Open Agenda

Healthy Communities Scrutiny Sub-Committee

Tuesday 11 April 2017
7.00 pm
Ground Floor Meeting Room G01A - 160 Tooley Street, London SE1 2QH

Membership

Councillor Rebecca Lury (Chair)
Councillor David Noakes (Vice-Chair)
Councillor Anne Kirby
Councillor Sunny Lambe
Councillor Maria Linforth-Hall
Councillor Martin Seaton
Councillor Bill Williams

Reserves

Councillor Jasmine Ali
Councillor Gavin Edwards
Councillor Tom Flynn
Councillor Eliza Mann
Councillor Leo Pollak

INFORMATION FOR MEMBERS OF THE PUBLIC

Access to information You have the right to request to inspect copies of minutes and reports on this agenda as well as the background documents used in the preparation of these reports.

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Contact Julie Timbrell on 020 7525 0514 or email: julie.timbrell@southwark.gov.uk

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Members of the committee are summoned to attend this meeting
Eleanor Kelly
Chief Executive
Date: 3 April 2017

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Healthy Communities Scrutiny Sub-Committee

Tuesday 11 April 2017
7.00 pm
Ground Floor Meeting Room G01A - 160 Tooley Street, London SE1 2QH

Order of Business

Item No.	Title	Page No.

PART A - OPEN BUSINESS

1. APOLOGIES

1. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

In special circumstances, an item of business may be added to an agenda within five clear working days of the meeting.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

Members to declare any interests and dispensations in respect of any item of business to be considered at this meeting.

4. MINUTES

To approve as a correct record the Minutes of the meeting held on 28 March 2017 – minutes to follow.

5. INTERVIEW WITH THE LEADER OF THE COUNCIL ON THE HEALTH & WELLBEING BOARD

Interview with the Leader of the Council, Cllr Peter John , on the Health & Wellbeing Board, which he chairs.

6. SOCIAL CARE REVIEW - UPDATE

Reports to follow

Item No.	Title	Page No.
7.	**HOSPITAL QUALITY ACCOUNTS**	1 - 72

King's College Hospital NHS Foundation Trust (KCH) draft Quality Account is enclosed, with a cover report.

8. SCRUTINY REVIEW: SOUTHWARK GP PRACTICES - QUALITY OF PROVISION & LOCAL SUPPORT ARRANGEMENTS

DISCUSSION OF ANY OTHER OPEN ITEMS AS NOTIFIED AT THE START OF THE MEETING.

PART B - CLOSED BUSINESS

DISCUSSION OF ANY CLOSED ITEMS AS NOTIFIED AT THE START OF THE MEETING AND ACCEPTED BY THE CHAIR AS URGENT.

Date: 3 April 2017

EXCLUSION OF PRESS AND PUBLIC

The following motion should be moved, seconded and approved if the sub-committee wishes to exclude the press and public to deal with reports revealing exempt information:

"That the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in paragraphs 1-7, Access to Information Procedure rules of the Constitution."

DRAFT QUALITY REPORT 2016/17

Enc. 3.1

Subject:	**Draft Quality Report & Accounts 2016/17**
	For the attention of: **Health overview and scrutiny committees – Lambeth, Southwark and Bromley** **For comment by 13th April 2017**

Introduction

Each year the Trust is required to complete a quality report which details its performance against its chosen quality priorities and its performance against other quality metrics and indicators.

Statutory guidance requires that the Trust publishes the quality report as a standalone document and incorporate it in the Trust's Annual Report & Accounts (ARA) which is submitted to NHS Improvements at the end of May. The Quality Report is published on the Trust's website and NHS Choices after it has been laid before Parliament.

The guidance on the production of the quality report is very prescriptive, detailing what should be included and in some cases providing the form of words.

When the quality report is published within the ARA it will cross reference relevant sections which will support the Trust's quality agenda.

In its current form, the document is still in the draft stage with final proof reading, and latest data and other key information to be included. The draft is being sent to local stakeholders, including local Healthwatch and health overview and scrutiny committees as well as to King's governors for initial comments at this stage.

In the interim, more work will be done to ensure the document is correct and the updated information included. Once comments from commissioners, governors and local stakeholders have been garnered, the document will be reviewed by the communications team then sent to the Board for final approval.

Draft Document key

1. Red text – updated to be reviewed and finalised in final draft
2. Red text/yellow highlight – old information to be updated
3. Blue text – standard required form of words cannot be revised
4. Blue text/yellow highlight – required working additional information to be included

Quality Report

Nursing – early developments

In common with most hospitals nursi
few years of KCH were almost non-ex
and Bowman, with the help of the Bis
the Church of England Nursing Siste
John's House, led by the superintend
took over the nursing at KCH and fou
school in England. Katherine Henriett
as Sister Matron in 1885 and retired i
active member of the KCH building co
design the 3rd KCH which would be b
Hill. Her influence was enormous and
reredos in the St. Luke chapel was de
in 1917. This work of art was designe
William Powell, a firm of stained glass

Katherine Monk. First Matron of KCH

The mosaic rere hospital chapel

King's College Hospital NHS Foundation Trust
Quality Report & Accounts 2015/16

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

CONTENTS

GLOSSARY

ACRONYM/WORD	MEANING – To be updated
A&E	Accident & Emergency
ACC	Accredited Clinical Coder
AHP	Allied Health Professionals i.e. Physiotherapists, Occupational Therapists, Speech & Language Therapists etc.
AHSC	Academic Health Science Centre
ANS	Association of Neurophysiological Scientists Standards
BCIS	Bone Cement Implantation Syndrome
BHRS	British Heart Rhythm Society
BME	Black and Minority Ethnic
BREEAM	Building Research Establishment Environmental Assessment Method
BSCN	British Society for Clinical Neurophysiology
BSI	The British Standards Institution
BSS	Breathlessness Support Service
CCG	Clinical Commissioning Groups (previously Primary Care Trusts)
CCS	Crown Commercial Service
CCTD	Critical Care and Trauma Department
CCUTB	Critical Care Unit over Theatre Block
C-difficile	Colistridium Difficile
CDU	Clinical Decisions Unit
CEM	Royal College of Emergency Medicine
CHD	Congenital Heart Disease
CHR – UK	Child Health Clinical Outcome Review Programme (UK)
CLAHRC	Collaboration for Leadership in Applied Research and Care
CLINIWEB	The Trust's internal web-based information resource for sharing clinical guidelines and statements.
CLL	Chronic Lymphocytic Leukemia
CLRN	Comprehensive Local Research Network
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
COPD	Chronic Obstructive Pulmonary Disease
COSD	Cancer Outcomes and Services Dataset
COSHH	Control of Substances Hazardous to Health
CPPD	Continuing Professional and Personal Development
CQC	Care Quality Commission
CQRG	Clinical Quality Review Group (organised by local commissioners)
CQUIN	Commissioning for Quality and Innovation
CRF	Clinical Research Facility
CRISP	Community for Research Involvement and Support for People with Parkinson's
CT	Computerised Tomography

DAHNO	National Head & Neck Cancer Audit
DH/KCH DH	Denmark Hill. The Trust acute hospital based at Denmark Hill
DNAR	Do Not Attempt Cardiopulmonary Resuscitation
DoH	Department of Health
DTOC	Delayed Transfer of Care
ED	Emergency Department
EDS	Equality Delivery System
EMS	Environmental Management System
EPC	Energy Performance Contract
EPMA	Electron Probe Micro-Analysis
EPR	Electronic Patient Record
ERR	Enhanced Rapid Response
ESCO	Energy Service Company
EUROPAR	European Network for Parkinson's Disease Research Organization
EWS	Early Warning Score
FFT	Staff Friends & Family Test
FY	Financial Year
GCS	Glasgow Coma Scale
GP	General Practitioner
GSTS Pathology	Venture between King's, Guy's and St Thomas' and Serco plc
GSTT	Guy's St Thomas' NHS Foundation Trust
H&S	Health & Safety
HASU	Hyper Acute Stroke Unit
HAT	Hospital Acquired Thrombosis
HAU	Health and Aging Units
HCAI	Healthcare Acquired Infections
HCAs	Health Care Assistants
HESL	Health Education South London
HF	Heart Failure
HIV	Human Immunodeficiency Virus
HNA	Holistic Needs Assessment
HQIP	Healthcare Quality Improvement Partnership
HRWD	'How are we doing?' King's Patient/User Survey
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HTA	Human Tissue Authority
IAPT	Improving Access to Psychological Therapies
IBD	Inflammatory Bowel Disease
ICAEW	Institute of Chartered Accountants in England and Wales Code of Ethics
ICNARC	Intensive Care National Audit & Research Centre
ICO	Information Commissioner's Office
ICT	Information and Communications Technology
ICU	Intensive Care Unit
IG Toolkit	Information Governance Toolkit

IGSG	Information Governance Steering Group
IGT	Information Governance Toolkit
IHDT	Integrated Hospital Discharge Team
iMOBILE	Specialist critical care outreach team
IPC	Integrated Personal Commissioning
ISO	International Organization for Standardization
ISS	Injury Severity Score
JCC	Joint Consultation Committee
KAD	King's Appraisal & Development System
KCH, KING's, TRUST	King's College Hospital NHS Foundation Trust
KCL	King's College London – King's University Partner
KHP	King's Health Partners
KHP Online	King's Health Partners Online
KPIs	Key Performance Indicators
KPMG LLP	King's Internal Auditor
KPP	King's Performance and Potential
KWIKI	The Trust's internal web-based information resource. Used for sharing trust-wide polices, guidance and information. Accessible by all staff and authorised users.
LCA	London Cancer Alliance
LCN	Local Care Networks
LIPs	Local Incentive Premiums
LITU	Liver Intensive Therapy Unit
LUCR	Local Unified Care Record
MACCE	Major Adverse Cardiac and Cerebrovascular Event
MBRRACE-UK	Maternal, Newborn and Infant Clinical Outcome Review Programme
MDMs	Multidisciplinary Meeting
MDS	Myelodysplastic Syndromes
MDTs	Multidisciplinary Team
MEOWS	Modified Early Obstetric Warning Score
MHRA	Medicine Health Regulatory Authority
MINAP	The Myocardial Ischaemia National Audit Project
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant staphylococcus aureus
MTC	Major Trauma Services
NAC	N-acetylcysteine
NADIA	National Diabetes Inpatient Audit
NAOGC	National Audit of Oesophageal & Gastric Cancers
NASH	National Audit of Seizure Management
NBOCAP	National Bowel Cancer Audit Programme
NCEPOD	National Confidential Enquiry into Patient Outcome & Death Studies
NCISH	National Confidential Inquiry into Suicide & Homicide for People with Mental Illness
NCPES	National Cancer Patient Experience Survey
NDA	National Diabetes Audit

NEDs	Non-Executive Directors
NEST	National Employment Savings Trust
NEWS	National Early Warning System
NHFD	National Hip Fracture Database
NHS	National Health Service
NHS Safety Thermometer	A NHS local system for measuring, monitoring, & analysing patient harms and 'harm-free' care
NHSBT	NHS Blood and Transplant
NICE	National Institute for Health & Excellence
NICU	Neonatal Intensive Care Unit
NIHR	National Institute for Health Research
NJR	National Joint Registry
NNAP	National Neonatal Audit Programme
NPDA	National Paediatric Diabetes Audit
NPID	Pregnancy Care in Women with Diabetes
NPSA	National Patient Safety Agency
NRAD	National Review of Asthma Deaths
NRLS	National Reporting and Learning Service
NSCLC	Non-Small Lung Cancer
OH/ORPINGTON HOSPITAL	The Trust acquired services at this hospital site on 01 October 2013
OSC	King's Organizational Safety Committee
PALS	Patient Advocacy & Liaison Service
PbR	Payment by Results
PICANet	Paediatric Intensive Care Audit Network
PiMS	Patient Administration System
PLACE	Patient Led Assessments of the Care Environment
POMH	Prescribing Observatory for Mental Health
POTTS	Physiological Observation Track & Trigger System
PROMS	Patient Reported Outcome Measures
PRUH/KCH PRUH	Princess Royal University Hospital. The Trust acquired this acute hospital site on 01 October 2013
PUCAI	Pediatric Ulcerative Colitis Activity Index
PwC	PricewaterhouseCoopers
QMH	Queen Mary's Hospital
RCPCH	Royal College of Paediatric and Child Health
RIDDOR	Reporting of Injuries, Dangerous Diseases and Dangerous Occurrences Regulations
ROP	Retinopathy of Prematurity
RRT	Renal Replacement Therapy
RTT	Referral to Treatment
SBAR	Situation, Background, Assessment & Recognition factors for prompt & effective communication amongst staff
SCG	Specialist Commissioning Group (NHS England)
SEL	South East London

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

Chief Executive's statement of quality

King's has always put quality and safety at the forefront of everything that we do and this year our efforts have been focused on cementing our quality paradigm 'Best Quality of care. Our values are deeply embedded in our culture and form the foundation of our key strategies and exciting plans for King's as we enter another challenging but opportunity laden year. We are actively engaging staff, to find out, not only about what they think about working at King's but their opinion on the changes that need to be made to ensure King's remains a positive figurehead of healthcare delivery in the NHS in the face of increased operational and financial pressures. We do not underestimate the ongoing pressure on our staff and have a renewed focus this year on comprehensive staff engagement following analysis of this tears staff survey. In March 2017 we launched the staff health and well being initiatives and we will launch a new inclusivity initiative this year. We are implementing an ambitious and innovative transformation programme. The organisational restructure was launched in January 2016 and this will ensure that the most effective and innovative leaders will be driving transformation in the organisation whilst ensuring that quality and safety of patients / families and staff remain the highest priority.

Quality Priorities

Our stakeholder engagement around the setting of quality priorities this year has been carried out across two patient catchment areas; we have had discussions with key stakeholders representing Bromley in addition to Lambeth and Southwark

In 2015/16 we chose 7 challenging quality priorities. Outstanding progress has been achieved in all seven areas and to ensure we continue to embed the improvements two priorities are being continued this year. A major new focus this year and over the next 3 is improved focus on mind and body health and we are planning an ambitious programme to improve our patient /family and staff wellbeing. We have made good progress in some areas of improving the experience of cancer patients but more work needs to be done and is part of a longer term plan.

Our quality priorities for 2016/17, as devised and agreed with local stakeholder groups include:

1. Enhanced recovery after surgery (ERAS)
2. Improved outcomes after emergency abdominal surgery
3. Improving the care of children and adults with mental, as well as physical, health needs at KCH
4. Improving outpatient experience for children and adults
5. Improving the experience of patients with cancer and their families
6. Aim to improve implementation of sepsis bundles for patients with positive blood cultures and diagnosis of sepsis as defined by EPR order set.
7. Surgical Safety: Aim to improve the quality of the surgical safety checks by 10% year-on-year, as measured by the annual surgical safety checklist.

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

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

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

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

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

In 2014/15 we recognised limitations around our data sets around referral to treatment targets and diagnostic waits. The Trust was granted a reporting holiday and is now reporting again whilst work is ongoing to deliver a new data set.
Our governors also chose xxxxxx
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. Following these steps, to my knowledge, the information in the document is accurate.

Structure of this report

The following report summarises our performance and improvements against the quality priorities and objectives we set ourselves for 2015-2016. It also outlines those we have agreed for the coming year.

We have outlined our quality priorities and objectives for 2017-2018 and detailed how we decided upon the priorities and objectives and how we will achieve and measure our performance against them. The regulated Statements of Assurance are included in this part of the report.

We have also provided other information to review our overall quality performance against key national priorities and national key standards. This includes the 2016/17 requirement to report against a core set of indicators relevant to the services we provide; using a standardised statement set out in the NHS (Quality Accounts) Amendment Regulations 2013. We have also published the Statements from Clinical Commissioning Groups, NHS England, Health Overview and Scrutiny Committees, and Healthwatch that outline their response to this Quality Account.

Having had due regard for the contents of this statement to the best of my knowledge, the information contained in the following Quality Account is accurate.

Signed:

Nick Moberly
Chief Executive

Date:

Part 2: Priorities for improvement and assurance statements

Selecting our improvement priorities

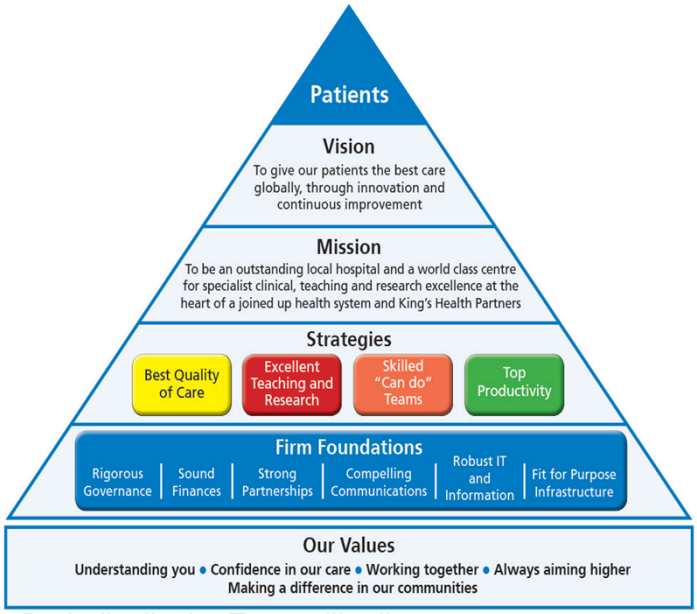
The Trust had a Care Quality Commission re -inspection in October 2016 – currently we have not received the results of this inspection. The inspectors were able to see much progress since the inspection in 2015.
The Trust is aware that there is a lot more to do to improve and we are committed to achieving a good or outstanding rating in the future.

During the period we have started to implement the strategic tool below which enshrines our commitment to patients, which sits at the peak of the triangle, and solidify our vision '*to give our patient the best care globally through innovation and continuous improvement'*.

With this tool we are driving our patient focus strategy, informing our decision making processes and influencing our performance
Embedded in the fabric of the Trust's culture is the ethos of providing the best quality of care to patients always. We are a busy acute hospital which is always making improvements to its services and practices.

In addition to our regular programme of improvement works, we have chosen seven priorities within the patient outcomes, patient experience and patient safety domains to give additional focus this year.

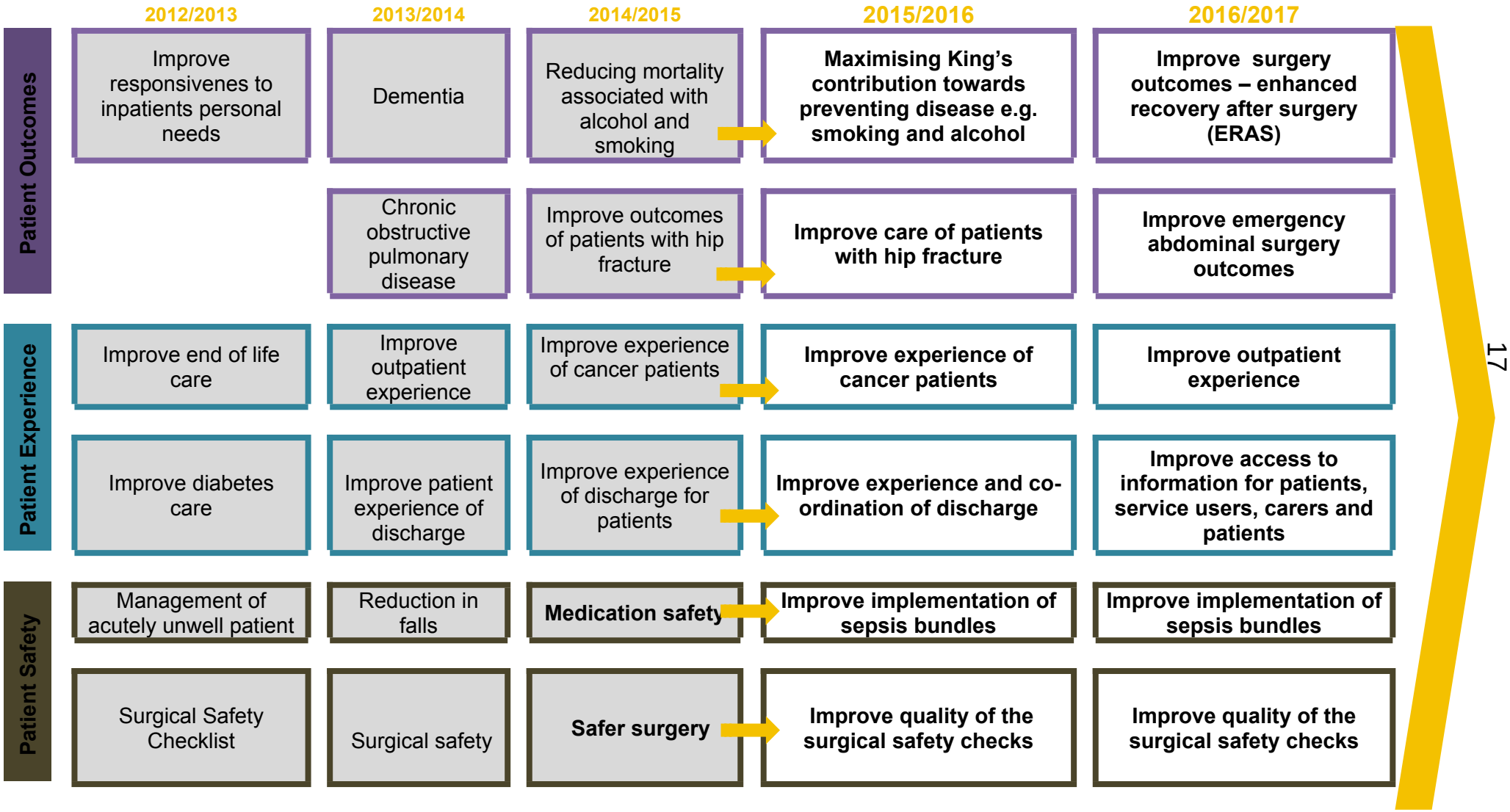
Our holistic process for choosing these quality improvement priorities includes consultation with local commissioners, health watch, staff, governors, senior executives and the Board of Directors.



1: King's Strategy Triangle

Periodically the Trust will roll over some priorities to give more focus to drive more improvements. The table overleaf details our past and present priorities.

Past and Present – Our Quality Improvement Priorities Need to update 2017/18 once confirmed



Performance against 2015/16 Quality Priorities

PRIORITY 1. Enhanced Recovery After Surgery

Enhanced recovery after surgery (ERAS) is a programme that aims to improve recovery after major planned surgery by ensuring that patients:

- Are as healthy as possible before their surgery.
- Receive the best possible care during their operation.
- Receive the best possible care while recovering.

An ERAS programme is based on research findings on the specific steps proven to have the greatest impact on patient outcomes.

We said we would:

- Take actions to ensure that all the relevant steps in the pathways are undertaken at KCH hospitals
- Review the discharge information provided to patients.
- Initially work to build on actions already taken in colorectal, orthopaedic and hepatobiliary surgery.
- Include all KCH hospital sites, at Denmark Hill and in Bromley.

We were successful in:

- Reviewing current ERAS programmes at all KCH hospital sites, Denmark Hill and in Bromley, and building on actions already taken.
- Integrating work with our Transformation Programme, and in particular establishing ERAS as a core component of the pre-assessment Transformation Programme.
- Initiating a pilot ERAS programme in surgery of the liver, gallbladder, bile duct and pancreas – known as 'hepatobiliary (HpB) surgery.' This included detailed information for patients. Results from the first 10 patients showed a reduced median length of stay, from 8 (6 to 12.5) to 6 (4.5 to 10.5), and no readmissions within 30 days of surgery.
- Completing learning visits to two other Trusts (Guildford, University College London).
- Taking steps to enter hepatobiliary surgery and colorectal ERAS cases into the national Perioperative Quality Improvement Programme (PQIP) being run by the Royal College of Anaesthetists. This will support the measurement and national comparison of complications, mortality and patient-reported outcomes.

PQIP
Perioperative Quality Improvement Programme

Ongoing activities:

We are continuing to develop our ERAS work and our contribution to PQIP, particularly for hepatobiliary surgery. For this reason, we intend to focus specifically on the development of enhanced recovery after hepatobiliary surgery as a quality priority for 2017-18.

PRIORITY 2. Emergency abdominal surgery

Our aim was to improve outcomes following emergency abdominal surgery by ensuring a well-coordinated, standardised care pathway is in place at Denmark Hill and PRUH.

We said we would:

- Improve data entry to the National Emergency Laparotomy [abdominal surgery] Audit project and take local action to improve against the key audit criteria.

We were successful in:

- Increasing our data quality and case ascertainment of appropriate cases on the NELA database.
- Increasing our specialist consultants in elderly medicine care at PRUH and Denmark Hill.
- Ensuring that CT scans are undertaken and reported by a consultant for appropriate patients.
- Improving Emergency theatre pathways to reduce the interval from decision to operate to arrival in theatre.

The result of these and many other improvement actions can be measured against the key quality criteria measured within the National Emergency Laparotomy Audit (NELA). Improvements were seen at both Denmark Hill and PRUH hospital sites, including:

- Consultant surgeon review within 12 hours of admission.
- CT scan reported before surgery by a Consultant Radiologist.
- Documentation of risk preoperatively.
- Preoperative review by consultant surgeon and consultant anaesthetists.
- Consultant surgeon present in theatre.
- Improvement in high risk patients admitted directly to critical care post-operatively.
- Postoperative assessment by care of the elderly specialist in patients aged over 70.

NELA
National Emergency Laparotomy Audit

Ongoing activities:
Work continues to ensure that these improvements are maintained and that our care improves even further. For this reason, we intend to continue to identify emergency laparotomy as a Trust quality priority for 2017-18.

[Claire Palmer has 2 x graphs that can be sent separately on request if wanted]

Priority 3:
Accessible information

Our aim was to improve access to information for patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

We said we would:

- Put systems in place to ensure that invite letters for appointments and admission provide opportunity for patients and carers to highlight any adjustments that need to be made for their visits.
- Put systems in place to ensure that inpatients assessment includes identification of any impairment or sensory loss and subsequent actions and adjustments.
- Develop, pilot and implement feedback tools for patients with communication difficulties / learning disability.
- Training and support King's Foundation Trust Members / Volunteers to support gathering of feedback in targeted areas of need
- Ensure admission, pre assessment and discharge information is appropriate.

Measures of success:

- Associated audits demonstrate good rates of responsiveness, action and patient feedback.

We were successful in:

- Patient letters have standardised wording advising patients who to contact should they need support to access information about the hospital
- District Nursing Referrals and Assessment Notices and referrals to Social Services on EPR include an option to identify the patient as having a hearing or visual impairment
- Funding has been secured to purchase a range of resources to support people with communication difficulties such as white boards to write on for patients who have difficulty with verbal communication
- Developing a draft easy read How are we doing patient satisfaction survey for people with learning disabilities. This was developed in collaboration with the Experience team, Clinical Nurse Specialist for Learning Disability and Speech and Language Therapists. The draft is now ready for testing with local LD groups including Southwark Speaking Up and Lambeth LD Assembly
- Training is being developed for King's volunteers about how to support patients with a learning disability or communication difficulties both in a traditional befriending role and to gather patient feedback
- Draft survey developed to assess patients' communication needs

Work is ongoing:

- Test draft easy read survey and communication assessment and implement
- Develop a range of accessible way to gather feedback from patients with particular needs such as patients with aphasia or other communication difficulties
- Complete training of cohort of volunteers to support patients

Priority 4: Improving outpatient experience

Our aim was to improve one key metric where our performance is particularly disappointing – communication in clinic about delays

We said we would:

- Identify specific divisions and specialties where the most improvement is required for the question "If you had to wait for your appointment, were you told how long you would have to wait?".
- Roll-out the Trust's 'Experience' patient feedback reporting system within target areas to provide staff with timely and accessible patient feedback.
- Increase survey response rates in our focus areas to ensure that improvement plans are based on robust data.
- Improve information and communication about waiting.

Measures of success

- Based on the 'how are we doing?' survey and Friends and Family Test data, identify clinics in two of our clinical divisions at both the PRUH and Denmark Hill which are most in need of improvement.
- Identify areas where performance is good as a means to share good practice and learning.
- Gather a better understanding of what makes for poor experience and, importantly, how patients think we can improve by conducting interviews with patients and relatives.
- Establish baseline data and agree improvement targets.
- Key staff will have access to and training on 'Experience' system
- Regular discussion of patient feedback at clinical and operational team meetings.
- 'You Said We Did' posters to be displayed in clinic areas.
- Develop plan to increase survey responses.
- Implement a range of accessible options for patients to provide feedback about their experience, e.g. the use of electronic surveys and SMS and supported completion with the help of King's volunteers.
- Develop action plan for improvement.
- Implement agreed improvement interventions.
- Increase scores for "If you had to wait for your appointment, were you told how long you would have to wait?".
- Decrease in the number of negative comments relating to information on waiting.

We were successful in:

- Identifying key areas for improvement - focussing work with Ophthalmology Clinics at both the Denmark Hill and Princess Royal sites
- Patient story at Board of Directors describing outpatient experience
- Held four patient discussion groups, two at Denmark Hill and two at the Princess Royal to gain a better understanding of patient experience of all aspects of communicating with outpatients including communicating with patients about delay in clinic and, more generally, to understand what a 'top class' outpatient service would be like for our patients. Staff from Ophthalmology took part in these discussions

- The results of these discussions were shared with the King's Way Transformation Team which launched a large scale project to transform outpatients and outpatient experience in January 2017
- Trained Members and Governors to gather patient experience in both DH and PRUH clinics to increase the amount of feedback
- Provided access and training for staff on the trust 'Experience' reporting system
- Developed a draft patient information leaflet to describe what the patient journey in an ophthalmology clinic to help patients to understand the process, what tests they might have

Work is ongoing:

- Linking with the outpatient transformation programme to develop a range of actions for improve how we communicate with our patients and to learn from high performing areas
- Further work to increase response rates including scoping of text or interactive voice messaging for patients after discharge to ask for their feedback, increasing supported completion of surveys using tablets
- Survey scores continue to be below target although there was some improvement during the last four months of the year
- Launch range of information materials in clinic

Priority 5: Sepsis

We said we would:

- Undertake an audit of all positive blood cultures in early 2016-17 and review adherence to sepsis bundles in order to achieve baseline data.

- Patients with positive blood cultures to be reviewed at least once per day (7 days per week) by a consultant with a clear management plan and microbiology input into drug treatment and duration.

- Develop an EPR order set for sepsis (culture set) this will then allow assessment of this identified cohort against sepsis bundles, consultant and microbiology review

We were successful in:

- A retrospective case note review was undertaken to review the quality of care provided to the diagnostic group of patients with ‘septicaemia (except in labour), shock’ and a clinical audit of all patients with positive blood cultures was undertaken. The data was combined for an overall baseline analysis to assess improvements and deviations going forward.

- The clinical audit of patients with positive blood cultures also examined whether or not patients who were unwell had daily Consultant review. In 82 % of cases, there was clear documentation regarding this.

- In the remaining cases where a Consultant review was not clear, weekends were not over-represented (17 %) demonstrating that such reviews were available across the seven day week periods rather than being restricted to weekdays

- All patients with significant positive blood cultures had their management plan discussed with a Microbiology Consultant in regard of appropriate antibiotic prescribing, anti-microbial

stewardship and relevant likely resistance patterns.

- The trust developed both EPR (Electronic Patient Record) and Symphony (ED electronic system) based toolkits to support the roll out of the sepsis quality initiatives. This has a number of functionalities of benefit in managing patient's with sepsis:

The EPR toolkit incorporates a *Sepsis screening tool*- This allows patients meeting local criteria to be screened for sepsis. It supports the assessment of such patients with integrated work-flow prompts and gathers diagnostic level information which will eventually link with coding data. It is further used to operationalize the review of patients by the critical care outreach *(iMobile)* service by generating daily patient lists, for the *iMobile* service to utilise, of those who have been diagnosed with sepsis over the last 72 hours in the screening programme. Monthly data is linked to hospital outcomes such as critical care admission, hospital outcome, palliative care coding and LoS data to allow a picture of the hospital's sepsis patients to be built in real-time from prospective data and this should enable us to provide a better standard of care for patients with sepsis and septic shock.

The EPR tool kit incorporates: *A sepsis 6 bundle tool.* This allows the tracking of sepsis 6 bundle compliance in patients identified through screening as having high risk/red flag sepsis, severe sepsis, or septic shock – what we have termed 'bad' sepsis.

The Symphony toolkit incorporates a Triage tool to capture screening data on patients coming through ED

The Symphony tool kit incorporates an Outcome Tool which captures the sepsis 6 bundle compliance and time to antibiotics data in ED.

- We have improved the percentage of patients screened for sepsis to significantly above the improvement target set by NHSE in regard of our nCQUIN commitments

We are also working on:

- Iterative evolution of EPR and symphony toolkits to enable efficient data collation

- Iterative evolution of EPR and symphony toolkits to incorporate paediatrics which is currently paper based

- Extension of electronic toolkits to the Princess Royal University Hospital when the EPR system is in situ

INSERT IMAGE/QUOTE

Priority 6: Safer Surgery

We said we would:

- Develop and implement a strategy to ensure the surgical safety checklist (SSC) is integrated into the working practices of all theatre and/or interventional teams.

  Improvement was to be assessed against the following objectives:
  - Zero Surgical Never Events.
  - 100% compliance with completion of safer surgical checklist.
  - >75% compliance with quality of checks performed.
  - 20% improvement in Surgical Safety Culture rating.

We were successful in:

- In 2016/17, 9 surgical Never Events were reported and further work is being carried out to reduce these. Work focused in particular on reducing incidents relating to retained foreign bodies using seldinger technique and wrong implants in ophthalmology for which there have now been robust processes designed across the whole organisation.
- Improving the quality of the surgical safety checks remained similar to 2015/16 figures in 2016/2017 (as measured by the annual observational audit). As one of the Trust's Sign-Up to Safety priorities the Trust has committed to improving the quality of checks by 10% year-on-year
- Making electronic routine checklist completion data (broken down by speciality, theatre and surgeon) This shows 100% compliance consistently in a number of areas and enables remedial action where this is not achieved to be focussed on high risk areas. As this is new we are working on devising a process on doing this.
- The observational audit was also able to provide more detailed qualitative audit tool highlighting specific aspects that are working well and where improvements can be focused.

We are also working on:

- Continuing developing local surgical safety interventional procedure standards (LOCSSIPs) in accordance with published national standards for all specialties that undertake invasive procedures.
- Surgical Safety as our Sign up to Safety Pledge
- A review of junior doctor competency sign-off to ensure that adequate training and support is available to junior staff undertaking invasive procedures using seldinger technique

2017/18 Improvement Quality Priorities

2017/18 Improvement priority 1

Enhanced recovery after surgery (ERAS) in surgery of the liver, gallbladder, bile duct and pancreas ('hepatobiliary' (HpB) surgery). Our aim is to improve patient outcomes following HpB surgery by ensuring that care is based on the steps proven, through research, to have the greatest impact on patient outcomes.

We will:

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

Measures of success:

- Reduced length of stay in hospital.
- No increase in emergency readmissions.
- Increased admission on the day-of-surgery.

2017/18 Improvement priority 2

Emergency abdominal surgery. Our aim is to continue to improvement emergency abdominal surgery at Denmark Hill and PRUH.

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

We will:

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

Measures of success:

- Improvement against key National Emergency Laparotomy Audit (NELA) criteria, including:
  - Consultant surgeon review within 12 hours of admission.
  - CT scan reported before surgery by a Consultant Radiologist.
  - Documentation of risk preoperatively.
  - Preoperative review by consultant surgeon and consultant anaesthetists.

- Consultant surgeon and consultant anaesthetist present in theatre.
- Postoperative assessment by care of the elderly specialist in patients aged over 70.
- Reduced length of stay.

2017/18 Improvement priority 3

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

We will:

- Strive to develop truly integrated 'mind and body' services for patients in South East London and Bromley by:
  - Identifying the mental health care needs of KCH patients and tracking both mental and physical health outcomes.
  - Supporting our staff in providing care for mental and physical ill-health, through training and on-going supervision.
  - Improving joint-working with mental health services in the community and primary care to facilitate timely discharge.
  - Developing information technology to support us in understanding the close relationship between mental and physical health and using this information to shape clinical care.
  - Providing self-health resources for our patients.

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

Measures of success:

- The complexity of this project means that it will be a Trust Quality Priority for at least three years. The first year of the project will work to identify the measures of success that can be used as the improvement work is implemented.

2017/18 Improvement priority 4

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

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

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

We are therefore proposing to embark on a 3 year programme of work to transform

our outpatient service so that we can provide an excellent patient experience for all our outpatients.

In the first year of this programme we will:

- listen to and involve patients, their relatives and carers to develop, test and launch a set of Patient Experience Standards for outpatients
- set up an outpatient 'User Reference Group' to ensure that patients and our local community are involved at all stages of outpatient transformation and have a real voice in how services are developed to meet the needs of patients and their families
- Develop and test a suite of improved communication tools, for example: patient appointment letters, appointment reminders, improved telephone contact
- Develop and launch standardised trust-wide appointment booking system
- Scope and pilot a range of alternatives to traditional outpatient appointments such as virtual clinics
- Engage with patients and stakeholders in discussions about design of improved Outpatient estate
- Undertake appropriate stakeholder engagement in any service change and carry out equal impact assessments to consider how options for change impact on our more vulnerable patients and patients from all equality groups
- Agree and set targets for year two in collaboration with 'User Reference Group' and based on evidence gathered through patient feedback

Measures of success:

- Launch of Outpatient Experience Standards
- Recruitment and launch of 'User Reference Group' and 3 x meetings
- Satisfaction audit of patient appointment letters - pre and post implementation
- Audit of telephone responsiveness
- Improved satisfaction with appointment booking, measured by the Outpatient How are we doing survey
- Overall improvement of patient satisfaction in pilot areas measured by the Friends and Family Test and How are we doing outpatient survey
- Audit of satisfaction with virtual clinic model in pilot areas
- Agree improvement targets for year 2

2017/2018 IMPROVEMENT PRIORITY 5

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

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

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

We propose a two year programme

We will:

- use the results of the 2015 and 2016 National Cancer Patient Experience Surveys to identify focussed areas for improvement. Based on 2015 data, these will include:
  - improving information for patients about all aspects of medication and treatment side effects including chemotherapy
  - enhancing opportunities for patients and their families to talk to someone if they are worried or fearful about any aspect of their care
  - ensuring that they have practical and accessible information about access to support such as benefits or financial support
  - further enhancing accessibility to our Clinical Nurse Specialists
- undertake a review of existing data about cancer patient experience including the King's How are we doing surveys, intelligence from cancer support groups, voluntary agencies and other trusts, to help us to better understand the experience of cancer patient and their families and any specific target populations to inform improvement work
- set up patient reference groups - virtual or face to face - for our key cancer services such as breast and haematology, to ensure that patients, their families and carers have a say in shaping improvements and making sure that what we do has maximum impact on patient experience.
- Explore additional support for patients and their families from the King's volunteer service and peer support programmes
- develop a suite of feedback tools to gather first-hand experience of care from our patients and their families to include a bespoke cancer patient How are we doing patient survey as well as regular feedback through patient stories
- build on Macmillan Values training for staff to spread good practice in cancer care
- share good practice between the key cancer specialties at King's to ensure that all patients receive the same level and quality of service
- build on previous work to review and refresh our Holistic Needs Assessments and Health and Wellbeing events
- As part of the Trust's plan to apply to become a Level 3 Paediatric Oncology Shared Care Unit (POSCU) Level 3 scope improvement areas for children and their families
- Set up a working group of the Trust Cancer Committee to scope a co-ordinated, trust wide approach to improving all aspects of cancer care and treatment, including patient experience. A key remit of the working group will be to address specific issues linked to the design of our services which, by their nature, necessitate our cancer patients being treated across a number of specialties including surgery, liver and neurosciences, as well as across different sites

Measures of success:

- improved patient experience in key areas measured by the annual National Cancer Patient Experience Survey
- Improvement in experience measured by internal How are we doing Cancer surveys
- audit levels of patient experience for our different cancer services and

achieve high levels of satisfaction across those services
- Audit staff awareness and skills in relation to cancer care
- Involve patients and their families in agreeing priorities for improvement
- Audit patient satisfaction with HNAs and health and wellbeing events

2017/2018 IMPROVEMENT PRIORITY 6

Sepsis

Aim is to improve implementation of sepsis bundles for patients with positive blood cultures and diagnosis of sepsis as defined by EPR order set.

We will:

- Ensure sepsis screening and treatment bundles are evolved across the Emergency Department and inpatient populations
- Work to align prospective coding datasets for sepsis
- Develop QSOFA to support the identification of high risk patients
- Explore the development of sepsis dashboards

Measures of success:

- Successful screening of patients against those that meet criteria for screening, and treatment bundle adherence, will rise to the upper quartile
- The number of patients appropriately coded with sepsis will rise from the baseline in 2015_16
- Improve SHIMI and/or Shelford group ranking (except in labour) as against the 2015_16 baseline
- Reduce length of stay for patients who are coded with septicaemia (except in labour) as against the 2015_16 baseline.

2017/2018 IMPROVEMENT PRIORITY 7

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

- Further develop processes to use electronic checklist completion data effectively to feedback to teams and for training and improvement purposes as this is largely reviewed at the SSIG currently by Theatre & Surgical Speciality and reviewed at audit mornings
- Facilitate local training in areas where there are requirements for improvement identified identified through audit (including theatre staff, a human factors component & feedback on Never Events etc.)
- 'Team Brief' and 'Debrief' could not be added as a specific time slot on Galaxy which was previously planned. QI project work to further embed this.
- Work with the theatre transformation team (King's Way for Theatres) to improve safety
- Continued audit of implementation of new invasive device insertion sticker and process (two person contemporaneous check) across all areas (including non-ICU areas) where seldinger technique is used to embed practice
- Reinvigorate communication campaign re surgical safety to target MDT staff and increase secret shopper audits. Focus on qualitative feedback of exemplar practice and areas requiring improvement.
- Continue with the roll-out of NatSSIPs and developing LocSSIPs in areas

where interventional procedures are performed and further develop recognition of risk in non-main theatre areas

Measures of success:

- Audit of overall quality checks needs to be increased to 92% form 62% by March 2019. Several associated performance indicators will also be measured: Audit of seldinger technique device insertion checklists. A baseline audit will be undertaken in early 2016-17 and a 50% improvement against baseline expected by March 2019

- Audit of junior doctor competency documents (to include competency in central line insertion, chest drain insertion, NGT placement confirmation through aspirate and x-ray interpretation).

- Improvement in the overall % of procedures that have sign-in, time-out and sign-out recorded on Galaxy (to at least 95% by March 2019).

INSERT IMAGE/QUOTE

Statements of assurance from the board

Relevant health services
During 2015/16 the Trust provided and/or sub-contracted **[9]** relevant health services

The Trust has reviewed all data avalaible to them on the quality of care in [all] these relevant health services.

The income generated by the relevant health servives reviewed 2015/16 represents **[100]**% of the total income generated fromt heprovision of relevant health services by the Trust for 2015/16.

Clinical Audits and National Confidential Enquiries
During the 2016/17, 50 national clinical audits and 4 national confidential enquires covered relevant health services that the Trust provides.

During that period the Trust participated in 48/49 (98%)% national clinical audits and 4/4 (100)% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2016/17 are listed on pages 142-146.

The national clinical audits and national confidential enquires that the Trust participated (with data collection completed) during 2016/17 can be found on pages 142-146.

The national clinical audits and national confidential enquires that the Trust participated in and for which data collection was completed during 2016/17 are listed on pages 142-146 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The NCEPOD studies the Trust participated in are detailed on page 146.

The reports of 42 national clinical audits were reviewed by the provider in 2016/17 and the Trust intends to take the actions detailed on pages [147-165] to improve the quality of healthcare provided.

The reports of 28 local clinical audits were reviewed by the provider in 2016/17 and The Trust intends to take the actions described on pages [166-168].

Information on participation in clinical research
The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was [13,384 – current figure needs to be updated with end-March data].

Clinical coding error rate
Payment by Results (PbR)

King's was not identified as necessary for a Payment by Results (PbR) clinical coding audit in 2015/16, however for

Trusts that were subjected to PbR audit in 2014/15, the national average coding error rate identified in the Data Assurance Framework was 8.0% for inpatients.

From the above statements, assurance can be offered to the public that the Trust has in 2015/16:

- Performed to essential standards (e.g. meeting CQC registration), as well as excelling beyond these to provide high quality care;
- Measured clinical processes and performance to inform and monitor continuous quality improvement;
- Participated in national cross-cutting project and initiatives for quality improvement e.g. strong and growing recruitment to clinical trials.

Payment by Results (PbR)

The Trust was not identified as necessary for a Payment by Results (PbR) clinical coding audit in 2015/16, however for Trusts that were subjected to PbR audit in 2015/16, the national average coding error rate identified in the Data Assurance Framework was [8]% for inpatients.

The percentage of records in the published data:

- Patient's valid NHS Number:
  - 98% for admitted patient care;
  - 99% for outpatient (non-admitted) patient care; and
  - 92.5% for accident and emergency care.
- Patient's valid General Medical Practice code:
  - 100% for admitted patient care;
  - 99.8% for outpatient (non-admitted) patient care; and
  - 99.8% for accident and emergency care.

Information Governance Assessment

The Trust's Information Governance Assessment Report overall score 2015/16 was [74]% and was graded green (satisfactory)

Commissioning for Quality and Innovation (CQUIN) framework

The Trust income in 2015/16 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the Trust was operating on the default rollover tariff (DTR) and was therefore not entitled to access CQUIN funding.
Therefore, King's has agreed with its Commissioners the implementation of four Local Incentive Premium initiatives for the 2015/16 (£6.4m) in place of local CQUIN schemes and are listed below:

- Local Incentive Premium Scheme 1 - Medicines Optimisation (DH)
- Local Incentive Premium Scheme 2 - Care Planning (DH)
- Local Incentive Premium Scheme 3 – Prevention - Every Contact Counts (DH and PRUH)
- Local Incentive Premium Scheme 4 – Emergency Care (PRUH).

The value of the CQUIN for 14/15 was £17.5m.

Care Quality Commission+

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is requires improvement with no conditions.

The Trust has not participated in any

special reviews or investigations by the CQC during the reporting period.

The CQC inspected all three hospital sites in April 2015. The Trust received a rating of *requires improvement* for the Denmark Hill and PRUH sites. Orrington Hospital received an overall rating of *good*. The trust continues to work on delivering actions against each of the 'must do' and 'should do' actions. These actions are being reviewed through the CQC Steering Group and at executive meetings, with up-dates to the Board of Directors.

Inadequate ratings at core services level at the PRUH related to below.

Patient flow in PRUH urgent and emergency services
The Trust commissioned and delivered an Emergency Pathway Whole System review. We engaged with over 100 stakeholders to understand the root causes of poor performance in Emergency Care across the entire South East health care economy and what needs to be put in place for the end to end emergency care pathway to achieve the desired quality, safety and patient experience.

The resulting PRUH Emergency Care Recovery Plan has been put in place comprising:

- Improvement to patient flow for supported and simple discharge through creation of a supported Transfer of Care Bureau with the mandate and authority to manage the interface between in-hospital and out-of-hospital services.

- Improvement to the management of patient flow through the Emergency Department and enhancement of Emergency Department's controllable processes.

- Improvement of time from referral to be seen by specialists through agreement of new Standard Operating Procedures for timely patient handover and its implementation between Emergency Department and specialty teams.

- Creation and implementation of a sustainable performance management system (in-hospital and between PRUH and out of hospital services)
- Creation of a separate emergency pathway for frail elderly patients and provision of alternative treatment options beyond inpatient care.

All key milestones on the Emergency Department Recovery Plan have been met, but the Trust still continues to face challenges related to activity levels.

Waiting times and patient flow in PRUH outpatient department are being addressed through:

- A review of booking and scheduling of existing capacity to support demand and capacity analysis of key specialties, which was completed.

- **Ongoing review of utilisation of Outpatient Department capacity across the Trust** by Outpatient Steering Group and review of how QUIPP Programme can be utilised to reduce new and follow-up attendances. This will feed into the scoping of the outpatient transformation programme (see below).

- **Scoping of outpatient transformation work stream** currently undertaken to achieve step change in outpatient patient flow. Work to cover all areas from booking to in-clinic processes.

Actions to address key issues underlying the rating of *requires improvement*

Referral to treatment times at Denmark Hill and PRUH:
To enable the Trust to improve its performance against the national referral to treatment targets a programme of work was completed. This Referral to Treatment Recovery Plan included development and implementation of policies, procedures, training and education, standard operating procedures, action cards, standardisation of documentation, launch of RTT systems and reporting, including trust-wide Patient Tracker List, nationally compliant reporting rules and validation timelines. This has provided a clear understanding of the number of patients waiting. Patients are now prioritised and seen as appropriate to reduce the backlog.

Documentation of care, including incomplete records, DNACPR documentation and safer surgery checklist

These actions all include improvement of process, staff skills and knowledge. The implementation of electronic data capture of the use of the surgical checklist at KCH has helped with monitoring local performance. Findings from the electronic data information corroborated the findings from the observational audit in identifying very well performing areas and areas in need of improvement. Training and learning can therefore be more focused when needed.

These actions all include improvement of process, staff skills and knowledge as well as improvement in monitoring and ensuring that processes are being followed. We are also introducing e-DNACPR forms by the end of 2016 at DH and in December 2017 at the PRUH.
CQC also commented on availability of paper records at the PRUH. Availability of paper notes in clinic at PRUH improved to 94% in November 2015.
Work is ongoing with next milestones to be achieved in March 2016 and introduction of EPR at the PRUH towards beginning of 2017.

Environment and Capacity
Denmark Hill's environments for Liver and Renal outpatients, Maternity and Critical Care wards and PRUH's Surgical Admission Lounge were found to require improvement. Where possible, changes to the environment have been, or are currently being made. Alternatively services have been moved to locations that better meet patients' needs.
Regular reviews of capacity are in place for areas with capacity constraints ensuring that patient safety is maintained. Where required practice has been reviewed and changes communicated to staff to ensure that capacity is managed as efficiently as possible. All capacity issues have been resolved within the limitations of the existing estate of DH. We are in the process of building a new Critical Care Unit with a planned completion date of early 2018. A consultation for the move of the surgical admission lounge at the PRUH is currently being undertaken and the move will take place as soon as issues have been resolved.

Improving skills, knowledge and processes to improve patient safety
The trust is embedding a process for review of RTT root cause analysis reports and deciding on potential harm caused, including psychological harm. This further feeds into the incident management process to ensure learning is identified and embedded.

The organisation has appointed a Medical Director for Quality, Patient Safety, Complaints and Patient Experience and revised the job descriptions for the consultant governance leads to ensure robust and consistent approaches to patient safety at the organisation. The governance structure has been reviewed in line with organizational restructure.

The Patient safety team is working collaboratively with the communications team to publicise learning from incidents and are rolling out a campaign in line with this. This will encapsulate work already underway of sharing learning from incidents through vignettes and newsletters. The organisation is also working towards triangulating its quality information between teams such as patient safety, complaints, patient experience and outcomes effectively to help prioritise quality improvements.

The Trust will be taking the following actions to improve data quality:

- Training programmes have been established in 2015/16 to deliver education on waiting list and RTT and the impact of poor data quality on these items.

- Uncashed appointments have been highlighted trust-wide as an area of focus. These have a significant financial impact along with impact on waiting lists, operational planning and finances.

- In conjunction with the RTT training a review was undertaken of outpatient procedures undertaken at Denmark Hill and recording commenced in September 2015.

- GP practice closures have now had a systematic approach applied to them and all patients at these practices are traced to minimise clinical risk.

- A significant amount of work has been invested across BIU to improve the data quality of our SUS and contract monitoring data which has suffered significantly since the acquisition of SLHT services. The work has also uncovered many data quality issues relating to commissioning data – this work has informed the 2016/17 planning round and has enabled a more robust understanding of our data both internally and externally.

- Work has been continuing on aligning all centrally reported data which has allowed many operational reports to be rolled out across all sites, allowing greater transparency across the trust.

Actions planned for 2016/17:

- Continuing the existing trust-wide training programme for all outpatient staff to ensure all outcome fields and referral information is complete to assist with waiting list monitoring, therefore improving quality of care and also to ensure all appointments are charged for.

- The recording of outpatient procedures at Denmark Hill will continue to be monitored and will become a key income stream for 2017/18 – this has historically been an area of very poor data quality for the trust and some services running at a loss due to under-recovery of income.

- Continue progress on aligning all data systems trust-wide to allow for easier operational reporting and minimising duplication of work.

These statements are included in accordance with both Monitor's NHS

Foundation Trust Annual Reporting Manual (December 2013) for the quality report, as well as the Department of Health's Quality Accounts Regulations (2013, 2012, 2011, 2010).

INSERT IMAGE/QUOTE

Statement of assurance evidence

The following list is based on that produced by the Department of Health and Healthcare Quality Improvement Partnership (HQIP).

Audit Title	Reporting period	Participation	Number (%) of cases submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	01/04/16 to 31/03/17	Yes	Awaiting publication
Adult asthma	01/11/16 to 31/01/17	Yes	Awaiting publication
Adult Cardiac Surgery	01/04/16 to 31/03/17	Yes	Awaiting publication
Asthma (paediatric and adult) care in emergency departments	01/08/16 to 31/01/17	Yes	Awaiting publication
Bowel Cancer	01/04/16 to 31/03/17	Yes	Awaiting publication
Cardiac Rhythm Management	01/04/16 to 31/03/17	Yes	Awaiting publication
Case Mix Programme – Intensive Care National Audit & Research Centre (ICNARC) – Medical & Surgical Critical Care Unit	01/04/16 to 31/03/17	Yes	Awaiting publication
Case Mix Programme – Intensive Care National Audit & Research Centre (ICNARC) – Liver Intensive Therapy Unit	01/04/16 to 31/03/17	Yes	Awaiting publication
Child Health Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death	Data collection ongoing to date.	Yes	Awaiting publication
Chronic Kidney Disease in Primary care	n/a - not relevant to acute trusts	n/a	n/a
Congenital Heart Disease	01/04/16 to 31/03/17	Yes	Awaiting publication
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	01/01/16 to 01/12/17	Yes	Awaiting publication
Diabetes (Paediatric) (NPDA)	01/04/16 to 31/03/17	Yes	Awaiting publication
Elective Surgery (National PROMs Programme)	01/04/16 to 31/03/17	Yes	Awaiting publication
Endocrine and Thyroid National Audit	Jul-16 to Jun-17	Yes	Awaiting publication
Falls and Fragility Fractures Audit Programme (FFFAP) – National Hip Fracture Database	10/01/15 to 31/12/15	Yes	DH: 153; PRUH: 361
Falls and Fragility Fractures Audit Programme (FFFAP) – Fracture Liaison Service Database	Jan 2016 to Sep 2016	Yes	Awaiting publication
Falls and Fragility Fractures Audit Programme (FFFAP) – National Audit of Inpatient Falls	12/05/15 to 29/05/15	Yes	DH-30 PRUH - 30
Head and Neck Cancer Audit	n/a - Service not provided at KCH	n/a	n/a

Audit Title	Reporting period	Participation	Number (%) of cases submitted
Inflammatory Bowel Disease (IBD) programme	Adult: 01/03/2016 to 13/01/2017 Paediatrics: 01/03/16 to 13/01/17	Yes	Awaiting publication
Learning Disability Mortality Review Programme (LeDeR Programme)	n/a – pilot phase	Yes	100%
Major Trauma Audit	01/04/2016 to 31/03/2017	Yes	To date (20/2/17) DH 394; PRUH: 51
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Data collection ongoing to date	Yes	Awaiting publication
Medical & Surgical Clinical Outcome Review Programme (NCEPOD)	Various (see below)	Yes	Various (see below)
Mental Health Clinical Outcome Review	n/a - mental health services only	n/a	n/a
National Audit of Dementia	Patients discharged 01/04/2016 to 30/04/2016	Yes	DH-53 PRUH - 62
National Audit of Pulmonary Hypertension	n/a - service not provided at KCH	n/a	n/a
National Cardiac Arrest Audit	01/04/16 to 31/03/17	Yes	Not yet published
National Chronic Obstructive Pulmonary Disease Audit - Secondary care continuous audit	February 2017 to Spring 2017	Yes	Data collection in progress
National Chronic Obstructive Pulmonary Disease Audit – Pulmonary rehabilitation audit	February 2017 to July 2017	Yes	Data collection in progress
National Comparative Audit of Blood Transfusion – Audit of Patient Blood Management in Scheduled Surgery	n/a	No	Participated in previous round of audit. Team priorities for this year were platelet management and the single unit initiative.
National Diabetes Audit (NDA)	26/09/16 to 30/09/16	Yes	Awaiting publication
National Diabetes Foot Care Audit	01/04/16 to 31/03/17	Yes	100%
National Pregnancy in Diabetes Audit	01/04/16 to 31/03/17	Yes	Awaiting publication
National Emergency Laparotomy Audit (NELA)	Jan 16 to Jan 17	Yes	DH: 50% to 69%; PRUH: <50%
Heart Failure Audit	01/04/16 to 31/03/17	Yes	Awaiting publication
National Joint Registry	01/04/16 to 31/03/17	Yes	Awaiting publication
National Lung Cancer Audit	01/01/16 to 31/12/16	Yes	Awaiting publication
National Neurosurgery Audit Programme	01/04/16 to 31/03/17	Yes	Awaiting publication
National Ophthalmology Audit	01/04/16 to 31/03/17	Yes	Awaiting publication

Audit Title	Reporting period	Participation	Number (%) of cases submitted
National Prostate Cancer Audit	01/04/16 to 31/03/17	Yes	Awaiting publication
National Vascular Registry	01/01/16 to 31/12/16	Yes	Awaiting publication
Neonatal Intensive and Special Care (NNAP)	01/01/16 to 31/12/16	Yes	Awaiting publication
Nephrectomy Audit	01/01/14 to 31/12/16	Yes	Awaiting publication
Oesophago-gastric Cancer (NAOGC)	01/04/13 to 31/03/16	Yes	Awaiting publication
Paediatric Intensive Care (PICANet)	01/01/2013 to 31/12/16	Yes	Awaiting publication
Paediatric Pneumonia	01/11/16 to 30/04/17	Yes	Awaiting publication
Percutaneous Nephrolithotomy	01/04/16 to 31/03/17	Yes	Awaiting publication
Prescribing Observatory for Mental Health	n/a - mental health services only	n/a	n/a
Radical Prostatectomy Audit	01/04/16 to 31/03/17	Yes	Awaiting publication
Renal Replacement Therapy (Renal Registry)	February 2017 – no end date	Yes	Awaiting publication
Rheumatoid and Early Inflammatory Arthritis	01/02/15 to 29/01/16	Yes	103
Sentinel Stroke National Audit Programme (SSNAP)	01/10/15 to 31/12/16	Yes	DH: 227 (90+%); PRUH: 215 (90+%)
Severe Sepsis and Septic Shock – care in emergency departments	01/08/16 to 31/01/17	Yes	100%
Specialist Rehabilitation for Patients with Complex Needs	Not applicable – data collection not yet started	n/a	n/a
Stress Urinary Incontinence Audit	n/a - service not provided at KCH	n/a	n/a
UK Cystic Fibrosis Registry	01/04/16 to 31/03/17	Yes	Awaiting publication

Trust participation in NCEPOD Studies

NCEPOD Title	Reporting period	Participation	% of cases submitted
Non Invasive Ventilation	01/02/15 to 31/03/15	Yes	Clinical questionnaire returned = 2/6 (33%) Organisational questionnaire returned = 1/2
Young Person's Mental Health Study	Prospective: 07/03/15 to 20/03/15 Retrospective: June 2016 - ongoing	Yes	Due to be published Oct-17
Chronic Neurodisability	01/04/16 - ongoing	Yes	Due to be published Nov-17
Cancer in Children, Teens and Young Adults	01/09/16 – 31/01/17	Yes	Due to be published Dec-17

Clinical audit projects reviewed by the Trust

Key:

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

National Audit	Data source	Rating		Summary of analysis
		DH	PRUH	
Sentinel Stroke National Audit Programme (SSNAP): Hyper Acute Stroke Unit (HASU) data Published: Jul-16	Royal College of Physicians			**Positive analysis:** DH HASU scored the highest levels of attainment (A and B) for 9 out of 10 domains. PRUH HASU scored the highest levels of attainment (A and B) for 7 out of 10 domains.
Sentinel Stroke National Audit Programme (SSNAP): Stroke Unit (SU) data Published: Jul-16	Royal College of Physicians			**Positive analysis:** DH SU achieved the highest levels of attainment (A and B) for 6 out of 6 domains. PRUH SU achieved level A or B attainment for 4 out of 6 domains.
National Pregnancy in Diabetes Audit Published Nov-15	Diabetes UK and Health and Social Care Information Centre			**Positive analysis:** KCH performed in line with London and national averages across most of the standards. 20% of women were taking the recommended 5mg folic acid (national 13%). 20% of women had a first trimester HbA1C<48mmol/mol (national 13%). Proportion of macrosomia babies, 4000g and over has reduced from 8% in 2013 to 7% in 2014 (national 14%). **Neutral analysis:** KCH has a 15% (n=56) miscarriage rate (national average 5%). This is influenced by better identification at KCH than other centres. KCH stillbirth rate is 0 (n=56) (national is 1%).
National End of Life Care Audit – Dying in Hospital Published Mar-16	Royal College of Physicians, Marie Curie and Healthcare Quality Improvement Partnership			**Positive analysis:** KCH performed above national average across 5/5 key end of life quality indicators. KCH achieved 5/8 of the quality indicators in the organisational audit.
National Diabetes Inpatient Audit (NaDIA)	Healthcare Quality Improvement			**Positive analysis:** DH performed in line with or better than national average for most of the indicators.

National Audit	Data source	Rating		Summary of analysis
		DH	PRUH	
Published Mar-16	Partnership, Diabetes UK, Public Health England			PRUH performed in line with national average for key indicator 'good diabetes days'. **Negative analysis:** PRUH did not perform in line with the national average for key indicators 'management errors' and 'severe hypoglycaemic episode' but there is no evidence of a negative impact on patient outcome. Many improvement actions have been implemented, including introduction of site-wide training in diabetes management and safe prescribing, enhanced specialist input, enhanced pharmacy support for diabetes and adaption of Denmark Hill protocols and associated paperwork.
National Audit of Percutaneous Coronary Interventional (PCI) Procedures Published Apr-16	National Institute for Cardiovascular Outcomes Research and British Cardiovascular Intervention Society.			**Positive analysis:** DH performed better than expected for most indicators, including patients receiving primary PCI within 90 minutes of arrival. **Negative analysis:** Only 60% cases submitted to the audit. Blue rating given due to insufficient data to rate performance.
Congenital Heart Disease Published Apr-16	National Institute for Cardiovascular Outcomes Research			**Methodological issue:** Sample too small to enable rating of performance.
2015 UK Parkinson's Audit Published: Apr-16 a) Elderly Care and neurology	Parkinson's UK; UK Parkinson's Excellence Network			**Methodological issue:** Sample too small to enable rating of performance.
b) Occupational Therapy				**Positive analysis:** Good compliance with *NICE Guideline CG35: Parkinson's disease in over 20s: diagnosis and management* and adherence to national standards for occupational therapy and physiotherapy.
c) Physiotherapy				**Methodological issue:** Sample too small to enable rating of performance.
d) Speech & Language Therapy				**Positive analysis:** Good compliance with NICE Guideline CG35.
The Trauma Audit and Research Network (TARN) Online Survival Data Published Apr-16, Nov-15, Jul-16	The Trauma and Audit research Network (TARN)			**Positive analysis:** The TARN data demonstrates that more trauma patients admitted to DH and PRUH are surviving compared to the number expected based on the severity of their injury.
TARN: Clinical Report Clinical Report I: Core	TARN			**Positive analysis:** The TARN data demonstrates that DH and

National Audit	Data source	Rating		Summary of analysis
		DH	PRUH	
Measures - thoracic and abdominal injuries, patients in shock Published Apr-16				PRUH are within the expected range.
TARN: Clinical Report II: Core Measures for all patients head and spinal injuries Published Dec-15	TARN			**Positive analysis:** South East London, Kent and Medway (SELKM) Trauma Network is the best performing network in comparison to all other Trauma Networks nationally. DH survival is within expected range.
TARN: Adult Major Trauma Dashboard Published Aug-16	TARN			**Positive analysis:** DH performance is better than expected for delivery of consultant led trauma teams.
TARN: Children's Major Trauma Dashboard Published Aug-16	TARN			**First Children's Major Trauma Dashboard.**
National Neonatal Audit Programme (NNAP), 2016 Annual Report on 2015 data Published: Sep-16	Royal College of Paediatrics and Child Health			**Positive analysis:** Denmark Hill (DH) performance is above the national average for 4/5 criteria audited; similar to nat av for 1/5. Princess Royal University Hospital (PRUH) is above the national average for 3/5 criteria audited, similar to nat av for 1/5 and below nat av for 1/5 – parents receiving consultation with senior member of team.
National Diabetes Audit (NDA) Published Jan-16	Diabetes UK & Health and Social Care Information Centre			**Methodological issue:** The results combine both acute and primary care in the denominator. KCH performance not separately identified.
National Bariatric Surgery Registry – Surgeon Specific Outcomes Published Feb-16	National Bariatric Surgery Registry			**Positive analysis:** Surgeon-specific outcomes are within expected range across DH and PRUH.
UK Renal Registry (UKRR) Published Dec-15 & Apr-16	Renal Association			**Positive analysis:** KCH one-year-after-90-day incident survival (adjusted to age 60) from the start of renal replacement therapy is similar to the national average (KCH 90.0%, national average 91.8%), even though King's has the 2nd highest rate in England of patients starting on renal replacement therapy who have diabetes, and the highest in London, at 39.2%.
Heart Failure Audit Published: July 2016	National Institute for Cardiovascular Outcomes Research			**Positive analysis** DH performance is in line with or better than the expected target for 9/13 criteria measured. PRUH performance is in line with or better than the expected target for 5/13 criteria measured.

National Audit	Data source	Rating DH	Rating PRUH	Summary of analysis
				Negative analysis: DH performance for 8/13 criteria has dropped compared to previous year's performance.
National Clinical Audit for Rheumatoid and Early Onset Arthritis – 2nd Annual Report Published July 2016	The British Society for Rheumatology			**Positive analysis:** 71% of KCH patients achieve an improvement of >1.2% in their Disease Activity Score (DAS 28), compared to national average of 60%. **Neutral analysis:** Reduction of disability score Outcome measure within expected range.
The Second Patient Report of the National Emergency Laparotomy Audit (NELA) Published: July 2016	Royal College of Anaesthetists and Royal College of Surgeons			**Neutral analysis:** Improvement in the Trust's overall performance since last year. Emergency laparotomy remains a Trust Quality Priority.
Clinical Outcomes Publication Programme - Endocrine Surgery Published: January 2016	British Association of Endocrine and Thyroid Surgeons			**Positive analysis:** Surgeon-specific outcomes are within expected range across DH and PRUH.
National Audit of Cardiac Rhythm Management Devices (CRM) Published Aug-16	National Institute of Cardiovascular Outcomes Research			**Positive analysis:** KCH (DH and PRUH) undertakes in excess of the minimum numbers of cardiac implants as recommended by BHRS and NICE. King's has not been identified as an outlier and has reported a sufficient number of implants to satisfy the requirement for training.
UK Renal Registry (UKRR) Published Dec-15 & Apr-16	Renal Association			**Positive analysis:** KCH one-year-after-90-day incident survival (adjusted to age 60) from the start of renal replacement therapy is similar to the national average (KCH 90.0%, national average 91.8%). King's has the second highest rate in England of patients starting on renal replacement therapy who have diabetes, and the highest in London, at 39.2%.
National DAFNE Audit 2014. (DAFNE: Dose Adjustment For Normal Eating) Published Jun-16	Central DAFNE Diabetes Resource Centre			**Positive analysis:** Outcomes of patients attending DAFNE at King's significantly better than for the collaborative as a whole. King's has demonstrated the 2nd highest proportion of patients achieving target A1c at 1 year (50%). This compares to 30% in National Diabetes Audit.
National Diabetes Foot Care Audit Published Mar-16	Health and Social Care Information Centre			**Neutral analysis:** DH performed below the national average for most of the outcomes indicators. This is a casemix issue relating to the high proportion of foot ulcers with a SINBAD score of 3 or more, which means severe, 70.5% compared with 46.2% nationally.
National Liver Transplantation Audit Report for 2015/16	NHS Blood and Transplant			**Positive analysis:** Elective patient: Post transplant survival: DH has the second highest 1 year un-adjusted

National Audit	Data source	Rating		Summary of analysis
		DH	PRUH	
Published: Sep-16				survival rate nationally at 95.0% (95% CI 92.7, 96.6) (National 93.4%; 95% CI 92.3, 94.4), and the highest 5 year un-adjusted survival rate at 83.0% (95% CI 78.7, 86.5) (National 80.5%; 95% CI 78.5, 82.3) compared to all 7 centres. Super Urgent patient: Post transplant survival: DH has the second highest five year un-adjusted survival rate at 83.6%. (95% CI 72.9, 90.3), (National 78.9%; 95% CI, 73.1, 83.6) compared to all 7 centres.
National Liver Transplantation Audit Report for 2015/16 Published: Sep-16	NHS Blood and Transplant			**Positive analysis:** **Elective patient: Post transplant survival:** DH has second highest 5 year un-adjusted survival rate at 93.2% (95% CI 85.4, 96.9) compared to all 3 centres. **Super Urgent patient:** Post transplant survival: DH has the second highest 1 year un-adjusted survival rate nationally at 79.5% (95% CI 57.2, 91.0) compared to all three centres.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: Resources and Organisation of Pulmonary Rehabilitation Services in England and Wales Published Nov-15	Royal College of Physicians and British Thoracic Society			**Positive analysis:** Both DH and PRUH met all 10 organisational Quality Standards specified by the British Thoracic Society.
Clinical Audit of Pulmonary Rehabilitation Services in England and Wales 2015 Published Feb-16	Health and Social Care Information Centre			**Positive analysis:** KCH performed considerably better than national average against a range of functional outcomes indicators.
Emergency Oxygen Audit Published Nov-15	British Thoracic Society			**Neutral analysis:** No evidence of negative impact on patient outcomes. **Negative analysis:** 61% of DH patients and 41% of PRUH patient did not have a prescription or bedside order in place. Action plan in place.
National Prostate Cancer Audit Published Nov-15	Royal College of Surgeons			**Neutral analysis:** Treatment provided by an integrated GSTT & KCH team –performance information not currently provided but planned for next report.
National Bowel Cancer Audit Published Dec-15	Health and Social Care Information Centre			**Positive analysis:** KCH (and network) adjusted 90-day and 2 year mortality rates are within expected range, 90-day unplanned readmission and 18-month stoma rate are within expected range.

National Audit	Data source	Rating		Summary of analysis
		DH	PRUH	
National Joint Registry – enhanced surgeon and hospital information Published Nov-15	National Joint Registry – online			**Positive analysis:** Patient-Reported Improvement Measures, 90-day mortality and revision rate are within expected range for hip and knee replacement. Consent rate is better than expected at Denmark Hill and Orpington.
Neurosurgical National Audit Programme Published Dec-15	Society of British Neurological Surgeons			**Positive analysis:** KCH is within expected range for 30-day standardised mortality rate.
National Oesophago-Gastric Cancer Audit Published Nov-15	Health and Social Care Information Centre			**Neutral analysis:** DH and PRUH patients receive treatment at GSTT. The complication rate achieved by GSTT, at 5.2%, is the lowest achieved by a London Trust. King's achieved an overall data completeness rating of green at 81-90%. The adjusted 30-day and 90-day mortality rates achieved by GSTT is within expected range at 1.4% and 2.9% respectively.
National Lung Cancer Audit Published Dec-15	Royal College of Physicians			**Positive analysis:** King's performance equals or exceeds the level suggested in the NLCA report, and is statistically better than the national average for: • Anticancer treatment • Non-small-cell lung cancer (NSCLC) stage IIIB/IV and PS 0–1 having chemotherapy 3 out of 4 process, imaging and nursing measures equal or exceed the level suggested in the NLCA report 2014. King's performance is statistically similar to the national average for: • NSCLC having surgery • Small-cell lung cancer (SCLC) patients having chemo-therapy. **Negative analysis:** King's is below the level suggested by the report for 'Patient seen by nurse specialist', achieving 51.1% for this measure (NCLA

National Audit	Data source	Rating DH	Rating PRUH	Summary of analysis
				recommends 80%). This was due to staff absence which has now been rectified.
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis Published Jan-16	The British Society for Rheumatology			**Positive analysis:** Reduction in Disease Activity Score (DAS) by at least 1.2 – KCH achieved 71% (national average 62%). Similar to national average for practice in accordance with NICE Quality Standards. **Neutral analysis:** Rheumatoid Arthritis Impact Disease (RAID) score of 0.3 is below national average of 2.4. This is a data issue which has now been resolved.

Local Audits

Local clinical audits are managed within the Trust's Divisional management structure and many hundreds of clinical audits are undertaken every year. In addition, the Trust audits its NICE derogations and a comprehensive pateint safety audit programme.

Local clinical audit	Reporting period
Audit of NICE derogation CG122 Ovarian cancer	An audit on gynaecological cancers including ovarian cancer and rapid access service is performed annually. Audit results demonstrate KCH cross site compliance with the NICE guidance.
Audit of NICE derogation CG154 Ectopic pregnancy and miscarriage	The Early Pregnancy Unit audits its outcomes on an annual basis including outcome of management options. The data generated from this informs the continuous updating of the unit management protocols.
Audit of NICE derogation CG95 Chest pain of recent onset	Attendance, investigation and outcomes are audited for all patients who are managed in the rapid access chest pain clinic.
Audit of NICE derogation CG112 Sedation in children and young people	The audit demonstrated a high-level of compliance with the paediatric sedation protocol. The audit identified several areas for improvement in the quality of documentation, currently being addressed.
Audit of NICE derogation CG151 Neutropenic sepsis	Ongoing monthly mortality audit of deaths within 30 days of chemotherapy, including participation in network neutropenic sepsis audit with development of local action plan.
Audit of NICE derogation CG156 Fertility: assessment and treatment of people with fertility problems	Routine audit of outcomes is undertaken. A review of KPIs is undertaken on a monthly basis.
Patient Safety Audit Programme: • Clinical record-keeping • Consent • Surgical Safety Checklist • Discharge • Moving and handling • Falls assessment • Patient observations (deteriorating patient) • Clinical handover (nursing) • Skin integrity and pressure ulcers	The Patient Safety Audit Programme sets out King's approach to ensuring that areas identified as high risk are subject to routine review and, where required, improvement. The Programme is a key component of King's Risk Management Strategy and is reported through the Patient Safety Committee to the Trust's Quality Governance Committee.

• Patient identification • Infection prevention and control • Nutrition • Nasogastric and orogastric tube placement • Availability of patient records • Screening procedures and diagnostic test procedures • Blood transfusion • Hospital Acquired Thrombosis (HAT) • Medicines management • Resuscitation • Piped medical gas administration • Safeguarding • Tracheostomy	

Reporting against core indicators

All trusts are required to report against a core set of indicators, for at least the last two reporting periods, using a standardised statement set out in the NHS (Quality Accounts) Amendment Regulations 2012. Only indicators that are relevant to the services provided at King's are included in the tables below.

Performance Measures

Indicator	Measure	Current Period	Value	Previous Period	Value	Foundation Trusts Comparable Value (Shelford Group) Highest	Lowest	National Average	Source	Regulatory Statement
Summary Hospital Mortality Index (SHMI)	score	01 July 2015 – 30 June 16	91	01 July 2014 - 30 June 2015	89	74.16	107.87	100	Hospital Episode Statistics via HED	*The King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons:* • *The Trust prioritises the delivery of excellent patient outcomes and has excellent mortality monitoring processes in place.* *The King's College Hospital NHS Foundation Trust intends to take/has taken the following actions to improve the SHMI, and so the quality of its services, by:* • *Continuing to invest in routine monitoring of mortality and detailed investigation of any issues identified.*

Performance Measures

Indicator	Measure	Current Period	Value	Previous Period	Value	Foundation Trusts Comparable Value (Shelford Group) Highest	Lowest	National Average	Source	Regulatory Statement
Patients deaths with palliative care coded at either diagnosis or speciality level	%	01 October 2014 - 30 September 2015	41.84	01 October 2013 - 30 September 2014	34.3	TBC	TBC	TBC	NHS IC	*The [name of trust] considers that this data is as described for the following reasons [insert reasons]. The [name of trust] [intends to take/has taken] the following actions to improve this [percentage/proportion/score/rate/number], and so the quality of its services, by [insert description of actions].*
Patients aged 0-15 (emergency) readmitted within 28 days of being discharged	%	01 April 2015 - 31 January 2016	1.6	01 April - 31 December 2014	3.9	TBC	TBC	TBC	PiMS (2015/16), CHKS (2014)	*The [name of trust] considers that this data is as described for the following reasons [insert reasons]. The [name of trust] [intends to take/has taken] the following actions to improve this [percentage/proportion/score/rate/number], and so the quality of its services, by [insert description of actions].*
Patients aged 16+ or over (emergency) readmitted within 28 days of being discharged	%	01 April 2015 - 31 January 2016	8.7	01 April - 31 December 2014	4.5	TBC	TBC	TBC	PiMS (2015/16), CHKS (2014)	*The [name of trust] considers that this data is as described for the following reasons [insert reasons]. The [name of trust] [intends to take/has taken] the following actions to improve this [percentage/proportion/score/rate/number], and so the quality of its services, by [insert description of actions].*

Performance Measures

Indicator	Measure	Current Period	Value	Previous Period	Value	Foundation Trusts Comparable Value (Shelford Group) Highest	Lowest	National Average	Source	Regulatory Statement
Admitted patients who were risk assessed for venous thromboembolism	%	01 April 2015 - 31 December 2015	96.53	01 April 2014 - 31 March 2015	97.28	TBC	TBC	TBC	VTE returns	*The [name of trust] considers that this data is as described for the following reasons [insert reasons]. The [name of trust] [intends to take/has taken] the following actions to improve this [percentage/proportion/score/rate/number], and so the quality of its services, by [insert description of actions].*
Cases of C difficile infection reported for patients aged 2 or over	Rate per 100K bed days	KCH APR15 - FEB16 Reportable cases rate /100,000 bed days	(80) 18.49%	KCH 2014/15 Reportable cases rate /100,000 bed days	(75) 15.43%	TBC	TBC	TBC	C-diff cases / KH03 G&A + Obs per 100,000. Note: KH03 excludes Well babies & Critical Care	*The [name of trust] considers that this data is as described for the following reasons [insert reasons]. The [name of trust] [intends to take/has taken] the following actions to improve this [percentage/proportion/score/rate/number], and so the quality of its services, by [insert description of actions].*

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Responsiveness to patients personal needs

Indicator	Measure	Current Period	Value	Previous Period	Value	National 2015 Scores: Highest	National 2015 Scores: Lowest	National Average	Data Source	Regulatory Statement
Were you involved as much as you wanted to be in decisions about your care and treatment?	Score out of 10 trust-wide	2015 National Inpatient Survey	7.4	2014 National Inpatient Survey	7	8.9	6.6	Not available	CQC	*King's College Hospital considers that this data is as described. The Trust is tasking its clinical divisions to develop patient, family and carer experience action plans to improve patient experience.*
Did you find someone on the hospital staff to talk to about your worries and	Score out of 10 trust-wide	2015 National Inpatient Survey	5.8	2014 National Inpatient Survey	5.2	7.8	4.4		CQC	*King's College Hospital considers that this data is as described. The Trust is tasking its clinical divisions to develop patient, family and carer experience action plans to improve patient experience.*
Were you given enough privacy when discussing your condition or treatment?	Score out of 10 trust-wide	2015 National Inpatient Survey	8.5	201 National Inpatient Survey	8.0	9.4	7.9		CQC	*The [name of trust] considers that this data is as described for the following reasons [insert reasons]. The [name of trust] [intends to take/has taken] the following actions to improve this [percentage/proportion/score/rate/number], and so the quality of its services, by [insert description of actions].*

Responsiveness to patients personal needs

Indicator	Measure	Current Period	Value	Previous Period	Value	National 2015 Scores: Highest	National 2015 Scores: Lowest	National 2015 Scores: National Average	Data Source	Regulatory Statement
Did a member of staff tell you about medication side effects to watch for when you went home?	Score out of 10 trust-wide	2015 National Inpatient Survey	4.2	2014 National Inpatient Survey	4.2	7.8	3.6		CQC	*King's College Hospital considers that this data is as described. The Trust is tasking its clinical divisions to develop patient, family and carer experience action plans to improve patient experience.*
Did hospital tell you who to contact if you were worried about your condition or treatment after you left hospital?	Score out of 10 trust-wide	2015 National Inpatient Survey	7.5	2014 National Inpatient Survey	7.3	9.7	6.4		CQC	*King's College Hospital considers that this data is as described. The Trust is tasking its clinical divisions to develop patient, family and carer experience action plans to improve patient experience.*

Patient Friends & Family Tests

Indicator	Measure	Current Period	Value	Previous Period	Value	Comparable Foundation Trust Value: Highest	Lowest	National Average December 2016	Data Source	Regulatory Statement
Patients discharged from Accident & Emergency (types 1/2) who would recommend the Trust as a provider of care to their family or friends?	%	April 2016 - Jan 2017 (latest available data)	TBC	April 15 - Jan 2016	82	100 Dec 2016	54 Dec 2016	86 Dec 2016	NHS England	*King's College Hospital considers that this data is as described. The Trust is tasking its clinical divisions to develop patient, family and carer experience action plans to improve patient experience. Work is also underway to transform the emergency pathway through the King's Way Trust Transformation programme and this includes patient experience*
Inpatients the Trust as a provider of care to their family or friends?	%	April 2016 - Jan 2017 (latest available data)	TBC	April 15 - Jan 2016	94	100 Dec 2016	73 Dec 2016	95 Dec 2016	NHS England	*King's College Hospital considers that this data is as described. The Trust is tasking its clinical divisions to develop patient, family and carer experience action plans to improve patient experience.*

Staff – Friends & Family Test and National Staff Surveys

Indicator	Measure	Current Period	Value	Previous Period	Value	Comparable Foundation Trust Value: Highest	Lowest	National Average	Data Source	Regulatory Statement
Staff employed by, or under contract who would recommend the Trust as a provider of care to their family or friends.	% *	2015 National Staff Survey (Quarter 3)	3.7	2014 National Staff Survey (Quarter 3)	3.88	4.10	3.3	3.76	NHS Annual Staff Survey Results	The Trust considers that this data is as described as it has been taken from the nationally published staff survey results: http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2015_RJZ_full.pdf
Staff experiencing harassment, bullying or abuse from staff in the last 12 months.	% *	2015 National Staff Survey (Quarter 3)	29	2014 National Staff Survey (Quarter 3)	25	16	42	26	NHS Annual Staff Survey Results	The Trust considers that this data is as described as it has been taken from the nationally published staff survey results: http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2015_RJZ_full.pdf

Staff – Friends & Family Test and National Staff Surveys

Indicator	Measure	Current Period	Value	Previous Period	Value	Comparable Foundation Trust Value: Highest	Lowest	National Average	Data Source	Regulatory Statement
Staff believing the Trust provides equal opportunities for career progression or promotion	% *	2015 National Staff Survey (Quarter 3)	84	2014 National Staff Survey (Quarter 3)	79	96	76	87	NHS Annual Staff Survey Results	The Trust considers that this data is as described as it has been taken from the nationally published staff survey results: http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2015_RJZ_full.pdf

**30% (255 staff responsed from a sample of 850 staff)*

Patient Reported Outcomes

Indicator	Measure	Current Period	Value	Previous Period	Value	Comparable Foundation Trust (Shelford Group) Value: Highest	Lowest	National Average	Data Source	Regulatory Statement
Patient Reported Outcomes Measures - groin hernia surgery	EQ-5D Index: 11 modelled records	Apr 14 - Mar 15	Figure suppressed by HSCIC to protect patient confidentiality.	Apr 13 - Mar 14	Figure suppressed by HSCIC to protect patient confidentiality.	0.897 (Cambridge University Hospitals NHS Foundation Trust)	0.050 (Sheffield Teaching Hospitals NHS Foundation Trust)	0.084	HSCIC 'Select 10' table, April 2014-March 2015, published August 2016)	*King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons:* • *our participation rate was too low.* *King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:* • *improving our participation rate in 2017-18.*
	EQ VAS: 48 modelled records		Adjusted average health gain: -08.42		Adjusted average health gain: 0.742	2.229 (Central Manchester University Hospital NHS Foundation Trust)	-0.255 (University College London Hospitals NHS Foundation Trust)	-0.509		

Patient Reported Outcomes

Indicator	Measure	Current Period	Value	Previous Period	Comparable Foundation Trust (Shelford Group) Value	Highest	Lowest	National Average	Data Source	Regulatory Statement
Patient Reported Outcomes Measures - varicose vein surgery	EQ-5D Index: 19 modelled records	Apr 14 - Mar 15	Figure suppressed by HSCIC to protect patient confidentiality.	Apr 13 - Mar 14	Figure suppressed by HSCIC to protect patient confidentiality.	0.090 (Sheffield Teaching Hospitals NHS Foundation Trust)	0.127 (Cambridge University Hospitals NHS Foundation Trust)	0.094		*King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons:* • *our participation rate was too low.* *King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:* • *improving our participation rate in 2017-18.*
	EQ VAS: 17 modelled records		Figure suppressed by HSCIC to protect patient confidentiality.		Figure suppressed by HSCIC to protect patient confidentiality.	0.567 (Oxford University Hospitals NHS Trust)	-0.587 (University College London Hospitals NHS Foundation Trust)	-0.53		
	Aberdeen Varicose Vein Questionnaire: 18 modelled records		Figure suppressed by HSCIC to protect patient confidentiality.		Figure suppressed by HSCIC to protect patient confidentiality.	-11.634 (Cambridge University Hospitals NHS Foundation Trust)	-1.346 (Guy's & St Thomas's NHS Foundation Trust)	-0.8237		

Patient Reported Outcomes

Indicator	Measure	Current Period	Value	Previous Period	Value	Comparable Foundation Trust (Shelford Group) Value: Highest	Lowest	National Average	Data Source	Regulatory Statement
Patient Reported Outcomes Measures - hip replacement surgery	EQ-5D Index: 206 modelled records	Apr 14 - Mar 15	Adjusted average health gain: 0.441	Apr 13 - Mar 14	Adjusted average health gain: 0.448	0.453 (Imperial College Healthcare NHS Trust)	0.402 (Sheffield Teaching Hospitals NHS Foundation Trust)	0.436		*King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons:* • *our performance is in line with Shelford Group peer and all our scores are consistently above national average, in keeping with earlier years trends.*
	EQ VAS: 200 modelled records		Adjusted average health gain: 12.835		Adjusted average health gain: 14.192	13.890 (Cambridge University Hospitals NHS Foundation Trust)	10.082 (Sheffield Teaching Hospitals NHS Foundation Trust)	11.973		
	Oxford Hip Score: 223 modelled records		Adjusted average health gain: 22.200		Adjusted average health gain: 22.135	23.267 (University College London Hospitals NHS Foundation Trust)	20.410 (Central Manchester University Hospitals NHS Foundation Trust)	21.443		*King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:* • *continuing to provide excellent elective orthopaedic services.*

Patient Reported Outcomes

Indicator	Measure	Current Period	Value	Previous Period	Comparable Foundation Trust (Shelford Group) Value	Highest	Lowest	National Average	Data Source	Regulatory Statement
Patient Reported Outcomes Measures - knee replacement surgery	EQ-5D Index: 282 modelled records	Apr 14 - Mar 15	Adjusted average health gain: 0.283	Apr 13 - Mar 14	Adjusted average health gain: 0.284	0.327 (Sheffield Teaching Hospitals NHS Foundation Trust)	0.261 (Central Manchester University Hospitals NHS Foundation Trust)	0.315		*King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons:* • *our performance is in line with Shelford Group peers.* *King's College Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:* • *addressing data collection issues – it appears that there may be errors in the form issued.* • *continuing to provide excellent elective orthopaedic services.*
	EQ VAS: 262 modelled records		Adjusted average health gain: 4.651		Adjusted average health gain: 2.624	10.411 (Imperial College Healthcare NHS Trust)	2.016 (Central Manchester University Hospitals NHS Foundation Trust)	5.761		

Access & Performance - Quality of care indicators

Indicator	Measure	Current Period	Value	Previous Period	Value	Comparable Foundation Trust values (as at Q3 or Feb 16) Highest	Lowest	National Average	Data Source	Regulatory Statement
6-week diagnostic waits	%	March 2016	5.8	March 2015	5.5	0	9.3	1.3	PiMs/ CRIS	The Trust has a weekly diagnostic waiting list meeting which reviews the breach portfolio and signs off action plans for the test modality as appropriate.
Maximum waiting time of 62 days from urgent GP referral to first treatment for cancers	%	Jan-March 2016	88.8	Jan-March 2015	84.2	93.5	55.5	83.5	Open Exeter	The Trust discusses all the cancer metrics weekly at the Performance Improvement Group and monthly at the Patient Access Board where key actions are reviewed and updated.

Access & Performance - Quality of care indicators

Indicator	Measure	Current Period	Value	Previous Period	Value	Comparable Foundation Trust values (as at Q3 or Feb 16) Highest	Lowest	National Average	Data Source	Regulatory Statement
Percentage on incomplete pathway within 18 weeks for patients on incomplete pathway at the end of the reporting period	%	March 2016	80.4	March 2015	92.2	98	73.8	92.1	PiMs/ Oasis	The Trust took a reporting holiday with the agreement of local commissioners and Monitor during the period. The Trust returned to reporting in March 2016. Auditors will conduct a review of the Trust's data as part of the external assurance process for the Quality Report. The Trust has taken robust action during the period to improve the quality of its data for this indicator and to ensure that longer waiting patients are cared for in the short-term .

Patient Safety - Quality of care indicators

Indicator	Measure	Current Period	Value	Previous Period	Value	Comparable Foundation Trust values: Highest	Lowest	National Average	Data Source	Regulatory Statement
Patient safety incidents reported to the NRLS where degree of harm is recorded as 'severe harm or death' as a percentage of all patient safety incidents reported	%	Oct 2015-Mar 2016	0.7	Apr-Sept 2015	0.7	2.0	0.0	0.4	NRLS	The data for Oct 2015 to Mar 2016 shows that King's College Hospital is a slight outlier in terms of the proportion of incidents with severe harm or death. King's considers that the data overestimates the proportion of severe harm/death incidents because a significant proportion of incidents graded in this way will be downgraded post-investigation. This is not always reflected in the NRLS data as it is taken at a point in time.
Rate patient safety incidents	Number/ 1000 bed days	Oct 2015-Mar 2016	42.85	Apr-Sept 2015	44.7	75.91	14.77	40	NRLS	King's College Hospital's rate of reporting compares favourably with most of its peer hospitals
Number of patient safety incidents	Number	Oct 2015-Mar 2016	9,603	Apr-Sept 2015	10208	11998	1499	4818	NRLS	Again this demonstrates there very positive reporting culture at the organisation

Patient Safety - Quality of care indicators

Indicator	Measure	Current Period	Value	Previous Period	Value	Comparable Foundation Trust values: Highest	Lowest	National Average	Data Source	Regulatory Statement
The Trust considers that the data is as described because it was taken directly from the National Reporting & Learning System database and relates to acute non-specialist trusts.										

King's College Hospital - Medication Safety Quality Accounts

Indicator	Measure	Current Period (n=2498)	Value	Previous Period (n=2943)	Value	Previous Period (n=2844)	Value	Comparable Foundation Trust: Highest	Lowest	National Average	Data Source
Pa 10-fold dosing errors 206 by stage of the medicine process	Number	April 2016 - Jan 17 (NB part year - 10 months)	30	April 2015-March 2016	41	April 2014-March 2015	46	Not Available	Not Available	n/a	Trust voluntary incident reporting system

Indicator	Measure	Current Period	Value	Previous Period	Value	Previous Period	Value	Highest	Lowest	National Average	Data Source
Number of medication errors involving the wrong patient	Number	April 2016 - Jan 17 (NB part year - 10 months)	68	April 2015-March 2016	81	April 2014-March 2015	97	Not Available	Not Available	n/a	Trust voluntary incident reporting system

Scorecard – latest version with text

Trust actions on duty of candour (incidents/actions)

Initial Implementation:

- Policy ratified and published on 30th September 2014.
- Standardised documentation for recording Duty of Candour conversations
- 'Candour Guardian' role identified - Dr Rob Elias, Consultant Nephrologist
- Presentations at Consultant Development Mornings, Audit Days, Divisional Governance meetings, Nursing for and significant Trust committees were facilitated by the Candour Guardian and the Patient Safety Team.
- A series of Candour drop in sessions were organised across all KCH sites to allow staff to find out more information.
- KWIKI webpages developed
- Development of standardised Duty of Candour Letters
- Changes to the Duty of Candour form in line with feedback from staff
- Collaborative presentation with KHP colleagues at National Safety Connections event 29/09/2016
- Roll out of EPR duty of candour form for DH & Orpington and access through the Clinical Portal for PRUH and QMS ('How to Guides' developed)
- KCH is now involved in the HIN (Health Innovation Network) Communities of Practice about Duty of Candour
- Since October 2016 Duty of Candour training is recorded for new medical starters as part of their induction. They must complete an online course for compliancy. They are all provided with written information on DoC.
- Candour working group has been replaced by the Clinical Ethics Forum which was established in 2016 where difficult candour cases can be discussed
- Development of FAQ based on comments from the Survey available on intranet site

Ongoing work to embed best practice in Candour:

- Education, focussed mainly on process, continued. Plans for a repeat round of training, including use of GMC, Health Improvement Network, and Action Against Medical Accidents resources. Aim for training sessions to explore challenges in delivering difficult conversations, as well as Candour process.
- Three KHP Medical Students are being mentored by the Candour Guardian Lead and are undertaking a quality improvement project working closely with three specialities at the Trust to improve Duty of Candour
- On-going coms campaign to maintain high profile

Plans for 2017

- New management structure in Trust means more formal recognition of role of Clinical Governance Leads, including their role in ensuring Duty of Candour is fulfilled. The newly created role of Corporate Medical Director, Quality, Governance and Risk will also help.
- Candour Guardian to meet with all clinical governance leads to update on implementation of duty of candour, troubleshoot and share learning
- From the student QI project develop specific tracking system and implement escalation process within the patient safety team, Candour Guardian and Medical Director for Quality and Patient Safety.
- Duty of Candour Lead is in discussion with a Human Factors training group to

develop a ½ day and 1 day training course for KCH staff
- Update of the KWIKI page to include some case studies from complex cases
- Implement more frequent auditing at three monthly intervals and publicise results

- Develop a methodology in conjunction with PPI to get feedback from patients involved in Duty of Candour conversations to evaluate their experience.

Trust action plan for Sign-Up to Safety Campaign

Campaign Pledges	Trust Patient Improvement Plans
1. Putting safety first. Committing to reduce avoidable harm in the NHS by half through taking a systematic approach to safety and making public your locally developed goals, plans and progress. Instil a preoccupation with failure so that systems are designed to prevent error and avoidable harm	***We will*** Commit to reducing avoidable harm in hospitals by 50%, with a particular focus on reducing avoidable harm relating to sepsis, medication omissions and invasive procedures. We will make public our goals and locally developed plans with respect to this aim. We will make sure our staff have the right skills, information and support to put patient safety first by: • Refining the incident reporting system to ensure that information about patient harm is accurate and comprehensive and that trends can easily be extracted from the dataset • Ensuring we have easily available and clear information for our staff and patients on known risks and what help is available to mitigate these risks • Ensuring that training and staff development responds to regular analyses of what is reported – this will include reference to topical safety issues at induction • Improving the recognition and reporting of harms relating to sepsis, medication omissions and surgical safety • Developing robust targets to underpin our efforts to reduce the highest risk harms reported • Develop and implement a ward accreditation scheme to enable regular, systematic review of safety performance
2. Continually learn. Reviewing your incident reporting and investigation processes to make sure that you are truly learning from them and using these lessons to make your organisation more resilient to risks. Listen, learn and act on the feedback from patients and staff and by constantly measuring and monitoring how safe your services are	***We will*** Ensure our organisation builds a more resilient safety culture, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are. We will ensure that actions and learning from information relating to patient safety, patient experience and patient outcomes (i.e. incidents, complaints, patient and staff surveys, mortality data etc) drive safety improvements by: • Ensuring that patient safety, experience and outcomes information is aggregated allowing for more sophisticated risk identification (eg. through the Patient Safety Scorecard. Fact of the Fortnight, Quarterly Reports to the Quality & Governance Committee etc) • Improve the feedback given to staff who report incidents through the development of automated email feedback, incident case studies, safety newsletters, and development of a "sharing safety stories" Kwiki page • Making sure that staff involved in incidents receive appropriate support • Audit of governance systems to ensure they provide assurance that the Trust is responsive to patient safety, experience and outcomes information, and take action where these systems need improvement • Ensuring that patient feedback is factored into discussions about safety, for example through the Duty of Candour process • Extending our reported outcome measures so that they include shared measures that are coproduced with our patients
3. Being honest. Being open and transparent with people about your progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong	***We will*** Commit to being transparent with people about our progress in tackling patient safety issues and to supporting staff to be candid with patients and their families if something goes wrong. We will embed an understanding of Duty of Candour in a way that it becomes part of everybody's daily activities, by: • Providing clear support including mentoring staff that have to deal with incidents, in particular serious incidents • Candour Guardian to advise staff on complex candour issues and provide support to staff involved in candour discussions • Ensuring staff awareness of the Duty of Candour requirements through training at induction, ongoing drop-in sessions and bespoke training for those staff involved in candour conversations • Regular audit of candour with feedback to staff involved

	□ Developing a culture in which staff never hesitate to raise a concern if they feel safety is compromised
4. Collaborate. Stepping up and actively collaborating with other organisations and teams; share your work, your ideas and your learning to create a truly national approach to safety. Work together with others, join forces and create partnerships that ensure a sustained approach to sharing and learning across the system	***We will*** Commit to supporting local collaborative learning, so that improvements are made across all of the local services that patients use. We will ensure multidisciplinary approaches to safety issues and work with patients and carers to agree our quality priorities. We will take a leading role in the work of the collaborative patient safety networks (Health Innovation Network - South London, CLARC - South London Research Network, King's Improvement Science, King's Health Partners Safety Connections) by: □ Active participation □ Supporting staff and students who want to join collaborative learning, evaluation or research programmes linked to these
5. Being supportive. Be kind to your staff, help them bring joy and pride to their work. Be thoughtful when things go wrong; help staff cope and create a positive just culture that asks why things go wrong in order to put them right. Give staff the time, resources and support to work safely and to work on improvements. Thank your staff, reward and recognise their efforts and celebrate your progress towards safer care.	***We will*** Commit to helping people understand why things go wrong and how to put them right. We will give staff the time and support to improve safety. We will listen to our staff, our patients and their carers We will celebrate those staff that make significant contributions towards improved patient safety, particularly in the areas that are high priority. We will introduce an electronic system by which all staff can report the good practice of their colleagues. We will improve our support for staff in developing their knowledge and leadership skills relating to harm reduction and quality improvement. This will be linked to our Transformation Programme. We will establish "Care To Share" events to provide a forum for staff to discuss difficult and emotional issues that arise when caring for patient.

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

To follow

Annex 2: Statement of directors' responsibilites 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.

Monitor 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 2015/16 and supporting guidance

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

– board minutes and papers for the period April 2015 to [the date of this statement]

– papers relating to Quality reported to the board over the period April 2015 to [the date of this statement]

– feedback from commissioners dated XX/XX/20XX

– feedback from governors dated XX/XX/20XX

– feedback from local Healthwatch organisations dated XX/XX/20XX

– feedback from Overview and Scrutiny Committee dated XX/XX/20XX

– the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX

– the [latest] national patient survey XX/XX/20XX

– the [latest] national staff survey XX/XX/20XX

– the Head of Internal Audit's annual opinion over the trust's control environment dated XX/XX/20XX

– CQC Intelligent Monitoring Report dated XX/XX/20XX

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with Monitor'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

NB: sign and date in any colour ink except black

Lord Kerslake, Chair .....

Nick Moberly, Chief Executive Officer .....

Date .....

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HEALTHY COMMUNITIES SCRUTINY SUB-COMMITTEE
MUNICIPAL YEAR 2016-17

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Councillor Gavin Edwards			
Councillor Tom Flynn			
Councillor Eliza Mann			
Councillor Leo Pollack			