Appendix 1

Kingston Hospital
NHS Foundation Trust

QUALITY REPORT 2017-2018

Working **together** to deliver **exceptional, compassionate care** every time

CONTENTS

PART 1

INTRODUCTION FROM THE CHIEF EXECUTIVE

Over the past year we have continued to step up our focus on quality at Kingston Hospital and build on our successes and achievements so far in improving the service and care we provide to our patients.

Delivering high quality care is at the forefront of everything we do at Kingston Hospital and this Report covers how we have performed against the Quality Priorities set for 2017-18 and sets out what our Quality Priorities will be during 2018-19.

We were focused on delivering 9 Quality Priorities during 2017-18, which had been agreed following consultation with our staff, members and governors, and patient groups. Out of the 9 we have achieved 6 and partly achieved 3. We are particularly proud to have achieved the completion of the Human factors training for a range of clinical staff in the Maternity unit and we are building on this across the organisation with structured quality improvement education for all staff which includes human factors. It is well recognised that there is a strong relationship between human factors and the management of risk and error. By introducing this education into the multidisciplinary team, and then into the in house training we seek to reduce the human factors associated with incidents. The Dementia Strategy production, a three year strategy with the implementation of year one is another proud achievement within the staff, with a hugely visible positive benefit directly for patients and their relatives. The Environment has been greatly improved for example in our Emergency Department as well as designated wards. Additionally, we have 200 new Dementia friends, developed a patient and carer leaflet to explain about 'delirium' as an illness, and moved towards using a specific pain measurement scale for patients with dementia to be able to tell us more ably about their pain, so we can help more.

We are also committed to providing 7 day working services, and changes to consultant working patterns and on call rotas has enabled Kingston to achieve 92% compliance against the measure of consultant review of patients within 14 hours of admission. This is above the 90% national target.

For the last few years we have worked hard to involve staff, the local community, partners and stakeholders in decisions about our services and priorities for improvement and always listen to the feedback we receive when things have gone well and when we could have done better. As in previous years, we have involved them in helping to set our Priorities for 2018/19, and these are described overleaf.

QUALITY PRIORITIES FOR 2018-2019

Patient Safety

1. Avoid delays in patient care on the wards.

2. Develop and implement a process to ensure that we spread learning from adverse incidents, complaints and all patient feedback.

Patient Experience

1. Improve our patient administration and communication processes in Outpatients.

2. Increase response rates for Friends and Family Test.

Clinical Effectiveness

1. Increase the number of patients having day case surgery whenever it is safe and appropriate to do so.

2. Increase staff engagement in quality improvement activities in the Trust.

The Quality Report presents a balanced picture of the Trust's performance over the period covered and, to the best of my knowledge, the information reported in the Quality Report is reliable and accurate.

Ann Radmore
Chief Executive
24th May 2018

WHAT IS A QUALITY REPORT?

All providers of NHS services in England have a statutory duty to produce an annual report to the public about the quality of services they deliver. This is called the Quality Report. Quality Reports aim to increase public accountability and drive quality improvement within NHS organisations. They do this by getting organisations to review their performance over the previous year, identify areas for improvement, and publish that information, along with a commitment to you, the public, about how those improvements will be made and monitored over the next year.

The Quality Report is now established as an important means of demonstrating and communicating improvements in the quality of patient care. We will continue to focus attention on making our Quality Report more readable and accepted as a core instrument in improving accountability to the public.

Kingston Hospital NHS Foundation Trust focuses on 3 areas that help us to deliver high quality services:

- Patient safety
- How well the care provided works (clinical effectiveness)
- How patients experience the care they receive

Information in a Quality Report is mandatory. However, information contributions decided by patients and carers, Foundation Trust Governors, staff, commissioners, regulators and our partner organisations can be incorporated.

Scope and Structure of the Quality Report

This report summarises how well we as a Trust have performed against the quality priorities and goals we set ourselves for the last year and, if we have achieved what we set out to do, we have explained why if not and what we are going to do to make improvements. It also sets out the priorities we have agreed for the coming year and how we intend to achieve them and track progress throughout the year. The Quality Report is prepared each year by the Director of Nursing and Quality and overseen by the Quality Assurance Committee. This group is chaired by a Non-Executive Director. Guidance is published to write the Quality Report and this has been adhered to.

One of the most important parts of reviewing quality and setting quality priorities is to seek the views of our patients, staff and key stakeholders (such as the Clinical Commissioning Groups, Council of Governors, Healthwatch Groups). The Quality Report includes statements of assurance relating to the quality of services and describes how we review them, including information and data quality. It also includes a description of audits we have undertaken, our research work, how our staff contributes to quality and comments from our external stakeholders.

If you, or someone you know, needs help understanding this report or would like the information in another format, such as large print, easy read, audio or Braille or in another language, please contact our Communications Department. If you have any feedback or suggestions on how we might improve our Quality Report, please do let us know either by emailing: Sally Brittain, Director of Nursing and Quality at sally.brittain@nhs.net or Lisa Ward, Head of Communications at lisa.ward@nhs.net or in writing to our Patient Advice Liaison Service (PALS) at: Kingston Hospital NHS Foundation Trust, Galsworthy Road, Kingston upon Thames, Surrey KT2 7QB.

PART 2

KINGSTON HOSPITAL NHS FOUNDATION TRUST PRIORITIES FOR 2018/19

How were the Priorities Chosen?

Working with stakeholders ensures that the quality priorities selected are pertinent and relevant to service users. In this section we will explain why we think each priority is important, what we aim to achieve, what we have done so far and what we plan to do in the year ahead. Where possible we refer to historical and/or benchmarked data to enable readers to understand progress over time and performance compared to other providers.

The number of priorities selected is in line with those stipulated in the NHS Improvement document *Detailed Requirements for Quality Reports for 2018/19.*

The description must include:

- At least three priorities for improvement (agreed by the NHS Foundation Trust's Board) indicating the relationship, if any, between the identification of these priorities and the reviews of data relating to quality of care referred to in the assurance statement.

  - Progress made since publication of the 2016/17 Quality Report; this should include performance in 2017/18 against each priority and, where possible, the performance.
  - In previous years.
  - How progress to achieve these priorities will be monitored and measured, and
  - How progress to achieve these priorities will be reported.

The dates of consultation are listed below:

- Quality Improvement Committee 10 January 2018
- Council of Governors 25 January 2018
- Quality Assurance Committee 18 January 2018
- Executive Management Committee 31 January 2018
- Trust Board Meeting (public) 07 February 2018

The proposed Quality Priorities were presented at the above meetings for review and voting. Individuals were asked to decide on the two top priorities from the list of 3 in each of the 3 sections, Patient Safety, Patient Experience and Clinical Effectiveness. An email was also sent to Governors. All responses were collated and then placed into the priority order from the voting cast. The top two from each section, so 6 collectively, were then proposed to the Executive Management Committee who also voted. The final proposals for the 6 Quality Priorities were the proposed to the Trust Board, and approved. These are the approved Quality Report Priorities 2018/19.

QUALITY PRIORITIES FOR 2018/19

Domain	Item	Priority	Rationale
Patient Safety	1	Avoid delays in patient care on the wards.	We want to ensure that patients do not have to experience any unnecessary waits during their in-patient stay. This will ensure that they can go home in the shortest time and early in the day. We know that this is better for patient experience and also reduces harm.
	2	Develop and implement a corporate process to ensure that we spread learning from adverse incidents, complaints and all patient feedback through the Trust.	Building on this year's quality priority about learning from incidents we will now develop our processes to ensure that this learning is shared widely and embedded in practice.
Patient Experience	1	Improve our patient administration and communication processes in out-patients.	Poor administrative and communication processes cause distress and inconvenience to our patients and staff. Improving these processes would enhance patient experience also help us make care more efficient for patients and staff.
	2	Increase response rates for Friends and Family Test.	Receiving feedback from our patients at every opportunity helps us to improve the way in which we provide care. Making it easier for patients to give us feedback will increase our chance of learning from every patient's experience.
Clinical Effectiveness	1	Increase the number of patients having day case surgery whenever it is safe and appropriate to do so.	We are committed to ensuring patients receive care in the optimal setting. We have an opportunity to do this by shifting procedures into day case and outpatient settings where this is clinically appropriate. Day surgery represents high-quality patient care with excellent patient satisfaction. Shorter hospital stays and early mobilization reduce harm and use resources more efficiently.
	2	Increase staff engagement in quality improvement activities in the Trust.	There is evidence that outstanding NHS Trusts prioritise staff engagement and that this is linked to their involvement in quality improvement activity. We will roll out a programme of quality improvement initiatives across the Trust.

PATIENT SAFETY

- **Quality Priority for Improvement 1**

Avoid delays in patient care on the wards.

Why we chose this Indicator
We want to ensure that patients do not experience any unnecessary waits during their in-patient stay. This will ensure that they can go home in the shortest time and early in the day. We know that this is better for patient experience but also reduces harm.

Monitoring
Monitoring the progress of this will be through the Quality Improvement Committee.

Primary Metric
Weekly number of patients on a ward with a length of stay over 6 days

Other measures:
- Average length of stay on the ward
- Proportion of patients discharged from the ward before 11am
- Measures of progress in implementing the SAFER bundle and Red to Green across our inpatient wards. SAFER and Red to Green are evidence based interventions that have been shown to support improved flow.

- **Quality Priority for Improvement 2**

Develop and implement a corporate process to ensure that we share learning from adverse incidents, complaints and all patient feedback through the Trust.

Why we chose this Indicator
Building on this year's quality priority about learning from incidents we will now develop our processes to ensure that this learning is shared widely and embedded in practice.

Monitoring
Monitoring the progress of this will be through the Quality Improvement Committee.

Measures to assess Achievement
- Peer Review qualitative information on knowing about the shared learning newsletter
- Evidence of reductions in themes in complaints
- Reduction in themes of concerns raised through PALS
- More completed incident reports
- Levels of no Harm

PATIENT EXPERIENCE

- **Quality Priority for Improvement 1**

  Improve our patient administration and communication processes in outpatients.

  Why we chose this Indicator
  Poor administrative and communication processes cause distress and inconvenience to our patients and staff. Improving these processes would enhance patient experience also help us make care more efficient for patients and staff

  Monitoring
  Monitoring the progress of this will be through the Quality Improvement Committee and the specialty and divisional performance and project reviews.

  Measures to Assess Achievement
  There are a number of factors that impact on patient experience of our outpatient services. Our first priority will be to use existing data to understand what really matters to our patients and target our improvements in line with those areas. Assessing the impact of improvements will be informed by a range of measures:

- Hospital and patient cancellation rates
- Did Not Attend rates
- Complaints / PALS thematic trends and qualitative themes
- Friends and Family Test response rates and local surveys
- Outpatient Appointment Letters dispatched to patient no less than 10 working days before appointment

- **Quality Priority for Improvement 2**

  Increase response rates for Friends and Family Test.

  Why we chose this Indicator
  Receiving feedback from our patients at every opportunity helps us to improve the way in which we provide care. Making it easier for patients to give us feedback will increase our chance of learning from every patient's experience.

  Monitoring
  Monitoring the progress of this will be through the Patient Experience Committee and the Quality Improvement Committee.

  Measures to Assess Achievement
  Friends and Family Test (FFT) response rates including developing localised improvement trajectories for selected services.

CLINICAL EFFECTIVENESS

- **Quality Priority for Improvement 1**

  Increase the number of patients having day case surgery whenever it is safe and appropriate to do so.

  Why we chose this Indicator
  We committed to ensuring patients receive care in the optimal care setting. We have an opportunity to do this by shifting procedures into day case and outpatient settings where this is clinically appropriate. Day surgery represents high-quality patient care with excellent patient satisfaction. Shorter hospital stays and early mobilisation reduce harm and use resources more efficiently.

  Monitoring
  Monitoring the progress of this will be through the Quality Improvement Committee and the specialty and divisional project review meeting.

  Measures to assess Achievement
  Implementation of shifts in care settings for specific procedures (e.g. in line with Getting it Right First Time (GIRFT) recommendations and our Theatres Efficiency programme)

- **Quality Priority for Improvement 2**

  Increase staff engagement in quality improvement activities in the Trust.

  Why we chose this Indicator
  There is evidence that outstanding NHS Trusts prioritise staff engagement and that this is linked to their involvement in quality improvement activity. We will create opportunities for staff to make improvements in their daily work and to develop their quality improvement skills.

  Monitoring
  Monitoring the progress of this will be through the Quality Improvement Committee.

  Measures to Assess Achievement
  - Progress in implementing improvement systems as part of daily work (e.g. outpatient improvement huddles and Red to Green on our inpatient wards).
  - Performance in the NHS Staff Survey - KF7: Staff ability to contribute towards improvements at work.
  - Number of staff trained in systematic improvement methods.

Overview of Services

During 2017/18 the Kingston Hospital NHS Foundation Trust provided and/or subcontracted 57 relevant NHS services, for adults and children in the following specialties:

Accident and Emergency	General Surgery
Assisted Conception	Gynaecology
Breast	HIV
Cancer in partnership with RMH	Neonatal Care
Cardiac Physiology	Nephrology
Cardiology	Neurology
Care of the Elderly and stroke services	Neurophysiology
Clinical Support Services – therapies related to an inpatient episode of care and/or referral for outpatient treatment(s)	Obstetrics
	Occupational therapy
	Ophthalmology
Colorectal	Ophthalmology (Community)
Community Midwifery	Oral and Dental Services
Community Paediatrics	Paediatrics
Critical Care	Pain Management
Day Surgery	Parent Craft
Dermatology	Pathology as part of the SWLP
Diabetes and Endocrinology	Patient Transport
Diagnostics (imaging and pathology)	Pharmacy in partnership with Boots
Dietetics	Physiotherapy outpatient
Digital Hearing Aids	Respiratory Medicine
Direct Access – Biochemistry	Respiratory Physiology
Direct Access – Cytology	Rheumatology
Direct Access – Haematology	Speech and Language Therapy
Direct Access – Cellular Pathology	Surgical Appliances
Direct Access – Immunology	Upper GI
Direct Access – Microbiology	Urology
Direct Access – Radiology/Imaging (MRI in partnership with Inhealth)	Trauma and Orthopaedics
	Vascular
Ear, Nose and Throat	
Endoscopy	
Gastroenterology General Medicine	
Genito Urinary Medicine	

The Trust has reviewed all the data available to it on the quality of care in 57 of these relevant health services.

The income generated by the relevant health services represents 81.8 % of the total income generated from the provision of relevant health services by the Trust for 2017/18.

Participation in Clinical Audits

Clinical audit is designed to improve patient care, treatment and outcomes. Its purpose is to involve all healthcare professionals in a systematic evaluation of delivery of care against evidence based standards, identify actions to improve the quality of care and deliver better care and outcomes for patients. The work carried out by the various National Confidential Enquiries involves review of patient care nationally. The resulting recommendations enable local hospitals to drive up standards and enhance patient care and safety.

During 2017/18 40 national clinical audits and 9 national confidential enquiries covered relevant health services that the Kingston Hospital NHS Foundation Trust provides.

During that period Kingston Hospital NHS Foundation Trust participated in 95% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquires which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Kingston Hospital NHS Foundation Trust was eligible to participate in during 2017/18 are listed in Appendix A.

The national clinical audits and national confidential enquiries that Kingston Hospital NHS Foundation Trust participated in during 2017/18 are also listed in Appendix A.

The national clinical audits and national confidential enquiries that Kingston Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed in Appendix A, 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 reports of 30 national clinical audits were reviewed by the provider in 2017/18. The actions that Kingston Hospital NHS Foundation Trust intends to take to improve the quality of healthcare provided are listed in Appendix B.

The reports of 120 local clinical audits were reviewed by Kingston Hospital NHS Foundation Trust in 2017/18. Examples of improvement actions taken as a result of national and local audit are shown in the table below.

Clinical audit results are discussed at clinical meetings in local departments and at wider meetings such as the Trust's annual Clinical Audit and Improvement Seminar. The results of both national and local clinical audits are used to drive local quality improvement. More detailed information about the actions we have taken from clinical audit will be available in our Clinical Audit and Effectiveness Annual Report via the Medical Director's department from July 2018.

National and local clinical audit results are used primarily by Kingston Hospital to improve patient care where gaps are found but are also used as assurance that the hospital is following best practice guidance. Four examples of how clinical audit results have provided assurance and improved care during 2017/18 are given in the boxes below.

CLINICAL AUDIT DRIVING IMPROVEMENT	
National Audit The third NELA report highlighted Kingston Hospital as an exemplar Trust for successfully using the NELA standards to drive improvements locally. The report stated: *"Kingston Hospital used NELA standards to define key measures to target for improvement: They assembled a multidisciplinary group of surgeons, anaesthetists, intensivists and radiologists who examined local NELA data together. They highlighted preoperative risk assessment, direct consultant supervision, critical care admission and timely CT imaging as their core focus. They then worked on those to improve outcomes, and by focusing on these four areas they were able to show a reduction in mortality across all age groups, particularly older patients, for whom mortality dropped by 45% during their improvement period."* As a result of this improvement work the adjusted mortality rate decreased from 16.3% in 2015 to 8.7% in 2016. In addition the hospital achieved the highest 'green' rating for 9 out of 10 key process measures, and for 20 out of 24 hospital facilities measures. Dr Britta O'Carroll-Kuehn (Anaesthetist and clinical audit lead) describes the improvement journey with NELA as: *"Dedication to quality improvement. Never stop. Allow time to embed changes in clinical practise and produce results. Continuing leadership, teamwork. EPOCH gave us an evidenced structure and 'buy in' from other specialties... regular meetings and specific results discussed. Success celebrated. Shortfalls reminded team about adherence. Trainee involvement – enthuse them, encourage and support presentation of results to appropriate national meetings. It was/is the perseverance of the team to continue and keep up the standard of care"*.	**Local Audit** An inspection by the Care Quality Commission in January 2016 identified improvements required for the safe and secure storage of medicines in outpatients, radiology, theatres, some wards, and the emergency department. As a result a Quality Improvement Project was undertaken with the aim of ensuring that: • Medicines and prescription pads are securely locked away. • Temperatures are regularly monitored in areas where medicines are stored. • The use of patients own medicines is supported in accordance with Trust policy. • Controlled drugs are managed in accordance with Trust policy. A monthly audit commenced in inpatient areas in June 2016 and has since been rolled out to maternity, outpatients and departments. The purpose of the audit is to regularly review compliance with Trust policy for storage and security of medicines to enable continuous improvement. The latest audit report for quarter 3, 2017/18 demonstrates improved performance compared to 2016/17 across all 3 areas and provides assurance that performance is in line with, or exceeding, the target set. • Maternity: Overall compliance in maternity is currently 83% for the year to date. This is an improvement from 70% achieved for 2016/17, and exceeds the target rate of 75%. • Outpatients and Departments: Compliance in outpatient areas and departments remains relatively high at 91% for the year to date. This is an improvement from 86% achieved in 2016/17, and exceeds the target rate of 75%. • Inpatient areas: Improvements achieved in 2016-17 have been sustained in most inpatient areas in quarter 1, quarter 2 and quarter 3, with overall compliance at 85% for the year to date. This is an improvement from 61% achieved for 2016/17, and is in line with the target of 85%.

CLINICAL AUDIT PROVIDING ASSURANCE	
National Audit Kingston Hospital performance in the latest annual report published for the National Hip Fracture Database demonstrates excellence in the care provided to our patients. Generally more patients treated at Kingston Hospital are receiving the 6 NICE recommended key aspects of care that all patients should expect after a hip fracture, compared to other Trusts nationally. In addition the audit shows that Kingston Hospital is in the best performing 25% of hospitals nationally for: • Assessment: Perioperative medical assessment provided, physiotherapy assessment by the day after surgery, mobilised out of bed by day after surgery and best practice tariff achievement. • Surgery: Surgery on the day of or day after admission, surgery supervised by a consultant surgeon and anaesthetist, patients treated with a sliding hip screw and the use of intramedullary nails. • Outcomes: Overall length of stay in hospital For a summary of actions taken to further improve the care of patients with hip fractures, see Appendix B.	**Local Audit** Oxygen is a drug which should be prescribed in all but emergency situations. Failure to administer oxygen appropriately can result in serious harm to the patient. The British Thoracic Society (BTS) national audit carried out in 2012 showed that at Kingston Hospital only 15% of patients had a prescription for the oxygen that they were receiving, and only 7% had a prescription that included a target range. In response to these results a quality improvement project was set up and succeeded in increasing the proportion of patients prescribed oxygen to 66% in the BTS national audit in 2015, in line with the national average. Oxygen prescribing is now monitored through a monthly local clinical audit and results have continued to improve. Since April 2017 the Trust has performed consistently above 80%. In quarter 3 2017/18, 88% of patients receiving oxygen, outside of emergency situations, had their oxygen prescribed, and 90% of those patients had oxygen saturations within the prescribed target at the time of the audit. These results demonstrate both assurance, in terms of exceeding the Trust target of 65%, and also continued improvement.

Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 894 (portfolio studies only), an increase from 633 in 2016/17.

The Trust was involved in conducting 58 clinical research studies during 2017/18, an increase from 28 in 2016/17.

There were 180 clinical staff participating in research approved by a research ethics committee at the Trust during 2017/18, an increase from 128. These staff participated in research covering 25 specialities, an increase from 16 in 2016/17.

Use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework

A proportion of income for Kingston Hospital NHS Foundation Trust in 2017/18 was conditional on meeting quality improvement and innovation goals agreed between Kingston Hospital NHS Foundation Trust and commissioners, Clinical Commissioning Groups, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for the reporting period are provided in the table below and for the following 12 month period are available electronically at this link:

https://www.england.nhs.uk/publication/cquin-indicator-specification

The key aim of CQUIN is to support a shift towards a vision where quality is the organising principle. The framework therefore helps ensure that quality is always part of discussions between commissioners and hospitals everywhere. In 2017/18 the Trust had a contract value of £4,822,905 for CQUIN activity (in the previous year, the value of this activity was £4,305,683). The table below illustrates how the Trust performed against the CQUIN schemes. The contract total for the associated payment in 16/17 was £196,495,283

The table below summarises the different schemes that the Trust engaged in during 2017/18.

THEME	AIM	% ACHIEVEMENT
Improving staff health and wellbeing	Introduction of health and wellbeing initiatives	100%
	Healthy food for NHS staff, visitors and patients	100%
	Improving the uptake of flu vaccinations for front line staff within Providers	100%
Reducing the impact of serious infections (Sepsis)	Timely identification and treatment for sepsis in emergency departments and acute inpatient settings	40%
	Timely treatment for sepsis in emergency departments and acute inpatient settings	30%
	Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours	100%
	Assurance of appropriate use of antibiotics	100%
	Empiric review of antibiotic prescriptions	100%
Improving services for people with mental health needs who present at A&E	Improving services for people with mental health needs who present to A&E.	100%
Offering advice and guidance (A&G)	Offering advice and Guidance (A&G)	100%
NHS e-Referrals	NHS e-Referrals	85%
Supporting proactive and safe discharge	Supporting proactive and safe discharge	0%
Local CQUIN	Local CQUIN (STP)	100%

	Local CQUIN (Risk Reserve)	0%
Dose Banding	CA2 Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy (SACT)	100%
Medicines Optimisation	MO Trigger 1 - Faster adoption of prioritised best value medicines as they become available	100%
	MO Trigger 2 - Improving drugs MDS data quality	100%
	MO Trigger 3 -Cost effective dispensing routes	100%
	MO Trigger 4 - Improving data quality associated with outcome databases (SACT and IVIg)	100%
	MO Trigger 5 - Reviewing and switching existing patients to clinically appropriate but also more cost effective regimen treatment	100%
Dental	Dental - Collection and submission of data on priority pathways procedures	100%
	Dental - Participate in the Acute Dental Systems Resilience Group (SRG)	100%
	Dental - Active participation in consultant led MCN	100%

**Note that Qtr 4 performance has not yet been confirmed by commissioners.*

CQUINS FOR 2018-19
The total value of 2018-2019 CQUINs is approximately £4.8 million.

Local CQUIN 2018/19
Local CQUIN goals were not finalised with commissioners at time of publishing.

National CQUINs 2018/19
The national indicators that KHFT is working on are:

1. Improving staff health and wellbeing
2. Reducing the impact of serious infections (Sepsis)
3. Improving services for people with mental health needs who present at A&E
4. Offering advice and guidance (A&G)
5. Preventing Ill Health by Risky Behaviours
6. Dose Banding
7. Medicines Optimisation
8. Dental

CARE QUALITY COMMISSION (CQC) REGISTRATION AND INSPECTIONS

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. It regulates care provided by the NHS, local authorities, private companies and voluntary organisations that provide regulated activities under the Health and Social Care Act 2008. The CQC registers, and therefore licenses, all NHS Trusts. It monitors Trusts to make sure they continue to meet very high standards of quality and safety. If services drop below the CQC's essential standards then it can impose fines, issue public warnings, or launch investigations. In extreme cases it has the power to close services down.

Kingston Hospital NHS Foundation Trust is registered with the CQC - every hospital has to be. This means that we are doing everything we should to keep patients safe and to provide good care. The CQC carries out regular checks to make sure that hospitals are meeting important government standards. There are currently no conditions attached to the registration and there has been no enforcement action during the reporting period.

The CQC undertake announced and unannounced compliance visits to assess if the service is safe, effective, caring, is responsive to people's needs and is well-led.

The Trust was inspected by the CQC in March 2017, with all of the Trust's services receiving a rating of 'Good' in the Caring domain and end of life care being rated as 'Outstanding'.

The CQC rated Urgent and Emergency Services; Medical Care and Outpatients and Diagnostic Imaging as 'Requires Improvement'. One service, urgent and emergency care was inspected as 'Inadequate'. Overall Kingston Hospital NHS Trust was inspected as 'Requires Improvement'.

The Trust was given seven "Must Do" actions and forty-two "Should Do" actions which were converted in to an action plan for achievement and monitoring.

The Trust's 7 "Must Do" actions were:

1. Ensure that the Duty of Candour is adhered to by including a formal apology within correspondence to relevant persons and that records are kept.
2. Ensure that individuals who lack capacity are subjected to a mental capacity assessment and best interest decisions where they require restraint and that this information is recorded in the patient record.

3. Make improvements to ensure medicines are not accessible to unauthorised persons; are stored safely, and in accordance with recommended temperatures.
4. Make improvements to the systems for monitoring of equipment maintenance and safety checks in order to assure a responsive service.
5. Ensure the management, governance and culture in A&E, supports the delivery of high - quality care.
6. Improve the quality and accuracy of performance data in A&E, and increase its use to identify care for improvement
7. Ensure all identified risks are reflected on the A&E risk register and timely action is taken to manage risks, performance and areas for improvement.

Detailed action plans were developed and delivered with clinical teams and departmental heads in relation to the "Must Do" and "Should Do" actions identified. Progress has been supported and monitored for delivery of the 7 Must Do actions to delivery and as a Trust, we continue to embed the actions taken for consistency. We continue to monitor and embed the actions taken and testing has been undertaken via audits, walkabouts and an internal self-assessment process has been commenced. In terms of internal assurance and monitoring, regular updates on progress with CQC must and should do actions are received at CQC Programme Board and our Commissioners. The Director of Nursing and Quality has continued to meet with the CQC liaison lead and this was in February, July and October 2017. Intelligent monitoring reports are reviewed and discussed at these visits. Internal self-assessments are completed and reported to Trust Board.

The 'Should Do' actions from the CQC have had sustained focus to enable delivery on virtually all actions with only the exception of the environmental area of the Coronary care area, which has constraints. Key actions completed include improvements to pre-assessment for patients, resolution of equipment issues highlighted by midwifery staff, improvements to the children's waiting area in the fracture clinic and establishment of a 9-5 face to face services seven days a week for specialist palliative care. Of the Should Do actions, notable improvements are greater privacy for inpatients attending the CT scanning unit as a consequence of a new Managed Equipment Service for radiology.

Kingston Hospital NHS Foundation Trust has not participated in any *special reviews* or *investigations* by the CQC during the reporting period.

IMPOVEMENTS SINCE THE CQC INSPECTION IN 2016 AS OUTLINED IN THE PROVIDER INFORMATION REQUEST RESPONSE

WHAT HAS CHANGED SINCE THE LAST INSPECTION?

SAFE

- Training has been delivered around Duty of Candour (DoC) and MCA (CQC must do) and compliance with guidelines audited.
- Fridge temperatures, equipment maintenance and safe chemical storage has been addressed with excellent compliance demonstrated from recent audits.
- Medicine storage and management has been improved and is regularly audited.
- Vital signs monitoring devices have been integrated into the clinical record, resulting in good compliance with National Early Warning Score (NEWS).
- The acute response function of critical care (outreach team) has been made 24/7. In addition, there is an electronic link to an alert that identifies raised and deteriorating NEW scores.
- Acute services have been increased with greater Consultant presence 7 days a week.
- Site Nurse Practitioner Team has an increased establishment delivering more out of hours oversight.
- Increased establishment of Practice Development Team to ensure safe practice and support for nursing staff across clinical areas

EFFECTIVE

- Hand hygiene scores are over 95% across the Trust and performance is consistently maintained.
- The national process for learning from deaths has been implemented.
- Mortality and Morbidity meetings and reviews follow a standard template.
- Structured Judgement Review (SJR) training is being rolled out and reviews undertaken.
- A Head of Improvement has been appointed to lead a team supporting improvement projects and also Trust-wide training in quality improvement methodology.
- Sepsis screening and treatment has improved with dedicated nurse and medical leadership resulting in greater staff awareness.
- 7-day working in palliative care has been implemented.

CARING

- A new system of collecting FFT information has been implemented and text messaging introduced to the Emergency Department.
- Partners are now able to stay overnight throughout the maternity unit and not just in the delivery suite.
- A new dementia strategy has been approved and includes greater involvement of carers and RemindMeCare, was also introduced in 2017/18.
- The Trust has promoted Big Word interpreting services and increased the accessibility of this service for staff in all clinical areas.
- A real-time feedback system aimed at parents and children ('Pants and Tops') has been introduced to paediatrics.
- The Trust has been successful with a number of Macmillan bids, thus increasing the cancer and palliative care nursing workforce.

RESPONSIVE

- The Trust has opened a new Clinical Decision Unit, Urgent Treatment Centre and extended Majors and Resus in the Emergency Department
- A large part of the outpatient department has been refurbished with new waiting areas, patient screens and improvement in privacy and dignity. The phlebotomy service has relocated thus providing better flow and experience.
- There are new child appropriate areas in outpatients, the Ophthalmology Department, Fracture Clinic and the Urgent Treatment Centre.
- All refurbishments in adult areas have incorporated dementia friendly elements to the design**.**

WELL-LED

- The Board has a number of new members both in the Executive and Non-Executive Director (NED) roles. Since the last inspection Ann Radmore has become the substantive CEO, Sally Brittain has become the Director of Nursing (DoN), Mairead McCormick the Chief Operating Officer (COO), Kelvin Cheatle the Director of Workforce (DoW) and Susan Simpson the Director of Corporate Governance.
- There have been 5 new Non-Executive Directors strengthening the Clinical and Financial capability of the Board.
- There have also been significant changes in the Quality Governance Team.

Data Quality - NHS Number and General Medical Practice Code Validity

Kingston Hospital NHS Foundation Trust submitted records to the Secondary Uses Service (SUS) throughout 2017/18. This data is included in nationally published Hospital Episode Statistics (HES) data. The Trust's Data Quality Group ensures performance meets and/or exceeds national performance.

The percentage of records in the published data which included the patient's valid NHS number and General Medical Practice Code was:

Data Quality – NHS Number and GP Code Data Completeness

DQ Indicator		KHT 2017/18 (Apr-Jan)	National 2017/18 (Apr-Jan)
Admitted Patient Care	% with Valid NHS number	99.4%	99.4%
	% with General Medical Practice Code	100%	99.9%
Out Patient Care	% with Valid NHS number	99.7%	99.6%
	% with General Medical Practice Code	100%	99.8%
Accident & Emergency Care	% with Valid NHS number	97.5%	97.4%
	% with General Medical Practice Code	100%	99.3%
Maternity - Births	% with Valid NHS number	100%	99.1%
	% with General Medical Practice Code	99.9%	99.4%
Maternity - Deliveries	% with Valid NHS number	99.7%	99.8%
	% with General Medical Practice Code	100%	100%
Data source: HSCIC SUS Dashboards – as published online 12th April 2018.			

Information Governance Toolkit Attainment Levels

The Trust's Information Governance Toolkit Assessment Report overall score for 2017/18 was 80% (2016/17 was 80%; Green-Satisfactory) and was graded Green - Satisfactory

The 2017/18 result is from version 14.1 of the Toolkit. As in previous years the evidence has been rolled over from previous versions to which we have added any new or revised policies and in-year evidence to support monitoring and compliance.

The Requirements have not changed between versions. There are currently 45 requirements for Acute Trusts. Next year the Toolkit will be changing to the Data Protection and Security Toolkit and is expected to be more cyber focused. The results this year by Assurance Level were as follows:

Assurance	2017/18 14.1	2016/17 V14
Information Governance Management	**80%**	**80%**
Confidentiality and Data Protection Assurance	**74%**	**74%**
Information Security Assurance	**73%**	**73%**
Clinical Information Assurance	**86%**	**86%**
Secondary Use Assurance	**100%**	**100%**
Corporate Information Assurance	**77%**	**77%**
Overall Total	**80%**	**80%**

Clinical Coding

Clinical coding is the translation of medical terminology written by clinicians and health care professionals on patient conditions, complaints or reason for seeking medical attention, into a nationally and internationally recognised coded format. During the process of coding all clinical coders follow national standards, rules and conventions, in order to achieve accurate, reliable and comparable data across time and sources.

As part of the internal clinical coding audit program, and to comply with the Information Governance Toolkit Standard 13-505, two separate audits were undertaken by qualified and accredited auditors of the Clinical Coding team each across 200 Finished Consultant Episodes during 2017/18. The error rates reported for that period for diagnoses and procedure coding (Clinical coding) were:

	KHT 2017/18	
Total number of episodes examined:	**General Medicine**	**General Surgery**
Primary Diagnoses Incorrect	**2.00%**	**6.50%**
Secondary Diagnoses Incorrect	**8.25%**	**10.95%**
Primary Procedures Incorrect	**3.75%**	**2.00%**
Secondary Procedures Incorrect	**1.10%**	**2.26%**

Data source: KHFT IG Audit, March 2018

It is important to note that the results should not be extrapolated further than the actual sample audited.

Data Quality

The Trust has now completed year two of the refreshed Information Strategy and Data Quality Strategy. This incorporated the recommendations from various national reports, 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' [Lord Carter, February 2016] and the 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry' [Robert Francis QC, February 2013], in respect of data quality and the use of information across services and the wider health economy. The following actions have been taken to improve data quality and are aligned with the in-year strategy progress:

- Continuing to monitor and correct data errors through exception reporting.
- Increasing data quality benefit awareness.
- Assurance through the Data Quality Group by setting data quality priorities and assurance processes.
- Development of data quality dashboards.
- Project commenced to replace existing data warehouse.
- Reduction of manual processing of data, more timely data and consistency of reporting.
- Rationalisation of data flows and development of bespoke data sets.
- Investigation and proposals for changes to system software to reduce the risk of users creating errors (system hardening).

The Trust also subscribes to the external CHKS benchmarking tool, which includes a data quality measurement component.

The following national publications are reviewed bi-monthly by the Data Quality Group:

- National Data Quality Maturity Index (DQMI)
- SUS+ Data Quality Dashboards
- ECDS CQUIN DQ Report

Mortality and Learning from Deaths

As a Trust we have a history of reviewing deaths and investigating any concerns and this year we have implemented the National Mortality Review process in line with national guidance in 2017/8 which has added greater rigor to our system. The changes we have made include approving a Learning from Deaths policy at the Trust Board and publishing it on the Trust website in June 2017, appointing a Non-Executive Director to provide Board assurance, assigning the responsibility for the process to the Medical Director and appointing a Trust Lead for Mortality. We also now have a multidisciplinary mortality meeting which oversees information from all the mortality review meetings across the Trust.

The Trust is also supporting the Learning Disabilities Review (LeDeR) Programme and the Trust also recognises the statutory duty to continue to support both the National Maternal Mortality review and the Child Death Review processes.

Our Mortality Lead has established the process of Structured Judgement Review in line with the national process as described by the Royal College of Physicians and has rolled out training to a number of senior clinicians across the organisation. The Serious Incident process and Structured Judgement Review process interlink so that we can be sure that we cross reference all our actions and learning. There is also a robust system of offering support through PALS to bereaved families immediately after the death of a patient. This ensures that any concerns or questions families have about the care of a patient are answered quickly and sensitively at the earliest opportunity.

Overall the Trust has maintained a Standardised Hospital Mortality Index (SHMI) in the 'below expected range' – year end 0.83. This is performance in the best quartile of performance nationally and means that the Trust was deemed 220 deaths less than would have been expected with the patient population we treat.

The metrics we measure are detailed in the tables below.

Total Number of Deaths (01/04/2017 - 28/02/2018)	**767**
Total Number of Deaths in Quarter 1 (01/04/2017 - 30/06/2017)	**207**
Total Number of Deaths in Quarter 2 (01/07/2017 - 30/09/2017)	**169**
Total Number of Deaths in Quarter 3 (01/10/2017 - 31/12/2017)	**227**
Total Number of Deaths in Quarter 4 (01/01/2018 - 28/02/2018)	**164**

	SI Reviews	M&M Reviews	SJR Reviews	Total Reviews in %
Total Number of Deaths Reviewed (01/04/2017 - 31/03/2018)	**11**	**376**	**15**	**60.23%**
Quarter 1 (01/04/2017 - 30/06/2017)	**3**	**17**	**0**	**9.66%**
Quarter 2 (01/07/2017 - 30/09/2017)	**3**	**123**	**1**	**75.15%**
Quarter 3 (01/10/2017 - 31/12/2017)	**4**	**120**	**4**	**56.83%**
Quarter 4 (01/01/2018 - 28/02/2018)	**0**	**116**	**10**	**76.83%**

	SI Review method was used to assess these cases.
Total Number of Deaths Reviewed (more likely than not have been due to problems in the care provided) (01/04/2017 - 31/03/2018)	**1.43%**
Quarter 1 (01/04/2017 - 30/06/2017)	**1.45%**
Quarter 2 (01/07/2017 - 30/09/2017)	**1.78%**
Quarter 3 (01/10/2017 - 31/12/2017)	**1.76%**
Quarter 4 (01/01/2018 - 28/02/2018)	**0.00%**

A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3

- To ensure that all interventions in falls prevention are implemented and documented.
- Consideration of all differential diagnoses when symptoms and signs are not adequately explained and ensure that handovers follow SBAR format with 'tell back'.
- To ensure that National Institute of Health and Care Excellence (NICE) guidelines are fully implemented in anticoagulation for atrial fibrillation (AF).
- A standardised protocol for the management of neurological abnormalities in the Intensive Treatment Unit (ITU) would have provided timely intervention.
- Despite improvements in oxygen prescribing escalating increasing requirements wasn't undertaken. The National Early Warning Score (NEWS) was not recorded accurately as respiratory rate not measured appropriately.
- Poor handover of care with all staff needs to be timely and effective.

A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4)

- Focus on communication of handover at junior doctors and Trust Induction.
- Oxygen prescribing Quality Improvement project.
- Implementation of integrated vital signs monitors and dashboard to alert outreach team to review patients.
- Falls group restarted with greater multidisciplinary membership.

➢ New ITU guidelines for neuro (brain) abnormalities. ➢ Improved processes in referral to anticoagulation (blood clotting) services for patients. ➢ Human factors training quality Improvement project to support staff in learning about human factors in patient safety.
An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.
➢ Improvement in Oxygen prescribing - local and national audit results. ➢ NEWS audit results all above 95% - ward audits. ➢ Falls audit results awaited. ➢ All Service lines tracking actions as a result of Serious Incidents (SIs). ➢ Overall improvement of M and M process with introduction of learning from deaths and the Structured Judgement Review (SJR) process. The main learning and action from the SJR process to date was that active care could be discontinued sooner and active palliative care commenced.

	SI Reviews
Total Number of Deaths Reviewed (01/04/2016 - 31/03/2017)	**12**
Quarter 1 (01/04/2016 - 30/06/2016)	**2**
Quarter 2 (01/07/2016 - 30/09/2016)	**1**
Quarter 3 (01/10/2016 - 31/12/2016)	**1**
Quarter 4 (01/01/2017 - 31/03/2017)	**8**

Total Number of Deaths that was Avoidable (more likely than not have been due to problems in the care provided) (01/04/2016 - 31/03/2017)	**1.53%**
Quarter 1 (01/04/2016 - 30/06/2016)	**0.99%**
Quarter 2 (01/07/2016 - 30/09/2016)	**0.65%**
Quarter 3 (01/10/2016 - 31/12/2016)	**0.56%**
Quarter 4 (01/01/2017 - 31/03/2017)	**2.61%**

Total Number of Deaths that was Avoidable (more likely than not have been due to problems in the care provided) (01/04/2016 - 28/02/2018)	**2.96%**
Quarter 1 (01/04/2016 - 30/06/2016) + (01/04/2017 - 30/06/2017)	**2.44%**
Quarter 2 (01/07/2016 - 30/09/2016) + (01/07/2017 - 30/09/2017)	**2.43%**
Quarter 3 (01/10/2016 - 31/12/2016) + (01/10/2017 - 31/12/2017)	**2.76%**
Quarter 4 (01/01/2017 - 31/03/2017) + (01/01/2018 - 28/02/2018)	**2.61%**

In the 2017-18 year, 98.4% of the incidents reported at KHFT were rated as 'low harm' or 'no harm'. National comparative data is not available yet for this time period, however the national average data for the 12 months between October 2016 to September 2017 is availabe[1]. The average proportion of No Harm and Low Harm incidents was 97.5% nationally for 'acute / general hospitals' between October 2016 to September 2017.

[1] *National Reporting Learning System (NRLS) extract published in March 2018.*

2017-18	Number of Patients Safety Incidents
Total number of patient safety incidents recorded for the period 01/04/2017 to 31/03/2018	6568 (on 5575 the actual harm has been confirmed by the incident investigator to date)
Severity of incidents by the degree of harm	99 Near Miss 3723 No Harm 1663 Low Harm 72 Moderate Harm 12 Severe Harm 6 Death
Percentage of Severe Harm and Death incidents(excludes near misses)	0.33%

National Data from NHS Digital

The Tables below represent Kingston Hospital's performance across a range of indicators, as published on the NHS Digital website (http://content.digital.nhs.uk/qualityaccounts). Many of these are reported monthly at the public board meetings as part of the Quality Report.

Indicator	Trust	National	Min	Max	Comment
Summary Hospital-Level Mortality Indicator (SHMI) Oct 2015-Sep 2016	0.8763 (Band 3)	1	0.6897	1.1638	Lower is better We are below the national average
Summary Hospital-Level Mortality Indicator (SHMI) Oct 2016 – Sep 2017	0.8233 (Band 3)	1	0.7270	1.2473	Lower is better We are below the national average
Latest Data Published	22 March 2018				

The Trust is in 'SMHI Banding 3' for both years benchmarking shown above. This means the Trust is "lower than expected" against the national average, where being lower than average is considered good.

Kingston Hospital NHS Foundation Trust considers that this data is as described for the following reasons – high level of clinical coding accuracy.

Kingston Hospital NHS Foundation Trust has taken the following action to improve the quality of its services – 7 day palliative care services reflective of case-mix and population.

Indicator	Trust	National	Min	Max	Comment
Percentage of deaths with palliative care coded Oct 2015-Sep 2016	38%	29.7%	0.4%	56.3%	We are above the national average
Percentage of deaths with palliative care coded Oct 2016-Sep 2017	43.1%	31.2%	11.5%	59.5%	We are above the national average
Latest Data Published	22 March 2018				

Kingston Hospital NHS Foundation Trust considers that this data is as described for the following reasons - high level of clinical coding accuracy.

Kingston Hospital NHS Foundation Trust has taken the following action to improve this percentage and so the quality of its services – provision of a well embedded palliative care specialist support team and training and guidance for staff and an approved End of Life Care Strategy.

Indicator	Trust	National	Min	Max	Comment
Age <16 readmissions within 28 days 2011/12	9.45%	10.03%	0%	14.94%	We were below the national average Lower number is better
Age <16 readmissions within 28 days 2012/13	No further data published.				
Latest Data Published	December 2013. Links confirmed to be accurate by NHS Digital as of March 2018				

Kingston Hospital NHS Foundation Trust considers that this data is as described for the following reasons - high level of data coding accuracy.

Kingston Hospital NHS Foundation Trust has taken the following action to improve this rate, and so the quality of its services - by working in partnership with our community colleagues.

Indicator	Trust	National	Min	Max	Comment
Age 16+ readmissions within 28 days 2011/12	11.06%	11.45%	0%	22.76%	We were below the national average Lower number is better
Age 16+ readmissions within 28 days 2012/13	No further data published.				
Latest Data Published	December 2013 (checked March 2018)				

Kingston Hospital NHS Foundation Trust considers that this data is as described for the following reasons - high level of data coding accuracy.

Kingston Hospital NHS Foundation Trust has taken the following action to improve this rate, and so the quality of its services - by working in partnership with our community colleagues.

Indicator	Trust	National	Min	Max	Comment
Trust's responsiveness to personal needs of patients Apr 2015-Mar 2016	64.6	69.6	58.9	86.2	We are below national average Higher number is better
Trust's responsiveness to personal needs of patients Apr 2016 – Mar 2017	66.8	68.1	60.0	85.2	We are below national average Higher number is better
Latest Data Published	August 2017				

Kingston Hospital NHS Foundation Trust considers that this data is as described for the following reasons - high level of data accuracy.

Kingston Hospital NHS Foundation Trust has taken the following action to improve this rate, and so the quality of its services – by delivering the inpatient action plan. By delivering the quality account priorities and corporate objectives

Indicator	Trust	National (Acute Trusts)	Min (Acute Trusts)	Max (Acute Trusts)	Comment
Staff who would recommend Trust as a provider to friends and family Staff Survey 2016	75%	70%	49%	85%	We are better than the national average Higher number is better
Staff who would recommend Trust as a provider to friends and family Staff Survey 2017	77%	70%	47%	86%	We are better than the national average Higher number is better
Latest Data Published	6th March 2017				

Kingston Hospital NHS Foundation Trust considers that this data is as described for the following reasons - high level of data accuracy.

Kingston Hospital NHS Foundation Trust has taken the following action to improve this rate, and so the quality of its services:

- By delivering the quality account priorities and corporate objectives.
- By improving staff engagement and delivering our workforce strategy.

Indicator	Trust	National	Min	Max	Comment
% of patients admitted that were risk assessed for VTE Jul 2017-Sep 2017	98.1%	95.2%	71.9%	100%	KFHT above national average Higher number is better
% of patients admitted that were risk assessed for VTE Oct 2017-Dec 2017	98.1%	95.3%	76.1%	100%	KFHT above national average Higher number is better
Latest Data Published	2 March 2018				

Kingston Hospital NHS Foundation Trust considers that this data is as described for the following reasons - high level of data coding accuracy.

Kingston Hospital NHS Foundation Trust has taken the following action to improve this rate, and so the quality of its services. The Trust has introduced mandatory field to mandate VTE risk assessments.

Indicator	Trust	National	Min	Max	Comment
Rate per 100,000 bed days for C.diff reported within the Trust for patients >2 years old Apr 2015-Mar 2016	12.4	14.9	0	82.7	KFHT below national average Lower number is better
Rate per 100,000 bed days for C.diff reported within the Trust for patients >2 years old Apr 2016-Mar 2017	10.9	13.2	0	67.2	KFHT below national average Lower number is better
Latest Data Published	6 July 2017				

Kingston Hospital NHS Foundation Trust considers that this data is as described for the following reasons – sustained focus across the organisation and close monitoring of results. Kingston Hospital NHS Foundation Trust has taken action to improve this rate, and so the quality of its services by delivering its infection control plan.

Indicator		Trust	National (Acute Trusts)	Min	Max	Comment
Number and % of patient safety incidents Apr 2016 – Sep 2016	Number	2,974	673,865	1,485	13,485	KFHT is lower than the National Average Rate for Acute Hospitals.
	Rate per 1,000 bed days	44.6	39.9	21.1	71.8	
Number and % of patient safety incidents Oct 2016 – Mar 2017	Number	2,453	696,643	1,301	14,506	KFHT is lower than the National Average Rate for Acute Hospitals.
	Rate per 1,000 bed days	30.5	40.5	23.1	69.0	
Latest Data Published		November 2017				

Kingston Hospital NHS Foundation Trust considers that this data is as described for the following reasons – derived from our own data collection procedures.

Kingston Hospital NHS Foundation Trust has taken the following action to improve this rate, and so the quality of its services – by promoting to staff the importance of completing incident reports, providing incident reporting training, and improving the feedback mechanisms to incident reporters.

Indicator		Trust	National (Acute Trusts)	Min (Acute Trusts)	Max (Acute Trusts)	Comment
Number and % of patient safety incidents that result in severe harm or death Apr 2016 – Sep 2016	Number	8	16.5	1	98	KFHT is lower than the National Average % for Acute Hospitals. Lower number is better
	%	0.27%	0.37%	0.0 2%	1.7 3%	
Number and % of patient safety incidents that result in severe harm or death Oct 2016 – Mar 2017	Number	10	17.5	1	92	KFHT is higher than the National Average % for Acute Hospitals. Lower number is better
	%	0.41%	0.38%	0.03%	2.13%	
Latest Data Published		November 2017				

Kingston Hospital NHS Foundation Trust considers that this data is as described for the following reasons – derived from our own data collection procedures.

Kingston Hospital NHS Foundation Trust has taken the following action to improve this rate, and so the quality of its services – by providing incident investigation training and working with staff to identify and embed the Duty of Candour (DoC) requirements.

- Duty of Candour audit reviewed and undertaken, with results reported to Serious Incident Group.
- Duty of Candour added to all Patient Safety and Risk Management training, for example, the Managers Toolkit and Health Care Assistant training.
- Introducing process to ensure collection of all learning from incidents, patient feedback, complaints, mortality and mortality reviews and sharing this learning Trust-wide.
- The Being Open Policy has been reviewed and approved as the Duty of Candour Policy.

The Trust has kept a consistent percentage in the number of patients who would recommend this hospital to family and friends from 16/17 to 17/18.

Clinical Area	Response Rate		% of patients who would recommend to Friends and Family	
	2016-17	2017-18	2016-17	2017-18
Inpatients	44.8%	34.3%	95.5%	95.4%
Outpatients			93.3%	93.2%
Day cases	17.5%	14.6%	98.3%	97.0%
A&E	5.8%	10.7%	94.6%	91.6%
Maternity			96.6%	96.6%

National Data from NHS Digital

Indicator		Trust	National	Min	Max
Patient Reported Outcome Measures (PROMS) **Hip Replacement** (Apr 2016-Mar 2017)	**Hip Replacement Primary** **Health Gain (EQ-5D)**	No Data	90.0%	74.4%	43.8%
	Hip Replacement Primary **Health Gain (EQ-VAS)**	No Data	68.0%	43.8%	100%
	Hip Replacement Primary **Oxford Hip Score**	No Data	97.4%	85.0%	100%
	Hip Replacement Revision **Health Gain (EQ-5D)**	No Data	72.8%	25.0%	100%
	Hip Replacement Revision **Health Gain (EQ-VAS)**	No Data	54.4%	11.1%	83.3%
	Hip Replacement Revision **Oxford Hip Score**	No Data	85.6%	50.0%	100%
Latest Data Published 8 February 2018 – Provisional Data (final data expected August ’18)					

Indicator		Trust	National	Min	Max
Patient Reported Outcome Measures (PROMS) **Knee Replacement** (Apr 2016–Mar 2017)	**Knee Replacement Primary** **Health Gain (EQ-5D)**	No Data	81.5%	33.3%	95.2%
	Knee Replacement Primary **Health Gain (EQ-VAS)**	No Data	57.6%	33.3%	88.2%
	Knee Replacement Primary **Oxford Knee Score**	No Data	94.0%	61.1%	100%
	Knee Replacement Revision **Health Gain (EQ-5D)**	No Data	71.1%	33.3%	100%
	Knee Replacement Revision **Health Gain (EQ-VAS)**	No Data	49.9%	48.5%	100%
	Knee Replacement Revision **Oxford Knee Score**	No Data	86.2%	50.0%	100%
Latest Data Published 8 February 2018 – Provisional Data (final data expected August ’18)					

Indicator		Trust	National	Min	Max
Patient Reported Outcome Measures (PROMS) – Groin Hernia 2016-17	**Health Gain (EQ-5D)**	No Data	50.5%	10.0%	83.3%
	Health Gain (EQ-VAS)	No Data	39.1%	13.3%	66.7%
Latest Data Published 8 February 2018					

Indicator		Trust	National	Min	Max
Patient Reported Outcome Measures (PROMS) – Varicose Vein 2016-17	**Health Gain (EQ-5D)**	No Data	51.9%	11.1%	83.3%
	Health Gain (EQ-VAS)	No Data	40.2%	0.0%	83.3%
	Health Gain Aberdeen Score	No Data	81.0%	42.9%	100.0%
Latest Data Published 8 February 2018					

Kingston Hospital NHS Foundation Trust considers that this data is as described for the following reasons - data derived from returns to national data collection procedures.

Please note that PROMS data on Groin Hernia and varicose vein surgery ceased to be collected on the 1st October 2017 following the consultation on the future of PROMs by NHS England.

PART 3

LOOKING BACK AT 2017/18

An online survey was conducted to identify the preferred quality priorities of Kingston Hospital NHS Foundation Trust Members and staff and other stakeholders to take forward throughout 2017/18. These were combined with feedback from various committees and forums to determine the Trust's priorities. The following table outlines the chosen priorities for 2017/18 and summarises if the priority was achieved, partly achieved or not achieved.

Last Year's Priorities:

Domain	Priority	Achieved
Patient Safety	1. Improve learning from incidents.	Achieved
	2. Implement measures to reduce hospital acquired infections caused by gram-negative bacteria.	Partly Achieved
	3. Improve safety awareness for staff through human factors training.	Partly Achieved
Clinical Effectiveness	4. Develop the Trust's next 3 year (2017-2020) dementia strategy and implement year 1.	Achieved
	5. Increase seven day working provision.	Achieved
	6. Commence Implementation of e-prescribing and electronic clinical records in the outpatient setting.	Partly Achieved
Patient Experience	7. Understand and improve the experience of patients with mental health conditions using hospital services.	Achieved
	8. Improve the experience of patients using the emergency department.	Achieved
	9. Improve the experience of patients with haematological cancer.	Achieved

DOMAIN : PATIENT SAFETY

PRIORITY 1 - Improve Learning from Incidents

Achieved

Goal	Aim
Safety	To build upon the work completed as part of the Trusts Sign up to Safety Pledges, by: Improving reporting rates of low harm patient safety incidents so that our reporting rate is within the second quartile of our peers on the National reporting and Learning System (NRLS) by the end of Quarter 4 2017/18. Improving existing mechanisms for the identification and dissemination of learning from patient safety incidents; with complaints and claims, etc.

Measure:

- Increases in the rate of low harm, patient safety incidents reported to the National Reporting and Learning System (NRLS).
- Additional feedback mechanisms in place for the dissemination of learning from incidents.
- Levels of patient safety and Root Cause Analysis training sessions for staff.
- Positive changes in rankings issued in the NHS England's 'Learning from Mistakes league table' during 2017/18.

Reference for data source: National Reporting and Learning System (NRLS) patient safety incident reporting rates.

Governed by standard national definitions? Yes, the Trust uses the National Patient Safety Agency/NHS Improvement definition of a patient safety incident.

Why did we choose this?

The Trust encourages a culture of openness and reporting of incidents and near misses. By working on improving awareness of incident reporting and management processes, we are also building on the work undertaken as part of our Sign up to Safety Campaign pledges. By providing further Root Cause Analysis training to our staff, and increasing our feedback mechanisms to communicate learning from incidents, we are also aiming at reducing incident and near miss recurrences.

What we said we were going to do

- Improve reporting rates of low harm patient safety incidents so that our reporting rate is within the second quartile of our peers on the National reporting and Learning System (NRLS) by the end of Quarter 4, 2017/18.
- Improving existing mechanisms for the identification and dissemination of learning from patient safety incidents; with complaints and claims.

How did we do?

In the 2017-18 year, 98.4% of the incidents reported at KHFT were rated as 'low harm' or 'no harm'. National comparative data is not available yet for this time period. However, national average data for the 12 months between October 2016 to September 2017 is availabe. The average proportion of No Harm and Low Harm incidents was 97.5% nationally for 'acute / general hospitals' between October 2016 to September 2017.

From this we can conclude that as a Trust we are not an outlier in terms of reporting when compared to our Peers. We have commenced reporting mechanisms to support patient safety improvements, such as ward scorecards, and a system of reviewing them, as well as a clear vision for sharing learning through the Trust.

2017-18 Position as of the 22 April 2018 (local figures pre-validation)	
	Number of Patients Safety Incidents
Total number of patient safety incidents recorded for the period 01/04/2017 to 31/03/2018	6568 (on 5575 the actual harm has been confirmed by the incident investigator to date)
Severity of incidents by the degree of harm	99 Near Miss 3723 No Harm 1663 Low Harm 72 Moderate Harm 12 Severe Harm 6 Death
Percentage of Severe Harm or Death incidents (excludes near misses)	0.33%

PRIORITY 2

Implement measures to reduce Hospital-Acquired Infections caused by Gram Negative Bacteria

Partly Achieved

Goal	**Aim**
Safety	To meet the E. coli and other gram negative bacteria reporting and improvement requirements of Public Health England (PHE) and NHS Improvement (NHSI) in 2017/18

Measure:

- Trust E.coli bacteraemia (blood stream infection) rates.
- Other gram negative bacteraemia rates (as defined by PHE & NHSI reporting and reduction requirements).
- Implementation of gram-negative action plan as per PHE & NHSI guidance during 2017.

Reference for data source: Public Health England (2016) *Escherichia coli (E. coli) bacteremia: annual data***.** Available from: https://www.gov.uk/government/statistics/escherichia-coli-e-coli-bacteraemia-annual-data [Accessed 07.02.17].

Governed by standard national definitions? Yes, Public Health England.

Why did we choose this?
The Trust has made significant improvements in reducing hospital acquired infections such as MRSA bacteraemia and *Clostridium difficile*, and significant focus has been placed upon improving the recognition and management of sepsis. There is growing concern nationally and internationally regarding the rise in antimicrobial resistance and specifically Gram negative infections. Gram negative bacteria such as E. coli can cause blood stream infections in hospitalised patients. In selecting this quality account priority the Trust would focus on further improvements to infection control, which will include; antibiotic prescribing practice; and the management of Catheter Associated Urinary Tract Infections (often linked to Gram negative bacteraemia), both of which require working with colleagues in primary and community care to achieve.

What we said we were going to do
Meet the E. coli and other gram-negative bacteria reporting and improvement requirements of Public Health England (PHE) and NHS Improvement (NHSI) in 2017/18.

How did we do?
The Trust was listed in the thirty Trusts with the lowest rates of E. coli bacteraemia in 2016/17 (NHS Improvement, 2017). There were 22 Trust apportioned E.coli bacteraemias in 2016-17 and 31 in 2017-18. This increase occurred despite implementation of an action plan and the completion of post infection review on all cases. The senior nursing team and the Infection Protection Control Team (IPCT) are currently exploring options to progress the GNBSI reduction agenda. It has been recognised that this is particularly challenging within the scope of existing resources.

The full year 17/18 figures for E.coli and other gram negative bacteraemias

Bacterium	2016-17	2017-18	% Change
Ecoli (All)	168	148	-12%
Ecoli (Hospital Aquired)	22	31	41%
Klebsiella spp (All)		35	
Pseudomonas aeruginosa (All)		15	

The Infection Prevention & Control Team (IPCT) implemented an action plan in Jan 2017, which included post infection review of all *E.coli* blood stream infections (BSIs). Baseline figures from April 1st – 8th 2017 demonstrated that 57% of *E. coli* BSIs were related to urinary tract infections and learning points for improving care were identified. Other causes (hepatobiliary, gastrointestinal and endocarditis) didn't identify any further learning points.

The emphasis is currently on reducing urinary tract infections and a Gram-negative blood stream infection (GNBSI) project group has been established to deliver the action plan. The project has four distinct phases:

1. Data collection, case review and identification of themes
2. Discuss implementation plan with community partners
3. Implement reduction plan and expand this as required.
4. Evaluate the project.

Improvements which have been implemented:

- Post Infection Reviews for all Trust apportioned GNBSIs are reported through Service Line (departmental) meetings and the Serious Incident Group to ensure learning and care improvements are both recognised and shared to support future care improvements.
- There is a monthly reporting of *E. coli* numbers to Public Health England with Trust-apportioned cases and themes reported in the internal Infection Control Quarterly Report.
- There has been a Catheter care and continence study day delivered to Trust and non-Trust staff in June 2017.
- Exploration of further service improvements that may impact a reduction GNBSI are:

    - Use of Red Bag Scheme (patients from a community care provider with a 'red bag' to ensure correct kit and items are provided at discharge.
    - Catheter training for Emergency Department staff.
    - Catheter passport (a document which has all details of the catheter) and home pack.

- A Patient support group has commenced.
- An E-trigger for catheter removal.
- Dedicated Emergency Department urology unit.
- Streamlining equipment.
- Implementation of catheterisation packs in the Trust.
- Implementation of COBWEB (a computer-based software package providing central patient management to deliver the best patient care).

PRIORITY 3

Improve Safety Awareness for Staff through Human Factors Training

Partly Achieved

Goal	Aim
Safety	Completion of Human Factors training by 20% (n=265) of clinical staff by the end of Quarter 4 of 2017/18. A nominated Human Factors lead in place for each Clinical Division by the end of Quarter 2 of 2017/18.

Measure
Clinical staff trained in Human Factors illustrated as a percentage of the total whole time equivalent clinical workforce.

Governed by standard national definitions? Yes, NHS England, Health Education England and NHS Improvement.

Why we chose this indicator
Research into safety in complex systems like healthcare tells us that human factors such as teamwork, communication, situational awareness and leadership are significant in the causes of failures. However we also know that training in these areas can improve outcomes for patients and have a positive impact on staff morale. Developing a Trust-wide programme for human factors training would facilitate better awareness of these issues and support our safety improvement initiatives. This will also support our identification of learning from incidents.

What we said we were going to do
Implement Human Factors training with staff by the end of Quarter 4 of 2017/18.

Introduce a nominated Human Factors lead in place for each Clinical Division by the end of Quarter 2 of 2017/18.

How did we do?
The maternity service was successful in their bid for the Maternity training fund for 2016/17. The aim of the fund was to support maternity teams with the implementation of the national ambition to reduce the rate of stillbirths, neonatal and maternal deaths and intrapartum brain injuries in babies in England by 20% by 2020 and 50% by 2030, to ensure England is one of the safest places in the world to have a baby. The ambition is part of a wider government aim to reduce all avoidable harm by 50% and save 6,000 lives by 2017. It will form a key part of the work of the patient safety campaign.

The funds were used to commission a ‘train the trainer’ 5 day course delivered in house by Global Air Training (March 2017).This was attended by 8 members of the maternity

multidisciplinary team, including 3 Consultant Obstetricians, a Consultant Anaesthetists, 2 Practice Development midwives, Antenatal Matron and Consultant Midwife.

Human factors is a discipline that seeks to optimise the relationship between technology and humans, applying information about human behaviour, abilities, limitations and other characteristics to the design of tools, machines, systems, tasks, jobs, and environments for effective, productive, safe and comfortable human use.

Over recent years there has been greater recognition within maternity services as to the benefits that can be gained through adopting a human factors approach to the assessment and management of risk and error. This approach is hoped to recognise and therefore reduce Human factors issues that are contributing to maternity incidents, through developing systems and strategies to learn from mistakes to minimise their occurrence and effects.

The objectives for maternity in 2017/18 were to incorporate Human Factor components into in house multi-disciplinary training. To date maternity has implemented this within the PROMPT (Practical Obstetric Multi-Professional Training), foetal well-being classroom and shop floor training sessions, Maternity Support Worker training induction, Anaesthetic training and Live Simulation Drills. Since January 2018, weekly sessions for Junior Doctors have been held focussing on monthly themes for example ‘optimising decision making’ and ‘assertiveness’ the content is also available in short videos and a WhatsApp group has been formed to support sharing and on-going learning.

Changes have been within the multi-disciplinary morning handover to ensure appropriate attendance, clear introductions are made and that each member is aware of their responsibilities within the team.

To improve the culture of safety, communication and team work in acute clinical areas work has been focused on ensuring the team have timely breaks, good clinical support and a freedom to speak out if they have any concerns or issues that they feel other need to be aware of.

Human factors has been incorporated within the maternity risk management process, through encouraging reporting of incidents, timely review of these incidents, and during the moderate harm and serious investigation process applying DuPont’s dirty dozen model to ensure we have considered the factors that may have had an impact on human error.

In January 2018 a team of 20 midwives and obstetricians attended a one day workshop ‘Resilience in healthcare’, and the learning and skills gained from this will be cascaded through the Professional Midwifery Advocate (PMA) restorative supervision sessions that all midwives engage with.

The evaluation of the impact of the Human Factors train the trainer programme is via the Maternity Training Group (Quarterly) who oversees all training within maternity currently and this is a standing agenda item. The success of this has led to a commitment for the Trust to plan to implement this across the Trust.

In terms of taking this into the organisation, Human Factors is incorporated into the Quality Improvement training methodology which we adopted in the Trust, and currently being implemented. This priority is, therefore, partly achieved.

DOMAIN : CLINICAL EFFECTIVENESS

PRIORITY 4 – Develop the Trust's next 3 Year (2017-2020) Dementia Strategy and implement Year 1

Achieved

Goal	Aim
Effectiveness	To develop the Trust's next three year dementia strategy and implement year one of the strategy

Measure:

- Year 1 milestones of strategy (to be approved in Q1 2017/18)
- Patient & carer satisfaction using carer survey
- Clinical audit

Reference for data source: Patient survey, complaints, clinical audit, dementia scorecard

Governed by standard national definitions? Yes, NICE Clinical Guideline 42 - Dementia: supporting people with dementia and their carers in health and social care.

Why we chose this indicator

Over the last three years the Trust has focused on improving the care provided to patients with dementia, and support to their carers. The initial strategy had been implemented, and building upon this the Trust prioritised to develop a further strategy for the next three years. With successes over recent years for example the opening of a new dementia friendly ward and the development of therapeutic activities for patients, this objective will enable the development of a new strategy to focus on areas for further development. We will commence delivery of the first year plans. Dementia remains an important concern for our local population given its prevalence and increasingly ageing population.

To develop the new strategy, the Trust hosted its second Dementia Conference in April 2017. This involved a wide range of stakeholders including staff, carers, community partners and voluntary organisations reviewing the achievements of the Strategy 2014-2017 and looking forward to what the Trust wanted to achieve in the next 3 years. From this the new Dementia Strategy 2017-2020 was written and approved by the Trust Board of Directors in July 2017.

What we said we were going to do

To develop the Trust's next three year dementia strategy and implement year one of the strategy.

The strategy was written in May 2017 and approved at Trust Board of Directors in July 2017. Implementation of year is on target against plan.

How did we do?

Year one of the strategy is being implemented and the following outcomes have been achieved in each strategic priority.

Care relationships and staff skills:

- Created 200 new dementia friends.
- Training incorporates dementia carer and patient stories.
- Staff will have access to a full day on dementia management, managing agitation and behaviours that challenge.
- Incorporated dementia on the elderly care education programme.

- We are also developing specific training for health care assistants (HCAs) who carry out enhanced observations (to commence in March 2018) and piloting a different ways of doing 1:1 care to meet the specific needs of patients with dementia.

Environments of care:

- Incorporate dementia friendly design into Emergency Department refurbishment plans.
- Outpatient areas to have dementia friendly artwork throughout departments (on track for March 2018).
- Design dementia friendly signage strategy.
- De-clutter ward environments both of equipment and notice boards.
- Design planned for a carers' room on the orthopaedic ward.
- Additionally dementia friendly refurbishment has occurred across 4 wards as part of the overall estate improvements fire safety works with more planned for 2018.
  Active Days and Calm nights.
- Introduce remind me care on Derwent ward and train dementia volunteers and ward staff.
- Recruit more dementia volunteers through student placements.
- The activity room now runs a full programme with daily groups including lunch clubs, exercise classes and memory cafes.

Partnership with carers:

- Expand Dementia support worker role to 2 days a week to support carers.
- Staff education has commenced about the importance of carers and 'John's Campaign'.
- Recruit more carer representatives to the strategy group.
- We have developed a leaflet about delirium for patients and carers.

Diagnosis, clinical care and treatment:

- Develop pain pathway for assessing and monitoring pain including the abbey pain scale.
- Implement the 'red bags' initiative where Red Bags containing what patients need and information about how to care for them move with patients through any care setting containing all their needs and information.

PRIORITY 5 - Increase 7 Day Working Provision

Achieved

Goal	Aim
Effectiveness	To improve the provision of 7 day working services in the Trust and improve quality of care for patients by having timely consultant ward reviews, every day, on every ward (including the acute assessment unit) The Trust will aim to meet the 4 priority standards as defined by NHS England

Measure
NHS England have issued 4 priority standards in relation to seven day services:

- Patients reviewed within 14 hours of arrival by consultant
- Patients reviewed within 14 hours of admission by suitable consultant
- Suitable consultant once daily reviews
- Suitable consultant twice daily reviews

Reference for data source: NHS England National Self-Assessment Audit on 7 day services.

Governed by standard national definitions? Yes, via NHS England priority standards.

Why we chose this indicator
Emergency services are available every day in the hospital but access to seeing senior doctors and to diagnostic tests are better Monday to Friday than at the weekend. This objective would focus on delivery of the four national priorities to have available the same standards every day. These are; being seen by a Consultant within 14 hours of arrival in hospital, twice daily whilst acutely unwell and every day when needed thereafter, and access to emergency diagnostic tests within one hour and urgent within 12 hours seven days a week. Achieving these standards will mean that we avoid delays for our patients and may reduce the length of time they have to spend in hospital.

What we said we were going to do
Improve the provision of 7 day services and the quality of care for patients by having timely consultant ward reviews, every day, on every ward (including the acute assessment unit), thereby aiming to meet the 4 priority standards as defined by NHS England.

How did we do?
In 2013, ten clinical standards for seven day services in hospitals were developed through the Seven Day Services Forum, which was chaired by Sir Bruce Keogh and involved a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. The standards define what seven day services should achieve, no matter when or where patients are admitted. In order to prepare for seven day services, bi-annual audits commenced in March 2016. The audits focused on four of the key clinical standards on the basis of their potential to positively affect patient outcome:

Standard 2 Time to first consultant review.
Standard 5 Access to diagnostic tests.
Standard 6 Access to consultant-directed interventions.
Standard 8 Ongoing review by consultant twice daily if high dependency patients, daily for others.

Compared to March 2017, the overall percentage of Kingston Hospital patients reviewed within 14 hours of admission by a suitable consultant has improved from 80% to 92%, and exceeds the 90% target set by NHS England. The percentage for weekday admitted cases has improved from 84% to 93% and the weekend admitted cases from 74% to 89%, just 1 review short of achieving the 90% target. The latest audit which took place in September 2017 focused solely on Standard 2 - time of consultant review from admission to hospital, as NHS England were satisfied with the results from Standards 5, 6 and 8 as tested in previous audits.

Clinical Standard 2: First consultant review within 14 hours of admission
Results by admitting specialty. September 2017 Audit.

	KH performance Sep 2017		Previous KH performance	
Admitting specialty	**Number**	**%**	**Mar 2017**	**Sep 2016**
Acute Internal Medicine	93/100	93%	93%	94%
Emergency Medicine	1/2	50%	-	-
General Surgery	21/23	91%	75%	83%
Obstetrics and Gynaecology	2/2	100%	50%	50%
Paediatric Medicine	22/22	100%	88%	95%
Respiratory	1/1	100%	-	100%
Trauma and Orthopaedic Surgery	13/15	87%	73%	70%
Urology	4/5	80%	0%	50%
Total	157/170	92%	80%	84%

The Trust actively participates in the twice-yearly national audit on 7 day services. The Trust has appointed one of the Associate Medical Directors to lead on 7 day services. The last audit round in October 2017 demonstrated 92% compliance with Clinical Standard 2, which is above the national target of 90% and compares extremely well with peers. This has been achieved by changes to consultant working patterns and on call rotas to facilitate timely review of emergency admissions.

PRIORITY 6

Commence Implementation of E-prescribing and Electronic Clinical Records in the Outpatient Setting

Partly Achieved

Goal	Aim
Effectiveness	To improve patient safety, by undertaking a pilot to introduce electronic patient medication records in adult outpatients. Accurate and available electronic records for all patient encounters.

Measures for electronic prescribing:

- Frequency of prescribed outpatient medication.
- Boots Hospital Pharmacy data on clerical and clinical interventions.
- Ulysses Incident reporting data.

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Reference for data source: Boots Pharmacy intervention data, Kingston Hospital Foundation Trust Ulysses data, and Documentation data on CRS using a Cerner tool/our Data Warehouse extracts and prescribing records in CRS.

Governed by standard national definitions? Yes, Carter recommendations to put in place a fully integrated e-prescribing system, and NHS England recommendations for paperless patient records.

Why we chose this indicator

The Trust has already introduced electronic prescribing and electronic records to inpatient wards and A&E. This is important because implementing electronic patient records and information technology solutions help reduce the amount of time staff spend on administrative tasks. This releases more time for them to provide patient care. It also allows us to introduce systems that support improved patient safety, for example electronic records cannot be lost or delayed getting to a consultation in the same way paper records can be, and are always available for clinical care.

This quality goal would mean we would focus on rolling out these systems to outpatient areas. Prescribing electronically has already been shown to have benefit in inpatient areas, and this will allow the Trust to reduce medication errors resulting from illegible paper prescriptions, non-formulary drug selection and inaccurate dosing information in outpatients.

What we said we were going to do

- Improve patient safety, by undertaking a pilot to introduce electronic patient medication records in adult outpatients.
- Put in place accurate and available electronic records for all patient encounters.

How did we do?

Electronic Prescribing Pilot
A six month pilot (June 2017-November 2017) was performed in one Consultant clinic, to review the feasibility of electronic prescribing using the Clinical Record System. As a result a report on the Outpatient e-prescribing pilot, and an options paper for the implementation of e-prescribing in the outpatient setting, was taken to the Information Management and Technology (IM&T) Steering committee in March 2018.

A phased roll-out to the main outpatient clinics was approved for this financial year, in addition to the Haematology Day Unit in June. A scoping document will be drawn up to document all other remaining outpatient areas, and detail whether they are appropriate for e-prescribing or not. Therefore, this has been partly achieved with firm actions to take this forward described above.

Electronic clinical records was unable to be achieved as workflows could not be adequately replicated on the Clinical Record System (CRS).

DOMAIN : PATIENT EXPERIENCE

PRIORITY 7 : Understand and Improve the Experience of Patients with Mental Health Conditions using Hospital Services

Achieved

Goal	Aim
Patient Experience	To understand and improve the experience of patients with mental health conditions using Kingston Hospital; to increase staff awareness of the needs of patients with mental health conditions; and develop a programme of improvement

Measure:

- Development of a new multi-agency Mental Health Steering Group.
- Agreed improvement action plan in place in collaboration with South West London & St George's NHS Mental Health Trust (SWLStG).
- Timeliness and quality of referrals to psychiatry liaison.
- Incident reporting for a designated group to be defined via the Mental Health Steering Group.
- Number of mental health first aid trainers trained (n= 5) and mental health training available for all staff in the Trust (numbers attended to be reported).
- Patient experience mechanisms e.g. focus groups, one to one interviews, feedback from patients via survey sources (for example the Friends and Family Test (FFT) surveys).

Reference for data source: NICE Guidance, Royal College of Psychiatrists.

Governed by standard national definitions? Yes, NICE clinical guidance for the management of mental health conditions (e.g. NICE Guidance documents - NG58, NG54, CG 42, CG120, QS34).

Why we chose this indicator
One in four people in the UK experience a mental health problem each year. A high percentage of patients at Kingston Hospital will therefore have both a physical and mental health issue. This objective would therefore focus on better equipping our staff to be able to recognise and care for patients' mental health needs.

What we said we were going to do
Develop a programme of improvement to further understand the experience of patients with mental health conditions using Kingston Hospital, and increase staff awareness of the needs of patients with mental health conditions.

How did we do?
Training commenced in October 2017 and consisted of a suite of educational sessions including Educational sessions on the Mental Health Act in the Emergency Department with other educational programmes planned to commence across the hospital. The Mental Health Project group continues to meet regularly. Evaluation was agreed and finalised with our Project sponsor (Kingston University) and baseline data gathered.

- Training in development and commencing at year end:
  - Making 'Specialling' Special; enhanced observation training for Health care Assistants, Band 2 staff
  - Conflict management training including de-escalation training
  - Children's and Young persons' simulation training supported by Children and Adult Mental Health Services (CAMHS).
- Mental Health First Aid Instructors trained and implemented monthly Adult and Youth training from January 2017.
- Initial scoping completed including a learning needs analysis for needs of mental health training.
- Approach to enhancing awareness defined; including Mental Health first aid and integrating expertise from SWLSTG into existing training events including care of the elderly.

PRIORITY 8 : Improve the Experience of Patients using the Emergency Department

Achieved

Goal	Aim
Experience	To improve the experience of patients attending the main Emergency Department and the Royal Eye Unit Emergency Department

Measure:
- Improvements to the physical environment of the Emergency Department.

- Improved Family and Friends Test (FFT) response rate in the main Emergency Department to 15% by Q4.
- Consistent positive FFT feedback above 95%.
- Formal complaints rates in these two areas are reduced at year end compared to previous year.
- PALS data is demonstrating less contacts when compared to the previous year.

Reference for data source: FFT reports, ED action plans from FFT feedback, and Complaints/Compliments.

Governed by standard national definitions? Yes, NHS England and NHS Digital.

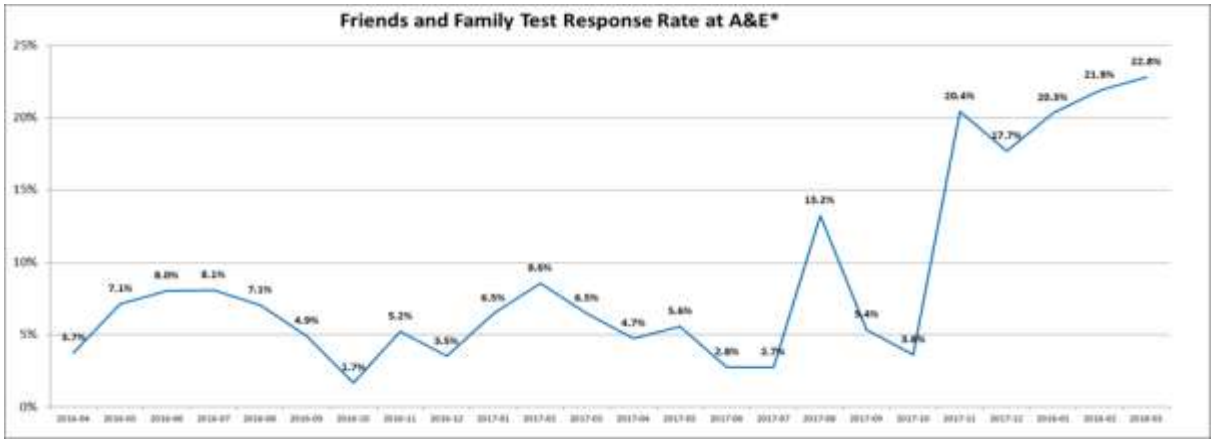
Why we chose this indicator
The Trust sees and treats over 110,000 patients a year through its two emergency departments – the main Emergency Department (which includes paediatric A&E) and the Royal Eye Unit Emergency service. Over the last year the Trust has made further improvements to the Emergency Department, in order to improve the experience of waiting. This has included the opening of a new Clinical Decisions Unit in November 2016.

We know from our CQC inspection in 2016, our A&E survey results and other sources of feedback e.g. complaints; and Friends & Family Test results that there is opportunity to improve the experience of patients using these services. This objective will therefore focus on improving the experience for patients in both the main Emergency Department and in the Royal Eye Unit Emergency Service.

What we said we were going to do
Improve the experience of patients attending the main Emergency Department and the Royal Eye Unit Emergency Department.

How did we do?
There has been a significant increase in feedback for the emergency area following the introduction of a new electronic system to attain patient feedback. The response rate is above the 15% in the last quarter (see table below) so this set goal has been achieved.

Table depicting Friends and Family Test Response rates in A&E 2016-17



There has been significant progress to develop new areas in the emergency department providing a much improved and updated environment for patients, visitors and staff. The new Urgent Treatment Centre enables separation of the different types of patient care needs attendances from the main department which means these patients can be seen more quickly by an appropriate clinician in a calmer environment. Waiting areas have been refurbished and further updates are planned to provide a more comfortable space for patients and relatives whilst waiting to be seen and ensuring they have access to patient information and waiting times data.

The Dementia Friendly Zone has been specifically design to create a calming space with orientation equipment and cues, colour and reduced unnecessary medical equipment. This area and the new resuscitation cubicles also have specific areas to accommodate relatives.

There is a reduction in the number of formal complaints in the Emergency Department in 17/18 when compared to the previous year. This demonstrates achievement of the set goal. We encourage a culture of resolving complaints at the earliest opportunity and PALS are the first port of call for people who have a concern. It is therefore not unexpected that, given the increased activity in the Emergency Department, the number of contacts through PALS has increased slightly.

Table showing 16/17 complaints and PALS comparison to 17/18 for the Emergency Department.

Accident and Emergency Department

	Formal Complaints	PALS Concerns
2016-17	63	106
2017-18	46	119

Following the results of the National Emergency Department Survey 2016, which does not delineate specific Emergency Departments, the Trust centred the majority of improvement work on improving the main Emergency Department. Within the Royal Eye Unit (REU) the following improvements have been made based on national survey data and day to day patient feedback:

- The area has been decluttered with new privacy screens in place protect confidentiality and improve the environment.
- The welcoming process at reception has been revised and a training programme is in place.
- The improvements to Car Parking facilities simplify the process for those who do not know how long their treatment will take.
- Waiting times have been reduced by increasing the number of treating clinicians.
- The department is also employing allied health care professionals to provide emergency care. Waiting times displayed in the waiting area are regularly updated with closer monitoring of waiting times by department Matron and team to respond to flow and communicate to those waiting.

Going forward, the new FFT system allows the department to see commentary specifically about the patient experience in the REU ED for the first time. The department are now able to respond to feedback on a daily basis and while feedback is largely positive, improving waiting times remains an improvement priority.

PRIORITY 9 : Improve the Experience of Patients with Haematological Cancer

Achieved

Goal	Aim
Experience	Improve the experience of patients with haematological cancer.

Measure:
Patient experience results from the NCPES and repeat local survey to monitor improvement in satisfaction levels.

Reference for data source:
- NCPES results 2016 which are due to be published in July 2017.
- Results from repeat local survey scheduled for September 2017.
- Relocation of the haematology service into the Sir William Rous Unit.

Governed by standard national definitions? Yes, NICE Guideline 47 - Haematological cancers: improving outcomes.

Why we chose this indicator
The Trust has made significant improvements in the care of patients with cancer, which has resulted in us being one of the best in the country for improving patient pathways to achieve cancer wait targets. We do recognise from the results of patient surveys that in the haematology cancer pathway there is an opportunity to improve patient experience. This would include redesigning the environment of care for patients receiving treatment at Kingston Hospital and moving the service into an expanded Sir William Rous Cancer Unit. This move would have the additional benefit of giving patients easier access to the Macmillan Information Centre and wellbeing support which is located in the unit.

What we said we were going to do
Improve the experience of patients with haematological cancer.

How did we do?
The National Cancer Patient Experience Survey (NCPES 2016) results came out on 31 July 2017. The results showed Haematology had improved in a number of areas. For example 70% (63% the previous year) felt their test results had been given in a completely understandable way, 97% (88% national average) found it easy to contact the Clinical Nurse Specialist (CNS) and 93% (89% national average) received understandable answers to important questions all or most of the time.

In September the haematology service met with cancer services to discuss the areas where NCPES 2016 highlighted area where improvements were needed for example; patients completely understood the explanation of what was wrong and being told about side effects from their treatment that could affect them in the future.

An action plan was developed and is bringing about change in clinical practice – the haematologists discuss the importance of clear communication on the junior doctors' induction programme. The lead haematology CNS is developing guidelines for all nurses communicating side-effects of treatments is consistent.

The importance of highlighting the possible side effects and signs and symptoms of a recurrence is the basis for our new initiative – 'Health and well-being after treatment for cancer'. From January 2018, all patients are now being invited to attend a post treatment health and well-being information and support session, where side-effects can be discussed including management of them once again. Of the thirty four patients that attended the first session, nine of the patients had a haematology cancer.

Since August 2017, Kingston's cancer services (under the Cancer Vanguard, Royal Marsden Partners) began a pilot real-time feedback survey with the **IWantGreatCare** organisation. Being a real-time feedback survey, the Trust is now in a position to act on any negative comments immediately. There have been 118 haematological completed surveys All of the respondents said they had been treated with dignity and respect (113 rated the service a 5 out 5 and 5 rated it as a four out of 5). 96.8% said they would recommend this service to others.

Since June 2017, we have trained a number nurses to administer chemotherapy to the haematology inpatients. This improved skill mix means the patients will be better informed of the possible side effects and the other nurses on the ward will be more informed and able to provide better care to their patients. We have also secured additional funding for; a dedicated haematology-oncology Clinical Nurse Specialist (CNS) (Band 7) and for another chemotherapy nurse on the haematology–oncology day unit (Band 5)

In September a design steering group with the key stakeholders was convened to discuss the plans to relocate the haematology-oncology day unit to the Sir William Rous Unit (SWRU). The designs have refined to reflect the key stakeholders' requirements. The project is on target and the SWRU extension should be completed by the end of 2018.

The Single Oversight Framework

NHS Improvement is responsible for overseeing NHS foundation Trusts in England and offers the support foundation Trusts need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. The Single Oversight Framework is the principal means by which NHSI holds Trusts to account and assesses whether or not to intervene to ensure services are sustainable.

There are five themes to the Single Oversight Framework:

- Quality of care (safe, effective, caring, responsive)
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

The Single Oversight Framework helps NHSI to identify potential support needs, by theme, as they emerge. It allows tailored support packages to be provided and is based on the principle of earned autonomy. NHSI has segmented the provider sector according to the scale of issues faced by individual providers. This segmentation is informed by data monitoring and judgements are made based on an understanding of providers' circumstances.

2017/18 Outcomes by Quarter of the Single Oversight Framework

Ref	Metric	Q1	Q2	Q3	Q4	Target	Q1	Q2	Q3	Q4	YTD
k6.02	RTT 18 weeks - incomplete					92%	94.6%	94.2%	94.4%	94.1%	**94.3%**
k6.06	A&E 4 hour waiting time (all types)					95%	89.8%	92.0%	89.5%	85.3%	**89.2%**
k6.16	Cancer - Two month urgent referral to treatment wait (from urgent GP referral) - post local breach allocation					85%	95.7%	94.0%	89.3%	91.7%	**92.7%**
k6.17	Cancer - 62 day wait for first treatment following referral from an NHS Cancer Screening Service - post local breach re-allocation					90%	93.3%	92.3%	100.0%	100.0%	**96.1%**
	Cancer - Two month urgent referral to treatment wait (from urgent GP referral) - pre local breach allocation										
	Cancer - 62 day wait for first treatment following referral from an NHS Cancer Screening Service - pre local breach re-allocation										
k6.15	Cancer - 31 day second or subsequent treatment - surgery					94%	100.0%	98.0%	100.0%	96.8%	**98.8%**
k6.14	Cancer - 31 day second or subsequent treatment - drug					98%	100.0%	100.0%	100.0%	100.0%	**96.1%**
k6.13	Cancer - Patients receiving first definitive treatment within one month (31 days) of a cancer diagnosis					96%	100.0%	99.6%	98.5%	98.7%	**99.2%**
k6.11	Cancer - Two week wait					93%	98.9%	98.6%	98.4%	98.2%	**98.5%**
k6.12	Cancer - Two week referral to 1st outpatient - breast symptoms					93%	99.0%	98.9%	98.5%	94.3%	**97.9%**
k1.08	C.Diff due to lapses in care (YTD)					<9	0	0	2	3	**5**
k1.07	Total C.Diff YTD (including cases deemed not to be due to lapse in care and cases under review)						3	3	6	6	**18**
	C.Diff cases under review						0	0	0	3	**3**

In the month of March 2018 the Diagnostic (<6 week) Performance was 99.85%. For the entire 2017-18 year, the performance was 99.40%.

Segmentation is into 4 segments, as described below. The Trust has been placed in segment 2

Segment 1: Providers with maximum autonomy − no potential support needs identified across the five themes – lowest level of oversight and an expectation that provider will support providers in other segments

Segment 2: Providers offered targeted support − potential support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS Trusts) and/or formal action is not needed

Segment 3: Providers receiving mandated support for significant concerns – the provider is in actual/suspected breach of the licence (or equivalent for NHS Trusts)

Segment 4: Special measures − the provider is in actual/suspected breach of its licence (or equivalent for NHS Trusts) with very serious/complex issues that mean that they are in special measures

NHSI Risk Assessment Framework

The list of indicators for the period of 1 April 2017 – 30 September 2017 that apply to Kingston Hospital NHS Foundation Trust are included within the Single Oversight Framework above.

Other Improvements to Quality of Care at Kingston Hospital

'Our Hospital, Our Future' Improvement Strategy
Developing our improvement system

In March 2017 the Trust recruited a Head of Improvement and launched its new improvement team. The aim was to support the development of an improvement culture at Kingston Hospital and to support the three key elements of the 'Our Hospital, Our Future' improvement programme.

Figure 1 - Our Hospital, Our Future

Following a review of the knowledge base on healthcare improvement systems, the Improvement team identified a number of characteristics common to organisations that have transformed themselves into outstanding providers of care:

- They set priorities that are focused on the patient and help everyone understand the role they play in achieving those goals.
- They develop leaders who empower and enable staff to succeed in their roles.
- They support everyone to make improvement a core part of their daily work rather than something they have to find extra time for.

- They provide training, coaching and support to help people adopt these new ways of working.

  These characteristics were used to develop a framework for a Kingston improvement system (Figure 2). Since May 2017, this framework has been used to direct our efforts with progress made in a number of key areas:

- Pilot of lean improvement methods in outpatient and ward settings to embed improvement into daily work:

  - Outpatient administration teams adopting visual management and performance huddles to reduce waste and improve patient experience.
  - Developing our 'Model Ward' to ensure safe and timely transfers of care - testing improvement huddles and 'Red to Green' visual management alongside the SAFER bundle in two medical wards.

- Engagement of Executives and senior leaders in visibly enabling this work by attending huddles with front line teams.
- Training over 270 staff in our Kingston model for improvement. This includes a combination of core improvement training, Lean simulations and bespoke training for different professional groups.
- Redevelopment of Trust processes and resources to provide support for improvement with the aim of creating a single point of access for support and advice. This has included redevelopment of the intranet site, collaboration with Clinical Effectiveness and Audit and the creation of a new library of support materials.
- Alignment of improvement programmes and 2018/19 quality priorities to focus our efforts at all levels of the organisation. This includes the identification of three priority improvement programmes for 2018/19 and beyond:

  - Outpatient transformation
  - Flow programme
  - Theatre efficiency

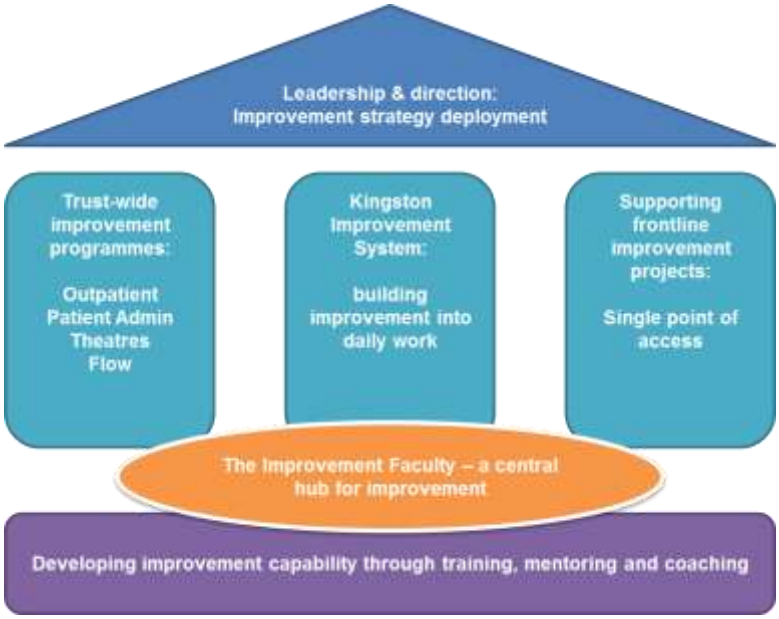


Figure 2 - Kingston Improvement System

Recruitment and Retention

A Recruitment and Retention Forum has been established to ensure a strategic, consistent and planned approach to recruitment and retention activity across the Trust. The work programme for this year includes: Workforce Planning, a strategic recruitment programme, introducing value based recruitment, enhancing recruitment processes and the development and implementation of retention strategies.

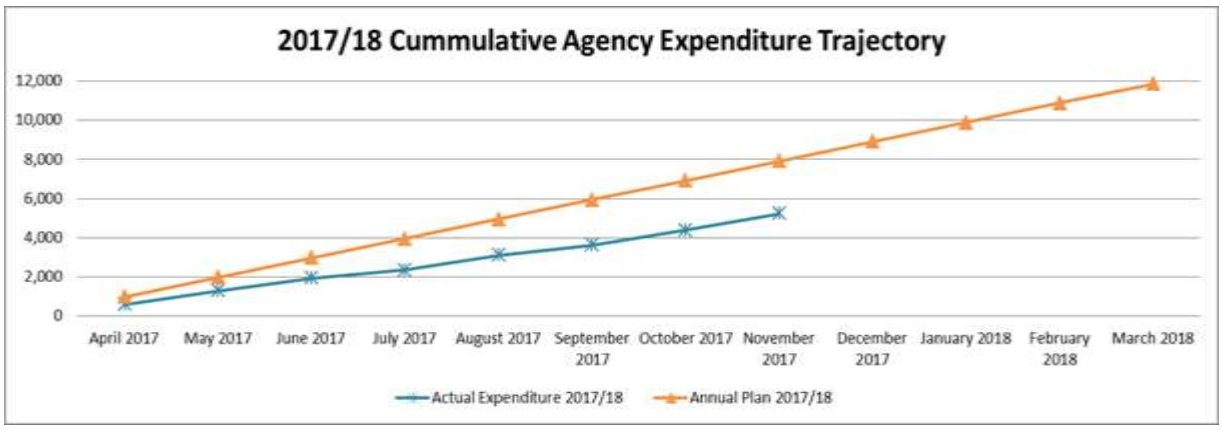
The Safer Staffing Group continues to meet fortnightly to monitor the recruitment progress for nursing, midwifery, nursing assistants and midwifery support workers (MSW). The meeting also focuses on turnover/vacancy rates, roster management and agency/bank utilisation, and acuity data (level of nursing need per patient) for each of the inpatient areas. The Trust continues to manage successful national and international recruitment campaigns for its nursing workforce, with a healthy pipeline in place for 2017/18.

The vacancy rate at the time of writing the report is 9%, which is low when benchmarked against comparator Trusts in London, and is predicted to meet the target we have set ourselves of 5% by the end of 2017/18.

The Trust has a Workforce Strategy in place that provides a framework for retaining staff and includes a staff health and wellbeing programme, flexible benefits, an enhanced learning and development offering and an Equality and Diversity work plan including staff support groups. In addition to this the Trust is employing a range of retention interventions. These include deep dive reviews in areas of high turnover supported with bespoke action plans and a variety of engagement tools – 100 Day Focus groups, probationary periods, exit interviews, a revised corporate and local induction programme and a talent management pool. The Trust's turnover rate is predicted to be below that of last year's by the end of 2017/18.

The Trust's Temporary Staffing Service, managed by Bank Partners, has been in place nearly a year and has been successful in reducing agency staff spend and increasing bank workers across all staff groups. The Trust is engaged in the South West London Collaborative Bank, with the aim of further reducing agency staff spend; this will be launched for nursing staff in January 2018. The Trust is also engaged in the Pan London break glass rates for medical locums, which were launched in October 2017. Over the previous two years the Trust has reduced agency spend as a percentage of the pay bill from 13.30% to 4.81% (as at April 2017).

The Trust has a planned trajectory target of £11.9m agency spend for this year. As the graph below demonstrates, the Trust is currently at £5.2m against a year-to-date target of £7.9m; this equates to £2.7m favourable against the plan.



The Trust's Workforce Pay Control Group has oversight of pay spend and has been successful in controlling spend of both the permanent and temporary workforces.

National Inpatient Survey Results and Actions

From the Inpatient Survey 2016 (published 2017) results, actions have focussed on providing our patients with a restful night supported by the provision of eye masks, and ear plugs.

Knowing whom to approach with queries has been supported by nurses wearing 'Nurse in Charge' badges. This helps identify the senior nurse on duty who can help with questions and queries but also to support other staff to answer questions.

Several improvement actions have been undertaken to facilitate a smooth discharge including increasing the capacity of the discharge coordination team to support complex discharges, improved collaboration with our community provider colleagues to enable appropriate and timely rehabilitation away from the acute hospital.

Enhancing the Frailty team (a multi-professional team between Your health Care and KHFT) Kingston with new funding for a medical lead and Nurse practitioner who focus on supporting people to be able to go home rather than be admitted, and length of stay while increasing the number of people who can go home to their usual place of residence by completing comprehensive specialist assessment on admission.

The Trust-wide Pain Improvement Group was established in summer of 2017 and numerous action have been undertaken support staff to be more ably manage pain for patients. This has included acute pain being introduced into the nurse induction programme, cue cards for staff to refer to for managing pain and patient information leaflets for helping patients with dementia who are in pain/distress. To support staff to more easily document about when patients are in pain, the Vital Signs and pain assessment tool on the CRS system has been relocated for ease of access. There is also a copy of the Pain Policy, which describes how to support ant resolving pain for patients, at each nurses' station and an easy reference algorithm/flow chart.

Several improvements to the care environment have also been made including to the medical in patient wards, decluttering making the environments more 'dementia friendly'

A new interactive FFT system now in place providing areas with real time data. The system enables staff to be responsive to feedback the day it is provided. Staff are being trained in how to make the most of the system to make real time improvements.

Quality Improvement Projects Overview

As well as our top quality priorities, we continue to run a whole suite of improvement projects. We focus on areas where there is improvement required, but in this section we want to highlight some of our other areas of focus and performance.

The topics for our Quality Improvement projects are chosen for a variety of reasons, where the Trust is either not performing at the standard it expects or because new ways of working show that patient care could be improved.

The Improvement in services for patients with chronic obstructive pulmonary disease (COPD) was partly instigated by the publication of the Trust's results in the COPD national clinical audit, which showed further improvement in patient care could be achieved.
The example of the introduction of specialist (Fascia) nerve blocks in the treatment of patients with fractured hips, was chosen because this method of pain relief had been shown to be superior and in use at other hospitals.

EFFECTIVE

Nutrition

The Trust is on target to provide more healthy food options for visitors and staff (as detailed the national health eating Commissioning for Quality Innovation (CQUIN) for 2017 and 2018) by making a significant reduction in high salt, sugar and fat (HSSF) containing products on sale in the canteen and vending machines. During Food and Hydration week beginning 12 March the dietician team provided bite-size teaching sessions on the importance of nutrition and hydration and showcasing testing recipes for 'mocktails' made with the oral nutritional supplements. This means the foods available for staff and visitors is healthier and more nutritious.

A nutrition audit completed in all inpatient areas and the emergency department during September 2017 showed improvements in the assessment of patients to establish nutrition support needs. With the number of patients needing support increasing, a number of steps are in place to meet those needs at meal times including staff training, a pending new meal ordering system and recruiting volunteer dining companions. A project to meet national patient safety recommendations supporting safe Nasogastric tube practice is also well underway. The Trust has developed competencies to train relevant staff, processes and procedures have been revised, including documentation process and new products have been purchased in line with the new recommendations.

RESPONSIVE

Children and Young Person Board

The National Children and Young People's Inpatient and Day Case Survey 2016 (published 2017) highlighted the:

Overall: 91% of parents rated care at 7 or more out of 10.
Hospital staff: 78% of parents always had confidence and Trust in the members of staff treating their child (0-15 years).
Overall: 90% of parents stated they were always treated with dignity and respect by the people looking after their child (0-7 years).

In 2018 the Peadiatric Department is planning on working with a group of young people from Kingston Health Watch Youth Forum and asking them to complete the 15 steps challenge (NHS England) in order to provide feedback on the Peadiatric unit and Peadiatric Emergency Department environment. The Children and Young Peoples Board was set up at the Trust to make improvements to the care of children and young people whenever they are seen in the Trust and has representatives from all areas that see and treat children and young people, as well as a parent and young people's representative.

CARING

Volunteering Report

There are currently 496 volunteers supporting the Trust. 44% of these were recruited within the last year and 52% have been volunteering for over 12 months. We saw many receive their long service awards at a special tea party in the autumn of 2017, celebrating from 5 to 30 years with us.

Our volunteers support patients and staff across many services including:

- The Emergency Department through offering practical and emotional help.
- Discharge Support to aid older patients by offering a listening ear to reduce stress and anxiety. As well as organizing their belongings and transport, purchasing basic shopping, supporting them over the phone for up to 6 weeks and signposting to various agencies.
- Meal times by offering companionship and encouragement to patients, spotting ways to make dining easier and feeding those who need extra help.
- Cardiac wards, whereby former cardiac patients come in and help with various activities in the evening.

Our volunteers add significant value to our work by helping us to provide the best care for our patients. The largest group of our volunteers are between 16 to 24 years old and those over 50 coming next, including some aged 75 to 95.

2017 saw us refresh the Volunteering Strategy to build on previous achievements and set out a plan for targeted growth in areas of greatest impact and innovation leading up to 2020. These building blocks are aligned with the Trust's priorities and responsive to emerging needs.

The strategy has also demonstrated over three years and at significant scale, that volunteering improves overall patient experience. Exemplar programmes such as Dining Companions have also evidenced that targeted volunteering aimed at an improvement theme e.g. patient experience at mealtimes, reveal even greater improvements for the experience of patients specific to that measure or need.

We have continued to demonstrate a national reputation as a sector lead for volunteering in healthcare. The positive evidence generated through the Volunteering Strategy has distinguished the Trust's 'High Impact' volunteering approach from its peers. It has been celebrated through awards and external appraisal.

We were awarded 'Best Value NHS Support Service" as part of the Health Service Journal Value Awards 2017 under the category - Improving the Value of NHS Support Services. We were recognised as having a High Impact Volunteering programme aimed to strengthen relationships between our Trust and communities by establishing a high impact volunteering model and thriving volunteer function.

We have a renowned, robust and thriving volunteering function that helps us to deliver services.

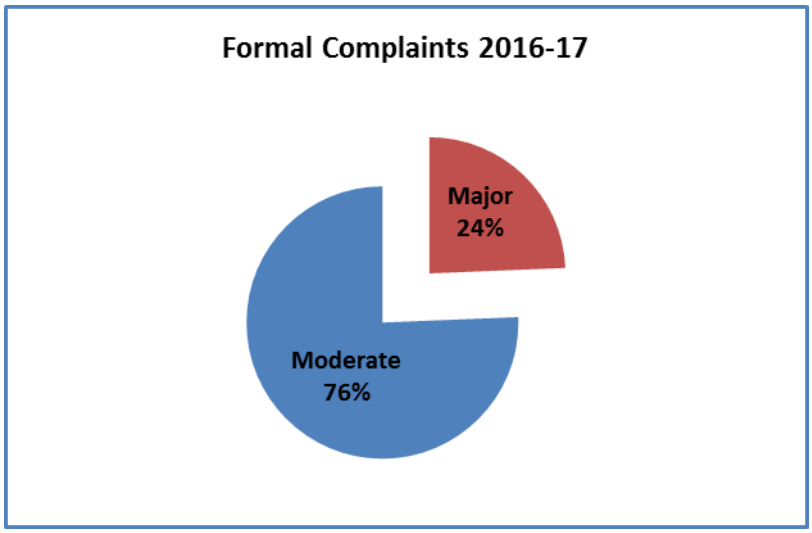
We also enrich our community via highly valued volunteering programmes. For example, our continued sound relationships with Kingston College and various sixth forms across several local boroughs. By facilitating beneficial volunteering opportunities for the Access to Midwifery course and access to first experience steps in a healthcare setting for those leaning towards a career in these fields.

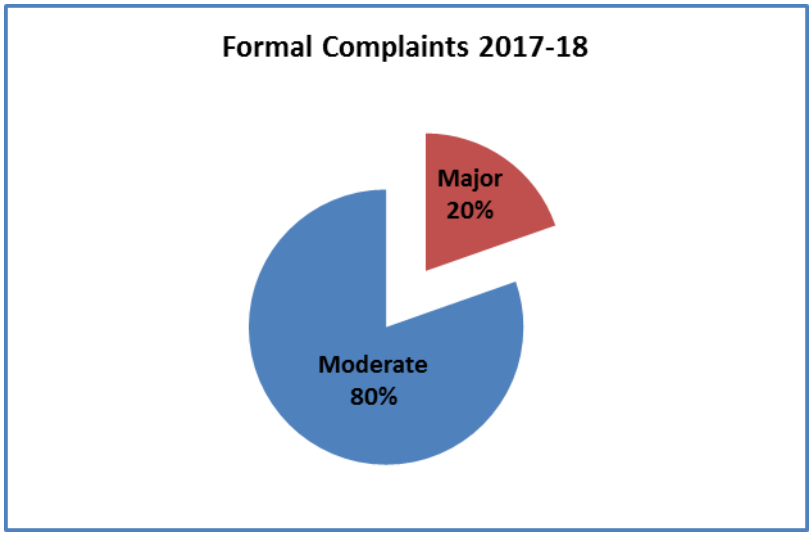
WELL LED

Complaints Performance

There has been a decrease in complaints during 2017/18 as shown in the table below. The percentage of the complaints that are graded as major has also decreased in 2017/18.

Total complaints 2016-17 01/04/2016-31/03/2017	Total complaints 2017-18 (01/04/2017 31/03/2018)
390	**326**





We recognise that swift action in responding to complaints is key to resolving them. As such, we endeavour to respond within 25 working days to all complaints, or by the timeframe agreed with the complainant. During 2017/18, this deadline was met in 72% of complaints**,** compared with 80% in 2016/17. There is ongoing work to improve the timeliness of complaint responses.

The most prominent three themes of complaints were communication (19%), care/treatment (17%), and appointment administration (13%). In 2016/17, communication, and care and treatment related complaints accounted for 21% each of the complaints received, and appointment administration 14%.

Complaints can be made in writing or by email, and information about how to do this is on the hospital website. A questionnaire is sent to complainants to understand their experience of the complaints process when their complaint has been responded to and any improvements to the process will be made as necessary.

Patient Advice and Liaison Service (PALS)

There has been an increase in PALS cases during 2017/18 as shown in the table below:

PALS Cases 2016-17	PALS Cases 2017-18
1470	**1600**

The most prominent three themes of concerns raised were communication concerns (35% of total concerns raised), appointment administration concerns (24%), and care and treatment concerns (14%). During 2016/17, appointment administration concerns accounted for 32% of the concerns received, communication concerns 25%, and care and treatment concerns 14%.

Patient and Public Involvement Strategy

The Patient and Public Involvement (PPI) Strategy has succeeded in establishing robust mechanisms to include and collaborate with services users; from the granular department level to the strategic oversight functions of the organisation. Relationships between the Trust and the local community continue to develop with a need to respond at pace to the evolving shifts in the local demographic, including that of the staff.

- Throughout 2017, the Trust has seen an increase in successful outcomes as a result of integrated PPI activity.
- Good progress has been made following the last strategy review with a shift in engagement with diverse communities and the underrepresented.
- The key areas of focus during 2018 and beyond is to increase FFT response rates in the Emergency and Outpatient Departments, to provide supported engagement opportunities for patients with mental health issues and children and young people, to continue to increase the scope of voluntary sector engagement and develop closer working with the Korean community.
- Commence consultation to refresh the strategy for the future.

Staff Survey Results 2017

The results of the 2017 survey are very positive and amongst the best in London, with the Trust scoring in the top 20% of acute Trusts nationally for 16 key areas. ***Key findings*** from the survey are provided below.

Response Rate

The response rate is 52.8%, an increase on last year's score of 51.1%. The Trust performs well in this respect, ranked 13 out of 93 Acute Trusts, with the national average at 44%.

Engagement Score

The engagement score has increased to 3.92 compared to last year's score of 3.88. This is in the highest 20% when compared to other acute Trusts nationally, ranked 11 out of 93 and is the third best score in London.

Historical Staff Survey Results	2015				2016						2017					
	Our Trust	Other Picker Acute Trusts	Compare other Picker Trusts		Our Trust	Other Picker Acute Trusts	Compare Other Picker Trusts		Compare last year		Our Trust	Other Picker Acute Trusts	Compare Other Picker Trusts		Compare last year	
Response Rate	46.0%	45.0%	1.0%	⇧	51.1%	39.9%	11.2%	⇧	5.1%	⇧	52.8%	45.5%	11.2%	⇧	1.7%	⇧
Engagement Score	3.79	3.79	-	⇨	3.88	3.81	0.07	⇧	0.02	⇧	3.92	3.79	0.07	⇧	0.04	⇧

There are three key findings relating to the staff engagement score:

- Staff recommendation of the Trust as a place to work or receive treatment.
- Staff motivation at work.
- Staff ability to contribute towards improvement at work.

For all three of these important areas, the Trust scores in the highest 20% compared to all acute Trusts nationally. These results demonstrate a high level of engagement and that the survey is the majority view of our staff.

Areas of Improvement and High Performance

- The Trust is significantly better than the Picker Acute Trust Average on 51 questions of the 88 asked. The main question areas where the Trust performs strongly are: Your Job, Your Managers, and Your Organisation.
- The areas of improvement and high performance cover a wide spectrum including appraisal, training, support and recognition from managers, communication with senior management, job satisfaction, health & wellbeing, commitment to the organisation, and patient care and experience.
- Of the 88 questions asked, the Trust is significantly better on 3 questions compared to last year:
  - Mandatory Training undertaken in the last 12 months.
  - Received an appraisal in the last 12 months.
  - Appraisal/performance review training, learning or development needs identified.

Areas that Require Improvement

- The number of staff satisfied with pay has decreased from 32% to 27%.
- Staff experiencing harassment, bullying or abuse from patients, relatives or the public.
- Staff experiencing discrimination and believing the organisation provides equal opportunities for career progression or promotion.
- Access to training.
- Of the 88 questions asked, the Trust is significantly worse on 2 questions compared to last year:
  - Satisfied with level of pay.
  - Not experienced physical violence from patients/services users, their relatives or members of the public.

Top and Bottom Ranked Scores

The survey highlights the top and bottom 5 ranked scores for the Trust. These are tabled below:

Top 5 ranking scores		2015		2016				2017			
		Our Trust	National Average	Our Trust	National Average	Our Trust compare to last year	Our Trust compare to National	Trust	National Average	Our Trust compare to last year	Our Trust compare to National
KF6: % of staff reporting good communication between senior management & staff	higher =better	38%	32%	43%	33%	5% ↑	10% ↑	44%	33%	1% ↑	11% ↑
KF32: Effective use of patient / service user feedback	higher =better	3.75	3.70	3.86	3.72	0.11 ↑	0.14 ↑	3.86	3.71	- →	0.15 ↑
KF3: % of staff agreeing their role makes a difference to patients/ service users	higher =better	91%	90%	92%	90%	1% ↑	2% ↑	92%	90%	- →	2% ↑
KF5: Recognition and value if staff by managers and the organisation	higher =better							3.59	3.45		0.14 ↑
KF31: Staff confidence and secuirty in reporting unsafe clinical Practice	higher =better							3.77	3.65		0.12 ↑

There are three questions that have remained in the top 5 ranked scores for the past three years. This year the Trust has two new questions that have shown significant improvement to now reach the top five.

Bottom 5 ranking scores		2015		2016				2017			
		Our Trust	National Average	Our Trust	National Average	Our Trust compare to last year	Our Trust compare to National	Our Trust	National Average	Our Trust compare to last year	Our Trust compare to National
KF16: % of staff working extra hours	lower =better	76%	72%	75%	72%	-1% ↓	3% ↑	75%	72%	- →	3% ↑
KF20: % of staff experiencing discrimination at work in the last 12 months	lower =better	12%	10%	14%	11%	2% ↑	3% ↑	17%	12%	3% ↑	5% ↑
KF25: % of staff experiencing harassment, bullying or abuse from patients, relative or the public in the last 12 months	lower =better							31%	28%		3% ↑
KF28: % of staff witnessing potentially harmful errors, near misses or incidents in the last month	lower =better	32%	35%	35%	31%	3% ↑	4% ↑	33%	31%	-2% ↓	2% ↑
KF21: % of staff believing that the organisation provides equal opportunities for career progression or promotion	higher =better	82%	87%	83%	87%	1% ↑	-4% ↑	83%	85%	- →	-2% ↓

For the bottom ranked scores, the Trust has four questions that have remained bottom for the past three years. One new question on bullying and harassment has been introduced this year.

The Trust is required to report on the following staff survey results:

Key Finding 21 % believing that the organisation provides equal opportunities for career progression or promotion	
Kingston Trust in 2017: 83%	(median) for acute Trusts nationally: 85%

**the higher the score the better*

Key Finding 26 % experiencing harassment, bullying or abuse from staff in last 12 months	
Kingston Trust in 2017: 26%	(median) for acute Trusts: 25%

**the lower the score the better*

An action plan has been developed in response to the results of the Staff Survey, approved by the Trust Board. A series of events for staff will be held in April to engage further on the survey and the Trust's plans for improvement. The Trust's success in addressing these priorities will be measured by the results of the next year's Staff Survey.

Independent Practitioner's Limited Assurance Report to the Council of Governors of Kingston Hospital NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Kingston Hospital NHS Foundation Trust to perform an independent limited assurance engagement in respect of Kingston Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and additional supporting guidance in the 'Detailed requirements for quality reports 2017/18' (the 'Criteria').

Scope and subject matter

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

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

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

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance issued by NHS Improvement.

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

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance and the six dimensions of data quality set out in the ''Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2017 to 24 May 2018;
- papers relating to quality reported to the Board over the period 1 April 2017 to 24 May 2018;
- feedback from commissioners dated 1 May 2018;
- feedback from governors dated 16 April 2018;
- feedback from local Healthwatch organisations dated 25 April 2018;
- feedback from the Overview and Scrutiny Committee dated 8 May 2018;
- the national patient survey dated 31 May 2017;
- the national staff survey dated 6 March 2018;

- the Care Quality Commission inspection report dated March 2017;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 31 March 2018; and
- any other information obtained during our limited assurance engagement.

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

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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

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

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may

change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Kingston Hospital NHS Foundation Trust.

Our audit work on the financial statements of Kingston Hospital NHS Foundation Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as Kingston Hospital NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Kingston Hospital NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Kingston Hospital NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Kingston Hospital NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Kingston Hospital NHS Foundation Trust and Kingston Hospital NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP

Chartered Accountants

30 Finsbury Square

London

EC2A 1AG

24 May 2018

APPENDIX A

National Confidential Enquiries

National confidential enquiries for inclusion in quality report 2017/18	Participation 2017/18	Number of cases submitted
Child health clinical outcomes review programme: Young people's mental health	Yes	Data collection complete Clinical Questionnaire: n = 5/5 (100%) Case notes: n = 5/5 (100%) Organisational Audit: n = 2/2 (100%)
Child health clinical outcomes review programme: Chronic neurodisability	Yes	Data collection complete Clinical Questionnaire: n = 3/3 (100%) Case notes: n = 3/3 (100%) Organisational Audit: n = 2/2 (100%)
Child health clinical outcomes review programme: Long-term ventilation in children, young people and young adults	N/A	Enquiry in development. No data collected 2017/18
Medical and surgical clinical outcomes review programme: Acute heart failure	Yes	Data collection in progress Clinical Questionnaire: n = 6/6 (100%) Case notes: n = 5/6 (83%) Organisational Audit: n = 1/1 (100%)
Medical and surgical clinical outcomes review programme: Pulmonary hypertension	N/A	Enquiry in development. No data collected 2017/18
Medical and surgical clinical outcomes review programme: Non-invasive ventilation	Yes	Data collection in progress Clinical Questionnaire: n = 5/5 (100%) Case notes: n = 5/5 (100%) Organisational Audit: n = 1/1(100%)
Medical and surgical clinical outcomes review programme: Perioperative diabetes	Yes	Data collection in progress Anaesthetist Questionnaire: n = 4/4 (100%) Surgeon Questionnaire: n = 4/4 (100%) Case notes: n = 3/4 (75%) Organisational Audit: n = 1/1 (100%)
Medical and surgical clinical outcomes review programme: Cancer in children, teens and young adults	Yes	Data collection complete Clinical Questionnaire: N/A Case notes: N/A Organisational Audit: n = 1/1 (100%)
LeDer: Learning disability review programme	Yes	Data collection in progress Case ascertainment: n = 1/4 (25%) (3 cases pending reviews)
Maternal, newborn and infant: Maternal programme	Yes	Not applicable – no maternal deaths reported
Maternal, newborn and infant: Perinatal programme	Yes	n = 37/37 (100%)

Eligible National Clinical Audits 2017/18 – Participation Rates

National clinical audits for inclusion in quality report 2017/18	Participation 2017/18	Number of cases submitted
British Association of Urological Surgeons (BAUS): Female stress urinary incontinence audit (2016 cohort)	Yes	n = 6 (100%)
BAUS: Nephrectomy audit (2014-2016 cohort)	Yes	n = 101 (102.9%)
Cancer: National bowel cancer audit (2016/17 cohort)	Yes	n = 154 (100%)
Cancer: National lung cancer audit (2016 cohort)	Yes	n = 120
Cancer: National oesophago-gastric cancer audit (2016/17 cohort)	Yes	n = 38 (100%)
Cancer: National prostate cancer audit (2015/16 cohort)	Yes	n = 193
Chronic obstructive pulmonary disease (COPD) audit programme: Secondary care (2017/18, Q1-3 cohort)	Yes	n = 223 (100%)
Diabetes: National foot care in diabetes audit (2016/17 cohort)	No	n = 0
Diabetes: National diabetes in-patient audit (NaDIA) (2017 cohort)	Yes	Inpatient diabetes management bedside audit: n = 49 Inpatient experience: n = 27
Diabetes: National pregnancy in diabetes (NPID) (2017 cohort)	Yes	n = 5
Diabetes: National diabetes audit (NDA) (2016/17 cohort)	Yes	n = 200 (100%)
Diabetes: National diabetes transition audit	Yes	Audit extracts data from NDA and NPDA submission.
Diabetes: National paediatric diabetes audit (NPDA) (2016/17 cohort)	Yes	n = 160
Elective surgery (National PROMs programme) – Groin hernia and varicose vein only	Yes	Pre-operative participation rate: 2.3% Post-operative response rate: 100%
Falls and fragility fractures audit programme (FFFAP): Fracture liaison service database – organisational audit only	Yes	n = 1 (100%)
FFFAP: National audit of inpatient falls (2017 cohort)	Yes	n=33 (>100%)
FFFAP: National hip fracture database (2016 cohort)	Yes	n=302 (88.6%)
Heart: Cardiac rhythm management (2015/16 cohort)	Yes	n = 112
Heart: Myocardial infarction national audit project (MINAP) (2015/16 cohort)	Yes	n = 201
Heart: National audit of percutaneous coronary interventions – organisational audit only	Yes	n = 1 (100%)
Heart: National heart failure audit (2015/16 cohort)	Yes	n = 196 (61%)

National clinical audits for inclusion in quality report 2017/18	Participation 2017/18	Number of cases submitted
Intensive Care National Audit and Research Centre (ICNARC): Case mix programme: Adult critical care (2016/17 cohort)	Yes	n = 689
ICNARC: National cardiac arrest audit (NCAA) (2016/17 cohort)	Yes	n = 16
Inflammatory bowel disease (IBD) registry: Biological therapies audit – adults only (2017/18, Q1-3 cohort)	Yes	n=57
National audit of breast cancer in older people (2016 cohort)	Yes	n = 200 (100%)
National audit of dementia	N/A	Audit did not collect data 2017/18
National audit of dementia - Delirium spotlight audit (2017 cohort)	No	n = 0
National audit of seizures and epilepsies in children and young people	N/A	Audit did not collect data 2017/18
National clinical audit of care at the end of life (NACEL)	N/A	Audit did not collect data 2017/18
National clinical audit for rheumatoid and early inflammatory arthritis (NCAREIA)	N/A	Audit did not collect data 2017/18
National comparative audit of blood transfusion programme: Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients (2017 cohort)	Yes	n = 29
National comparative audit of blood transfusion programme: 2017 National comparative audit of transfusion associated circulatory overload (TACO)	N/A	Audit did not collect data 2017/18
National comparative audit of blood transfusion programme: Audit of patient blood management in scheduled surgery (2016 cohort)	Yes	n = 29
National comparative audit of blood transfusion programme: Audit of the use of blood in lower GI bleeding	Yes	Audit did not collect data 2017/18
National emergency laparotomy audit (NELA) (cohort 2016/17)	Yes	n = 93
National joint registry (NJR) (2016 cohort)	Yes	n = 41
National maternity and perinatal audit (NMPA) (2016/17)	Yes	n=5211 (100%)
National neonatal audit programme (NNAP) (2017 cohort)	Yes	n=339 (100%)
National ophthalmology audit: Adult cataract surgery (2016/17 cohort)	Yes	n = 829
Royal College of Emergency Medicine (RCEM): Fractured neck of femur (2017/18 cohort)	Yes	n = 91 (100%)
RCEM: Pain in children (2017/18 cohort)	Yes	n = 42 (84%)
RCEM: Procedural sedation in adults (2017/18 cohort)	Yes	n = 52 (100%)
Sentinel stroke national audit programme (SSNAP) (2017/18, Apr-Nov cohort)	Yes	90%+ (Level A)
Serious hazards of transfusion (SHOT):	Yes	n = 6

National clinical audits for inclusion in quality report 2017/18	Participation 2017/18	Number of cases submitted
UK national haemovigilance scheme (2017 cohort)		
Trauma audit research network (TARN) (2017 cohort)	Yes	49-57% (as of 22/11/17)
UK Parkinson's Audit (cohort 2017)	Yes	n = 35 (>100%)
Adult cardiac surgery	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
BAUS: Percutaneous nephrolithotomy (PCNL)	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
BAUS: Radical prostatectomy audit	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
BAUS: Cystectomy	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
BAUS: Urethroplasty audit	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
COPD audit programme: Primary care	N/A	Trust not eligible to participate in the national audit, as it relates to primary care
COPD audit programme: Pulmonary rehabilitation	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
Endocrine and thyroid national audit	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
Head and neck cancer audit (DAHNO)	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
Mental health clinical outcome review programme **• Suicide by children and young people in England (CYP)** **• Suicide, homicide & sudden unexplained death** **• Safer care for patients with personality disorder** **• The assessment of risk and safety in mental health services**	N/A N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
National audit of anxiety and depression	N/A	Trust not eligible to

National clinical audits for inclusion in quality report 2017/18	Participation 2017/18	Number of cases submitted
		participate in the national audit, service not provided by the Trust
National audit of intermediate care (NAIC)	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
National audit of pulmonary hypertension audit	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
National bariatric surgery registry (NBSR)	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
National clinical audit of psychosis **• Core audit** **• EIP spotlight audit**	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
National congenital heart disease (CHD)	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
National lung cancer audit: Consultant-level data	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
National neurosurgical audit programme - Consultant-level data	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
National oesophago-gastric cancer audit (NOGCA) - Consultant-level data	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
National vascular registry	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust
Paediatric intensive care (PICANet)	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust

National clinical audits for inclusion in quality report 2017/18	Participation 2017/18	Number of cases submitted
Prescribing observatory for mental health **• Assessment of side effects of depot and LA antipsychotic medication** **• Use of depot/LA antipsychotics for relapse prevention** **• Prescribing antipsychotics for people with dementia** **• Monitoring of patients prescribed lithium** **• Rapid tranquilisation** **• Prescribing for bipolar disorder (use of sodium valproate)** **• Prescribing Clozapine** **• Prescribing high-dose and combined antipsychotics on adult psychiatric wards**	N/A	Trust not eligible to participate in the national audit, service not provided by the Trust

APPENDIX B

Actions to be taken following completed National Clinical Audits and National Confidential Enquiries

National Clinical Audit	Actions to Improve Quality
British Association of Urological Surgeons (BAUS): Female stress urinary incontinence audit Updated: Apr 2017	Patient reported outcomes achieved at the Trust are comparable to the national data for pad usage before and after procedure and urine leakage after procedure. No complications were recorded and 100% of patients reported that their symptoms had improved.
BAUS: Nephrectomy audit Updated: Sep 2017	Outcomes achieved for patients treated at Kingston Hospital are within expected range. The Trust is not identified as an outlier for complication, transfusion or mortality rates.
Cancer: National bowel cancer audit Published: Dec 2017	The latest data from the National Bowel Cancer Audit shows that the outcomes achieved by patients operated on at Kingston Hospital are within expected range for adjusted 90-day mortality (both Trust-level and individual surgeon) and for re-admission rate. Following a review of the audit data the Colorectal consultant will review the information given to patients at pre-assessment regarding expectations around length of stay following surgery, and to improve data completeness and quality data will be reviewed prior to submission, with particular focus on laparoscopic surgery and urgent/ emergency surgery and whether seen by clinical nurse specialist.
Cancer: National lung cancer audit Published: Jan 2018	The latest published report is currently under review within the specialty; action planning in progress.
Cancer: National oesophago-gastric cancer audit (NOGCA) Published: Dec 2017	Kingston Hospital achieved the highest green rating for both case ascertainment and for patients with a new diagnosis of oesophago-gastric cancer having a staging CT scan to investigate the extent to which the disease has spread. The gastroenterology service will monitor stent procedures and any complications which arise to further improve patient care and outcomes.

National Clinical Audit	Actions to Improve Quality
Cancer: National prostate cancer audit Published: Nov 2017	To improve data quality and completeness the multidisciplinary (MDT) forms are validated following MDT review by the Urology Cancer Lead Clinician, prior to data submission. The audit data shows that relatively few Kingston patients are undergoing radical prostatectomy. An internal review found that this is offset by patients being offered brachy therapy instead, which has comparable outcomes. The Cancer Leads at Kingston and the Royal Marsden will continue to prospectively monitor the outcomes of this patient group.
Chronic obstructive pulmonary disease (COPD) audit programme: Secondary care Clinical audit due for publication Mar-18. Audit provides live data feed via web tool actions to improve already in progress	Local Quality Improvement Project (QIP) set up to improve best practice tariff achievement - 60% of patients admitted with an acute exacerbation of COPD must have a respiratory specialist review within 24 hrs of admission and be issued with a COPD discharge bundle. As part of the QIP the following actions have already been taken - clinical lead monitors patients admitted with acute exacerbation of COPD to ensure respiratory review within 24 hours; additional support is in place for discharge bundles; and a new band 7 respiratory specialist nurse will start in post from April 2018. The appointment of the nurse specialist will further improve patient care and outcomes for this patient group.
Diabetes: National footcare in diabetes audit (NFDA) Published: Mar 2017	Actions are in progress to improve patient identification, data completeness and data quality, with data being actively entered for the 2017/18 audit. From 2018/19 an audit form will be completed for every patient at the first assessment after appointment at diabetic foot care clinic.
Diabetes: National diabetes in-patient audit (NaDIA) Published: Mar 2017	In response to the results of the national audit, the In-patient Diabetes Quality Improvement Project (QIP) was established to improve patient experience and diabetic management so that future audit results will be in line with national benchmarking. Work streams relate to staff capacity, engagement and knowledge, availability and suitability of equipment and improved processes concerning referrals, discharge and insulin administration. To improve patient care and outcomes the following actions have been taken – provision of hypoglycamic training to band 2 and 5's, hypo boxes available on wards, a new inpatient diabetes nurse appointed, clinical Champions recruited to provide a program of education for nursing staff with a focus on diabetes care, diabetes foot check assessment forms available on CRS and diabetic foot training.

National Clinical Audit	Actions to Improve Quality
Diabetes: National pregnancy in diabetes (NPID) Published: Oct 2017	Very few women with pre-existing diabetes deliver at Kingston Hospital. The audit report did not contain Trust-level data as fewer than 10 women consented to participate in this audit. Participation in the audit will be improved from January 2018 following the removal of the requirement to explicitly consent patients by the national audit supplier.
FFFAP: National Audit of in-patient falls Published: Nov 2017	Kingston Hospital achieved the highest 'green' rating for 2 out of the 7 key indicators assessed by the audit – continence care package and call bell within reach. To improve patient management and care going forwards the Falls Group will be undertaking a monthly audit of the patient's environment. Recommendations for improvement will be fed back to wards and clinical staff.
FFFAP: National hip fracture database Published: Sep 2017	The treatment of all fracture neck of femur patients is reviewed on a monthly basis by the Hospitals' Multidisciplinary Hip Risk Group with the group identifying and monitoring any actions needed to improve hip fracture care. To improve patient care and outcomes further the action plan for this year includes a monthly review of all patients not achieving the 36 hour time frame to theatre.
Heart: Cardiac rhythm management Published: Feb 2017	The Trust received notification of outlier status for proportion of patients reported as receiving physiological pacing 2014/15 (53%) and 2015/16 (61%). The national average in 2015/16 is 89.5%. A review of these cases is underway and input will be sought from the national cardiac rhythm management clinical audit lead, who is also a tertiary centre consultant, to assess appropriateness. Since 2016 the following actions have been taken to improve patient care and outcomes include the 2017 appointment of a new pacing lead. In addition to ensure appropriateness patients listed for elective devices are discussed at an arrhythmia MDT and the indication and type of device is decided and approved with a consultant. To improve data quality, data completeness and activity will be regularly reviewed at the local governance meeting.
Heart: Myocardial infarction national audit project (MINAP) Published: Jun 2017	The audit demonstrates areas of excellence in the quality of care provided to our patients with the most recently published data showing that performance is both above national average and improved compared to previous for nSTEMI patients who had angiography during admission and patients who received all secondary medication for which they were eligible. Performance has also improved compared to previous for nSTEMI patients seen by a cardiologist or a member of team.

National Clinical Audit	Actions to Improve Quality
	To improve further organisations that are performing well for admissions to a cardiac ward within 24 hours of admission, angiography within 72 hours and reduced length of stay will be identified from the audit data and clarification sought as to how this was achieved. In addition a business case will be developed for additional Consultant Cardiologist. The ACS nurse role to be included in the business case to work alongside Cardiologists to provide in-reach to patients on the ACS pathway, identifying patients early in admission pathway for angiography and supporting ward staff in safe preparation.
Heart: National heart failure audit Published: Aug 2017	The latest national audit results demonstrate improved performance by Kingston Hospital for 10 out of 13 best practice standards relating to assessment, diagnosis, treatment, discharge and follow up. Performance is also above the national average for 6 standards relating to treatment and follow up. To improve further a new improvement project looking at setting up an inpatient appointment pathway is currently being considered. Although this project is still at its planning stage, once implemented it will offer patients appointment dates before they are discharged from hospital. In addition the audit data will be used to inform business planning to ensure that the service continues to provide an evidence-based service. The data is also shared across the Trust and work is undertaken with other clinical teams and CCGs to drive forward improvements in care quality.
Intensive Care National Audit and Research Centre (ICNARC): Case mix programme: Adult critical care Published: May-17	Kingston Hospital achieved a 'green' rating (good to excellent) for 8 out of 9 RAG rated quality indicators including high-risk admissions from the ward, unit acquired infection in blood, out of hours discharges to the ward and discharges direct to home. Performance is also better than the national average for delayed discharges. The audit data has been reviewed and actions planned to improve further.
ICNARC: National cardiac arrest audit (NCAA) Published: May-17	The risk-adjusted survival data produced by the audit shows that survival at Kingston Hospital is within control limits i.e. similar to expected.

National Clinical Audit	Actions to Improve Quality
	To improve patient care and outcomes further the cardiac arrest and peri arrest guidelines are being attached to all resuscitation trolleys in the Trust to support the cardiac arrest team during the arrest; and all resuscitation trolleys are now sealed with a plastic tag so it is clear when a trolley has been used and requires immediate restock. To improve the quality of the data submitted to the audit the Trust cardiac arrest audit form has been reviewed and a new resuscitation form has been designed to make it more user friendly. The form is currently being piloted in the Emergency Department and the Acute Assessment Unit, with a view to it becoming available on CRS once the results from the pilot have been assessed. This will also include a new 'launch' of the audit form to encourage completion.
National audit of dementia Published: Jul 2017	Kingston Hospital was in the top 25% of performing hospitals nationally for 2 of the 7 key domains of care assessed by the audit - discharge and assessment. Above the national average performance was also demonstrated for governance and nutrition. Following the completion of the audit the following actions were proposed to improve the assessment of dementia patients by including 4AT on CRS, adding it to junior doctor teaching, implementing general training for delirium and implementing delirium flash cards to help prompt doctors. To improve carer input into patient care the following actions were agreed – to implement a carer lounge, a dementia friendly garden that patients can enjoy with their carers and to put up posters to inform carers that they are welcome all times. Since January 2017 a support team from Alzheimer's Society has been speaking to carers in the hospital. In addition the current champion program will be reinvigorated and the carers' satisfaction survey re-issued as changes have taken place since last data collection and report.
National emergency laparotomy audit (NELA) Published: Oct 2017	The latest national audit report highlighted Kingston Hospital as an exemplar Trust for successfully using the NELA standards to drive improvements locally The Trust achieved the highest 'green' rating for 9 out of 10 key process measures, and for 20 out of 24 hospital facilities measures. The adjusted mortality rate decreased from 16.3% in 2015 to 8.7% in 2016.

National Clinical Audit	Actions to Improve Quality
	To improve patient care and outcomes a multidisciplinary group of surgeons, anaesthetists, intensivists and radiologists examined local NELA data. They highlighted preoperative risk assessment, direct consultant supervision, critical care admission and timely CT imaging as a core focus. The Trust has focused on these four areas and has been able to show a reduction in mortality across all age groups, particularly older patients. In addition a 24 hour interventional service is now available across the network, and out of hours CT reporting has been outsources, which has improved the CT timing and reporting.
National joint registry (NJR) Published: Sep 2017	The Trusts performance in the national audit clearly demonstrates excellent outcomes and with all three hospitals achieving the top 'green' rating for 90-day mortality and revision rates for hips and knees, as well as case ascertainment (compliance). To improve the consent rate to the NJR a reminder has been sent to all relevant Consultants requesting that they ask any patient undergoing joint replacement (where appropriate) for consent to submit their information to the registry.
National comparative audit of blood transfusion programme: Audit of patient blood management in scheduled surgery Published: Oct 2017	A very small number of patients required a transfusion post elective surgery. To improve the management of pre-operative anaemia the Trust is in the process of setting up an anaemia management service and the policy will be updated accordingly. In addition an audit assessing the preoperative management of anaemia has been undertaken by the Trusts anaesthetics team.
National maternity and perinatal audit (NMPA) Published: Oct 2017	Kingston Hospital overall performance is in line with expected. The Maternity Service continues to review the data on a regular basis to ensure appropriate care of women and babies.
National neonatal audit programme (NNAP) Published: Sep 2017	The performance of the neonatal team in NNAP demonstrates excellence in the quality of care provided to babies who are born too early, with a low birth weight or who have a medical condition requiring specialist treatment. Of the 8 best practice standards assessed by the audit the neonatal team achieved a higher than national average performance for 6 criteria; whilst performance against the remaining 2 standards was in line with performance nationally.

National Clinical Audit	Actions to Improve Quality
	To improve further the national audit results will be discussed in the unit to increase awareness. Ongoing education and awareness will continue amongst the neonatal team and midwifery team with regards to maintaining normal temperature for better outcome, as well as the use of plastic bags for extreme preterm and low birth weight babies to reduce hypothermia in line with evidence based best practice. In addition the neonatal team is taking part in ATAIN programme (Avoiding term admission in neonatal unit). A team of link nurses from the neonatal unit will collaborate with linked midwives to reduce term admissions.
National ophthalmology audit: Adult cataract surgery Published: Jul 2017	Kingston Hospital has participated in the audit since late 2016. Actions have been taken within the service line to ensure full participation in the 2017/18 audit. This has resulted in the successful submission of the entire dataset. The Ophthalmology Team is eagerly awaiting the publication of the audit report in July 2018 with preliminary results indicating excellent outcomes.
Royal College of Emergency Medicine (RCEM): Moderate and acute severe asthma Published: May 2017	Kingston Hospital performance is in line with then national picture. To improve the care provided to patients presenting with moderate and acute severe asthma the following actions are planned - to re-examine the triage process including a comprehensive review of staffing/escalation/prioritisation; to implement training and education that includes consideration of psychological and social factors; to implement a new pro forma; and to work with IT/CRS development team to incorporate a red flag of these patients.
RCEM: Severe Sepsis and Septic Shock Published: May 2017	Kingston Hospital performance was generally above the national average for the standards audited. Actions planned to improve the identification and management of patients presenting with severe sepsis and septic shock include the implementation of additional training of triage/streaming nursing staff to recognise and escalate sepsis patients; implementation of changes to CRS triage to highlight escalation and screening of patients with NEWS scores >3; development of a written pro forma to ensure screening compliance for potentially septic patients - pro forma to include the sepsis 6 tick box and written fluid/antibiotic prescribing to facilitate adherence of the 60 minute target window for administration of intravenous drugs; and development of a patient information sheet leaflet.

National Clinical Audit	Actions to Improve Quality
RCEM: Consultant sign off Published: May 2017	Kingston Hospital performance is in line with the national picture. As a result of the audit a number of actions are being implemented locally to improve patient care these include a review of the senior staff rota, ensuring clear allocation of who is responsible for reviewing/signing-off high-risk patient groups on each shift, process mapping the process for reviewing unscheduled returns and identifying what can be applied/transferable to other high-risk groups; and to work with IT/CRS development team to incorporate a flag of high-risk patients at triage and to develop a discharge tick-box to record that a consultant/ or senior has reviewed the patient prior to discharge.
Sentinel stroke national audit programme (SSNAP) (Aug-17 to Nov-17) Published: Feb 2018	Performance in the clinical audit demonstrates excellence in quality of care provided by the stroke team at Kingston Hospital, with the most recently published data showing that: • The service is providing a world class stroke service – achieving an 'A' rating for overall performance (SSNAP level), placing them amongst the top 20% performing teams nationally. • The service is achieving the highest 'A' level rating for 7 out of 8 key domains assessed by the audit, 1 domain achieved level B, which is indicative of good practice (team centred data). The service is currently achieving the highest 'A' rating for case ascertainment. To maintain this a number of actions have been taken locally to ensure the SSNAP pro forma is comprehensively completed, with a particular focus on the documentation of mood assessment.
Serious hazards of transfusion (SHOT): UK national haemovigilance scheme Published: Oct 2017 (site-level data)	All adverse incidents and reactions are reported to SHOT and the data reviewed by the Hospital Transfusion Committee. Any incidents are logged via the Trusts incident reporting process and progressed via routine governance processes. Following publication of the national report the Trust has implemented a new checklist to reduce the risk of transfusion acquired circulatory overload.
Trauma audit research network (TARN) Data refresh: Nov 2017	Actions are in place locally to improve data completeness and data accuracy, including additional staff aiding the identification of TARN eligible patients, a review of the algorithm used to identify TARN eligible patients and the recruitment of TARN co-ordinator.

National Confidential Enquiry	Actions to Improve Quality
NCEPOD Treat as one: Mental health in general hospitals Published: 2017 Latest update: Feb 2018	Of the 19 recommendations relevant to the Trust, 8 are fully compliant and 11 are in progress. A template has been agreed for preliminary mental health assessment in ED, which will be added to CRS; mental health training for ED staff to include appropriate assessment and documentation of co-existing mental health conditions; work towards PLAN membership and accreditation in progress; consultant name to be added to psychiatric liaison template; to investigate getting a third computer with access to both RiO and CRS for psychiatric liaison team to ensure timely transfer of notes; to update psychiatric liaison template to ensure all aspects covered in documentation; to use correct terminology in training programme; to liaise with communications team to plan campaign to highlight use of appropriate terminology to medical staff; staff training to be provided on smoking cessation support and relationship between nicotine withdrawal and behaviour; to liaise with Public Health at Royal Borough of Kingston to establish current provision of specialist drug and alcohol support services; to explore current smoking cessation support within the Trust and review programme as necessary; mental Health Act Policy to be approved and documentation requirements reviewed; mental health first aid training to be provided to all staff; bespoke training to be developed as part of Health Education England project, targeting care of the elderly, ED, AAU, Paediatrics, and back office staff including PALS and complaints; psychiatric liaison representative to join dementia strategy group; and diagnosis and code to be added to template for transferring to CRS notes.
NCEPOD Sepsis: Just say Sepsis! Published: Nov 2015 Latest update: Feb 2018	Of the 16 recommendations relevant to the Trust, 5 are fully compliant and 2 remain in progress. Assessment of relevance awaited for 2 additional recommendations. To bring local practice in line with best practice recommendations adult, paediatric and maternity guidelines for the early identification and immediate management of patients with sepsis have been approved; a standardised sepsis CRS pro forma has been trialled in AAU and the ED. A revised version to be trialled following the publication of NICE guidance; developed and implemented blood culture training for nurses; and patient information booklets on sepsis available throughout the hospital. In addition audit data demonstrates improved use of NEWS/PEWS score in ED.

National Confidential Enquiry	Actions to Improve Quality
	To improve further follow up for post ITU patients will be re-considered and an audit looking at the recording of the diagnosis of sepsis in discharge summaries will be included in the Sepsis CQUIN audit.
Traumatic head injury in children and young people Published: Sep 2015 Latest update: Feb 2018	Of the 13 recommendations relevant to the Trust, 9 are fully compliant and 4 are in progress. A head injury pro forma has been developed and is available on CRS and since Feb-16 all locum staff have been required to have at least Level 2 safeguarding training and a notice of this requirement has been sent to all of the agencies from which locums are sourced as well as Bank partners. Periodic reminders are sent to locum agencies. ED guidance is currently being developed on the features of abusive head injury vs. accidental head injury and an audit of paediatric head injury is in progress assessing whether non accidental injury was considered and decision. The provision for support for post-concussion syndrome requires discussion at the South West Trauma meeting.
NCEPOD: Gastrointestinal haemorrhage: Time to get control? Published: Jul 2015 Latest update: Feb 2018	Of the 21 recommendations relevant to the Trust, 10 are fully compliant and 11 are in progress. Minimal endoscopy training is provided to theatre nurses to enable support of endoscopy lists out of hours; and an endoscopy equipment plan has been drawn up to ensure sufficient equipment, particularly for sigmoidoscopy and proctoscopy in theatres, ED and surgical wards. Further actions proposed include setting up a working group for pathways, updating the blue book on advice on gastrointestinal bleed management; to incorporate ‘re-bleed plan’ into Infoflex endoscopy reporting system; to consider the development of a new sedation policy for endoscopy which will include guidance on ECG monitoring; and to devise plans for joint mortality and morbidity meetings with emergency surgeons.

National Confidential Enquiry	Actions to Improve Quality
NCEPOD: Tracheostomy care: On the right trach? Published: Jun 2014 Latest update: Mar 2018	Of the 25 recommendations relevant to the Trust, 15 are fully compliant and 10 are in progress. A number of actions are in progress to improve patient care, these include: • Ambuscope slim, used for difficult tracheal intubation, is now available on the respiratory ward and is used by ENT for ward tracheostomy patients when required. • 2 tracheostomy link nurses in post, attendance at tracheostomy simulation training in progress. • Core competency paperwork is available. Help to be sought from the practice development team to ensure completion. • All unplanned tube changes to be reported locally as critical incidents and investigated in line with Trust policy. • Patients to be referred to Speech Language Therapy as soon as tracheostomy inserted.
NCEPOD: Subarachnoid haemorrhage: Managing the flow Published: Nov 2013 Latest update: Feb 2018	Of the 7 recommendations relevant to the Trust, 6 are fully compliant and 1 is in progress. Local guidance has been approved and implemented for the care of aneurysmal subarachnoid haemorrhage patients. Guidelines to be added to the blue book.
NCEPOD: Alcohol related liver disease: Measuring the units Published: Aug 2013 Latest update: Mar 2018	Of the 26 recommendations relevant to the Trust, 22 are fully compliant and 4 are in progress. • There is a dedicated alcohol care team with an alcohol nurse and consultant. This is not yet 7 days a week. QIPP bid to be resubmitted to CCG to enable provision of a 7 day service. • The importance of accurate monitoring of fluid balance to be highlighted in nursing education sessions and regular training of nursing staff of documentation of fluid balance chart on CRS. This is currently a Trust priority. • MUST scores to be completed within 48 hours of admission – audit to be undertaken twice yearly.
NCEPOD: Cardiac arrest procedures: Time to intervene Published: Jun 2012 Latest update: Feb 2018	Of the 21 recommendations relevant to the Trust, 11 are fully compliant and 10 are in progress. Actions planned to improve further include to collect NEWS data on the ward via CRS; to put the DNAR order form on CRS; DNAR status is included on clerking forms – to audit following March 2018 launch; to ensure the action plan from the Emergency Standards review is in place and include review by Consultant within 12 hours' in in-patient record keeping audit; to investigate the national initiative called RESPECT that will overtake the DNAR and will include do not resuscitation and ceilings of care.

National Confidential Enquiry	Actions to Improve Quality
	The Resuscitation team is currently working with a regional group of Resuscitation staff at our local hospitals to incorporate RESPECT at Kingston Hospital. Support is needed from the CCHG's and GP's to achieve this. A new audit form is in development that will include a question around this; and to roll out SBAR in Acute Medicine.
NCEPOD: Peri-operative care: Knowing the risk Published: Dec 2011 Latest update: Feb 2018	Of the 11 recommendations relevant to the Trust, 11 are fully compliant. Actions relating to daily medication reviews, fluid management documentation and review by medical consultant within 12 hours are now complete.
NCEPOD: Surgery in children. Are we there yet? Published: 2011 Latest update: Feb 2018	Of the 15 recommendations relevant to the Trust, 6 are fully compliant and 9 are in progress Actions planned to improve further include implementing a new Children's Surgery Policy updated in line with the NCEPOD recommendations, recording re-admissions related to previous surgery via the Trusts incident process, presenting data including audit, serious incidents and caseload monitoring to the Paediatric Surgical Forum, twice yearly, updating the pre-assessment form, developing a local early warning tool in line with nationally available best practice guidance (e.g. NICE), developing paediatric pain guidelines and designing competency based training for nurses in main theatres and dental.
An age old problem: Surgery in the elderly Published: 2010 Latest update: 2017	Of the 23 recommendations relevant to the Trust, 21 are fully compliant and 2 are in progress. Actions remain in progress relating to daily medication reviews and fluid management documentation.
MBRRACE-UK: Saving lives, improving mothers care Published: 2016 Latest update: Feb 2018	Of the 12 recommendations relevant to the Trust, 11 are fully compliant and 1 is in progress. A consultant with a special interest in maternal medicine has been appointed and a clinic for medically complex pregnant women is planned to start in Q4, 2017/18.

National Confidential Enquiry	Actions to Improve Quality
Perinatal confidential enquiry: Term, singleton, normally formed, antepartum stillbirth report Published: 2017 Latest update: Feb 2018	The Trust is fully complaint with all recommendations listed in the report.
National confidential inquiry into suicide and homicide by people with mental illness Published: 2017 Latest update: Feb 2018	Of the 9 recommendations relevant to the Trust, 7 are fully compliant and 2 are in progress. Further planned actions to improve include: • Liaise with Public Health team in Kingston to establish current provision of specialist drug and alcohol support services • Raise awareness in ED department around risk. • NHS England bid for 0.5 WTE psychiatrist (to begin April 2018) • Undertake audit of ligature points • Review 1:1 policy, look at training HCA staff to look after more complex mental health patients and investigate different level of observations to ensure adequate supervision • Regular Audits to ensure compliance with NICE
National review of asthma deaths (NRAD) Published: May 2014 Latest update: Feb 2018	Of the 18 relevant recommendations to the Trust, 16 are fully compliant and 2 are in progress. Asthma KPI developed for primary care; primary care to take part in the annual asthma audit; asthma admission tool developed and implemented; use of the asthma discharge bundle increased; in-patient asthma nurse appointed - will see all inpatient asthma patients, which will help with continuity of care and ensuring follow up arrangements; inhaler technique training provided to nurses on Hamble and AAU, asthma admission power plan implemented; primary and secondary care self-management plans aligned; additional Respiratory consultant appointments made; primary care to invite patients for yearly asthma review; community pharmacy training undertaken; smoking cessation team provide education to ward nurses to support smoking cessation; and London asthma toolkit in use in primary care. Further plans include the appointment of an ‘airways’ nurse due to start early April, who will work between Kingston Hospital and the community in a joint role. In the mornings they will ‘in-reach’ into the Acute Assessment Unit (AAU) and the wards with the aim to see Asthma and COPD patients, complimented by the Respiratory AAU ‘in-reach’ consultant (Monday – Friday).

National Confidential Enquiry	Actions to Improve Quality
	They will optimise management and action plans, and help facilitate early discharge by linking with the community. They are prescribers and will therefore optimise inhalers. They will also assist in the completion of both the COPD and Asthma discharge bundles and run weekly hot clinics to rapidly see those recently discharged to avoid further admission. In the afternoons they will be community based and provide education to the community respiratory GP based airways nurses.

APPENDIX C

Language and Terminology

It is very easy for people who work in the NHS to assume that everyone else understands the language that we use in the course of our day to day work. We use technical words to describe things and also use abbreviations, but we don't always consider that people who don't regularly use our services might need some help. In this section we have provided explanations for some of the common words or phrases we use in this report.

Admission: There are three types of admission:

- **Elective admission:** A patient admitted for a planned procedure or operation
- **Non-Elective (or emergency) admission:** A patient admitted as an emergency
- **Re-admission:** A patient readmitted into hospital within 28 days of discharge from a previous hospital stay

Benchmarking: Benchmarking is the process of comparing our processes and performance measures to the best performing hospitals, or best practices, from other hospitals. The things which are typically measured are quality, time and cost. In the process of best practice benchmarking, we identify the other Trusts both nationally and/ or locally and compare the results of those studied to our own results and processes. In this way, we learn how well we perform in comparison to other hospitals.

Care Quality Commission (CQC): The CQC is the independent regulator of health, mental health and adult social care services across England. Its responsibilities include the registration, review and inspection of services and its primary aim is to ensure that quality and safety standards are met on behalf of patients.

Care Records Service (CRS): The NHS has introduced the NHS Care Records Service (NHS CRS) throughout England and Wales. This is to improve the safety and quality of your care. The purpose of the NHS Care Record Service is to allow information about you to be safely and securely accessed more quickly. Gradually, this will phase out difficult to access paper and film records. There are two elements to your patient records:

Summary Care Records (SCR) - held nationally
Detailed Care Records (DCR) - held locally

CHKS: Data provider used by the hospital for benchmarking and performance information. Shows local and national data for a range of performance, safety and quality indicators.

Clostridium Difficile (C diff): Clostridium Difficile is a bacterium that is present naturally in the gut of around 3% of adults and 66% of children. It does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C diff bacteria can multiply and cause symptoms such as diarrhoea and fever.

CQUIN: A CQUIN (Commissioning for Quality and Innovation) is payment framework that enables commissioners to reward excellence, by linking a proportion of the hospital's income to the achievement of local quality improvement goals.

Day case: A patient admitted electively (i.e. from a waiting list) during the course of a day with the intention of receiving care without requiring the use of a hospital bed overnight.

Delayed Transfer of Care (DTOC): Delay that occurs once the Multi-Disciplinary Team have decided the patient is medically fit for discharge and it is safe to do so.

Duty of Candour (DoC): The duty of candour is a formal requirement that requires healthcare staff to be open and honest with a patient if they have suffered harm. This means that if you suffer any unexpected or unintended harm during your care, we will tell you about it, apologise, investigate what happened and give an open explanation of the findings.

End of Life Care: Support for people who are approaching death.

Foundation Trust: NHS foundation Trusts in England have been created to devolve decision-making to local organisations and communities so that they are more responsive to the needs and wishes of local people.

Friends and Family Test (FFT): This is a survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. This information is measured as a percentage score however the survey also asks patient's for the reason for their response and this qualitative information is then used to extract topics and key phrases which is used to support and drive quality improvement.

Gram Negative Bacteria: Gram negative bacteria causes infections including UTI's, biliary/gut sepsis, pneumonia, bloodstream infections, and wound or surgical site infections. They are increasingly resistant to a number of antibiotics

Haematological Cancers: These are cancers in blood-forming tissue, such as the bone marrow or the cells of the immune system; for example leukaemia, lymphoma, and multiple myeloma.

Healthcare Associated Infections (HCAI): Healthcare associated infections are infections that are acquired in Hospitals or as a result of healthcare interventions. There are a number of factors that can increase the risk of acquiring an infection, but high standards of infection control practice minimise the risk of occurrence.

Human Factors Training: "Human factors" is a discipline which studies the relationship between human behaviour, system design and safety.

Information Governance (IG) Toolkit: The IG Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards. It also allows members of the public to view participating organisations' IG Toolkit assessments.

Inpatient: A patient admitted with the expectation that they will remain in hospital for at least one night. If the patient does not stay overnight after all they are still classed as an inpatient.

Meticillin Resistant Staphylococcus Aureus (MRSA): It is a bacterium from the Staphylococcus aureus family. MRSA bacteria are resistant to some of the antibiotics that are commonly used to treat infection, including methicillin (a type of penicillin originally created to treat Staphylococcus aureus (SA) infections).

Mortality: Mortality rate is a measure of the number of deaths in a given population.

National Reporting and Learning System (NRLS) – The National Reporting and Learning System is a central database of patient safety incident reports which was set up in 2003. All of the incident information that is submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.

It also benchmarks Trusts on patient safety incident occurrences, as the data is split by incident categories, levels of harm and location of occurrence etc.

National Early Warning System. NEWS score – a score made up of a set of observations which are an indicator of acute illness, used against a criteria to indicate and support timely patient review

Outpatient: An attendance at which a patient is seen and the patient does not use a hospital bed for recovery purposes.

Patient Falls: Patients of all ages fall. Falls are most likely to occur in older patients, and they are much more likely to experience serious injury. The causes of falls are complex and older hospital patients are particularly likely to be vulnerable to falling through medical conditions *including delirium (acute confusion), side effects from medication, or problems with their balance, strength or mobility. Problems like poor eyesight or poor memory can create a greater risk of falls when someone is out of their normal environment on a hospital ward, as they are less able to spot and avoid any hazards.*

Patient Safety Incident: A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

Pressure Ulcers: Pressure ulcers are a type of injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. They are also sometimes known as 'bedsores' or 'pressure sores'. Pressure ulcers can range in severity from patches of discoloured skin to open wounds that expose bone or muscle.

Risk Adjusted Mortality Index: Hospital mortality rates refer to the percentage of patients who die while in the hospital. Mortality rates are calculated by dividing the number of deaths among hospital patients with a specific medical condition or procedure by the total number of patients admitted for that same medical condition or procedure. This risk adjustment method is used to account for the impact of individual risk factors such as age, severity of illness and other medical problems that can put some patients at greater risk of death than others. To calculate the risk-adjusted expected mortality rate (the mortality rate we would expect given the risk factors of the admitted patients), statisticians use data from a large pool of patients with similar diagnoses and risk factors to calculate what the expected mortality would be for that group of patients. These data are obtained from national patient records.

Root Cause Analysis (RCA): When incidents happen it is important that lessons are learned to prevent the same incident occurring elsewhere. Root Cause Analysis (RCA) is a term used in investigations where a comparison is made between what happened and what should have occurred. This comparison is undertaken to identify any contributory factors and lessons that can be learnt.

RCA Investigations identify how and why patient safety incidents happen. Analysis is used to identify areas for change and to develop recommendations which deliver safer care for our patients.

Sepsis Six (6): The **Sepsis Six** is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. A training program became the official educational package of both the Surviving Sepsis Campaign and the UK Sepsis Trust.

The Sepsis Six consists of three diagnostic and three therapeutic steps – all to be delivered within one hour of the initial diagnosis of sepsis. Many centres throughout the world have since adopted the Sepsis Six, which has been associated with decreased mortality, decreased length of stay in hospital, and fewer intensive care bed days.

Serious Incident Group (SIG): The SIG membership includes Divisional Clinical Directors and Corporate Directors, as well as, Risk Managers, a representative from the Kingston Clinical Commissioning Group (CCG) and is chaired by the Medical Director. The group ensures that comprehensive serious incident investigations take place within the Trust, and that appropriate recommendations and robust actions are identified and delivered. Thus ensuring learning from incidents to improve both the quality of patient care.

Sign up to Safety: Sign up to Safety is a national patient safety campaign that launched in June 2014 with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world.

As part of signing up to the Sign up to Safety campaign organisations commit to setting out actions they will undertake in response to the following 5 pledges:

1. Put safety first. Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.

2. Continually learn. Make their organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.

3. Honesty. Be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

4. Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

5. Support. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

The Standardised Hospital Mortality Index (SHMI): SHMI gives an indication for each non-specialist acute NHS Trust in England whether the observed number of deaths within 30 days of discharge from hospital is 'higher than expected', 'lower than expected' or 'as expected' when compared to the national baseline. A 'higher than expected' SHMI value should not immediately be interpreted as indicating good or bad performance and instead should be viewed as a 'smoke alarm' which requires further investigation by the Trust. The SHMI can be used by Trusts to compare their mortality related outcomes to the national baseline. However, it should not be used to directly compare mortality related outcomes between Trusts and it is not appropriate to rank Trusts according to their SHMI value.

Venous Thrombus Embolism (VTE): Venous thromboembolism (VTE) is a condition in which a blood clot (thrombus) forms in a vein. Blood flow through the affected vein can be limited by the clot, and may cause swelling and pain. Venous thrombosis occurs most commonly in the deep veins of the leg or pelvis; this is known as a deep vein thrombosis (DVT). An embolism occurs if all or a part of the clot breaks off from the site where it forms and travels through the venous system. If the clot lodges in the lung a potentially serious and sometimes fatal condition, pulmonary embolism (PE) occurs. Venous thrombosis can occur in any part of the venous system. However, DVT and PE are the commonest manifestations of venous thrombosis.

Vital Signs: The assessment, measurement and monitoring of vital signs are important basic skills for all clinical staff. The vital signs we look for include temperature, heart/pulse rate, respiratory rate and effort, blood pressure, pain assessment and level of consciousness. Important information gained by assessing and measuring these vital signs can be indicators of health and ill health.

62 day cancer target: Patients beginning their first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer. The target compliance for this is 85%

The Dementia Strategy

dementia strategy 2017-2020 final.pdf

ANNEXE Containing Regulation 5 Statements

The Trust is grateful for the feedback received from our commissioners and other stakeholders, and looks forward to working closely with them in the coming year to improve the services we provide to the people of Kingston.

Where we have received direct comments back from patient representatives (outside of the formal response from stakeholders) we have endeavoured to include these in the final version of the Quality Report. Some feedback has been annotated as the comments made have been resolved.

Feedback from Kingston CCG (acting as Lead Commissioner)

Thank you for sending us a copy of the Quality Report (Draft) for your commissioners to provide feedback.

Please find below the narrative we would propose for you to incorporate into your final version:
"The Kingston Clinical Commissioning Group (CCG) welcomes the opportunity to provide a response to the Quality Report for 2017/18 by Kingston Hospital NHS Foundation Trust. The CCG is the lead commissioner for the Trust and this feedback represents the views of south west London CCG's (Richmond, Merton, Sutton, Wandsworth and Croydon).

The Quality Report provides information and a review of the performance of the Trust against quality improvement priorities set for the last year and gives an overview of quality for this period. We were consulted with regarding the selection of priorities for the coming year and we are pleased to endorse the areas identified for improvement. We welcome the wide consultation the Trust has undertaken in the selection of priorities and note the change in the required number of priorities compared to previous years.

We can review the quality of services at the Trust through a wide variety of forums throughout the year and we welcome the open and transparent engagement we experience with clinical and managerial staff. We are pleased to report effective working partnerships at the Clinical Quality Review Group with partner commissioners present. Throughout the year, the Trust has provided progress reports on the achievement of the Priorities selected and it is noted that the Draft Report indicates that 6 of the 9 Priorities were achieved and 3 were partially achieved. It is highlighted within the Report the good progress made in the areas partially achieved. The success in improving safety awareness for staff through human factors in the maternity unit and the onward plan for organisational-wide implementation, continued focus on dementia care, seven day working, and the development of a programme of improvement to further understand the experience of patients with mental health conditions align with the ambitions from the previous year's report.

We welcome the continued attention the Trust has provided in reducing vacancy rates, turnover rates and levels of agency usage.

The section detailing other quality improvements are an indication of the successful focus on quality throughout the wider Trust and the improvements detailed in the results of the 2017 staff survey are very positive and place the Trust amongst the best in London. The Trust has also been successful in achievement of a number of quality goals supported by the Commissioning for Quality and Innovation (CQUIN) payment framework.
There were some areas in the draft report which the CCG has indicated that further comment would be helpful:

- The Trust has selected six priorities for the coming year, and a focus around prevention and early intervention as part of care rather than continuing with the 'see, treat and discharge' process would be welcome (perhaps through an alternative quality programme).
- In respect of the proposed measure on Clinical Effectiveness for day surgery cases, it would be important to monitor incidents in this area to make ensure that there are no adverse outcomes.
- Staff recruitment and retention doesn't make mention of Brexit, the risks and the plans being put in place, further explanation would provide greater assurance of the Trusts plans.

The CCGs welcome the continued progress reports regarding Care Quality Commission inspection and look forward to expected improvements in the upcoming inspection.

Performance against a wide range of quality indicators have shown sustained improvements – notably in cancer performance, planned patient waiting times and mortality rates. The partnership work across the local health economy (progressed through the Accident and Emergency Delivery Board) has resulted in considerable improvements in delayed transfer of care rates at the Trust.

There are a number of areas where the Trust will need to continue to focus including response times for written complaints, patients' experience of waiting times for care in Accident and Emergency. We look forward to the coming year where our combined focus and partnership on A&E performance and reducing delays transfer of care will need to significantly improve above the performance over the last year.
Trust Response

Thank you for reviewing the Quality Report. We note all your comments, and look forward to a continuing collaboration to support and improve the services and care for our patients and local population.

Kingston Hospital NHS Foundation Trust – Governor Feedback

"As chair of the Governor's Quality Scrutiny Committee I have reviewed the Quality Report for 2017/18 on behalf of the Council of Governors. The report represents a comprehensive record of a range of improvements achieved by the hospital which have contributed to continuing high quality care for our patients and improving their experience. The Governors were consulted regarding the choice of quality priorities for 2018/19, we have asked for assurance that the Trust's membership be given the opportunity to participate in this process next year.

We appreciate that the report has to conform to a strict format but given that, it is an accessible read and helped by moving some of the data to an appendix at the end.

We are pleased to note that the majority of the 2017/18 quality priorities have been achieved but would suggest that better clarity may be needed in the narrative describing how each priority is achieved. It is appreciated though that the report we are commenting is a final draft. Where priorities are not fully achieved it would be helpful if there is a clear action plan for completing the activity. We would particularly commend the Trust for its work on improving the experience of patients with dementia not only in Derwent Ward but by dementia friendly refurbishments in other wards and inclusion of dementia friendly design in new areas such as Outpatients, the Urgent Care Centre and Emergency Department.

The improvements to the Emergency Department and the newly opened Urgent Care Centre are very much welcomed along with the important achievements towards improving the experience of patients with mental health conditions using our hospital services.

We are pleased to support the chosen six priorities across the three domains of patient safety, clinical effectiveness and patient experience for 2018/19. The Governor's Quality Scrutiny Committee will look forward to receiving regular updates on progress against these priorities and hope robust measures are identified to assess this progress to help us to fulfil our quality assurance responsibilities.

Chair: Governor's Quality Scrutiny Committee"

Trust response Thank you for providing scrutiny to the Trust Quality Report 2017/18, the comments of which we fully take on board. The points raised about achieving the priorities have been addressed in the final version with additional commentary and evidence.

Royal Borough of Kingston upon Thames

Kingston Health Overview Panel- Comments on the draft KHT quality report 2017/18

The Health Overview Panel notes the progress the Trust has made in the past year on Quality in general and in relation to the nine targets for 2017/18. We would however comment on the fact that the draft Quality Report which we were given the opportunity to consider had many information gaps - especially around audit.

In previous years the Health Overview Panel has scrutinised **dementia** care and we welcome the progress in the past year, the focus on care relationships, staff skills, improvements to the patient environment and introduction of the Red bag scheme. This is particularly important for our older residents in Kingston and our ageing population.

The Panel has also scrutinised **7 day working** so we are pleased to see the progress made in this area - this is another area which is especially important to patients.
It is good to see continued progress on areas identified by the Care Quality commission as requiring attention and especially the progress in A&E.

We are pleased to note that the Trust received the **Health Services Journal award** for "Best Value NHS Support Service" in relation to its success in developing a strong and successful volunteering programme plus development of experience steps for sixth form and Kingston College students.

It is good to see the rigor of the **staff survey** and the use of the information to support staff recruitment and retention and particularly the steps to address staff bullying and harassment, equal opportunities and access to training. We note staff concerns around pay and are aware of the local difficulty of Kingston Hospital not being an inner London Hospital and wonder whether there are some other avenues which could be explored. We are however pleased to see the continued reduction in the use of agency staff and other budget savings. More prominence could be given to the Trust's Health and Wellbeing Strategy and the impact this is having on improving staff wellbeing and retaining staff.

In relation to the **6 quality priorities** identified for the coming year, we note the reduced number compared to last year and we question whether these are sufficiently challenging for a Trust which has focussed on quality for a number of years. We welcome the focus on increasing day case surgery as this is of benefit to patients and the health economy but question whether this is a target for inclusion for Quality rather than being a contractual matter.

Whilst we welcome further work to improve out-patient administration and communication processes and increasing learning from complaints and incidents and greater staff engagement in quality improvement initiatives but these are areas which have been worked on previously, should already be embedded in the Trust's quality culture and we wonder whether this is a missed opportunity to undertake something more challenging. However, will read with interest how these have been progressed in a year's time.

Marian Morrison
Democratic Services Officer
24 April 2018

Trust response:

Thank you for reviewing the Trusts Quality Report. We note the comments on reduced priorities (3 areas of quality improvement were set out in the NHSI January 2018 Guidance) and areas of further work. As a Trust we feel the consultation undertaken has steered guidance on the priorities, and as well as embedding an improvement culture, we are now formally embedding an increased organisational wide improvement capability, which will support patient safety and experience, and enable staff to drive local improvements to best optimise patient care.

healthwatch Kingston Upon Thames healthwatch Richmond upon Thames

Healthwatch Richmond welcomes this year's Quality Report from Kingston Hospital Foundation Trust (KHFT).

We are pleased to see the extensive work carried out in the Trust's Dementia Strategy including enhanced training provision and the dementia-friendly improvements in recent refurbishments.

We also welcome the various improvements that have been made for example to the Emergency Department and note the reported decrease in the numbers of formal complaints and PALS contacts made by patients. Unfortunately no measures are given for these so it is unclear how significant an improvement this is. In addition the report that we read did not include details covering the Royal Eye Unit Emergency Department. It is good that the additional mental health training that has been undertaken by staff but it is unclear whether the Trust has met its own targets for the numbers of staff trained and the timeliness/quality of referrals to psychiatric liaison. We would also encourage the Trust to provide an update on the engagement carried out with patients with mental health conditions. Insufficient detail regarding specific actions and targets is often a feature of Quality Priorities for 2018/19. We hope that this is improved in the final Account.

We are pleased that the Trust are focusing on preventing unnecessary delays for patients receiving inpatient care. However, the report does not specify how the Trust will practically go about reducing delays nor what their actual targets are. Similarly whilst we welcome the Trust's desire to increase the number of patients receiving day surgery, the report does not explain how this will be achieved or how change will be measured. The rise in staff experiencing discrimination at work (12%, 2015, to 17%, 2017) is a concern but it is good that the Trust have recognised, committed to actions to improve this, and provided measures that can demonstrate change as a result. Healthwatch Richmond is pleased to read of all the other achievements the Trust has made over the last year in addition to their key priorities but we are disappointed that we are unable to quantify the Trust's achievement.

Trust response:

Thank you reviewing the Trusts Quality Report and the comments are duly noted, and the final version reflects this. We very much look forward to increasing our collaboration in the future to serve the needs of our local population.

LONDON BOROUGH OF RICHMOND UPON THAMES

Richmond upon Thames' Health Services Scrutiny Committee response to Kingston Hospital Foundation NHS Trust Quality Account

8 May 2018

Following on from the meeting held on Monday 23 April 2017, to discuss Kingston Hospital Foundation NHS Trust Quality Account (hereinafter 'QA'), we welcome the opportunity to provide additional input, as the London Borough of Richmond upon Thames (hereinafter 'LBRuT') is determined to champion the interests of its residents by playing a full and positive role in ensuring that the people living and working in the LBRuT have access to the best possible healthcare and enjoy the best possible health.

Whilst we appreciate that the version provided is a draft and the final version is yet to be approved we have a number of points we wish to raise and a number of suggestions we wish to proffer. We would like to take this opportunity to commend the Trust on a well written report. We were pleased to hear the progress that has been made against the Trust's priorities, particularly:

- The Trust's received a rating of 'Good' in the Caring domain and end of life care being rated as 'Outstanding'. The stated ambition to move other services to 'outstanding' was also welcomed;
- That the number of junior doctors had been stable;
- A recognition of the value of experienced staff;
- The measures to manage patient flow;
- The Trust has opened a new Clinical Decision Unit, Urgent Treatment Centre
- The improvements to systems for monitoring and managing equipment maintenance;
- Improving support for patients with mental health needs;
- The investment to upgrade the multi-faith facilities;
- The Trust's approaches to ensure a strategic and consistent and planned approach to recruitment and retention activity such as support for career plans and career clinics. That nurses leave the Trust to broaden their experience also often return later in their career. We additionally noted the measures to try and recruit nursing staff from abroad and the occasional time delays owing to the need to register with the Nursing and Midwifery Council;
- That recruitment of middle grade registrars was difficult but this was reflected nationally;

As well as these achievements, we also noted:

That priorities would be continually under review to ensure they were still the right areas of focus;

The commitment to focus on having the right teams and culture;

The progress on patient engagement and involvement including feedback from local Healthwatch organisations and from the Friends and Family Test.

Your suggestion that LBRuT as a local authority could further support opportunities to engage with patients.

Conclusion

Our aim is to ensure that your Quality Account reflects the local priorities and concerns voiced by our constituents as our overall concern is for the best outcomes for our residents. Overall, we are happy with the QA, agree with your priorities and feel that it meets the objectives of a QA – to review performance over the previous year, identify areas for improvement, and publish that information, along with a commitment about how those improvements will be made and monitored over the next year.

We hope that our views and the suggestions offered are taken on board and acted upon. We wish to be kept informed of your progress throughout and thereafter.

London Borough of Richmond upon Thames Health Scrutiny Committee

Trust response:

Thank you for reviewing the Trust Quality Report, and inviting us to your meeting which was a pleasure to attend. We fully note all comments and look forward to updating you on our progress. Thank you for undertaking to support opportunities to increase our patient feedback and engagement mechanisms, all of which facilitate improved care and experience for the patients we provide services for.

Statement of Directors' Responsibilities in respect of 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 2017/18 and supporting guidance.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
- Board minutes for the period 01/04/2017 – 31/03/2018.
- Papers relating to quality reported to the Board over the period 01/04/2017 – 24 May 2018.
- Feedback from Commissioners, dated 1 May 2018.
- Feedback from local Healthwatch organisations, dated 24/4/18 and 25/4/18
- Feedback from Overview and Scrutiny Committee, dated 8/5/18
- The Trust's Complaints Report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, due July 2018
- The 2017 National Inpatient Survey, dated 31st May 2017 and next due May/June 2018
- The National Staff Survey, dated 6th March 2018
- The Head of Internal Audit's annual opinion over the Trust's control environment, dated 31st March 2018
- The Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at:
- www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at:
www.monitor.gov.uk/annualreportingmanual).

The Directors confirm that, 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

Sian Bates
Chairman
24th May 2018

Ann Radmore
Chief Executive
24th May 2018