Knowledge & Skills)
- Outstanding Care C (Patient & Staff Experience)
- Outstanding Care D (Documentation).

2.8 King's College Hospital NHS Foundation Trust intends to undertake further audits to improve the quality of healthcare provided. Actions generated by these audits will be managed locally and specialist Quality Improvement support is available from the QI team, with the key QI projects outlined in the next section. Management of the MEG system and validation of local audits is provided by the Quality Assurance team. Challenges for delivering Quality Improvement at King's include:

- A low rate of patient and public involvement (PPI) with approximately 15% of Quality Improvement projects involving PPI.
- A low rate of Quality Improvement projects progressing beyond the definition and analysis of a problem to test changes, at approximately 20%.
- A relatively long average duration time to complete a Quality Improvement piece of work, at approximately 2 years.

Quality Improvement

In line with the Trust BOLD strategic approach, the Quality Improvement team is taking action to create a more inclusive, scalable and innovative improvement offer, with developing our brilliant people at its core. The key components are:

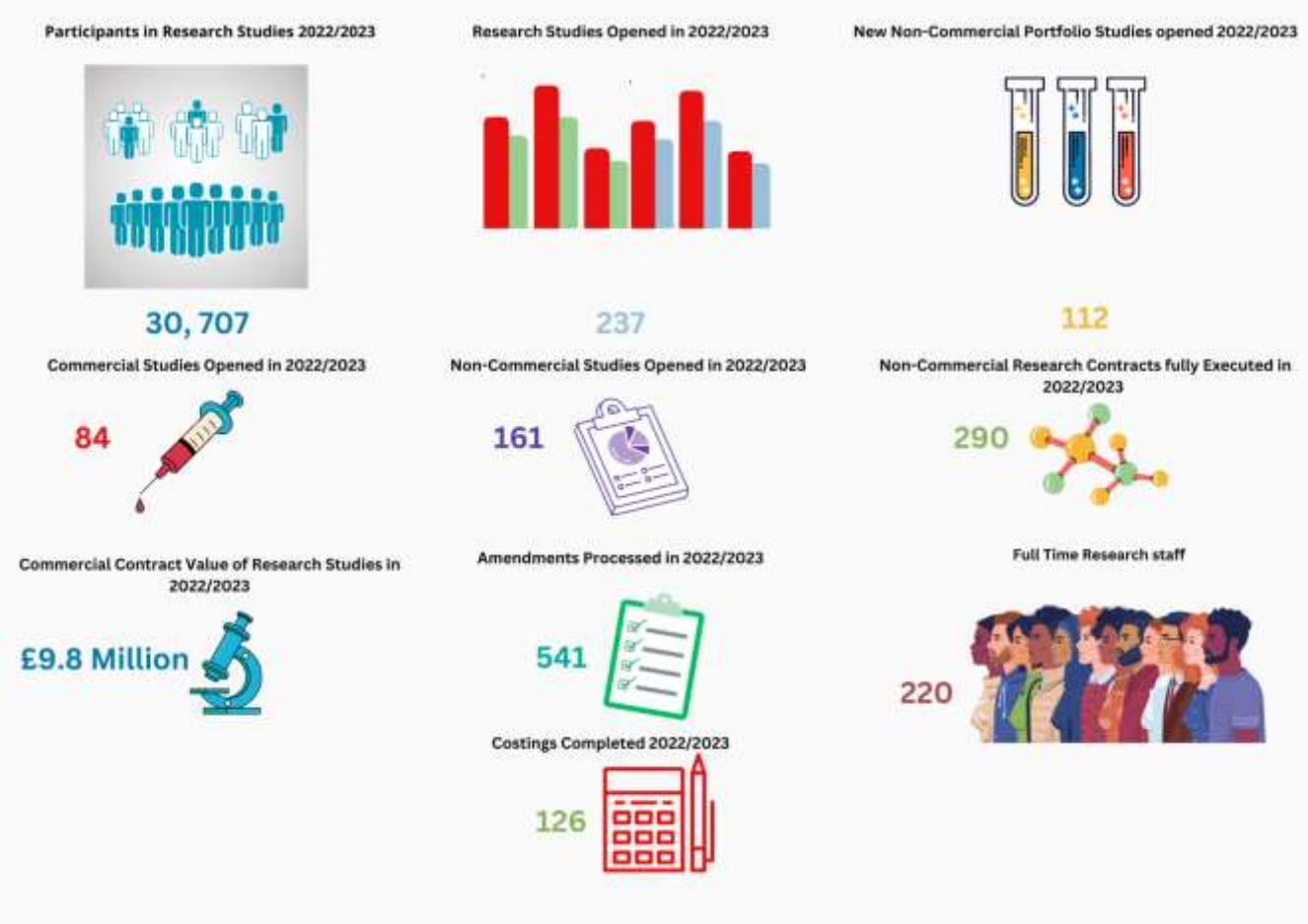
- **Quality Improvement Training –** Our in-house developed training programme is developed to equip our people with the skills, knowledge, confidence, and tools they need to deliver quality improvement. It is provided online and in-person with a variety of entry levels to suit all experiences. In 2022 we trained the cohort of patients in the methodology and seek to expand the approach in 2023.
- **Quality Improvement Coaching** – Graduates of training programmes are automatically supported with bespoke coaching from a member of the quality improvement network to put theory into practice. There are currently 70+ service-led projects receiving coaching and the intention is to scale the programme to 100+ through 2023 from a starting point of 59. They range from projects to improve patient and staff experience, through to reducing Nitrous Oxide waste and projects to improve patient outcomes including those on the organizational Quality Account Priorities (QAPs).
- **Innovation Support** – The team is developing a new innovation support function for 2023 to take the brightest grass-roots ideas from staff and support them through to prototype, development and scaling. There are currently 19 innovation projects in process. The function includes financial and business support where investment or commercialization is required, delivered in partnership with local grant providers such as the Q Exchange, networks such as the NHS Clinical Entrepreneur's Programme and KHP Ventures. We intend to scope and develop a patient-led version of the support offer for 2024.

- **A King's Improvement Network** – The Trust is nurturing an improvement network of enthusiastic and supportive members who connect to support each other deliver their improvement ideas. The network is also used for sharing learning and opportunities. Membership is currently 3,000+ with intentions to grow by 50% from a starting point of 2,000 through 2023.
- **Improvement Rewards and Recognition** – 2023 saw the first 'Improvement Conference' at King's to share the wide range of support offers and successes in Quality Improvement with colleagues. The team is developing a specific support offer to help staff and patients win quality improvement awards, display their work in publications and conferences, and attract grants.
- In the longer term circa 5 years, the Quality Improvement team is working with other Trust corporate support functions such as Patient Safety and Transformation to develop an organisational 'Quality Management System' (QMS), in line with national best practice and NHS England guidance. This will define clear Quality Planning, Quality Control and Quality Assurance functions and how they interact with improvement activity. It will help staff to make improvements at the most appropriate time, using the most appropriate improvement methods, and provide support to make sure they are sustainable. In addition, the Quality Improvement team is focusing on several specific projects in 2023 to further develop improvement infrastructure at King's, as follows:
- **Patient Safety Improvement Programme** – Supporting the Patient Safety team to introduce quality improvement approaches to how the Trust identifies safety themes and addresses them with sustainable improvement activity. A key enable to the Trust Patient Safety Incident Response Framework (PSIRF) programme mandated by NHS England.
- **Improvement Website** – An interactive and public resource to connect with collaborators, access latest information, download resources and request support.
- **Scale and Spread Methodology** – The team is developing a coaching support offer to take examples of best practice in the Trust and systematically share it across departments using quality improvement methodology. The first project of 2023 aims to share best practice on reducing IV line infections.
- **Improvement Menu** – a clear, consolidated menu of support offers to help staff and patients improve care with direct access to the team providing it.
- **A Patient Co-Production Process** – In partnership with the Patient Experience team, designing and delivering a standardized process for people in the Trust to meaningfully co-design improvements to services with patients and members of the public.

Information on participation in clinical research

3. The number of patients receiving relevant health services provided or subcontracted by King's College Hospital NHS Foundation Trust in 2022-23 that were recruited during that period to participate in research approved by a research ethics committee was 30,707. This is the highest annual research recruitment at the Trust ever. Kings College Hospital were also the top recruiting Trust in the United Kingdom to the National Institute for Health and Care Research (NIHR) research portfolio, see figure 11 below.

Figure 9: Financial year 2022-23 research data



Commissioning for Quality and Innovation (CQUIN) framework

4. Having been paused for several years, during the COVID pandemic, the framework was reintroduced from 2022-23. Several changes were made to the framework, including the requirement for providers to work towards, and report on, all CQUINs (Commissioning for Quality and Innovation) that fall within their contracted services.

4.1 Details of the performance achieved against the 2022-23 targets/ agreed goals for the following 12-month period can be obtained on request.

4.2 King's College Hospital NHS Foundation Trust income in 2022-23 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework due to the contracting arrangements in place

Care Quality Commission (CQC)

5. King's College Hospital NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current overall registration status is 'Requires Improvement'. King's College NHS Foundation Trust does not have any conditions on registration. The Care Quality Commission has not taken enforcement action against King's College Hospital NHS Foundation Trust during 2022-23. Table 6 below shows the overall ratings by site.

6. King's College Hospital NHS Foundation Trust has participated in special reviews or investigations, unannounced inspections, by the CQC relating to the following areas during 2022-23:

- Medical care (including older people's care); Orpington Hospital
- Medical care (including older people's care); PRUH & SS (inspected but not rated)
- Maternity; DH
- Maternity; PRUH & SS
- Medical care (including older people's care); DH
- Services for Children and Young People; DH
- Well-led; Trustwide (announced inspection).

7. As part of the Strong Roots, Quality Care programme, King's College Hospital NHS Foundation Trust has made the following progress by 31 March 2023 to address the conclusions or requirements reported by the CQC - see tables 11, 12, 13 and 14

Table 10: Overall CQC rating, King's College Hospital NHS Foundation Trust, published February 2023

		Safe	Effective	Caring	Responsive	Well led	Overall
Overall: KCH NHS FT		RI Feb 2023	RI Feb 2023	G Feb 2023	RI Feb 2023	↑ G Feb 2023	RI Feb 2023
King's College Hospital		RI Feb 2023	RI Feb 2023	G Feb 2023	RI Feb 2023	RI Feb 2023	RI Feb 2023
Orpington Hospital		↓ RI Sep 2022	G Sep 2015	↓ I Sep 2022	G Sep 2015	G Sep 2015	↓ RI Sep 2022
Princess Royal University Hospital		RI Aug 2021	RI Aug 2021	G Aug 2021	RI Aug 2021	RI Aug 2021	RI Aug 2021
Urgent and emergency care	King's College Hospital	RI Feb 2020	G Feb 2020	G Feb 2020	RI Feb 2020	RI Feb 2020	RI Feb 2020
	Orpington Hospital	NA	NA	NA	NA	NA	NA
	Princess Royal University Hospital	RI Aug 2021	RI Aug 2021	G Aug 2021	RI Aug 2021	RI Aug 2021	RI Aug 2021
Medical care (incl. older people's care)	King's College Hospital	↓ RI Feb 2023	G Feb 2023	G Feb 2023	↓ RI Feb 2023	G Feb 2023	↓ RI Feb 2023
	Orpington Hospital	↓ RI Jul 2022	NR	↓ I Sep 2022	NR	NR	↓ RI Jul 2022
	Princess Royal University Hospital	G Jan 2018	G Jan 2018	G Jan 2018	G Jan 2018	RI Jan 2018	G Jan 2018
Surgery	King's College Hospital	RI Jun 2019	RI Jun 2019	G Jun 2019	RI Jun 2019	RI Jun 2019	RI Jun 2019
	Orpington Hospital	G Sep 2015	G Sep 2015	G Sep 2015	G Sep 2015	G Sep 2015	G Sep 2015
	Princess Royal University Hospital	RI Jun 2019	G Jun 2019	G Jun 2019	RI Jun 2019	G Jun 2019	RI Jun 2019
Critical care	King's College Hospital	RI Jan 2018	G Jan 2018	G Jan 2018	G Jan 2018	G Jan 2018	G Jan 2018
	Orpington Hospital	NA	NA	NA	NA	NA	NA
	Princess Royal University Hospital	G Jan 2018	G Jan 2018	G Jan 2018	RI Jan 2018	G Jan 2018	G Jan 2018
Maternity	King's College Hospital	RI Dec 2022	↓ RI Dec 2022	G Dec 2022	↓ RI Dec 2022	↓ RI Dec 2022	↓ RI Dec 2022
	Orpington Hospital	NA	NA	NA	NA	NA	NA
	Princess Royal University Hospital	↓ RI Dec 2022	G Dec 2022	G Dec 2022	↓ RI Dec 2022	G Dec 2022	↓ RI Dec 2022
Children and young people	King's College Hospital	RI Feb 2023	G Feb 2023	G Feb 2023	G Feb 2023	G Feb 2023	G Feb 2023
	Orpington Hospital	NA	NA	NA	NA	NA	NA
	Princess Royal University Hospital	RI Sep 2015	G Sep 2015	G Sep 2015	O Sep 2015	G Sep 2015	G Sep 2015
End of life care	King's College Hospital	G Jun 2019	G Jun 2019	G Jun 2019	G Jun 2019	G Jun 2019	G Jun 2019
	Orpington Hospital	NA	NA	NA	NA	NA	NA
	Princess Royal University Hospital	RI Jun 2019	RI Jun 2019	G Jun 2019	G Jun 2019	G Jun 2019	RI Jun 2019
Outpatients	King's College Hospital	RI Jun 2019	NR	G Jun 2019	RI Jun 2019	RI Jun 2019	RI Jun 2019
	Orpington Hospital	RI Sep 2015	NR	G Sep 2015	G Sep 2015	G Sep 2015	G Sep 2015
	Princess Royal University Hospital	RI Jun 2019	NR	G Jun 2019	RI Jun 2019	RI Jun 2019	RI Jun 2019

Table 11: Maternity quality improvement actions completed by 31 March 2023 to address the CQC's findings

CQC Concerns	Completed Improvement Actions
Maternity Services at DH and PRUH	
The service did not control infection risk well. Staff did not always follow best practice to protect women, themselves and others from infection.	• Cleaning schedules reviewed and enhanced cleaning schedule implemented. • Cleaning posters now situated in the clinical areas. • Infection control risk assessments completed and action taken as necessary. • Regular attendance at the Maternity Quality Governance meetings by the Infection Prevention Control team. • New electronic quality auditing system introduced across the Trust in July – Medical e-governance (MEG), with audits completed daily / weekly / monthly cycle and results reviewed locally with oversight through the quarterly site performance review for maternity services.
The service did not manage medicines well.	• Full medication safety and security audit across maternity services undertaken. • A Standard Operating Procedure with regards to safe handling and storage of medications in the community was developed and implemented. • Additional weekly bite-size training sessions on medicines management introduced during handover over a period of two weeks. • Monthly medication audits undertaken on MEG to ensure that improvements are sustained and that improvements are identified early and action is taken. • Quarterly audits undertaken by the Pharmacy Team in addition to the local monthly audits.
Staff did not always assess risks to women, act on them and keep good care records	• The maternity service now undertakes monthly 'outstanding care' audits covering a range of risk assessments of relevance to women and birthing people. • The Birmingham Symptom-specific Obstetric Triage System (BSOTS) has been implemented on the DH (already in place on the PRUH), standardising triage systems within maternity and enables rapid assessment and escalation. • Additional equipment has been purchased to support staff in making timely and accurate care records.
The service did not manage safety well and learnt lessons from them. There were delays in the investigations of incidents and lessons learned were not always shared amongst the whole team and the wider service. The service provided mandatory and maternity specific training in key skills to all staff but did not always ensure everyone had completed it.	• Women's Health Patient Safety managers are now in post. • All non-HSIB maternity serious incident (SI) reports identified by the CQC have now been reviewed at the Trust's Serious Incident Committee (SIC). • A recovery plan is in place to review all open amber adverse incidents with support from the Women's health Clinical Director. • Monthly maternity newsletter and a dedicated Maternity Microsoft Teams channel open to share learning from incidents and complaints. Patient Safety Masterclass was conducted by one of our Midwifery Consultants to improve staff awareness of lessons learned. • Mandatory training compliance is presented and monitored at Women's Health Board and will be owned by the departmental matrons, with over 90% of our midwives having completed their one day in house multi-professional training.
Although staff understood how to protect women and had training on how to recognise women, not all staff had completed the mandatory safeguarding training and not all staff were aware of the baby abduction process. No recent simulations of obstetric emergencies and baby abduction drill had been conducted within the hospital and community setting in the service for over 12 months at the time of inspection.	• Safeguarding training sessions are now provided online which are more accessible to our staff. • Action plan in place to increase PROMPT and CTG training to >90% of maternity staff eligible. Two professional groups (maternity support workers (MSWs) and medical staffing) have been identified as requiring targeted support to ensure sustained compliance with 90%. • A baby abduction drill was undertaken in August 2022 following the CQC inspection.
The design, maintenance and use of facilities, premises and equipment did not always follow safety standards. The service did not always maintain, service or replace equipment. Some equipment safety checks were out of date and daily	• The Trust has completed an audit of all equipment and PAT testing has been completed. • The Equipment Standard Operating Procedure has been implemented with clear guidance for management of equipment following use. • The maintenance schedules were reviewed and updated as appropriate.

CQC Concerns	Completed Improvement Actions
Maternity Services at DH and PRUH	
checks had not always been completed.	
The design, maintenance and use of facilities, premises and equipment did not always adhere to safety standards. Some equipment safety checks were out of date and daily checks were not always completed. The community service did not have emergency equipment.	• Ongoing risk on our risk register exploring relocation of the Maternity Assessment Unit onto the acute site to improve patient safety. • The Trust has completed an audit of all equipment and PAT testing has been completed. The Equipment Standard Operating Procedure has been implemented with clear guidance for management of equipment following use, including replacement of replacement of broken equipment. Maintenance schedule have been reviewed and updated where needed. • The Trust has carried out a review of the clinical areas with in maternity and swipe ID has been implemented in all storage areas. • The Trusts resuscitation team have conducted a review of the community services and provided the correct emergency equipment required for the clinical area, with the appropriate training and support in place.
Leaders did not always operate effective governance processes, throughout the service and with partner organisations.	• Organisational governance structure within the maternity department changed to align more closely with the Trust's clinically led model. • Stronger relationship with the operational site team, supporting leaders to address quality across all departments. • Women's Health Governance team transferred under the Director of Quality Governance to support the development of robust processes and support effective oversight. • Women's Health meeting structure and governance framework has been reviewed to ensure the correct agenda items are being discussed at meetings at the right time and with the right frequency with robust action plans to ensure the loop is always closed.
Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service	• Leaders continue to meet with staff to discuss and learn from the performance of the service. • Regular staff listening events are now in place, used to discuss key issues. • The Trust has invested in the Professional Midwifery Advocate (PMA) team to ensure sufficient staff support. • A communication midwife has been employed cross-site by the trust to improve communication with all staff levels.
The service did not always have the planned number of midwifery and nursing staff to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.	• Trust working with care group to support robust recruitment plans which has seen an overall improvement in Nursing & Midwifery vacancies across the care group and an overall improvement turnover. • A local Escalation Policy for Maternity Services to maintain safety is in place: Specialist midwives' job plan have been reviewed to ensure they are able to work clinically and support the team.

Table 12: Medical care including older people's care quality improvement actions completed by 31 March 2023 to address the CQC's findings

CQC Concerns	Completed Improvement Actions
Medical Care, including older people's care DH, PRUH and Orpington Hospital	
The trust should ensure that medicines are managed in accordance with safe and professional practice standards.	• Medication safety peer review audits performed, with weekly spot checks. • Additional weekly bite-size training sessions on medicines management introduced during handover over a period of two weeks. • Monthly medication audits undertaken on MEG to ensure that improvements are sustained and that improvements are identified early and action is taken. • Quarterly audits undertaken by the Pharmacy Team in addition to the local monthly audits.
The trust should ensure that staff provide care and treatment in ways which have regard and respect for the individual needs of patients, and	• Focused education and training session on continence care and the importance of privacy and dignity. • Monthly Outstanding Care audits undertaken on MEG to ensure that

CQC Concerns	Completed Improvement Actions
Medical Care, including older people's care DH, PRUH and Orpington Hospital	
in a manner, which is not degrading.	improvements are sustained and that improvements are identified early and action is taken.
The trust should ensure there are enough staff on duty to enable the delivery of patient care needs in a responsive manner.	• Robust recruitment and retention plan in place, including a reassessment of the budgeted establishment. • Monthly MEG Matron's audit to ensure that improvements are identified early and action is taken in relation to staffing and patient care needs.
The trust should ensure staff effectively manage infection control risks.	• Standardisation of catheter stands and products procured. • Monthly infection prevention and control audits undertaken on MEG to ensure that improvements are sustained and that improvements are identified early and action is taken.
The trust should ensure nutrition and hydration needs of patients are clearly identified to ensure patient safety.	• Bitesize training on nutrition and hydration support. • Design of patient bed boards reviewed to support feeding.
The service should ensure that fridge temperature variations are escalated and addressed, as per policy.	• Spot checks in place to appropriate escalation of variations in temperatures. • New probes to establish internal fridge temperatures system that is consistent and robust.
The service should ensure that patients risk assessments are recorded in a single accessible location.	• This will be resolved with EPIC, the new electronic patient record providing a single point of access for all patient records. To be rolled out in the autumn of 2023.
The service should ensure staff are up to date with statutory and mandatory training.	• Monthly review of all training compliance records with support provided to staff to complete.
The service should continue to work with system wide partners to ensure timely discharge of patients.	• The Trust is exploring options to improve discharges together with the ICS and our peer Guy's and St Thomas'.

Table 13: Children and young people quality improvement actions completed by 31 March 2023 to address the CQC's findings

CQC Concerns	Completed Improvement Actions
Children and young people, DH	
The trust must ensure they manage staffing levels in children and young people's services, so they ensure patients safety is not compromised and that staff can respond to patients in a timely manner.	• MEG quality audits regularly undertaken on wards auditing staffing levels and responsiveness to patients. • Care Group Quality Ward Rounds set up in January 2023.

Table 14: Well-led quality improvement actions completed by 31 March 2023 to address the CQC's findings

CQC Concerns	Completed Improvement Actions
Well-led	
The trust should review and improve the practices of the human resources team to enable its own policies/procedures to be enacted promptly.	• A review of the Employee Relations team is underway. A review is also underway of the senior workforce team. This includes roles, responsibilities and remit. This will be complete by end May, with any changes implemented thereafter.
The trust should consider how it may improve the accuracy of information related to trainee doctors and continue to review their rotas to ensure they meet required standards.	• There are a number of workstreams in place to achieve this including the appointment of a Chief Registrar at each site. The postholders will be responsible for improving communication and addressing rota issues. There is a well-established system of Guardian of Safe Working, with Guardians at both sites. There is a robust system in place to escalate issues as needed. There is a monthly junior doctor forum at both sites with regular executive attendance.
The trust should improve opportunities to listen to the views of its staff and how it considers	• The Trust has a number of mechanisms in place including "Ask the Chief" with the CEO and his executive team, staffside monthly meetings. Care groups are being asked to.

CQC Concerns	Completed Improvement Actions
Well-led	
information expressed by those individuals.	
The trust should have a lead clinician for sepsis, so the profile of this matter remains high on the agenda.	• A job description has been drafted and is with the CMO for sign-off.
The trust should continue to work on the Workforce Disability Equality Standards and Workforce Race Equality Standards to improve its achievement of expected targets.	• EDI remains a core priority for the Trust and plans are in place to achieve WRES/DES targets. This have been signed off at Board level.
The trust should ensure care groups identify target dates for specific actions within the staff survey action plan.	• All Care Groups have been asked to identify their people priorities for 2023/24. Guidance has been provided on content.

Records Submission

8. King's College Hospital NHS Foundation Trust submitted 2,691,040 records during 2022-23 M1-12 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

8.1 The percentage of records in the published data April 2022 to March 2023, which included the patient's valid NHS number, was:

- 99.5% for admitted patient care;
- 99.6% for outpatient (non-admitted) patient care; and
- 66.6% for accident and emergency care (due to inclusion of Greenbrook UTC data at Denmark Hill).

8.2 The percentage of records in the published data April 2022 to March 2023, which included the patient's valid General Medical Practice Code, was:

- 100.0% for admitted patient care;
- 99.9% for outpatient (non-admitted) patient care; and
- 98.5% for accident and emergency care.

Information Governance Assessment

9. King's College Hospital NHS Foundation Trust's 2022-23 submission of the Data Security and Protection Toolkit is due on 30th June 2023. King's College Hospital NHS Foundation Trust's 2021/22 submission of the Data Security and Protection Toolkit made in June 2022 covering the period of 1st July 2021 to 30th June 2022 reports an overall assessment of Approaching Standards (Approved Improvement Plan is in place). Once the Improvement Plan has been completed the assessment status will be changed to Standards Met.

Payments by Results (PbR)

10. King's College Hospital NHS Foundation Trust was not subject to the Payment by Results (PbR) clinical coding audit during 2022-23 by the Audit Commission.

Data Quality

11. There are several 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 many different systems and processes. Only some of these are subject to external assurance, or included in internal audit's programme of work each year.
- Many teams collect data across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflect

clinical judgement about individual cases, where another clinician might have classified a case differently.

- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to re-analyse historic data.
- The Trust and its Board have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above.
- The requirement for external audit has been removed from the Quality Accounts due to national NHS response to managing the COVID-19 pandemic.

Learning from Deaths

12 During 2022-23, 2692 King's College Hospital NHS Foundation Trust patients died. This comprised the following number of deaths, which occurred in each quarter of that reporting period:

- 622 in the first quarter (April to June 2022);
- 654 in the second quarter (July to September 2022);
- 708 in the third quarter (October to December 2022).

12.1 708 in the fourth quarter (January to March 2023). By 31 March 2023, 331 case record reviews (Mortality Review Forms) and 30 investigations (patient safety incidents) have been carried out in relation to 242 of the 2692 deaths included above.

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

- 101 in the first quarter;
- 117 in the second quarter;
- 79 in the third quarter;
- 34 in the fourth quarter.

12.3 3 patient deaths (0.1%) of all the deaths between Q1 and Q4 are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 1 representing 0.037% for the first quarter;
- 1 representing 0.037% for the second quarter;
- 0 representing 0% for the third quarter;
- 1 representing 0.037% for the fourth quarter.

12.4 Summary of learning from case record reviews and investigations

- Ensuring adult medicine and child health joint management of death in 16/17 year olds.
- Improving intravenous cannulation and line care through refresh training and IV Line Care Improvement Meeting in Oliver Ward.
- Review of Palliative Care Support for Orpington Frailty Wards.
- Advanced Care Planning (ACP) and Chronic Fatigue Syndrome (CFS) training for all clinicians in Clinical Gerontology.
- Reiteration of the importance of correctly coding comorbidities on patients with Acute Myocardial Infarction (AMI) and involvement of acute coronary syndrome (ACS) Nurse to improve coding of AMI patients not admitted under Cardiology (SHMI higher than expected).
- Ward and critical care teams to instigate face-to-face safety huddles to review deteriorating patients.
- Sepsis identification training to become mandatory for all nursing staff and integrated into LEAP.
- Development of a clinical policy in relation to deterioration and escalation in children.
- Joint care between orthopaedics (PRUH) and medical teams for patients with severe medical problems.
- Identified need to enhance and update bereavement training for all neonatal staff especially knowledge of end of life care and care after death.
- A system for flagging patients to iMobile at admission.
- VTE assessment does not have fixed "hard stop" link with prescription of prophylaxis.
- Multidisciplinary team decision prior to high risk surgery.
- Safety-netting for critical care referral from the emergency department.

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

- Neonatal staff attended pan-London training on Care after Death: Practicalities around caring for the baby's body.
- Neonatal staff attending simulation training to develop skills in difficult communication.
- Improved join-up between adult and paediatric safeguarding and bereavement services.
- Admission process for trauma patients changed on EPR to include an automatic flagging of patients with lactate >4 for iMobile.
- Consideration of 'hard stop' for prescription of e-meds without VTE assessment (& prophylaxis).
- Changes made to trauma admission documents, part of global changes to emergency department admission process.
- Intravenous heparin trust protocol updated.

12.6 Previous reporting period

- 106 case record reviews and 11 investigations, which related to deaths, were completed after 31 March 2022 and which took place before the start of the reporting period.
- 0% of the patient deaths before the latest reporting period was judged to be more likely than not to have been due to problems in the care provided to the patient.
- These numbers have been estimated using the locally adapted version of the structured judgment review method of case record review method of case record review.

2.3 Reporting Against Core Indicators

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

See table 15 on the next page.

Table 15: Reporting against core indicators

Indicator	Measure 48	Current Period 48	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
Summary Hospital-level Mortality Indicator (SHMI)	Ratio of observed mortality as a proportion of expected mortality	01/01/22 to 31/12/22	0.9813 (95% CI 0.8967, 1.1152) - as expected	01/10/2020 to 30/11/2021	1.0296 (95% CI 0.9003, 1.1107) - as expected	1.0196 (0.8985, 1.1130) - as expected	0.7481 (0.8964, 1.1156) - lower than expected	1.0	NHS Digital	The Trust considers that this data is as described for the following reasons: it is based on data submitted to NHS Digital and the Trust takes all reasonable steps and exercises appropriate due diligence to ensure the accuracy of data reported. The Trust intends to take/ has taken the following actions to improve the SHMI, and so the quality of its services, by continuing to invest in routine monitoring of mortality and detailed investigation of any issues identified, including data quality as well as quality of care.
	Percentage of patient deaths with palliative care coded at diagnosis	01/01/22 to 31/12/22	49%	01/12/2020 to 30/11/2021	46%	65%	25%	40.50%	NHS Digital	
Patient Reported Outcomes Measures - hip replacement surgery *2020-21 data is reported as data not published at the time of publishing the Quality Account.*	EQ-5D Index:76 modelled records	Apr 20 - Mar 21	Adjusted average health gain: 0.471	Apr 19 - Mar 20	Adjusted average health gain: 0.452	0.459	0.423	0.465	NHS Digital	The Trust considers that this data is as described for the following reasons - our performance is in line with Shelford Group peers. The Trust intends to take the following actions to improve this score, and so the quality of its services: Improve PROMS data collection through the implementation of a new IT system from April 2021
	EQ VAS: 73 modelled record		Adjusted average health gain: 14.615		Adjusted average health gain: 12.922	14.087	10.866	14.769		
	Oxford Hip Score: 79 modelled records		Adjusted average health gain: 22.604		Adjusted average health gain: 22.280	22.280	19.907	22.579		
Patient Reported Outcomes Measures - knee replacement	EQ-5D Index:90 modelled records	Apr 20 - Mar 21	Adjusted average health gain: 0.307	Apr 18 - Mar 19	Adjusted average health gain: 0.340	0.336	0.276	0.315		

Indicator	Measure 48	Current Period 48	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
surgery *2020-21 data is reported as data not published at the time of publishing the Quality Account.*	EQ VAS: 86 modelled records 48		Adjusted average health gain: 5.246		Adjusted average health gain: 6.164	9.839	6.219	7.274		
	Oxford Knee Score: 94 modelled records		Adjusted average health gain: 15.478		Adjusted average health gain: 16.707	16.758	16.352	16.714		
Percentage of patients readmitted within 28 days of being discharged	Patients aged 0-14 – 0.85%	Apr-22 to Mar-23	0.84%	Apr-21 to Mar-22	1.02%	Data not comparable due to differences in local reporting.	Data not comparable due to differences in local reporting.	N/A	MS	The Trust considers that this data is as described for the following reasons – readmissions data forms part of the divisional Best Quality of Care scorecard reports, which are produced and reviewed by divisional management teams, and forms part of the monthly-integrated performance review with the executive team. The Trust intends to take the following actions to improve this score, and so the quality of its services, by rolling out a 7 day occupational therapy and physiotherapy service across medicine to support early identification, acute treatment and onward referral to for rehabilitation and discharge planning needs, proactive referrals to community health, social care and voluntary sector services for those who need support to enable seamless transfer and delivery of onward care on discharge.
	Patients aged 15+ 7.41%		7. 58%		8.26%	Data not comparable due to differences in local reporting.	Data not comparable due to differences in local reporting.	N/A		

Indicator	Measure 48	Current Period 48	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
Trust's responsiveness to the personal needs of its patients: • To what extent did staff looking after you involve you in decisions about your care and treatment?	Score out of 10 trust-wide	2021 National Inpatient Survey	7.0	2020 National Inpatient Survey	7.0	8.5	6.7	7.9	CQC	The Trust considers that this data is as described for the following as CQC national patient survey is a validated tool for assessing patient experience and in line with local survey results. The Trust intends to continue its work on discharge and Patient-led assessment of the care environment (PLACE) to improve the scores, and so the quality of its services.
• Did you find someone on the hospital staff to talk to about your worries and fears?	Score out of 10 trust-wide	2021 National Inpatient Survey	7.4	2020 National Inpatient Survey	7.3	9.2	6.4	7.6	CQC	
• Were you able to discuss your condition and treatment without being overheard?	Score out of 10 trust-wide	2021 National Inpatient Survey	6.1	2020 National Inpatient Survey	6.2	9.3	5.3	6.3	CQC	
• Thinking about any medicine you were to take at home, were you given any of the following?	Score out of 10 trust-wide	2021 National Inpatient Survey	4.6	2020 National Inpatient Survey	4.8				CQC	
• Did hospital tell you whom to contact if you were worried about your condition or treatment after you left hospital?	Score out of 10 trust-wide	2021 National Inpatient Survey	7.1	2020 National Inpatient Survey	6.8	9.7	6.2	7.6	CQC	

Indicator	Measure 48	Current Period 48	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
Staff employed by, or under contract to the Trust who would recommend the Trust as a provider of care to their family or friends	% (If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation) 48	2022 NHS Staff Survey	63.6%	2021 NHS Staff Survey	67.7%	86.4%	39.2%	61.9%	NHS England staff family and friends test data	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons – This is taken from data recorded in the National Quarterly Pulse Surveys and the National Annual Staff Survey. The Trust intends to take the following actions to improve this score, and so the quality of its services, by: Sharing the staff survey results transparently with all care groups and corporate teams, and asking all to pick their three lowest-scoring NHS People Promises to generate an improvement action plan. This improvement can be measured by the staff survey results in the following years. We are also launching an Engagement toolkit in Q2 as the link between people experience and patient care is well established.

Indicator	Measure 48	Current Period 48	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
The percentage of patients who were admitted to hospital and who were risk-assessed for venous thromboembolism during the reporting period	% patients 48 who have been risk assessed as at risk of VTE on admission, expressed as a percentage of all discharges including Renal Dialysis patients	Apr-22 to Mar-23	98.1%	Apr-21 to Mar-22	97.9%	Bart's Health NHS Trust 99.1%	Sheffield Teaching Hospital NHS Foundation Trust 95.0 %	95.5%	NHS Improvement	The Trust considers that this data is as described for the following reasons: This data was collected electronically. Ward audits are completed every month and they reflect similar compliance scores. The Trust intends to take the following actions to improve this score, and so the quality of its services, by: Optimising use of electronic solutions to enhance surveillance of VTE risk assessment rates. VTE CNSs (Clinical Nurse Specialist) will work closely with areas not meeting the National target for VTE risk assessment of 95% and develop action plans to address this. Use GIRFT (Getting it Right First Time) VTE survey data to highlight areas for improvement.

Indicator	Measure 48	Current Period 48	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
The rate per 100,000 bed days of cases of *C. difficile* infection reported within the Trust among patients aged 2 or over during the reporting period	Rate/ 100,000 bed days 48	April 2022 – March 2023	130	April 2021 – March 2022	103 cases	National data not available at time of finalising Quality Account	National data not available at time of finalising Quality Account	National data not available at time of finalising Quality Account	https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-by-prior-trust-exposure	The Trust considers that this data is as described for the following reasons; there were 130 Trust- apportioned cases of CDI (for patients aged ≥2), thus the performance target was not met. The number of *C.diff* has increased nationally The Trust intends to take the following actions to improve this score, and so the quality of its services, by: • Training of junior doctors as regards review, choice & duration of antimicrobials. • Audit of prolonged antimicrobial prescribing with feedback to clinical teams. • Continue to focus on equipment and environmental cleaning. • Sampling stewardship – continue the infection control review of stool samples, and discussion with clinical teams. • Ensuring hand wipes are offered to patients pre-meal.

Indicator	Measure 48	Current Period 48	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period	No. (rate per 1,000 bed days) 48	April 2022 – March 2023	36126 total incidents recorded 96.3 incidents per 1000 bed days	April 2021 – March 2022	29,661	Most recent national data for comparison covers 21/22 financial year. This data implies KCH reporting rate is 3rd lowest in London (34.4 reports per 1000 bed days) however number of incidents significantly lower than recorded internally. GSTT show a rate of 71.3)	Kingston are the lowest reporting acute trust in London (23.9) based on national data for 21/22	57.5 based on national data for 21/22	NRLS (National Reporting and Learning System) Datix	Reporting at King's College Hospital NHS Foundation Trust remains high. Further work to embed a good reporting culture as part of a wider safety culture will form part of both PSIRF implementation and going live with LFPSE (Learn from patient safety events) in 2023.
The number and percentage of such safety incidents that resulted in severe harm or death	No. (rate per 1,000 bed days)	April 2022 – March 2023	34 death (0.09 per 1000 bed days) & 106 severe harm (0.28)	April 2021 – March 2022	127 (23 deaths, 104 severe harm)	Most recent national data for comparison covers 21/22 financial year. Highest (negative) – Croydon (20 deaths (0.4)	Lowest (positive) – Homerton (1 death)	37 severe harm (0.27) & 20 deaths (0.15)	Data on patient safety incidents reported to the NRLS by each NHS trust in England April 2021 to March 2022 - full workbook Datix	The Trust continues to have a rate of significant harm below the national average. Significant work has been carried out to thematically review key system wide issues in preparation for PSIRF. Falls, pressure ulcers and deteriorating patients are the most common types of incidents resulting in severe harm or death. Wide ranging quality improvement programmes are ongoing across these themes.

Part 3: Other information

Part 3: Other information

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

Table 16: Overview of the quality of care offered by King's

Indicators	Reason for selection	Trust Performance 2022-23	Trust Performance 2021-22	Peer Performance (Shelford Group Trusts) 2022-23	Data Source
Patient Safety Indicators					
Duty of Candour	Duty of Candour was chosen as high performance as 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.	95%	97%	Not available	Datix
WHO Surgical Safety compliance	Even though the Trust has not listed Surgical Safety as a quality priority for 2019-20 it remains a key objective and workstream at the Trust. Since the beginning of 2017, the Trust has been able to electronically monitor compliance with the WHO checklist. The higher the compliance % the better.	92.7%	94.8%	Not available	Quality Metrics Scorecard
Total number of never events	Outside of Surgical Safety, the Trust has several workstreams that aim to reduce the number of Never Events.	3	3	GSTT (4), UCLH (3), Imperial (2)	Datix
Clinical effectiveness indicators					
SHMI Elective admissions	Summary Hospital-level Mortality Indicator (SHMI) is a key patient outcomes performance indicator, addressing Trust objective 'to deliver excellent patient outcomes'.	0.50 (95% CI 0.37, 0.64) – Better than expected	0.57 (95% CI 0.49, 0.73) – Better than expected	0.82 (95% CI 0.67, 0.99) – Better than expected	NHS Digital data via HED, period: December 2021 to November 2022
SHMI Weekend admissions		1.00 (95% CI 0.96, 1.04) – As expected	1.02 (95% CI 0.94, 1.12) – As expected	0.9 (95% CI 0.86, 0.94) – As expected	
Patient experience indicators					
Friends & Family – A&E	Overall, how was your experience of our service? % positive Friends and Family Test	64%	79%	Not Available	NHS England national statistics
Friends & Family – inpatients	Overall, how was your experience of our service? % positive Friends and Family Test	94%	96%	Not Available	NHS England national statistics
Friends & Family - outpatients	Overall, how was your experience of our service? % positive Friends and Family Test	90%	91%	Not Available	NHS England national statistics

Performance against relevant indicators

Table 17: Performance against relevant indicators

Indicators	Trust Performance 2022-23	Trust Performance 2021-22	National average	Target
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	73.7%	75.3%	60.7%	92.0%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	60.2%	69.3%	58.3%	95.0%
All cancers: 62-day wait for first treatment from Urgent GP referral for suspected cancer	64.6%	67.8%	61.5%	85.0%
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	74.7%	78.7%	69.1%	>99%
C. *difficile*:	126 cases	92 cases	n/a	110
Maximum 6-week wait for diagnostic procedures	96.2%	87.8%	71.6%	>99%
Venous thromboembolism risk assessment	98.7%	98.5%	n/a	95.0%

Access to services

The Trust's operational delivery and performance against patient access targets was impacted by the effects of the second COVID-19 wave during the first months of the financial year, following which the Trust enacted rapid recovery of elective and diagnostic activity whilst still meeting with required infection control standards in response to COVID-19.

The number of COVID-positive patients in our beds has reduced and this year we have typically been caring for on average 15 patients per day in our critical care beds and 145 patients in our General & Acute (G&A) beds. At the time of writing this report, there were 18 COVID positive patients in our critical care beds and 115 patients in our G&A beds.

As part of our on-going response to managing the unique demands of COVID, we have continued with our transformation of outpatient services by providing an increased number of non-face 2 face outpatient appointments via telephone. This is in addition to standardising provision of video-based appointments using one system supplier this year. Our outpatient text reminder service has been rolled out to patients attending all our hospital site clinics, as well as non-face 2 face appointments. This has required a complete re-build of our outpatient clinic templates for the PRUH and South Sites as well as Denmark Hill and Tessa Jowell sites which was completed by summer 2022.

The Trust's ED four-hour performance based on monthly ED Sitrep return submissions is 60.2% for the period April 2022 to March 2023. This is a reduction in performance compared to the performance level of 69.3% achieved for the same period last year.

2WW Cancer referral demand received from GP's in 2022-23 has increased by 7.6% between April 2022 to March 2023 compared to the same period last year. We have seen a 16% increase in Gynaecology 2WW referrals and a 13% increase in Colorectal 2WW referrals from GPs.

Referral to Treatment (18 Weeks)

Following the impact of the three COVID-19 waves and the commencement of our elective recovery programme, by March 2022 there were only 865 patients waiting over 52 weeks and 20,469 patients waiting over 18 weeks. This delivered RTT incomplete performance of 73.1%, below the 92% national target.

A cross-Trust Elective Assurance group was setup to ensure that effective action plans were in place to

recover elective activity, including day case/inpatient, outpatients as well as diagnostics. Planned investigation activity continues to monitor performance across RTT as well as diagnostic and cancer domains. This group continues to link with the South East London Operations Group as part of the Acute Provider Collaborative to ensure a consistent approach to elective recovery across the SEL sector.

The Trust continues to work closely with local commissioners and providers to secure access to Independent Sector and NHS mutual aid capacity to reduce the backlog of long waiting patients.

The Trust has continued with the implementation of its transformation programmes in outpatient re-design and digitisation to improve our patient's experience with the services that we provide. This is in addition to theatre productivity improvement programmes to maximise the use of our day case and inpatient theatres and outpatient clinic throughput in-week.

The Trust has implemented an Enhanced Theatre Support Programme which focusses on providing a daily forward and retrospective view of activity and sessions through all our theatre complexes. Targeted work is also underway across all our sites to improve pre-operative assessment capacity and throughput. An external support company has also been engaged to complete a period of triaging patients and completion of documentation updates from January 2023.

As part of our on-going elective recovery programme, the Trust continues to use two new operating theatres at Queen Mary's Hospital Sidcup to support our efforts in reducing waiting lists from patients undergoing routine procedures. These theatres are being used collaboratively by all 3 SEL Acute Trusts to carry out high volume, low volume complexity procedures.

A new operating theatre and recovery suite was also opened at Orpington Hospital which enables additional orthopaedic procedures to be performed, benefiting patients locally as well as patients living across South East London.

By the end of March 2023 the number of 52 week waiters had reduced by 74 cases (8.6%) this financial year to 791 patients, as we have seen the number of 52 week waiters increase in Q4 from January onwards this year. RTT incomplete performance has fluctuated throughout the year but has improved to 72.6% by March 2023, set against a PTL size of 82,385 waiters.

Cancer Treatment within 62 Days

2WW GP referral demand for suspected cancer has increased by 7.6% for April 2022 to March 2023 compared to the same period in 2021/22. There has been an increase of over 1,300 referrals in Colorectal Surgery which equates to a 13.2% referral increase. Despite this referral increase compliance against the cancer 2 week wait GP referral 93% target has been maintained throughout the year apart from June 2022 and March 2023. Performance has typically exceeded 95.1% in most months but performance in March 2023 has reduced below national standards to 90.7%.

We have not been compliant with the 62-day GP referral to treatment standard during 2022-23, where we have reported an average monthly performance of 64.6% compared to the national 85% target. Performance has been improving though from January 2023 to 68.5% for March 2023 as we continue to reduce the over 62 days patient backlog.

The 62-day PTL backlog reduction has broadly been tracking to plan throughout the year until December 2022, but has ended approximately 15% behind trajectory by March 2023. The impact of the nursing strike and first doctors strike during Q4 has contributed to this year-end position. This is notably better than the national position which is around 67% behind trajectory.

Except for September 2022, the Trust has exceeded the new 75% national target for the 28 Faster Diagnosis Standard for each month this year.

The Trust was successful in its bid to setup a Rapid Diagnostic Centre (RDC) which will improve both time to diagnostics and diagnosis, and was opened in quarter 1 earlier this year.

Diagnostic Test within 6 Weeks

By March 2023 the number of patients waiting on the diagnostic waiting list for a DM01 reportable test reduced from a prior year peak of 14,491 patients to 293 patients waiting over 6 weeks, and an associated performance of 97.7% of patients waiting under 6 weeks.

At the Denmark Hill site the largest backlog at the start of the financial year were in adult and paediatric endoscopy and cardiac echo where increased in-week and weekend outpatient capacity was implemented to reduce the number of long waiters - and cardiac MRI (Magnetic Resonance Imaging) for which an outsourcing solution was extended to ensure on-going achievement of cardiac MRI log-wait reductions.

The PRUH and South Sites has continued to

achieve the national 99% target for patients waiting under 6 weeks since March 2022 where 99.7% compliance was delivered. During 2022-23 PRUH and South Sites has maintained this compliant position, recording zero breaches in four months during the year.

By March 2023 the number of patients waiting on the diagnostic waiting list for a DM01 reportable test reduced by 171 (1.3%) to 12,906 waiters with only

293 patients waiting over 6 weeks, and an associated performance of 97.7% of patients waiting under 6 weeks.

Emergency Department four- hour standard

Achievement of the Emergency Department four-hour performance standard continues to be a challenge at Kings as both A&E type 1 and UTC type 3 activity at both acute sites. Type 1 A&E department attendance levels for the period April 2022 to March 2023 are 4.0% higher compared to the same period last year. Type 3 Urgent Treatment Centre attendances have reduced by -1.4% for the Denmark Hill and PRUH centres for the same period.

Four-hour performance at the Denmark Hill site has also remained pressured during the year, in particular Type 1 A&E performance which has remained below 50% since June 2022.

Bed occupancy at DH has remained exceptionally high throughout the year at 96.0% based on our daily Sitrep submissions. We have seen a dramatic increase in the number of patients waiting over 12-hours for admission into beds, from 82 cases reported in March 2022 to an in-year high of 304 cases reported in December 2022 and 302 cases reported in March 2023.

The Denmark Hill clinical team worked with the EPR team during the year to replace their current Symphony A&E system with the EPR Allscripts system which will better integrate clinical activity and documentation recording. The new ED system went live in July 2022 earlier in the year.

The ED team are working to deliver improvements in time to clinician assessment across Ambulatory Majors and SDEC (Same Day Emergency Care) for non-overnight patient cohorts and improvements in flow. The team is also working on the introduction of continuous flow model to support admitted patient pathway and reduce overcrowding.

Four-hour emergency performance at the PRUH site has been increasingly challenged during the financial year, reducing from 66.2% in March 2022 to 54.1% in December 2022. Performance has started to recover during quarter 4 of this year, reaching 61.3% by March.

Bed occupancy at PRUH has remained exceptionally high throughout the year at 98.8% based on our daily Sitrep submissions. We have seen a dramatic increase in the number of patients waiting over 12-hours for admission into beds, from 214 cases reported in March 2022 to an in-year high of 905 cases reported in December 2022 and 899 cases reported in March 2023.

Work continues to improve flow and discharge across the Trust and with system partners through the Integrated Flow Board. In January, a ‘Star Chamber’ approach has been taken to review each workstreams delivery against plan, with finalisation of focus until the end of quarter 4 this year.

Following a successful series of ward moves, we have expanded our SDEC footprint as well as our discharge lounge area to improve discharge lounge utilisation. We continue with LAS (London Ambulance Service) direct conveyance to our Medical Assessment Unit, and have implemented a refined Flow Navigator role and mobilised a provision of discharge team/social care at the front door of ED. Work is currently underway between PRUH, Greenbrooks Urgent Treatment Centre (UTC) and Oxleas to embed an enhanced assessment criteria and direct referral from UTC streaming.

Freedom to Speak Up

At King's we value speaking up as an opportunity to learn, develop and improve. We have ensured speaking up is reflected in our People and Culture Strategy, making raising concerns part of our normal working lives. This guarantees that Freedom to Speak Up (FTSU) contributes to safety, quality of care and improvements in the working environment and wellbeing of workers at King's.

Leaders at the trust understand that they set the tone when it comes to fostering a Speak Up, Listen Up, Follow Up culture. This year, all Board members have undergone the Follow up training by NHSE/National Guardians Office and completed the self-reflection tool. The FTSU Guardian has direct access to all executive members, all of whom respond immediately to requests for advice and discussion from the Guardian. The FTSU Guardian meets monthly with the trust CEO and every quarter with the CEO, Chair, Non- Executive and Executive leads for FTSU, as well as other senior executives.

Benchmarking data for 2022-23, demonstrates that we have consistently remained in the top 25% of trusts nationally (The Model Health System) for raising concerns. This is a positive indicator of worker confidence, as the more cases raised, the more evidence that staff are feeling confident about having conversations whenever they feel that something is not right.

2022-23 saw a 50% increase in Speaking Up cases compared with 2021/22. The majority of speaking up concerns (65%) are from workers based at the Denmark Hill site. However, the number of cases raised by workers at the Princess Royal University Hospital (PRUH) and the south sites has increased by 178% this year.

Nursing staff continue to be the highest reporting staff group. This is in line with the national picture. Nationally, doctors are the staff group least likely to speak up, this relates particularly to junior doctors. The number of cases raised by doctors overall has increased by 173% this year. We believe this is a positive outcome, resulting from the FTSU Guardian working jointly with the Guardians of Safe Working.

Although the data speaks for itself, we strongly believe that data can only provide a glimpse of how it feels to raise a concern at King's and for this reason, we look behind the data and listen to the voices of our staff. The 'Ask the CEO' sessions have provided a forum for staff to speak up about issues they may have otherwise been nervous about raising.

By listening to our workers, we have learned that the main reason they may be reluctant to speak up is because they believe nothing will change. We have really focused our attention on making sure that staff who speak up are thanked and kept fully informed of changes made.

We ensure staff are fully notified of all the other avenues to speaking up. This include primarily, their line managers. The FTSU Guardian continues to work very closely with the EDI and wellbeing teams, as well as staff networks, employee relations, Guardians of Safe Working and other key personnel. The aim is to ensure we provide staff with a safe and responsive way to raise concerns.

At King's we continue to be extremely sensitive and reactive to the needs of our BAME (Black, Asian and Minority Ethnic) staff and recognise the additional challenges they may face in speaking up. For this reason the Guardian works in partnership with the network Chair.

We recognise that it takes courage to speak up, but it also takes courage to listen up and not be defensive. Managers can really influence a person's psychological wellbeing and therefore, the likelihood of them speaking up. In previous Quality Accounts we have highlighted that managers can feel vulnerable when staff speak up and this may lead to a defensive response. This in turn can prevent staff from raising further concerns. As a trust, we are supporting our managers to listen with fascination when staff raise concerns. With the support of the Organisational Development team, we aim to give our managers the fundamental tools to respond appropriately.

This year we have seen an even higher increase in requests from managers for training and listening events. This is a positive indicator that speaking up and listening up is becoming the norm at King's and managers want to create an open culture

The Speak up Guardian continues to attend preceptorship programs and induction sessions, delivering training on a regular basis, including to our international recruits, who may otherwise feel nervous about raising concerns.

The trust recognises that having just one FTSU Guardian presents challenges, particularly regarding the ability of that individual to be regularly visible across all the trust sites. Consequently, the Executive team are committed to increasing the capacity of the

FTSU team, by recruiting an additional Guardian for the PRUH during the next financial year.

Our focus for the year ahead is to build on the incredibly positive progress made in 2022-23. We intend to make it even easier for staff to speak up so we will ensure managers and leaders have the skills to listen up and make changes when necessary. No staff member should feel disadvantaged because of speaking up. Speaking up is a gift and we will thank anyone who raises a concern.

Guardians of Safe Working – Rota Gaps

Consolidated annual report on rota gaps

In 2022-23, Health Education England (HEE) were unable to provide junior doctor trainees for 137 posts and put on hold filling an additional 59 junior doctor trainee posts.

This puts additional strain on Specialties to fill these gaps with local recruitment in addition to their own Trust junior doctor posts. The monthly breakdown is shown below in table 18.

Table 18: HEE rota gaps and hold gaps 2022-23

	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
HEE Rotation Gaps	21	2	4	0	23	15	21	6	5	0	25	15
HEE Hold Gaps	3	0	0	0	20	13	4	0	17	0	0	2

Plan for improvement to reduce these gaps:

- Where HEE training post gaps occur Trust clinical fellows are recruited with locum shifts utilised to temporarily cover posts where available.
- Trust post recruitment may be undertaken in anticipation of HEE gaps depending on essential service requirements within the care groups.
- Ensure schemes such as the Medical Training Initiative (MTI) are being fully utilised for International Recruitment and working closely with the Royal Colleges
- A working group is also underway led by the Trusts GMC (General Medical Council) Responsible Officer, Director of Medical Education and Guardians of Safe Working to identify areas of improvement for the Trust based on the 'Welcoming and Valuing International Medical Graduates (IMGs)'. The main aims are to standardise and enhance information provided to IMGs before they join the Trust and all elements of the Induction process for overseas doctors coming to the UK and working in the NHS for the first time.
- Continue to introduce roles such as Physicians Associates to support Junior Doctor rotas
- Retention of medical staff through introduction of permanent positions

Quality Alerts

Primary Care Quality Alerts and King's Reverse Quality Alerts

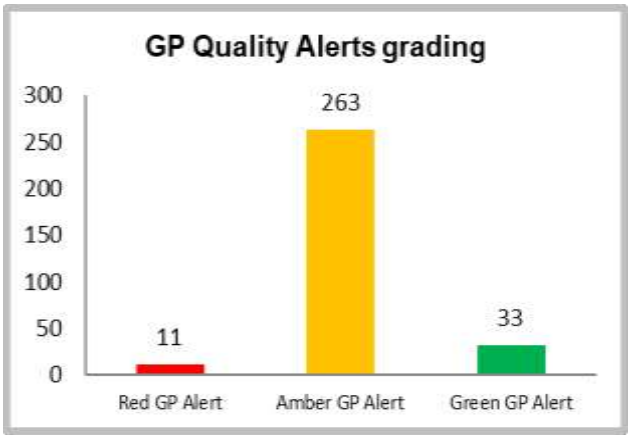
A Primary Care Quality Alert (also referred to as GP Quality Alert) is a formal notification from the Integrated Care System (ICS), raising quality concerns with the King's College Hospital NHS Foundation Trust. This is on behalf of our primary care colleagues, including general practices, community pharmacy, dental, optometry services and social care providers. A Quality Alert can also take the form of a complaint related to the Trust services raised from primary care.

King's Reverse Quality Alerts allow the Trust to formally raise quality concerns in relation to the care and treatment of our patients within the primary care via the ICS.

Primary Care Quality Alerts

For the period 2022-23, the Trust received 307 Primary Care Quality Alerts.

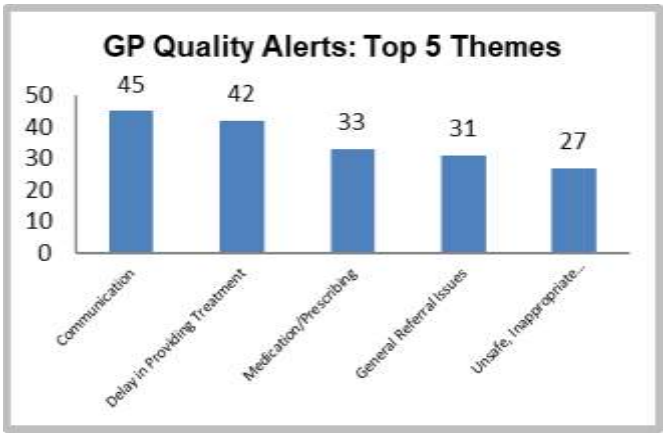
Figure 10: Primary Care Quality Alerts received by the Trust from the ICS 2022-23



Of the 11 red Quality Alerts, 3 were raised in relation to medication or prescribing issues. Responses have been sent to the ICS for 9 alerts which have been resolved, with improvements put in place as required. 2 of the alerts are still under investigation.

Of the 263 Amber Quality Alerts, 231 have been resolved with responses sent to the ICS. 32 currently remain under investigation. The top 3 themes for these alerts are as following; delay in providing treatment (39), communication (31) and general referral issues (28).

Figure 11: Top 5 Primary Care Quality Alert themes 2022-23



The Trust holds bi-weekly escalation meetings at the Denmark Hill and Princess Royal Hospital sites to highlight upcoming themes, trends and emerging concerns to the senior management team. Communication between and primary care providers is being improved through the updates to the Communicating with GP's Policy.

To improve the discharge process, ongoing improvement work is currently being undertaken, which includes creating simplified documentation to ensure safe discharge for patients. A new discharge checklist will help improve communication between the Trust and primary care providers.

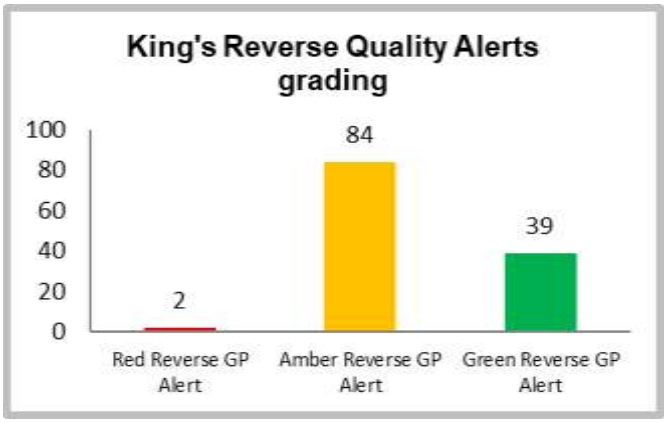
To reduce medication related incidents, improvements in documentation recording are being introduced. This is also being delivered on wards to ensure there is targeted awareness on changes.

Scheduled meetings between the Trust and the ICS have been created to discuss overdue quality alerts, upcoming themes and improvement work being undertaken within the Trust.

King's Reverse Quality Alerts

For the period 2022-23, the Trust sent out 125 King's Reverse Quality Alerts.

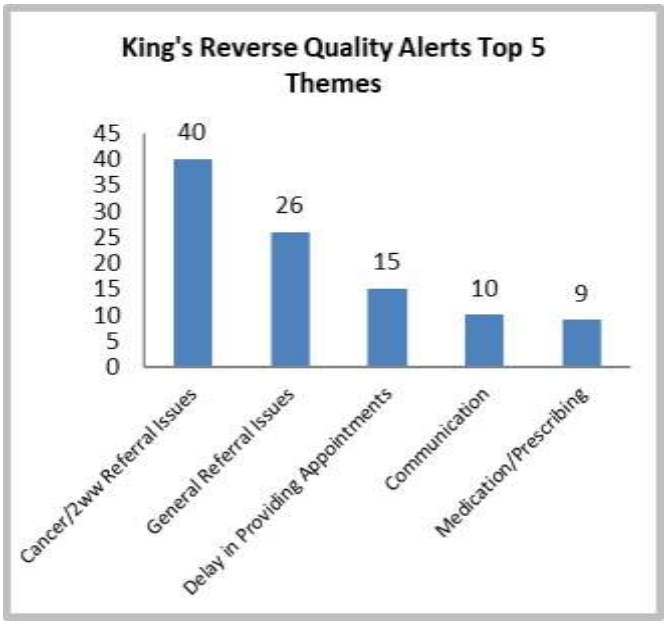
Figure 12: King's Reverse Quality Alerts raised with the ICS 2022-23



Of the 2 Red Reverse Quality Alerts, 1 was raised in relation to medication or prescribing issue and a response has been shared by the ICS. The other alert was raised in relation to a delay in providing treatment which is still under investigation.

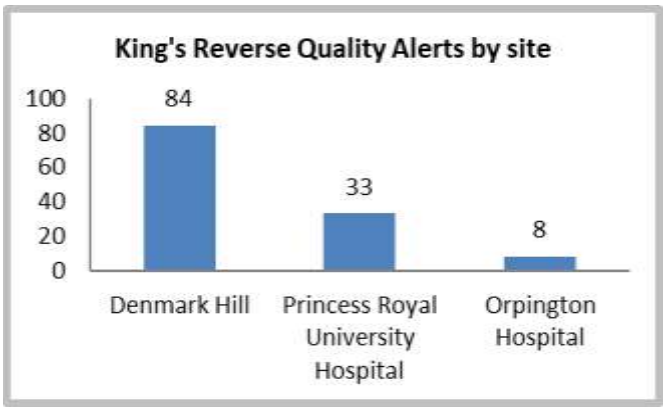
Of the 84 Amber Reverse Quality Alerts, 26 have been resolved with responses shared by the ICS. 58 currently remain under investigation. The top 3 themes for these alerts are as following; Cancer/2ww referral issues (33), general referral issues (12) and delay in providing appointments (10).

Figure 13: Top 5 themes for King's Reverse Quality Alerts 2022-23



Some of the work being undertaken to address the issues relating these themes include; identifying training gaps and delivering additional training provided for staff. Local guidelines for 2ww referrals are being reviewed to ensure compliance with available guidelines. This includes through regular audits on ERS.

Figure 14: King's Reverse Quality Alerts raised with the ICS by site 2022-23



Next steps:

With the Trust transitioning to a new local risk management system (LRMS) in April 2023, further work will be conducted to improve the oversight of the management of Quality Alerts and provide greater assurance in relation to policy requirements to monitor compliance. Technical configuration to the new LRMS will also enable the Trust to identify and record Quality Alert themes in relation to patient safety events. The addition of automated due dates on the new LRMS will signal to Care Groups and governance colleagues of approaching investigation deadlines. The Trust will also aim to move away from paper forms for collecting investigation information and allow clinicians to directly respond to alerts using the new LRMS. This will save staff time and improve the speed at which information is shared with the Trust Care Groups, ICS and primary care colleagues. As a result of these changes, patient safety concerns or compromises to positive patient experiences will be highlighted in a quicker timeframe.

To further improve quality and patient safety within the Trust, an internal staff Quality Alert newsletter has been developed to share learning, outcomes and further action taken following investigations.

Annex 1

South East London Integrated Care System Statement on King's College Hospital NHS Foundation Trust Quality Account 2022-23

South East London Integrated Care System

NHS South East London

SEL ICB King's Health Service Trust 2022-23 Quality Account Statement

Southeast London Integrated Care Board (SEL ICB) was formed in July 2022 serving the populations of Bexley, Bromley, Greenwich, Lambeth, Lewisham, and Southwark.

SEL ICB wishes to thank Kings College NHS Trust for sharing their 2022/2023 Quality Account with us and welcomes the opportunity to provide a commissioner statement. We are pleased that the working relationship between SEL ICB and the Trust continues to flourish particularly around quality and improvement. We confirm that we have reviewed the information contained within the Quality Account and, where possible, information has been cross referenced with data made available to commissioners during the year.

The ICB commends the Trust for their hard work and collaboration with external stakeholders as they strive towards their aim of being BOLD in a year that has had some challenges and their continuous efforts towards the delivery of quality healthcare.

The ICB acknowledges the progress made against the four key priorities for 2022-23 and notes the achievements in the implementation of quality improvement techniques to assist with refining patient, service, and staff experience. The ICS commends the work undertaken with Mental Health providers to improve the experience of patients presenting with mental health challenges including the establishment of a Mental Health Governance committee and increased staff training in the Mental Capacity Act. Also, to be commended is the development of an App to incorporate the well-being of patients with a neurological condition.

The ICB notes the plateau achieved on violence and aggression and appreciates that the reason for this remains unclear at the time of the quality account. However, it does recognise the work the Trust has undertaken in relation to staff training on conflict resolution and learning from incidents.

The Trust's participation in local and national audits has led to a number of improvement programmes being established and the ICB looks forward to the outcome of these initiatives over the coming year.

The Trust had several unannounced Care Quality Commission (CQC) inspections, and their overall rating is Requires Improvement. However, the ICB acknowledges the completion of improvement actions taken by the Trust to address feedback from the CQC.

The ICB is pleased to note the inclusion of information provided via the Quality Alert process and the development of the internal newsletter to ensure learning is shared and embedded within the Trust and looks forward to continuing to engage in identifying themes and trends and finding solutions to minimise recurrence.

The ICB would like to acknowledge the work the Trust has played in developing a southeast London approach to quality through participation in the SEL System Quality Group and in turn was pleased to participate in the mock CQC well inspection in 2022. The ICB welcomes the commitment of the Trust at the System Quality Group to develop a shared quality priority across the southeast London system during 2023/24 and looks forward to our continued partnership over the coming year.

Angela Helleur
Chief Nurse
NHS SEL ICB June 2023

Chair: Richard Douglas CB

Chief Executive Officer: Andrew Bland

Healthwatch Bromley:

Healthwatch Bromley Statement King's College Hospital NHS Foundation Trust Quality Account for 2022-23 and Quality Account Priorities for 2023-24.

Healthwatch Bromley response to King's Quality Account 2022-23 and priorities for 2023/24

In responding to the 2022-23 quality account, we note the wide range of improvement work undertaken by the trust during a year in which you have faced a number of challenges beyond your control. We would like to thank trust staff for their continued commitment to deliver improved care for the residents of South East London and beyond in these challenging circumstances.

The increasing involvement of patients and public in the development of the trust's services and the intensified focus on health inequality via the recently launched Equality, Diversity and Inclusion Strategy are very welcome. We trust this will continue in 2023/24 and look forward to strengthening our working relationship with the trust and its partners in the acute collaborative.

We note the delay to various projects and the publication of data due to the transition of IT systems, with a further planned IT change in September 2023. It would be helpful if delayed data on 2022-23 projects could be published via an interim report or as part of regular reporting to the public board meeting. As part of a two-year programme delayed projects can be recovered and may in fact benefit from the improved IT offer. There is some risk to the spread and scale of initiatives from these delays, so we would hope - where necessary and appropriate – for actions to be taken to prevent this.

In commenting on specific elements of the trust's performance in 2022-23 and the priorities for 2023/24 our response naturally has a Bromley focus.

2022-23 priorities

The report helpfully lays out the progress made, and metrics achieved in both summary and detailed form enabling a variety of audiences to understand the progress made. The wider quality information provided within the report is also very helpful.

We are pleased to note the progress within Ophthalmology and the further work planned. Spreading this best practice to other outpatient services as soon as possible would be most welcome.

The work on addressing violence against staff has progressed and we trust this will continue. The level of staff turnover means training and offers of support need to be reviewed and monitored frequently. It is disappointing to note that CODE 10 cannot be deployed beyond Denmark Hill and the RMN support at the Princess Royal University Hospital is limited. Where resource is an issue, we hope that the advent of the ICS and the removal of the commissioner / provider split will help to resolve this quickly.

Involvement of patients and public via the Mental Health Advisory Group and other newly established fora has great potential and provides opportunities to further develop the co-production of services across the trust, above and beyond the quality account priorities. Community engagement and asset building within the EDS program have similar potential.

The report references a plan to move towards an integrated quality improvement structure, referencing a timeline of “circa 5 years”. If possible, accelerating this timeline would be beneficial in the context of the transformation required in the coming years due to the challenging financial environment.

2023/24 priorities

Deteriorating patients: we strongly endorse the decision to focus on sepsis and the actions proposed and look forward to seeing the outcomes. Any relevant patient experience data or case studies collected during our engagement and sign posting activities will be shared to support this key initiative which will be of great benefit to Bromley residents and others.

The size and scope of King’s work mean it is impractical to mention or comment on every project, but we recognise the hard work and commitment of those involved and the outcomes achieved.

We were not able to clearly identify a cross-system priority, as requested by the ICS and referenced in the Oxleas Quality Account. The broad-ranging work being taken forward into 2023/24 includes several projects offering potential for cross system co-operation which could enhance outcomes. We suggest a focus on the physical health of mental health patients.

We would welcome the opportunity for further joint work with King’s, particularly in promoting Healthwatch, facilitating our Patient Experience officer’s regular visits to your services, and supporting your work by sharing our gathered intelligence.

Healthwatch Lambeth:

Healthwatch Lambeth Statement King's College Hospital NHS Foundation Trust Quality Account for 2022-23 and Quality Account Priorities for 2023-24.

King's College Hospital Quality Account 2022-23: Healthwatch Lambeth Response

Healthwatch Lambeth is the independent local health and social care champion for Lambeth residents. We work in close partnership with King's College Hospital (KCH) NHS Foundation Trust to improve the health services it provides to our residents. We are therefore pleased to be given the opportunity to comment on KCH's Quality Account for 2022-23.

We have a strong working relationship with the Patient and Public Involvement Team at KCH, and we have quarterly meetings with the team to update each other on our work, and to share information, insight and feedback.

We find the Patient Experience Committee a very useful forum for sharing information on the work we are doing, the feedback we are receiving, and to highlight any issues or challenges residents are bringing to our attention.

We are pleased to have restarted our quarterly information and advice stalls on the main Denmark Hill site, in the Golden Jubilee Wing, following a pause during the Covid-19 pandemic. We use these stalls to raise awareness of Healthwatch Lambeth (who we are and what we do), and provide information, advice and support to Lambeth residents experiencing problems accessing and using health and care services.

In terms of KCH's Quality Account priorities for 2022-23 and 2023-24, we wish to highlight Quality Priority 2 "To improve patient experience through effective communication" as being of particular importance to our residents. Poor communication is often behind patients and carers having poor experiences of, and poor outcomes from, their outpatient visits and inpatient stays. We are very keen to work alongside KCH on this priority to ensure good quality communication with patients and carers is at the heart of everything that is done there and we look forward to working together with you on this priority.

This year are undertaking projects and publishing reports on hospital discharge and maternity services, drawing on in-depth qualitative research with patients and carers from Lambeth's diverse communities. Communication is a key theme in both projects, so we look forward to working with you on implementing our recommendations to improve communication with patients and carers at the Trust.

We look forward to continuing to work very positively with the Patient and Public Involvement Team, and through the Patient Experience Committee, at KCH to improve health and care services for our Lambeth residents.

Healthwatch Southwark:

Healthwatch Southwark Statement King's College Hospital NHS Foundation Trust Quality Account for 2022-23 and Quality Account Priorities for 2023-24.

Healthwatch Southwark response to King's Quality Account 2022-23 and priorities for 2023/24

As the independent champions of patient voice in Southwark and partners of King's College Hospital, we appreciate the opportunity to comment on their Quality Account for 2022-23.

We value the positive relationship that the Trust has built with us and would like to commend the Patient and Public Involvement Team for their proactive efforts to liaise with us regularly to gather patient feedback through the Patient Experience Committee and our Quarterly Liaison meetings.

Whilst our sample of feedback has thinned significantly since the Covid-19 pandemic, we have received some positive feedback from KCH patients who described their experience with the oncology service as "excellent". However, this characterisation varies significantly from feedback on other services including neurosurgery, with one patient stating, "waiting times are off the scale and I have no idea when I will be treated".

Unfortunately, we are limited in our ability to comment on KCH's Quality Accounts 2022-23 due to changes to staffing and capacity constraints of our small team. We aim to gather more focused, local feedback around KCH by running theme-based surveys/focus groups and by holding feedback stalls in Trust waiting areas. This will enable us to offer more extensive commentary next year. Our comments on the KCH Quality Accounts 2022-23 are therefore inexhaustive but offer a brief response to KCH's priorities and achievements.

Priority 1: To improve the detection of the deteriorating patient and escalation as appropriate.

- We are pleased to see that the Trust has fully achieved the improvement of documentation in medical records. Likewise, the full implementation of appropriate training and support for staff indicates the sustained improvement of care for deteriorating patients and is likely to reduce inconsistencies in patient experience.
- We are pleased to see that progress has been made in relation to the Maternity Critical Care Unit component. We look forward to reviewing this progress after it has been determined whether changes will be adopted.
- Following on from last year's commitments, we are pleased to see that the pilot of patient activated triggers has progressed and would like to offer our support on this project moving forwards. As we play a key role in gathering and platforming the views and experiences of patients and service users, we are keen to offer our expertise in capturing patient experiences.

Priority 2: To improve patient experience through effective communication.

- We endorse KCH's priority to improve communication with patients and relatives / carers, especially with regards to wait times, and encourage KCH to recognise health inequalities such as access issues for patients with learning disabilities, in their approach to this priority. We continue to hear that patient's do not feel listened to due to discrimination, language, and communication barriers. As communication with patients, service users and relatives are our core remit, we would like to offer our support with this. For example, by sharing relevant feedback and recommendations we may generate through our health inequalities projects which will be published later this year.

Priority 3: Improving outcomes for patients receiving rehabilitation following a severe head injury or major trauma.

- We look forward to seeing the feedback obtained from the questionnaire that was disseminated in March 2023, asking for patient feedback on how to improve healthcare services. We are particularly keen to see how this data will inform KCH's strategy moving forwards.

Priority 4: Supporting Positive Behaviour to Increase Staff and Patient Safety

- We are pleased to see this development to KCH's 2021/22 Priority to reduce violence and aggression to staff and increase patient safety.
- As the Report notes that incidents of violence and aggression towards staff are underreported, we would like to know how impact will be measured.

New Priorities for 2023/24

Priority 1: To improve the identification and management of patients with sepsis.

- We support the inclusion of health inequalities contributions in this priority project. We continue to hear feedback that patients don't always feel listened to because of discrimination, for example because of their ethnicity.
- We are interested to see the results of the Trust's aims to understand and mitigate health disparities.

Priority 2: To improve patient experience through effective communication.

- We support King's prioritisation of improving communications with patients as this issue was flagged by some of our service users.
- We are pleased to see that the initiatives deployed in 2022/3 were successful.
- We support the Trust's aim to utilise community partnerships to co-design solutions to improve communications and are keen to collaborate on this by sharing feedback we receive.

Priority 3: Improving outcomes for patients receiving rehabilitation following a severe head injury or major trauma.

- We are pleased to see that the Trust's work on this priority will be led by patient feedback, and we look forward to the first results in December 2023.

We would like to highlight the hard work and dedication of all staff at KCH in supporting the Trust to deliver a strong service in our borough. We hope to sustain and develop our close relationship with King's as we jointly plan to improve service users experience of health and care and share learning.

Overview and Scrutiny Committees:

Bromley, Lambeth and Southwark Overview and Scrutiny Committees Statement King's College Hospital NHS Foundation Trust Quality Account for 2022-23 and Quality Account Priorities for 2023-24.

Bromley, Lambeth and Southwark Overview and Scrutiny Committees Southwark response to King's Quality Account 2022-23 and priorities for 2023/24

Lambeth Scrutiny Members welcomed the opportunity to respond and received the document in good time. Members have noted the draft quality accounts and have highlighted the priority areas that have not been achieved or have only been partially achieved which should continue to be monitored closely.

Statements from Bromley and Southwark Overview and Scrutiny Committees not received at the time of finalising the Quality Account.

Council of Governors feedback:

Council of Governors response to King's Quality Account 2022-23 and priorities for 2023/24

The Council of Governors were on 30 May 2023 given the King's Quality Assurance Framework document for 2023-24. This empowering document along with this Quality Account will provide the Council of Governors an ongoing progress monitoring tool to challenge progress by the board on the priorities in the coming year. The Council of Governors ongoing questions and comments by various committees (and full governors) throughout 2023- 2024 will help validate actions and successes and minimise impact of the points raised on Data Quality.

Use of the Quality Assurance Framework document will also be helpful in reassuring the Council of Governors that the CQC areas of concern are being successfully addressed.

Annex 2

Statement of Directors' Responsibilities for the Quality Report

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

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

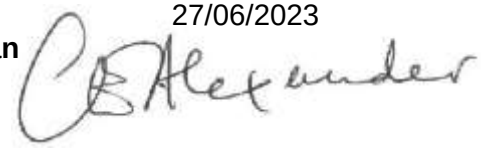
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2021-22 and supporting guidance, detailed requirements for quality reports 2018-19.
- the content of the Quality Report is consistent with internal and external sources of information including:
  - board minutes and papers for the period April 2022 to March 2023
  - papers relating to quality reported to the board over the period April 2022 to March 2023
  - feedback from commissioners dated 16/06/2023
  - feedback from governors dated 30/05/2023
  - feedback from Bromley (15/06/2023), Lambeth (20/06/2023) and Southwark (15/06/2023) Healthwatch organisations
  - feedback from Lambeth Overview and Scrutiny Committee, 16/06/2023
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30/06/2023
  - the national patient survey February 2023
  - the national staff survey March 2023
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated 15/06/2023
  - CQC inspection reports on Well-led (Feb 2023), Children and Young People DH (Feb 2023), Medical Care including Older People's Care DH (Feb 2023), Maternal Service at DH and PRUH & SS (Dec 2023) and Medical Care including Older People's Care Orpington (Sep 2022)
- 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, and is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

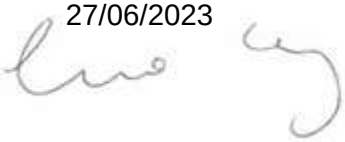
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Date 27/06/2023
Chairman



Date 27/06/2023
Chief Executive



Annex 3

Independent Auditor's Report to the Council of Governors

NHS providers are not expected to obtain assurance from their external auditor on their quality account / quality report for 2022-23.

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Quality Account 2022-23

Published June 2023