

# Quality Report 2014-15



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

Living our values *everyday*



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## **PART 1**

### **Quality Report 2014/15**

#### **1. Introduction from the Chief Executive**

This is the Trust's sixth Quality Report and over the last six years we have made some significant improvements to how we care for patients, their experience and their safety. This latest report is a review of how we have performed during 2014-15 and it looks forward to the year ahead and the quality priorities we will be focusing on.

Over the last year we have seen over 110,000 patients in A&E, undertook nearly 370,000 outpatient appointments, cared for 66,000 admitted patients and delivered around 5,900 babies, with quality very much at the forefront. To support this commitment to quality, last year a new vision was developed with the support of staff, patients and the community.

#### **'Working Together to deliver exceptional, compassionate care each and every time'**

The priorities identified for 2015-16 in this Quality Report and also our 16 Quality Goals for the coming year, all support the delivery of our vision.

I am very proud of the fact that having agreed on nine ambitious quality priorities for 2014-15, the Trust has achieved seven of them and partly achieved one. Dementia care has been a particular focus for the whole Trust over the last year and will continue to be this year. We are now in year two of implementing our first ever dedicated Dementia Strategy. We have improved the experience of our patients and carers and our focus is now on looking at how the environment can be improved and the Trust has launched a major fundraising appeal to support that. We have also received national recognition for the work we are doing on dementia and won a Patient Safety Award in July 2014.

There has also been a 20% improvement on the number of falls on the Care of the Elderly wards and in 2014-15 the rate was 6.02 per 1,000 bed days compared to 7.52 in 2014-13. We have also continued to make progress on reducing Hospital acquired infection and in 2014-15 there were no MRSA cases compared to 4 the previous year and the number of patients with C.difficile has reduced from 22 to 17.

The use of technology to improve patient care has been a focus for the Trust for a number of years and last year we achieved the priority of implementing e-prescribing and clinical documentation on at least five wards. We exceeded this target and this is now established on 11 wards, A&E and ITU.

The quality of our patient food has long been an issue that has generated complaints and a poor response from patients. Over the last year we have carried out a major overhaul of the provision of patient food and have made a number of changes. Patients can now choose from a much more extensive and flexible menu, which includes lighter options. Patients are also served cake and tea in the afternoon and all have access to ice cream and a cooked breakfast at the weekend.

One area where there is still more work to do is Safer Surgery for the Elderly and a project group has been set up and investment made in additional emergency surgeons and care of the elderly consultants.

We recognise the value of involving our local community 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. This feedback has played a key role in setting our priorities for 2015-16, which are:

Domain	Priority
<b>Patient Safety</b>	<ul style="list-style-type: none"> <li>- Improved recognition and management of sepsis in hospital</li> <li>- Implement patient safety elements of Year 2 of the Dementia Strategy</li> <li>- Reduce use of agency staff by reducing vacancies</li> </ul>
<b>Clinical Effectiveness</b>	<ul style="list-style-type: none"> <li>- To work towards paper light systems using information technology and record management across the Trust</li> <li>- To ensure all our staff are up to date with core (mandatory) training, have clear objectives, regular appraisal and a personal development plan reflecting our values</li> <li>- Increase in the provision of 7 day working of key staff and services</li> </ul>
<b>Patient Experience</b>	<ul style="list-style-type: none"> <li>- To transform administration across the hospital and make improvements in administration</li> <li>- End of Life Care</li> <li>- Improvements in discharge planning and processes</li> </ul>

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.



**Kate Grimes**

**Chief Executive**

## 2. 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 about how those improvements will be made and monitored over the next year.

Kingston Hospital NHS Foundation Trust focuses on three 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 (patient experience)

Some of the information in a Quality Report is mandatory but most is decided by patients and carers, Foundation Trust Governors, staff, commissioners, regulators and our partner organisations.

### 2.1 Scope and structure of the Quality Report

This report summarises how well we did against the quality priorities and goals we set ourselves for the last year and if we have not achieved what we set out to do, we have explained why 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.

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 contribute 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:

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[Duncan.Burton@kingstonhospital.nhs.uk](mailto:Duncan.Burton@kingstonhospital.nhs.uk) or Lisa Ward, Head of Communications at  
[lisa.ward@kingstonhospital.nhs.uk](mailto:lisa.ward@kingstonhospital.nhs.uk) or in writing to our Patient Advice Liaison Service (PALS)  
at:

Kingston Hospital NHS Foundation Trust, Galsworthy Road, Kingston upon Thames, Surrey,  
KT2 7QB.

### 3. 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

**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. Since the first year of the CQUIN framework (2009/10), many CQUIN schemes have been developed and agreed.

**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.



**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:** 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.

**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.

**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.

**Methicillin 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).

**NHS QUEST** – Is a member-convened network for Foundation Trusts who have a relentless focus on improving quality & safety. The membership is currently made up of 16 Foundation Trusts from across England, of which one is Kingston Hospital NHS Foundation Trust.

**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.

**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 programme 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.

**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.

## PART 2

### 4. Kingston Hospital NHS Foundation Trust Priorities for 2015/ 16

Working with stakeholders to select quality priorities ensures that they 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.

As stipulated in the NHS Foundation Trust Annual Reporting Manual 2014/ 15 (Monitor, December 2014) we have identified the following priorities to include:

- at least 3 priorities for patient safety
- at least 3 priorities for clinical effectiveness
- at least 3 priorities for patient experience

In December 2014 and January 2015, an online survey was conducted to identify quality improvement priority preferences of Kingston Hospital NHS Foundation Trust Members, patients and staff and other stakeholders with over 140 responses received. These responses were combined with feedback from various committees and forums to determine a long list of priorities. In February 2015 Trust Members, patients, staff, Governors, Volunteers, Healthwatch and other stakeholders were invited to take part in a second survey to develop the final nine Trust priorities. The Trust received 220 responses to this second survey. The table below highlights some of the important dates of consultation:

Quality Assurance Committee	14th January 2015
Governors Quality Scrutiny Committee	14th January 2015
Trust Board meeting (public)	29 <sup>th</sup> January 2015
Clinical Quality Review Group	18th February 2015
Kingston Hospital Monthly team brief document	6th February 2015
Healthwatch Forum	11th February 2015
Kingston Health Overview Panel presentation	23 <sup>rd</sup> April 2015
Chairman and Governors	5 <sup>th</sup> May 2015
Richmond Council Quality Account Sub-Committee	11 <sup>th</sup> May 2015

In the following section, we will discuss each of the indicators selected and where possible we refer to historical data and benchmarked data, to enable readers to understand progress over time and performance compared to other providers.

Domain	Priority
<b>Patient Safety</b>	<ul style="list-style-type: none"> <li>- Improved recognition and management of sepsis in hospital</li> <li>- Implement patient safety elements of Year 2 of the Dementia Strategy</li> </ul>

	<ul style="list-style-type: none"> <li>- Reduce use of agency staff by reducing vacancies</li> </ul>
<b>Clinical Effectiveness</b>	<ul style="list-style-type: none"> <li>- To work towards paper light systems using information technology and record management across the Trust</li> <li>- To ensure all our staff are up to date with core (mandatory) training, have clear objectives, regular appraisal and a personal development plan reflecting our values</li> <li>- Increase in the provision of 7 day working of key staff and services</li> </ul>
<b>Patient Experience</b>	<ul style="list-style-type: none"> <li>- To transform administration across the hospital and make improvements in administration</li> <li>- End of Life Care</li> <li>- Improvements in discharge planning and processes</li> </ul>

#### 4.1 Domain: Patient Safety

##### 4.1.1 Priority 1 - Improved recognition and management of sepsis in hospital

Goal	Aim	Actual Performance (2014/ 15)	KHT Data Available	Benchmarked/ Comparison
Safety	To eliminate all avoidable deaths from sepsis and septic shock	Baseline to be established as part of project development.	Yes	No

**Measure:** We plan to achieve the targets set out within the Sepsis 6 treatment bundle for 90% of our patients by December 2018 (we will set a trajectory for achievement in 2015 to deliver this year and each year to 2018). We will do this by improving the recognition and treatment of severe sepsis and septic shock through education and increased awareness.

Medical staff conducting review of patient records (mortality and morbidity review)

**Reference for data source:** Clinical Coding data

**Governed by standard national definitions?** Yes, Sepsis 6 bundle definitions

#### Why we chose this indicator?

We have chosen this indicator because sepsis and septic shock are treatable conditions that have a high mortality if not recognised or recognised late. Improving the recognition and treatment of severe sepsis and septic shock through education and increased awareness will therefore save lives. The UK Sepsis Trust estimates that approximately 100,000 hospital

admissions are for sepsis each year, and this has with an average cost of about £20,000 for each patient looked after.

We will provide education sessions across the Trust to ensure that all staff are aware of the signs of sepsis and we will monitor the number of staff trained, by staff group. We will introduce a coding mechanism that will allow us to track patients diagnosed with severe sepsis or septic shock so that we can identify all the patients and ensure that we can measure the time that we commence the first treatments and implement all the Sepsis 6 recommendations.

**How will progress be measured?** We will establish our baselines in the first stages of the project (June 2015).

**How will progress be monitored?** Achievement of the project milestones

**Lead Committee** Clinical Quality Improvement Committee

**Lead Executive** Medical Director

#### 4.1.2 Priority 2 - Implement patient safety elements of Year 2 of the Dementia Strategy

Goal	Aim	Actual Performance (2014/15)	KHT Data Available	Benchmarked/ Comparison
Safety	Implementation of the patient safety element of year 2 of the Trusts Dementia Strategy	N/A	No	No

**Measure:** We will set up systems that are able to specifically identify the level of harm to patients with dementia. We will establish a baseline of incidents and we will reduce the rate of harms to these patients by 10% in Q4 compared to the baseline in Q1. Having identified the key harm levels (e.g. falls, pressure ulcers in patients with dementia) we will plan a targeted safety improvement programme) by September 2015.

**Reference for data source:** Incident Reporting

**Governed by standard national definitions?** No

#### Why we chose this indicator?

Improving care for patients with dementia is important issue for Kingston Hospital, which is reflected by the Trusts Dementia Strategy 2014-2017. The life expectancy in our local population is high; as a result, nearly twice as many of our patients have Dementia as compared to the national average.

We want to eliminate all harms that happen to patients in hospital. We know that patients with dementia are specifically at an increased risk of harms whilst they are in hospital. Examples of such harms are falls, pressure ulcers and hospital-acquired infections.

In year 2 (2015/ 16) of the dementia strategy we plan to establish systems to be able to identify and track the harms that occur to patients with dementia. By doing this we will be able to better target improvement programmes to reduce harm. We will also be able to know if the work we are doing to improve the care of patients with dementia is working.

By establishing these systems in the coming year have planned to utilise this information in year 3 (2016/ 17) to identify and undertake specific targeted quality improvement programmes, to reduce harm and improve the safety for this patient group.

#### **How will progress be measured?**

We will put in place systems that enable us to easily identify through incident reports patients with dementia during the first half of the year.

We will identify which specific harms will be monitored as part of this programme of work and we will establish a reporting mechanism to compare with the overall Trust harm rates, and track for improvement.

The Dementia Strategy Group will utilise these reports alongside other measures such as the carers FFT we put in place in 2014/ 15, to track progress and develop further interventions to drive improvement.

#### **How will progress be monitored?**

Progress will be monitored through the Dementia Strategy Group and the six monthly Dementia Strategy progress reports to the Trust Board.

**Lead Committee**

Dementia Strategy Steering Group

**Lead Executive**

Director of Nursing & Patient Experience

#### **4.1.3 Priority 3- Reduce use of agency staff by reducing vacancies**

Goal	Aim	Actual Performance (2014/15)	KHT Data Available	Benchmarked/ Comparison
Safety	To reduce agency usage by 10%	£12,354,000 (all staff groups)	Yes	No

**Measure:** To increase recruitment to substantive posts and reduce the requirement to engage agency staff by 10%.

**Reference for data source:** Financial data and electronic staff roster system

**Governed by standard national definitions?** NA

**Why we chose this indicator?**

Kingston Hospital has to be able to respond to fluctuations in demand and staff availability through flexible staffing arrangements. The use of agency staff forms a key part of this flexibility for many Trusts. However, high levels of unmanaged use of agency staff can be costly, particularly when there are high levels of reliance on agency staff. In addition high levels of vacancies and extensive use of agency staff can worsen patient satisfaction and staff morale.

This is also important because staff who are substantively employed by the Trust are more likely to be familiar with our policies, procedures, the Trust values and have access to our programmes of work to improve patient safety.

**How will progress be measured?** Quarterly review of performance

**How will progress be monitored?** Monthly budget statements/ Electronic staff roster system

**Lead Committee** Workforce Committee

**Lead Executive** Director of Workforce

**4.2 Domain: Clinical Effectiveness**

**4.2.1 Priority 4 - To work towards paper-light systems using information technology and record management across the Trust**

Goal	Aim	Actual Performance (2014/15)	KHT Data Available	Benchmarked/ Comparison
Effective	To increase the amount of time nurses have available to spend with their patients	New programme of work.	No	No

**Measure:** The initial scope of this project will be focusing on releasing nursing time to care and reduce the amount of time nurses take to obtain and record patient's vital signs. We will establish a baseline prior to implementation of the project and improvement trajectory based on this baseline. (100 beds in first phase)

To reduce human error in recording patient's vital signs

To reduce the time taken to respond to a deteriorating patient's condition.

**Reference for data source:** Audit of patient safety alerts

**Governed by standard national definitions?** NA

**Why we chose this indicator?**

Currently vital signs are recorded on paper and the observations are transcribed onto a chart to manually calculate the Early Warning Score (EWS). Nursing staff are required to raise an alert based on vital signs being outside the normal range. This scheme enables nurses at Kingston Hospital to take and record patient's vital signs observations at the patient's bedside and in real time, and electronically record the results. The project will implement an alert mechanism for medical and critical care teams to respond to alerts regarding deteriorating patients allowing for swift intervention and treatment. The system will provide coverage for 100 beds at the Trust initially, based on the funding that has been awarded for this project (the funding was awarded from a national bidding process for ring fenced funds to support nurses use of information technology to improve patient care).

This is important because implementing electronic patient's records and information technology solutions help reduce the amount of time staff spend on documentation. This releases more time for them to provide patient care. It also allows us to introduce systems that support improved patient safety.

Where nurses have access to information at the bedside, they can make quicker decisions. Where they're free from administrative burdens, they have more time for patient care. Where automated alerts prevent medication errors, patients are safer. Information underpins improved care.

**How will progress be measured?** Project plan milestones and delivery

**How will progress be monitored?** Before and after study of time released and error rates, timeliness of alerts

**Lead Committee** IM&T Steering Group

**Lead Executive** Director of Nursing and Patient Experience

**4.2.2 Priority 5 - To ensure all our staff are up to date with core (mandatory) training, have clear objectives, regular appraisal and a personal development plan reflecting our values**

Goal	Aim	Actual Performance (2014/15)	KHT Data Available	Benchmarked/ Comparison
Effective	To have a committed, skilled and highly engaged workforce who feel valued, supported	95% Appraisal completed 76% Mandatory	Yes	Yes (via Staff Survey)



	and developed and who work together to care for our patients	training  55/100 score in national staff survey		
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**Measure:** 80% of staff to have had an appraisal and agreed objectives and a personal development plan (PDP) by the end of September 2015 and 95% by end of March 2016.

All managers have feedback on their people management skills from their staff and have the results built into their PDP.

80% of staff up to date with their mandatory training by end of March 2015

10% improvement in the reports from staff who say their appraisal left them feeling valued.

**Reference for data source:** Electronic Staff Record (OLM system)  
Annual Staff Survey results

**Governed by standard national definitions?** Annual Staff Survey results published nationally

#### **Why we chose this indicator?**

Results from our staff survey demonstrate a reduction in employee engagement this year over previous years. Furthermore information from exit interviews, 100 day new starter surveys alongside the views of staff gathered at the “conversation with the Board” has highlighted that a key issue for staff is development and recognition

Mandatory training is also important because staff who are regularly trained and updated in core subjects are better equipped to deliver safe care.

We know that giving staff feedback regarding performance, setting objectives, and importantly creating good personal development plans all lead to better staff and engagement and staff who have regular appraisals and one to one discussions are more engaged. We have already changed the staff paperwork supporting appraisal and we have also begun asking staff to report their experience of how effective their manager has conducted their appraisal and their development plan.

**How will progress be measured?** Electronic Staff Record report (OLM)  
National Staff Survey results compared to previous years

**How will progress be monitored?** Monthly review

**Lead Committee** Workforce Committee

#### 4.2.3 Priority 6 –Increase in the provision of 7 day working of key staff and services

Goal	Aim	Actual Performance (2014/15)	KHT Data Available	Benchmarked/ Comparison
Effective	<p>To improve the provision of 7 day working in the Trust and improve achievement of the London Quality Standards (related to consultant presence in Paediatrics, Surgery and Medicine)</p> <p>To have consultant ward reviews, every day, on every ward (including the acute assessment unit)</p>	NA	Yes	Yes (London Quality Standards Audit)

**Measure:** Analysis of medical staff job plans to ensure daily ward reviews are included in the work profile for staff

Length of stay on inpatient wards (including comparisons for week day and weekend admission dates to ensure reduced variation)

**Reference for data source:** Clinical Audit and Effectiveness audit  
Job plan review

**Governed by standard national definitions?** Yes, London Quality Standards

#### Why we chose this indicator?

The Trust is making a significant investment in seven day working and other essential quality improvements. This investment will ensure patients get the same level of care irrespective of the day of the week. At present there is a difference between mortality of patients admitted at the weekend (higher) and mortality of patients admitted on a weekday (lower). We also know that reviews of the patients by senior doctors with the support other healthcare professionals and access to diagnostic tests would make the patient stay much more efficient and would probably reduce the time that a patient spends in hospital.

At the moment fewer patients are discharged at the weekend and this makes the hospital very busy at the beginning of each week and means that patients cannot be moved quickly

from A and E. The A&E four hour standard is then very difficult to achieve. This investment will enable consultant ward reviews seven days a week for all patients in the hospital by the end of the year. The plans also make provision for more therapists and pharmacists to be working in the hospital at the weekend alongside other support staff who are vital to achieving the right standards of care every day.

**How will progress be measured?**

Improvement in length of stay and reduction in the different mortality rates between weekends and weekdays

Delivery of an increased number of the London Quality Standards (section related to seven day working)

**How will progress be monitored?**

Performance Review Meetings and Service Line Dashboards

**Lead Committee**

Executive Management Committee

**Lead Executive**

Deputy Chief Executive/ Medical Director

**4.3 Domain: Patient Experience**

**4.3.1 Priority 7 - To transform administration across the hospital and make improvements in administration**

Goal	Aim	Actual Performance (2014/15)	KHT Data Available	Benchmarked/ Comparison
Experience	<p>Patient letters and GP letters (discharge summaries &amp; clinic outcomes) are sent in a timely fashion to support on-going care</p> <p>Patients find it easier to contact the Trust regarding their care and treatment.</p>	<p>Complaints: 132 Clinic letters: 84% Discharge summaries: 70% Calls Answered: 74%*</p> <p>(*some of these calls are “answered” by answer machines – the new measure will count only calls answered by a member of staff)</p>	Yes	No

**Measure:** 30% reduction in the number of formal complaints relating to administration (41 fewer complaints in all).

>=85% of clinic letters sent within 10 working days

>= 85% of discharge summaries sent within 10 working days

Target of 75% of all calls answered in person (not answerphone)

**Reference for data source:**

Complaints received

Clinic letter data reports

Call centre activity data

**Governed by standard national definitions?**

No

### **Why we chose this indicator?**

It is widely recognised that Trust has faced significant challenges in establishing consistently excellent and sustainable approaches to patient administration. Work has been undertaken in the past, for example the devolution of the team structures out to the service lines in the autumn of 2013, but this has not addressed all of the issues, and there is still a high level of complaints regarding our administrative processes and the impact this has on patient experience.

A new programme approach commenced in December 2014 and will continue into 2015/16. The new approach focusses much more on the need to reach further and deeper into the challenges order to achieve the high quality, sustainable improvements we seek. This has meant targeting the underlying issues and needs that are preventing progress and, by taking a more strategic approach, doing more in our action planning to target root-causes, improve staff engagement and to provide more cohesion across multiple work streams.

### **How will progress be measured?**

A range of indicators have been established to track progress. We have chosen to focus on: a measure that monitors patient experience as an indicator of improved administrative processes; letter turnaround times as an indicator of both more effective processes and improved clinical effectiveness; and effectiveness of call handling as an indicator of improved access for patients.

**How will progress be monitored?**

Monthly reporting to the Executive Management Committee (EMC)

**Lead Committee:**  
(EMC)

Executive Management Committee

**Lead Executive:**

Deputy Chief Executive

#### **4.3.2 Priority 8- To improve our patients and their relatives experience of End of Life Care**

<b>Goal</b>	<b>Aim</b>	<b>Actual Performance (2014/15)</b>	<b>KHT Data Available</b>	<b>Benchmarked/ Comparison</b>
Experience	To establish a series of improvements for patients and their relatives based their experiences and feedback	New programme of work	NA	NA

**Measure:** Monitor the response rate to care of the dying evaluation questionnaire and deliver a communications campaign to increase response rates (15% improvement by end of year from first six months return rate)

Analysis of the themes identified by patients and their carer with the development of a programme of improvement work by August 2015

Having identified areas for improvement report on progress with improvements made as a result of feedback received

**Reference for data source:** Response to bereavement survey

**Governed by standard national definitions?** No

#### **Why we chose this indicator?**

End of life care is support for people who are approaching death. It helps them to live as well as possible until they die, and to die with dignity. It also includes support for their family or carers. End of life care includes palliative care. Hospital doctors and nurses, GP's, community nurses, hospice staff and counsellors might all be involved, as well as social services, religious ministers, physiotherapists or complementary therapists. It is important because; there is only one opportunity to get the care at the end of a patient's life right for them and their families.

We work to ensure that all patients have a dignified death, supporting their choice of where to die and working with those close to them before and after death to provide emotional and spiritual support. We work collaboratively with partner providers/ organisations to enable patients to have a 'good death' and to ensure that friends and family are well supported.

Through our care of the dying evaluation we will focus on the following areas:

- Support and care received from doctors and nurses

- The control of pain and other symptoms
- Communication with the healthcare team
- The emotional and spiritual support provided

**How will progress be measured?**

Annual audit of bereavement survey responses

**How will progress be monitored?**

End of Life Care Steering Group

**Lead Committee**

Patient Experience Committee

**Lead Executive**

Director of Nursing and Patient Experience

#### 4.3.3 Priority 9 - Improvements in discharge planning and processes

Goal	Aim	Actual Performance (2014/15)	KHT Data Available	Benchmarked/ Comparison
Experience	<p>Improvements in multidisciplinary assessment of complex patients.</p> <p>Improve the discharge planning of patients (to include estimated discharge dates)</p>	NA	Yes	No

**Measure:** By quarter 4, prompt screening of all patients with complex needs by the multidisciplinary team (including physiotherapy, occupational therapy and pharmacy).

By quarter 4 a system will be in place that will enable all admitted patients to have a discharge plan and estimated date of discharge as soon as possible (within 24 hours)

**Reference for data source:**

Patient records and coding

**Governed by standard national definitions?**

Yes

**Why we chose this indicator?**

The 2015/ 16 CQUIN will focus on the Trust providing 7 day multidisciplinary assessment and treatment for the complex patient and a safe, timely and appropriate discharge processes from the hospital for all patients. Primary, community and social care partners are recognised as key to the delivery of consistently high quality discharges 7 days a week.

Moving from a system whereby services are predominantly provided on a five day a week basis to delivery of a consistent high quality service for all patients every day of the week requires significant cultural shift as well as the practical and logistical changes that need to happen.

This priority is based on the implementation of the London Quality Standards. It focuses on standards relating to multidisciplinary assessments for the complex patient and safe, timely and appropriate discharging. This builds upon the 2014/ 15 7 day working CQUIN to improve standards, patient outcomes and experience.

Our Community partners have a similar CQUIN to support the integration of discharge teams and processes.

<b>How will progress be measured?</b>	Quarterly reports based on data set
<b>How will progress be monitored?</b>	
<b>Lead Committee</b>	CQUIN Board
<b>Lead Executive</b>	Deputy Chief Executive

## PART 3

### 5. Looking Back at 2014 – 15

The number of priorities selected is in line with the Monitor Annual Accounting Manual, published in December 2013 (updated March 2014). The indicator set selected has to include:

- at least 3 indicators for patient safety
- at least 3 indicators for clinical effectiveness
- at least 3 indicators for patient experience

In November 2014 the Trust conducted an online survey with staff and the public to inform a long list of quality priorities to be further consulted on.

In January 2014, an online survey of potential quality priorities was conducted to identify the preferences of Kingston Hospital NHS Foundation Trust Members and staff with almost 400 responses received. These were combined with feedback from various committees and forums to determine the Trust's priorities. The following table outlines the chosen priorities.

Domain	Priority
Patient Safety	<ul style="list-style-type: none"><li>- Preventing and reducing falls in care of the elderly wards</li><li>- Reduction of incidences of hospital acquired infection*</li><li>- Improvements in the inpatient ward environment - more dementia friendly (implementation of coloured crockery/ orientation clocks and calendars, memory boxes)</li></ul>
Clinical Effectiveness	<ul style="list-style-type: none"><li>- Displaying safe staffing levels to patients and the public</li><li>- Safer surgery for the Elderly including medicines review and frailty risk assessments</li><li>- Implementation of e-Prescribing/ clinical documentation as part of becoming a paper light organisation</li></ul>
Patient Experience	<ul style="list-style-type: none"><li>- Increase patient involvement in decision making (service re-design)</li><li>- Dementia strategy – improvement in experience of patient carers</li><li>- Improvements in experience of hospital food</li></ul>

*\*Feedback received stated that this should be broadened to hospital acquired infections rather than C.diff specifically. (This was the original proposal sent to respondents).*

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.



## 5.1 Domain: Patient Safety

ACHIEVED

### 5.1.1 Priority 1: Preventing and reducing falls in care of the elderly wards

Goal	Measure	Actual Performance (2013/14)	Actual Performance (2014/15)	% Improvement
Safety	Preventing and reducing falls by 10% in care of the elderly wards	Care of the Elderly wards 7.52 falls per 1,000 bed days  Trust wide 5.9 falls per 1,000 bed days	Care of the Elderly wards 6.02 falls per 1,000 bed days  Trust wide 5.6 falls per 1,000 bed days	19.9 %

Reference for data source:

Incident reports  
Clinical Quality Report

Governed by standard national definitions?

National Reporting and Learning System

Why did we choose this?

Falling is the leading cause of injury-related admissions to hospital in the over 65, costing the NHS an estimated £2.3billion per year. The National Institute for Clinical Excellence (NICE) has updated its guideline on falls to help reduce the number of older people who are falling over in hospitals. Certain groups of inpatients are at risk of falling in hospital and these include all patients age 65 or older, and those age 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition such as dementia or stroke. We recognised the need to provide additional focus in our care of the elderly wards, where patients are at the greatest risk of falling.

What we said we were going to do?

By quarter 4, to achieve a 10% reduction in falls per 1,000 bed days against the baseline level recorded in Quarter 1 for our Care of the Elderly wards. The falls rate in the four Care of the Elderly wards for the period April 2013 to March 2014 was 7.52 falls per 1,000 bed days (the Trust wide rate was 5.9 falls per 1,000 bed days). We intended to continue implementation of our falls action plan throughout 2014/15, reviewing trends in falls incidents, and amending our action plan as needed. We would undertake audit and review performance, making recommendations where indicated and work with other hospitals through NHS QUEST specifically on falls reduction, learning from practice and benchmarking with others.

How did we do?

We have achieved the target we set for 2014/15. Within the Care of the Elderly Wards falls per 1,000 bed days for the period April 2014 – March 2015 was 6.02, which was a reduction

from the 7.52 per 1,000 bed days in 2013/14. The Trust's overall rate for falls per 1,000 bed days also reduced for the period April 2014 – March 2015 to 5.6, as compared to 5.9 per 1,000 bed days in the 2013/14.

Members of Trust staff have undertaken visits to other organisations as part of our NHS QUEST membership, to learn from other organisations also aiming to reduce their falls rates. As a result of this the Trust is rolling out an initiative called 'SWARM'. This supports the immediate post fall identification of the cause of a fall and to prevent them from occurring in future. Any learning is then taken to other patients to help reduce the risk of further falls. The Trust has extended its use of falls alarms, by installing them in bathrooms. We have also begun to introduce coloured toilet seats to help clear identification of toilet bowls for those who may be visually impaired or suffering from dementia.

All falls which result in permanent harm are declared as Serious Incidents and full multidisciplinary investigations using Root Cause Analysis to identify the cause(s) of patient falls are undertaken. These investigation reports are presented to the Serious Incident Group. All learning from falls are shared with the relevant clinical teams whilst delivery of any post incident action plan is monitored by the Service Line governance structures. The Trust continues to have an active Falls Group, chaired by the Medical Director.

### 5.1.2 Priority 2: Reduction of incidences of hospital acquired infection

ACHIEVED				
Goal	Measure	Actual Performance (2013/14)	Actual Performance (2014/15)	% Improvement
Safety	10% Reduction of incidences of hospital acquired infections (C. Difficile/ MRSA bacteraemia, MSSA/ E Coli) compared to previous year	22 C. Difficile cases 4 MRSA cases 14 MSSA cases 24 E.Coli cases  Total: 64 cases	17 C. Difficile cases 0 MRSA cases 7 MSSA cases 25 E.Coli cases  Total: 49 cases	23.4 %

**Aim:** 10% reduction across the selected incidences of hospital acquired infections against 2013/ 14 performance (C. Difficile/ MRSA bacteraemia, MSSA/ E Coli).

**Reference for data source:**

**Public Health England**

**Governed by standard national definitions?**

**Yes**

#### Why did we choose this?

Despite progress in public health and hospital care, infections continue to develop in hospitalised patients, and may also affect hospital staff. Whilst historically we have reduced hospital acquired infections at Kingston Hospital we recognise we can reduce this further.

Many factors promote infection among hospitalised patients: decreased immunity among patients; the increasing variety of medical procedures and invasive techniques creating potential routes of infection; and the transmission of drug-resistant bacteria among crowded hospital populations.

Their effects vary from discomfort for the patient to prolonged or permanent disability and a small proportion of patient deaths each year are primarily attributable to hospital acquired infections.

### **What we said we were going to do?**

We developed and reviewed strategies that minimise the risk of patients acquiring infections in hospital and reduce, where possible, the level of harm sustained as a result of an infection. We continued to implement our infection control action plan throughout 2014/15 and reviewed trends in infection rate, amending our action plan as needed. We would undertake audit and review performance, making recommendations where required.

### **How did we do?**

We had a total of 49 hospital acquired cases in from April 2014 to March 2015 compared with 64 cases from April 2013 to March 2014.

The Health Care Associated Infection (HCAI) task and finish group, chaired by the Director of Nursing and Patient Experience, led the implementation of the action plan developed after the peer review in 2013.

Improvements with regard to Intravenous (IV) line care was led by the IV task and finish group. The IV task and finish group completed its purpose and concluded. An improvement in IV line care continues to be an area of focus and is the subject of one of our Quality Improvement Projects, which is being led by a Consultant Anaesthetist.

All C.Diff cases have been subject to a multidisciplinary Post Infection Review, to ensure that any learning is captured and shared. The results of these are presented to the Service Line and Serious Incident Group. There have been a total of 17 cases from April 2014 – March 2015, compared to 22 for all of 2013/14. There have been no cases of hospital acquired MRSA bacteraemia in 2014/15, which meets the national guidance on zero tolerance. This was compared to 4 cases which were reported during 2013/14. All MSSA cases have been subject to a multidisciplinary Post Infection Review, to ensure that any learning is captured and shared. The results of these are presented to the Service Line and Serious Incident Group. There were a total been a total of 7 cases from April 2014 – March 2015, compared to 14 for all of 2013/14.

E. coli bacteraemias are reported to the Department of Health (DH), however there is no DH set target for these. There have been a total of 25 cases from April 2014 – March 2015, compared to 24 for all of 2013/14. We did not achieve a reduction in E.coli bacteraemias. As these infections are often linked to Catheter Associated Urinary Tract Infections (CAUTIs), the Trust has started work to run through 2015/16, with 5 other hospitals in South London as part of a pilot project with the Health Innovation Network (HIN) to reduce CAUTIs.

### 5.1.3 Priority 3: Improvements in the inpatient ward environment - more dementia friendly (implementation of coloured crockery/ orientation clocks and calendars, memory boxes)

**PART ACHIEVED**

Goal	Aim
Safety	Deliver improvements in the inpatient ward environment - more dementia friendly

**Aim:** To deliver the commitments identified in the first year of the Dementia Strategy.

**Reference for data source:**

**Trust Board Papers**

**Governed by standard national definitions?**

**No**

#### Why did we choose this?

Dementia is a condition that affects Kingston Hospital more than most as we serve an area that has one of the highest life expectancies in the country. As a result, nearly half of our inpatients over 75 have dementia, which is double the national average. Someone with dementia may be admitted to a general or specialist hospital ward either as part of a planned procedure, such as a cataract operation, or following an accident, such as a fall. Hospital environments can be disorientating and frightening for a person with dementia and may make them more confused than usual. The person might find the ward loud and unfamiliar, and may not understand why they are there. There is much that can be done to help them adapt to the new environment.

#### What we said we were going to do?

The first year plan within the Trust's Dementia Strategy 2014-17 focused on the environment and set out the following commitments:

▬ Target partially achieved

✓ Target achieved

✗ Target not achieved

▬ Make available dementia friendly crockery, communal tables and spaces for dining & pictorial menus

✓ Build staff capacity and skills in dementia friendly hospital design & create design visuals to use for fundraising and improvement

✓ Establish Environment of Care Advisory Group and agree design principles for wards and departments

✗ Begin refurbishment programme - A&E with dementia friendly facilities

✓ De-clutter, develop and begin immediate impact programme for ward areas e.g. orientation clocks, art, use of colour

- ✓ Develop plans, identify space and funding opportunities for carers' hub - engage carers and partners in concept
- ✓ Establish clear set of fundraising and volunteering options to support planned work programme of improvements
- ✗ Develop 'Forget Me Not Garden' space for carers and patients (Volunteer Ground Force event) – Summer 2014

### How did we do?

The Trust has partially achieved this priority.

The Dementia strategy delivery group is chaired by the Director of Nursing and Patient Experience. A subgroup has been formed to specifically take forward the improvements in the environments of care. This sub group is chaired by the Deputy Director of Nursing Emergency Services and reports into the main Dementia strategy delivery group. It has representatives from nursing, estates & facilities staff and carers, and a volunteer. All refurbishments or changes to any ward environment are to be signed off through the Environment of Care advisory group to ensure they are suitable for people with dementia.

To help develop the Trust's understanding and skills in how to improve the care environment for patients with Dementia, we sponsored two staff from Estates & Facilities in 2013, and a further two people (a nurse and a carer) in 2014 to attend the Kings Fund residential programme on designing care environments for people with dementia.

We have developed a Dementia Activities room which is collocated with our care of the elderly wards. The space has also enabled communal dining with the creation of the Memory Lane lunch club where patients are able to come away from the ward areas to dine together. The room has also been used to support our Therapeutic Activities Programme which enables reminiscence activities such as looking and talking about images from the past, art activities, music and games. We have dedicated volunteers who have been trained in supporting therapeutic activities for patient with dementia. We have also introduced Pets as Therapy dogs into our care of the elderly and medical wards.

Pictured below is a reminiscence area which has been created within the room to support a relaxing and familiar environment for patients.



A number of steps have been taken towards making improvements in the inpatient ward environments to becoming more Dementia friendly as outlined in the first year of the Dementia Strategy. We have carefully chosen and ordered new clocks for all bays and side rooms which will be more visible for patients. These will be fitted during May 2015. We have begun the introduction of coloured toilet seats and will continue this as we refurbish our ward areas.

We undertook reviews of research and experience from other hospitals and it was deemed that the contrasting white plate and coloured trays we have in place need to change to support our patients with dementia. A number of suppliers have been identified and a specification of crockery and cutlery produced. In April 2015 our nursing assistants will work with suppliers to finish the purchase procedures.

We have begun to change the type of flooring in the entrance and corridor areas of the hospital, moving away from shiny flooring which is better for patients with dementia who may have sensory deficits.

We took steps to de-clutter our ward areas which included a tidy Thursday campaign to regularly reduce clutter in the inpatient wards and areas. We also introduced new storage in some ward areas to support this. With the future redevelopment of inpatient ward areas we will use this as an opportunity to create more storage areas for equipment.

In light of the current overall financial position, the refurbishment of the A&E department is now on hold. The Environment of Care Advisory Group will be reviewing during early 2015/16 what steps can be put in place within the existing A&E department to create more dementia friendly spaces.

The 'Forget Me Not Garden' space has not yet been developed, however the Trust has launched a fundraising campaign, with the aim to raise £750,000 in order that a Carers Centre and Dementia friendly wards can be developed. Draft visuals have been produced of the carers centre and possible locations have been identified. We have decided during the year to first focus funds that we receive on improving the care of the elderly ward areas, with the development of the carers centre to follow this. We have developed a specification of how we want the wards to be refurbished. We have also engaged architects working with our Environment of Care Advisory Group to develop detailed design plans of how the wards will look.

## 5.2 Domain: Clinical Effectiveness

ACHIEVED

### 5.2.1 Priority 4: Displaying safe staffing levels to patients and the public

Goal	Aim	Actual Performance (2014/15)	KHT Data Available	Benchmarked/ Comparison
Effective	Displaying safe staffing levels to patients and the public	NA	NA	Yes Autumn 2014

**Measure:** To ensure that safe staffing levels are published in all wards/ departments and Trust Board reports detailing planned versus actual staffing, with exception reports where there is variation. Twice a year the Trust Board will receive an in depth report in public.

**Reference for data source:**

**Trust Board Papers**

**Governed by standard national definitions?**

**No**

#### Why did we choose this?

Nursing, midwifery and care staff, working as part of wider multidisciplinary teams, play a critical role in securing high quality care and excellent outcomes for patients. There are established and evidenced links between patient outcomes and whether organisations have the right people, with the right skills, in the right place at the right time. Furthermore, perceptions of patients regarding adequate staffing levels feature within the top 3 areas which patients comment on within the Friends and Family Test. Following the Francis Enquiry there is now a national requirement to publish nursing, midwifery and care staffing information to the public.

#### What we said we were going to do?

- ✓ The Trust will develop a system which will clearly display information about the nurses, midwives and care staff present in each ward, clinical setting, department or service on each shift.
- ✓ Information will be made available to patients and the public that outlines which staff are present and what their role is.
- ✓ Information displayed will be visible, clear and accurate, and will include the full range of support staff available on the ward during each shift.

#### How did we do?

The Trust has successfully achieved this priority.

All wards now have an electronic information board at the entrance to the ward which displays the a picture and name of the ward sister/charge nurse, the name of the nurse in charge and the planned and actual numbers of staff on duty for that day/ night. Consistency



of completion daily identified as an area for improvement post implementation and a system is in place to monitor completion of these in line with requirements.

Each month the senior nursing team collect data regarding the numbers of planned and actual nurse staff for each ward and this data is published both on NHS Choices website and on the Kingston Hospital website.

The Trust Board receives a monthly clinical quality report which shows the safe staffing data. The Board also receives a 6 monthly report regarding nurse staffing levels and steps to further develop the nursing & midwifery workforce. These are presented by the Director of Nursing and Patient Experience. These reports are available on the Kingston Hospital website.

In addition to the above, the website also has a section which explains the different types of uniforms staff wear depending upon their role and these are displayed on the display screens and in posters in each patient bay (male staff wear the same colour uniforms).

### **NURSING UNIFORMS AT KINGSTON HOSPITAL**





## 5.2.2: Safer surgery for the Elderly including medicines review and frailty risk assessments

NOT ACHIEVED

Goal	Aim
Effective	Safer surgery for the Elderly including medicines review and frailty risk assessments

**Measure:** To improve the level of achievement of the recommendations from the National Enquiry into Patient Outcome and Death (November 2010) from 50% to 75% in 2014/ 15.

**Reference for data source:**

**NCEPOD gap analysis**

**Governed by standard national definitions?**

**Yes**

### Why did we choose this?

Frail older people are likely to have multiple co-morbidities, poly-pharmacy (multiple medicines), sensory and cognitive impairment - all of which are associated with an increased incidence of healthcare-associated harm. This complexity means that there are unique challenges in designing safe systems of care for frail older people.

### What we said we were going to do?

We said we wanted to improve the support for elderly patient who undergo surgery at the Trust.

We know that recognising comorbidity, disability and frailty as independent markers of risk in the elderly improves the patient's outcome. This requires multidisciplinary input including, early involvement of Medicine for the Care of Older People. For this reason care is better when a whole team of senior doctors and other healthcare professionals are involved in the decision making and plan of care for each patient.

### How did we do?

We did not achieve 75% of the standards that we set out to so we have marked this priority as not achieved as we did not make as much progress this year as we had hoped with the implementation of the multidisciplinary team. The additional investment required to support a higher level of achievement of the recommendations was approved in the last quarter of the year and the relevant service lines are now recruiting to the additional posts to support frailty assessments and medicines review for a larger group of patients.

The NCEPOD report included 24 recommendations (of which 23 are relevant to the Trust). The Trust is currently focussed on three main areas for the coming year:

Recommendation 1 – Improving the availability of specialist geriatric medical input to older people undergoing surgery - this will be addressed through the additional

provision of elderly care medical staff providing advice and input onto the surgical wards. There is no provision for this currently at the weekend, when patients will either be at pre-operative or immediately post-operative care, or the patients will have already had elderly care input and an appropriate plan for their care formulated before surgery.

Recommendation 7 – Specific guidance on the ideal levels of seniority and speciality input into the assessment and decision making phase of the care pathway for patients is needed and the provision for the involvement of elderly care physicians in the decision to operate has been made but it is not currently being used.

Recommendation 22 – to be updated

A further audit of the use of frailty scoring would ensure compliance with standards

A Project Team for Safer Surgery for the Elderly has been set up led by the Clinical Director for Surgery working closely with Consultant in Elderly Care Medicine. The team have presented their plans to the Executive Management Team and they have been given approval and investment to fully implement their action plan. Recruitment of Consultant Emergency Surgeons and Care of the Elderly doctors is in progress (expected to be complete by July 2015). These doctors will enable multidisciplinary decision making and assessment including frailty scoring. They will also enable optimisation of the patient's medical condition prior to surgery in both planned and emergency situations which is known to improve outcome and reduce length of stay following surgery. The anaesthetic department and therapies will be involved in the project.

Many of the elderly patients admitted with problems requiring surgery have other illnesses and their healthcare needs are complex. They may also present out of normal hours or at the weekend. We have plans in place in both medicine and surgery to review emergency patients every 12 hours as part of our delivery of the London Quality Standards and this will enhance early diagnosis, senior decision making regarding surgery, optimisation of the patient's condition before their operation and make sure that the recovery plans are effective. It is anticipated that recruitment will be successful and complete by the end of September 2015.

It is anticipated that we will fully meet all the standards in this section in 2015/ 16.

### 5.2.2 Priority 6: Implementation of e-Prescribing/ clinical documentation as part of becoming a paper light organisation

ACHIEVED

Goal	Aim
Effective	Implementation of e-Prescribing/ clinical documentation as part of becoming a paper light organisation on a minimum of five wards.  Achieved in 11 wards and A&E/ ITU departments during 2014/ 15

**Measure:** Implementation of E-prescribing (on a minimum of five wards)  
Implementation of clinical documentation (on a minimum of five wards)

**Reference for data source:** CRS Implementation Plan  
**Governed by standard national definitions?** No

#### **Why did we choose this?**

Implementation of an electronic patient record (EPR) system included the transfer of all our clinical documentation onto the Care Records Service (CRS), introducing electronic prescribing, and sending all correspondence to GPs electronically so that they can incorporate the information into their systems easily.

This system allows us to have safer prescribing and administration of patient medicines – all prescriptions will be legible, drug charts are accessible to staff across the Trust reducing delays for patients and records are stored and tracked electronically.

The system allows most nursing and medical records to be stored electronically – patient records are always available and accessible to all appropriate staff groups. Communication between staff in and out of the hospital will be greatly improved.

The overall benefits of the system include reducing the amount of time staff spend on administrative tasks, releasing time for staff to provide improved patient care.

#### ***What we said we were going to do?***

Evaluation of the pilot of the new CRS system in the clinical environment (initially Isabella and Keats wards) with roll-out to adult inpatient areas, ITU and theatres over the remainder of the year following pilot and testing period.

#### **How did we do?**

The Trust has successfully achieved and significantly exceeded this priority.

Following our successful pilot on Isabella and Keats Wards, all our inpatient wards, A&E department and Intensive Care Unit have gone live with clinical documentation and e-

prescribing between July 2014 and March 2015. We have also implemented e-Prescribing in maternity. These areas are now paper light, medicines management and clinical documentation are part of their daily clinical practice.

This has involved training all our staff in those areas in the new systems, and deploying new equipment such as tablet devices and Workstations on Wheels (WOWs) – as shown in the picture below. Staff have been supported by an Intensive Support Team, who are multidisciplinary team of staff with expertise in the system and training staff to use it.

During 2015/16 the Trust will continue to consolidate the support to staff in order to use the system more efficiently and make further improvements to the quality of documentation contained in the records. We also aim to deliver improvements in audit information from the system to drive patient safety improvements.



## 5.3 Domain: Patient Experience

### 5.3.1 Priority 7: Increase patient involvement in decision making (service re-design)

ACHIEVED

Goal	Aim
Experience	Increase patient involvement in decision making (service re-design)

**Measure:** Recruit to 8 x Service Improvement Volunteers  
Facilitate 2 x Volunteers Forum events  
Introduce a feedback mechanism for volunteers

**Reference for data source:** Patient Experience Committee Account  
**Governed by standard national definitions?** No

#### Why did we choose this?

The Department of Health's (2009) defines Patient and Public Involvement as follows: *"Patient and public [involvement] is the active participation of patients, carers, community representatives, community groups and the public in how services are planned, delivered and evaluated. It is broader and deeper than traditional consultation. It involves the ongoing process of developing and sustaining constructive relationships, building strong active partnerships and holding a meaningful dialogue with stakeholders. Effective engagement leads to improvements in health services and is part of everyone's role in the NHS."*

In accordance with this we want to work in partnership to redesign Trust services to ensure that the patient and public voice drives the delivery of care.

We set Patient and Public Involvement as a key driver of the way in which the Trust works through our Patient and Public Involvement Strategy 2013-15 and our Volunteering Strategy 2014-17.

#### What we said we were going to do?

- ✓ We will ensure that when services are redesigned, patient and public views and involvement are integral to the discussion and planning.
- ✓ We will ensure that key groups within the PPI structure are kept informed of Trust priorities which are likely to result in service redesign.
- ✓ We will invest in volunteering at Kingston Hospital, developing a specific volunteering role related to service improvement and take account of feedback received from the newly established Volunteers Forum.

- ✓ The Volunteering Project Manager and Business Intelligence Systems teams will undertake a monthly analysis for a pilot of three months to examine the relationship between volunteering and patient experience. We will also explore causal links between a positive or negative experience of volunteers and other factors, including patient perceptions of staffing, food, hospital cleanliness and other themes.

### **How did we do?**

The Trust has successfully achieved this priority.

The Trust has established new group of volunteers called the Quality Improvement Volunteers. This constitutes a minimum of 17 volunteers, each matched with a Service Line that best reflects their interests and ambitions around improvement for quality and patient experience.

When the Service Line undertakes service or quality improvement projects and is looking for patient and public involvement, the Quality Improvement Volunteer aligned to that Service Line is invited to join relevant groups, comment on papers and advise on the best ways to reflect the views and needs of patients within the project and its outcomes. They also act as a Forum advising on service improvement issues that cut across Service Lines at a strategic level.

The first meeting took place in January 2015. A mapping exercise has been completed to identify PPI representatives already involved in similar positions around the Trust to join this group. Their feedback on the issue of integrating patient's comments using social media have already been translated into an action at the Patient Experience Committee and influenced the way that the Trust monitors social media as a data source and measure of patient experience. The Quality Improvement Volunteers will meet quarterly, Chaired by the Deputy Director of Nursing to identify areas of commonality, strategic needs and themes to be taken forwards by the Hospital for improvement. Individuals will remain active throughout the year and opportunities will be posted to the Forum membership on a proactive basis. The Forum also offers a platform for peer networking and ongoing training and development to increase the skill and capacity of PPI volunteers in service re-design.

The Business Intelligence Team and Volunteer Service have achieved the target to develop a reporting card that tracks and monitors the impact of volunteering on patient experience. A baseline was taken November-December 2014 and will reports quarterly to the Patient Experience Committee.

The Trust has also invested in a new Head of Volunteering and successfully achieved additional funding from NESTA to expand volunteering in the Trust.

The Trust had a large scale Volunteering Conference (pictured below) in March 2015 to celebrate the significant contribution that volunteers make to the Trust. External speakers at the day described the Trusts approach to volunteering as pioneering.



### 5.3.2 Priority 8: Dementia strategy – improvement in experience of patient carers

ACHIEVED

Goal	Measure	Actual Performance (2014/15)	KHT Data Available	% Improvement
Experience	Dementia strategy – improvement in experience of patient carers	% Carers Positive response to FFT Q1 – 88.9% Q2 – 97.44% Q3 – 90.32% Q4 – 92.31% (45 responses)	Yes	30.7 %

**Aim:** To deliver the commitments identified in the first year of the Dementia Strategy. To establish a baseline in Quarter 1 for Friends and Family Test scores from carers aim to deliver a 20% improvement by Quarter 4.

**Reference for data source:**

**Trust Board progress report  
FFT results**

**Governed by standard national definitions?**

**No**

#### **Why did we choose this?**

As previously stated, dementia is a condition that affects Kingston Hospital more than most as we serve an area that has one of the highest life expectancies in the country. Dementia not only affects the person with the condition but their families and friends as well.



For care to be effective we need to learn about the person with dementia and how they function in everyday life. This means learning from families and carers who have been support the person with dementia at home, usually for some time, and involving them as partners in assessment, care planning and decision making.

It's important to recognise that carers themselves may feel vulnerable and in need and their needs often go unrecognised. Actively supporting carers is at the heart of our approach to providing consistently excellent dementia care.

### **What we said we were going to do?**

The first year plan within the Trust's Dementia Strategy 2014-17 focused on the patient's carers and set out the following commitments:

- ✓ Ratified operational carers policy in place by Feb 2014 and available to the public
- ✓ Establish set of KPI's to monitor carers experience and set baselines for improvement. Promote available existing carer support mechanisms – First Contact, Carer Passports, "Important things about me"
- ✓ Review and improve 24/ 7 facilities for carers in care of the elderly wards
- ✓ Redesign information and support leaflet;
- ✓ Develop professional 'Forget Me Not Pack';
- ✗ Design 'carers hub', identify space, pursue sources of funding and partnerships to support, delivery model & outcomes
- == Identify a visible area close to patients whereby existing patient and carer information from dementia charities is available and maintained

### **How did we do?**

The Trust has achieved this priority and progress is being made in a number of areas.

In December 2013 we implemented new visiting times for the whole day, in order to make it easier for people to visit patients and this was particularly important given the need to make it easier for carers. During September 2014 we undertook an evaluation of the visiting times, to make sure that they were open enough throughout the day. The evaluation involved asking patients, visitors and staff what they thought of the new arrangements. The response was overwhelmingly positive and we therefore continue with the new visiting times. In response to FFT comments we have ordered additional visitors chairs to make it more comfortable for visitors when they are here.

An operational Carers policy was published in June 2014 and is available to the public via the Trusts website. We have introduced information packs for carers, however we recognise we need to do more to make sure they are given to every carer and ward sisters/ charge nurses are regularly reminded of the importance of this activity.

Carers are a core and valued component of the governance structures supporting the dementia strategy including the Dementia Strategy Delivery Group and the Environments of Care Advisory Group.



Funding was achieved in 2014 for a Darzi Fellow who started in September 2014 to specifically focus on projects to support improvements in provision for carers. A Darzi Fellow a member of clinical staff who undergoes leadership development within London and works on improvement projects.

The Trust has put in place a carers FFT survey to monitor the experience of carers and the care that is provided to their loved on. We would like to see more responses to this survey and will be doing more work over the coming year to achieve increased levels of feedback. The results of the carers FFT have also been added to our Clinical Quality Report which is reported to the Trust Board and available to the public.

We achieved improvement in the percentage of positive comments received from carers during the year. We will continue to focus over the coming year on making further improvements to that experience.

We have been working with other organisations to support carers. The Kingston Carers Network are providing facilitators within the care of elderly wards and stroke unit to support carers. In January 2015 we established in collaboration with Home Instead, a Memory Café at the hospital. This is held every other Tuesday afternoon and is open to anyone in the local community for people with memory loss, Alzheimer's and other dementias, and their carers'. It is designed to provide a welcoming place where patients and carers can get support from staff, volunteers and others impacted by dementia. The below picture is taken at the hospitals Memory Café.



We have purchased more comfortable recliners for inpatient areas so that carers and relatives can stay with patients overnight should they wish to.

As described earlier possible locations of the carers centre have been identified and draft visuals produced for the fundraising programme, although we have decided this year to focus the funds raised on developing the inpatient elderly care ward areas first.

In March 2015, we committed to meeting the principles of 'Johns Campaign' which is a national campaign calling for the families and carers of people with dementia to have the same rights as the parents of sick children, and be allowed to remain with them in hospital for as many hours of the day and night as is humanly possible. During 2015/16 we will be taking forward measures to make it even easier and more comfortable for carers of patients with dementia to stay with their loved one. This will include ensuring all staff understands the principles of the campaign and their role in achieving this.

### 5.3.3 Priority 9: Improvements in experience of hospital food

ACHIEVED				
Goal	Aim	Actual Performance (2014/15)	KHT Data Available	% Improvement
Experience	To reduce the frequency of food as a comment suggesting improvement	Comments made regarding the need for improvement to food  Quarter 1 – 9% (n=128) Quarter 2 – 4% (n=77) Quarter 3 – 5% (n=62) Quarter 4 – 3% (n=40)	NA	59%

**Measure:** To reduce the frequency of food (as a comment suggesting improvement) by 25% in the analysis of Friends and Family Test feedback

**Reference for data source:**

**Friends and Family test**

**Governed by standard national definitions?**

**No**

#### Why did we choose this?

The delivery of adequate and appropriate nutrition to hospital patients is a key issue for all staff, including caterers, nurses and dieticians. Intake of nutritious food is crucial for patients who are recovering from the effects of medical or surgical procedures. Patients who receive good nutrition may have shorter hospital stays, fewer post-operative complications and less need for drugs and other interventions.

In order to ensure the effective delivery of good nutrition in healthcare facilities a team-based approach is essential. Caterers, kitchen staff, dieticians, nurses, doctors, ward housekeepers and porters all have an important part to play.

We have analysed the data from the Friends and Family test and other surveys and identified that concerns around food is a recurring theme and the most commented on

issue. This is also reflected in our feedback from volunteer dining companions, our inpatient survey results and PLACE assessment.

Ensuring every patient receives palatable food and has a positive experience at mealtimes, as well as the best nutritional care is fundamental to what we do. We have in place a dining companion programme of support for patients at meal times which we will continue to expand

### **What we said we were going to do?**

- ✓ FFT scores will be reviewed and analysed
- ✓ Feedback from dining companions
- ✓ Food quality audits and analysis of results
- ✓ Assistance for patients regarding food choices
- ✓ Development of a new Food and Nutrition Group

### **How did we do?**

The Trust has achieved this priority as the percentage of comments regarding food as an area for improvement has reduced during the year. Throughout the year the Trust undertook steps to understand what improvements patients wanted to the food, which included Quality Improvement Volunteers talking to patients to get a deeper level of understanding. We also listened to feedback from our dining companions to understand their observations and feedback received from patients and staff.

During 2014 we introduced warm cake in the afternoon and improved access to ice cream. Finger food designed specifically for patients who are most vulnerable such as those with dementia were also introduced. In January 2015 new patient menus were introduced for adult inpatients. Feedback from staff, volunteers, patient groups and outside bodies e.g. Healthwatch at an internal launch presentation was very positive. The new menu includes cooked breakfast at the weekends, a soup alternative, a choice of light or main meal. A plated meal system was introduced into Maternity, allowing mothers flexibility of meal time.



It is currently too early to assess from the FFT feedback whether the new menus introduced in January, have produced further sustained improvement in the FFT comments. The Trust will continue to monitor this on the FFT feedback, and utilise other methods of monitoring and make further improvements. During 2015 we will be making toast available in all inpatient wards.

Estates and Facilities will continue to engage with the Dining Companions by attending their regular meetings to receive feedback and to update on Catering in general. Dining Companions have also been invited to joint ISS Hostess/Trust Housekeeper meetings which are held once a month. ISS carry out monthly patient surveys specifically relating to food.

Food Quality will primarily be assessed through the Patient-led Assessments of the Care Environment (PLACE) Programme. A small-scale assessment is due to take place in March 2015, whilst the annual site-wide assessment will be held between March and June 2015.

The Food and Nutrition Steering Group (FNSG) replaced the previous Nutritional Steering Group in August 2014 and chair duties have been taken over by the Deputy Director of Nursing. The Food and Nutrition Steering Group (FNSG) is monitoring and working to improve staff engagement with patients regarding suitable food choices. The group also monitor the assessments associated patients who are identifies as being nutritionally at risk.

The Nutrition audit carried out at the end of 2014 indicated that we were improving the service to patients, however we needed to focus more on the identified at risk patients. Wards identified as requiring improvement present their action plans at the monthly Food and Nutrition meeting.



## **6. Other Improvements to Quality of Care at Kingston Hospital**

In the course of selecting our priorities each year, 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.

### **Eliminating Mixed Sex Accommodation**

In 2014/15 the Trust had no breaches of the mixed sex accommodation requirements. This means that patients who are admitted to the hospital will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area. This is a position the Trust has maintained since May 2011.

### **Public and Patient Involvement (PPI) in Service Improvement.**

The Trust has established a new group of volunteers called the Quality Improvement Volunteers and replaces the Patient Assembly. This constitutes a minimum of 17 volunteers, each matched with a Service Line that best reflects their interests and ambitions around improvement for quality and patient experience. When the Service Line undertakes service or quality improvement projects and is looking for patient and public involvement, the Quality Improvement Volunteer aligned to that Service Line is invited to join relevant groups, comment on papers and advise on the best ways to reflect the views and needs of patients within the project and its outcomes. They also act as a Forum advising on service improvement issues that cut across Service Lines at a strategic level.

The Quality Improvement Volunteers will meet quarterly, Chaired by the Deputy Director of Nursing & Patient Experience to identify areas of commonality, strategic needs and themes to be taken forwards by the Hospital for improvement. The Forum also offers a platform for peer networking and ongoing training and development to increase the skill and capacity of PPI volunteers in service re-design.

In 2015/16 the Trust plans to refresh its Patient & Public Involvement Strategy and will do so in partnership with key stakeholders which includes staff, volunteers, Healthwatch, Governors, patients & the public.

### **Nurse Technology Fund**

In December 2014 the Trust submitted a bid to the Government's Nurse Technology Fund and was successful in receiving an award of £836,000. This will enable the Trust to purchase devices to wirelessly transmit observations such as a patient's blood pressure and pulse directly into the electronic patient record. The new technology will also enable the introduction of an automated alert system which reviews the recorded clinical information and ensures that all staff are alerted to signs of deterioration in a patient.

Currently nurses enter observations manually into the electronic patient record. The new equipment will make the process much quicker and safer, freeing up nursing time to spend with patients. With the addition of an automated alert system to identify signs of deterioration of the patient's health, this will enable even more rapid treatment from the clinical teams. The system will take a year to implement.

### **Response to Saville checks**

The investigation reports in relation to Jimmy Saville's association with 28 NHS trusts were published in 2014/15, along with an Independent Oversight of the NHS and Department of Health investigations. Following the publication of the reports, Jeremy Hunt, Secretary of State for Health, accepted the recommendations and asked NHS England, CQC, Monitor and the NHS Trust Development Authority, along with all NHS organisations, to carry out a review of safeguarding procedures within the NHS.

Kingston Hospital NHS Foundation Trust took action to consider the recommendations and assessed its current processes for adequacy. The Trust identified the need to make some minor changes to the existing safeguarding, security and other policies in light of the recommendations and these have been completed. The Trust continues to review further recommendations from the Saville enquiry as they are published.

### **Sign up to Safety**

In July 2014 the Trust signed up to the Sign up to Safety national patient safety campaign which was launched in June 2014. The campaign mission is to strengthen patient safety in the NHS and make it the safest healthcare system in the world. It aims to deliver harm free care for every patient, every time, everywhere and champions openness and honesty and supports everyone to improve the safety of patients. Sign up to Safety's 3 year objective is to reduce avoidable harm by 50% and save 6,000 lives.

As part of the campaign we have confirmed our safety pledges under the headings of putting safety first, continually learning, honesty, working collaboratively and supporting people when things go wrong. We have also identified three specific safety improvement campaigns as follows;

- Reduce avoidable, hospital acquired grade 2, 3 and 4 pressure ulcers by 10% by March 2019
- To eliminate all avoidable deaths from severe sepsis and septic shock by March 2019. To reduce harm by ensuring that the Sepsis 6 Interventions are achieved for 90% of patients in hospital, within one hour of identification of severe sepsis or septic shock.
- To reduce harm by improving intrapartum foetal wellbeing assessment and management in high risk pregnancy.

The Trust has agreed to be one of their case study sites (one of approximately 10) for the national Sign up to Safety Team where they will follow us for the next three years and document our progress – purely for learning about what works and what could have been done differently to help create the learning culture across the NHS. This is a great opportunity to showcase our focus on quality and safety improvement.

### **Volunteering**

The Trust has a three year "Volunteering Strategy" which was launched in January 2014. There has been excellent progress in achieving the aims of the strategy during year one. The Trust is one of only six hospitals across the country to be awarded £100,000 to help significantly expand and improve our volunteering services. The funding has come from the Helping in Hospitals (HiH) programme which part of the work of the Centre for Social



Action's Innovation and is a partnership between the Cabinet office and NESTA – a charity dedicated to supporting innovation and ideas that help improve lives. The programme is aimed at helping grow existing volunteer schemes that work on improving overall patient experience and outcomes. The funding is being used to almost double the number of volunteers to 1100 by 2016, to train new volunteers to help patients with dementia, to provide extra help to navigate around the Hospital site and to provide even more support at mealtimes.

In March 2015 the Trust held its first Volunteering Conference which enabled celebration of the work of volunteers, and also brought together local stakeholders and national volunteering figures to inform national guidance on NHS Volunteering. Kingston Hospital's work on volunteering was described as pioneering by external representatives.

### **HSJ/Nursing Times Patient Safety and Care Award 2014 for Dementia Care**

Kingston Hospital was nationally recognised for its work to transform the care provided to patients with dementia when it won the Dementia Care Award at the Patient Safety and Care Awards held in July 2014.

The Trust has a three year dementia strategy, which was developed with patients, carers, staff, and voluntary and community groups. The strategy was officially launched in June 2014. A number of initiatives have been introduced to improve the experience of patients with dementia including the introduction of a therapeutic activities programme for patients, including the introduction of the Memory Lane lunch club and a dedicated therapeutic activities room collocated with the care of elderly wards. The Trust has also introduced a memory café every two weeks in collaboration with Home Instead a local care organisation. The Kingston Carers Network have also been working within our ward areas to help provide more support to carers. We have also started work on planning improvements to our ward environments and launched our fundraising appeal to fund these changes. Through the volunteering programme even more volunteers have been trained to support patients with dementia, and a pilot of a new hospital to home support scheme has commenced.

### **Quality Improvement Projects**

The Trust continues with its programme of Quality Improvement Projects, which are identified and championed by various clinical leaders. The progress of the approved projects is monitored by the Quality Improvement Working Group. An example of one of these projects was associated with Intravenous line insertion.

#### **Intravenous line insertion**

The project was born from a NCEPOD assessment, interest from Consultant Anaesthetists and a Serious Incident which highlighted the need for a robust and well documented pathway. Initial discussions and a clinical audit indicated that lines needed to be replaced soon after insertion and that the procedure was not always coded correctly. Line insertions were also delayed and the choice of lines did not follow a standard protocol.

The project progressed well and included re-procurement of consumables, design and implementation of referral forms, patient information, guidelines and training sessions for Clinicians in Anaesthetics and General Surgery. Training in aftercare for the ward based

nursing teams, ASPs and Infection Control nurses took place. There are now two midline insertion lists in theatres per week and a Peripherally Inserted Central Catheter (PICC) line service commences in 2015.

### **Duty of Candour and Incident Reporting**

Since November 2014 it has been a legal requirement for NHS bodies to meet the Duty of Candour. Meeting the duty means that providers of healthcare are open and transparent with people who use services in relation to care and treatment, and specifically when things go wrong. As a Trust we already discuss Serious Incidents (SI) with those patients and relatives involved, including sharing the results of the investigation. The Duty of Candour goes beyond this and includes patient safety incidents that result in moderate harm and prolonged psychological harm.

Staff have been made aware of the Duty of Candour requirements through team briefing in January 2015 and it is also included in the monthly corporate induction. In order to remind staff of the Duty of Candour and to track compliance with the requirements, changes have been made to the Trust's incident reporting system by introducing a mandatory 'Duty of Candour' section, requesting information on whether a patient was injured and whether the patient/relative/next of kin has been informed. If they have not been informed the reasons for this are documented.

### **Complaints**

A review of the NHS complaints system (the Clwyd Hart Report of October 2013), instigated by the Prime Minister, considered the handling of concerns and complaints in NHS hospital care in England. A number of recommendations were made, many of which the Trust already complied with such as the Chief Executive taking personal responsibility for the complaints procedure and signing off letters, and the Board and Chief Executive receiving monthly reports on complaints and actions.

Improvements were undertaken in line with the recommendations including a change to the complaint acknowledgement process with staff from the Service Lines now telephoning complainants on receipt of complaint letters and the instigation of a Complaints Committee. This Committee, chaired by a Non-Executive Director and attended by other Non-Executive and Executive Directors, meets every quarter and receives detailed information about current complaints and changes being made to improve services. Themes from complaints are identified and scrutinised, and Service Lines present the changes they have implemented as a result of learning from complaints.

The Trust is committed to learning from any complaint received. Individual complaints (in an anonymised format) are used in training at all levels and for all staff. They are also shared at specialty level meetings and in other committees. Complainants' stories are also shared as part of the Patient Story section of the Trust Board. The importance of responding to complaints in a timely fashion is well recognised and much work has been undertaken to reduce the time within which complaints are responded to with a significant improvement noted in the latter half of 2014/15. The Trust is currently exploring ways in which it can undertake surveying of patient's experience of the complaints process and will look to complete this during 2015/16.



### **Stroke Audit Success**

For the first time since the Sentinel Stroke National Audit Programme (SSNAP) started 2 years ago, Kingston Hospital NHS Foundation Trust has been graded an A for the clinical care that we give our patients for both the team based score (i.e. quality of care given at Kingston Hospital), but also for the overall SSNAP level score (which incorporates both Hyper Acute Stroke Unit care and Kingston care, and also takes into account audit and data quality).

This is a fantastic achievement for the Trust as only 13 teams in the UK have scored an A in this latest round of SSNAP (6% of all teams). The Trust has steadily improved from C, to a B and now to an A since October 2013. All the individual therapy teams have improved their performance, and we continue to maintain an extremely high standard in 'Multi-Disciplinary Team Working' and 'Discharge Planning'. SSNAP is the single source of stroke data and has 100% participation of acute hospitals in England and Wales. The aim is to improve the quality of stroke care by auditing stroke services against evidence based standards.

### **VTE Assessments**

The Trust's recording and accurate reporting of VTE risk assessment fell below the required 95% performance in the first part of 2014/15. In August 2015, at the request of clinicians, the Trust made this a mandatory field on CRS which prevents progression onto other steps such as electronic prescribing until this is completed. This change was introduced in November 2014. Since that time the Trust has exceeded the required 95% performance.

### **Nursing & Midwifery Staffing Requirements**

In 'Hard Truths', the Secretary of State outlined the requirement for NHS organisations to demonstrate they are delivering safe and effective care. A range of actions and support have been put in place nationally and locally to ensure that all Trusts achieve all of the recommendations. These include wards publishing actual versus planned staffing numbers on a monthly basis on NHS Choices and the National Institute for Health and Care Excellence (NICE) publishing safer staffing guidelines for acute adult care and endorsed staffing models.

The Trust has put in place a governance structure to respond to and oversee the multiple avenues of safe staffing guidance, reporting and action required. At the end of June 2014 the first set of monthly nursing, midwifery & care staffing data was published nationally via NHS Choices. The Trust also publishes this information on the Trust website by ward and continues to do so monthly. The Trust has complied with and continues to comply with the reporting deadlines and requirements for submission of this data. NHS England and the local CCG's have reviewed the data submissions and the Trust Board nursing reports to date and are content that they meet the "Hard Truths" reporting requirements.

Nurse recruitment and retention within London is extremely challenging currently. The Trust is undertaking a number of measures to ensure it maintain safe staffing levels. This includes an ongoing programme of UK and international nursing recruitment. Programmes of work to reduce turnover includes the team development programmes, leadership development and the support of practice development nurses for new staff. During 2014/15 improved inductions of new nurses and nursing assistants have been introduced.

## **Patient Experience Surveys**

Patients who have recently been treated at the Trust may receive a patient questionnaire as part of the programme of national survey's to find out more about their experiences of using healthcare services. The results of the survey are used to help the Trust to understand areas where services could be improved. The results are also used by the Care Quality Commission (CQC) to build up a picture of what NHS services are like across the country..

The Trust already undertakes the nationally mandated surveys of inpatients, maternity services, Accident & Emergency and the outpatient department. In the last year the Trust also participated in the cancer patient survey, and the paediatric inpatient & day case survey. An optional national survey of neo-natal services has also been commissioned by the Trust with the results expected in early 2015/16.

The results of the A&E and cancer patient's surveys have been published and the senior doctors, nurses and managers for these areas, work with patient's representatives to develop action plans based on the results to focus on areas for improvement.

### Accident and Emergency:

The survey was carried out using a random selection of patients who attended A&E in March 2014 and 242 patients responded to the survey

Our 2014 results compared to our 2012 results showed:

- The Trust has made significant improvements on six questions
- There are no areas where the Trust's performance has significantly worsened
- The Trust has showed no significant difference on 26 questions

The areas for improvement which the Trust is undertaking actions to improve include:

- First speaking with a doctor or nurse (triage)
- Involving family or friends - for family, or someone else close to them, having enough opportunity to talk to a doctor if they wanted to
- Feeling reassured by staff if distressed while in A&E

### Cancer Services:

The survey included all adult patients (aged 16 and over) with a primary diagnosis of cancer who had been admitted to the hospital as an inpatient or as a day case patient, and had been discharged between 1st September and 30th November 2013. 175 patients responded to the survey from the Trust.

The areas for improvement included:

- Providing information about the care and treatment provided in a simple form
- Timeliness of access to the hospital

A particular focus on improvement for the haematology cancer patient group is being overseen by the Cancer Board at the Hospital.

The results of other surveys undertaken during the year are not yet available but once published will be reviewed for progress on the actions over the last year and further areas for improvement over the coming year.

### **Friends and Family Test**

The Friends and Family Test (FFT) is an easy-to-understand question that is asked of patients about the care they received. It was introduced to obtain regular and timely feedback from patients about the care provided by the Trust. The Trust sees FFT as an important mechanism of patient feedback to make improvements.

At national level there has been a requirement that the FFT is implemented in inpatient areas, A&E and maternity services, and plans were put in place for further expansion to all patient groups over the course of the year. Data is reported for the required areas on a monthly basis and Trusts have been using this data to benchmark themselves.

The Trust offers the FFT across all services provided at Kingston Hospital NHS Foundation Trust. It is a national requirement to have this in place in adult inpatient areas, A&E and maternity services. National reporting for Outpatient and Day Case areas will start from 1 April 2015. There will be no target response rate for outpatients, however the Trust will ensure all patients get the opportunity to provide feedback.

The Trust also gathers parental feedback through the FFT in Paediatric areas. A trial of children's feedback was delivered in paediatric areas; however the children's questionnaire does not currently use an FFT-style question (although the parental questionnaire does).

During April 2014 to February 2015, over 24,500 responses have been received with more than 9 out of 10 indicating a positive experience. The Trust introduced quarterly analysis of the written comments provided. This deeper understanding of the reasons for scoring the FFT has led to changes such as the introduction of Wi-Fi, increase in the number of visitors chairs, changes to the hospital food and posters explaining what the different hospital uniforms mean.

### **Patient Experience – 'You said we did'**

During August 2015 the Trust commenced a communications campaign to provide feedback regarding changes made over previous months under the heading of "You said – We did". Large pop up banners and posters, and information on our electronic screens were erected around the hospital highlighting some of the changes we made in response to patient feedback including:

- ✓ Support available at mealtimes
- ✓ Providing ice cream and cakes in the afternoon
- ✓ Improved hand washing facilities
- ✓ Covers for meals to keep them warm
- ✓ New name badges for staff

Highlighting how the Trust has used this feedback to implement changes and improvement based on what patients and carers tell us is important as it also assures the public that the Trust listens and acts upon the feedback received.

### **End of Life care**

End of life care (EOLC) is the care experienced by people who have an incurable illness and are approaching death. Good EOLC enables people to live in as much comfort as possible until they die, and to make choices about their care. It is about providing support that meets the needs of both the person who is dying and the people close to them, and includes management of symptoms, as well as provision of psychological, social, spiritual and practical support. People are 'approaching the end of life' when they are likely to die in the next 12 months.

Over the last year the Trust has adapted its principles of care for dying patients (which replaced the Liverpool Care Pathway following the national Neuberger review). The work carried out here at the Trust was recognised and adapted for use across the wider London area. A funding award from the Hospital Charitable Funds Committee is being used to improve the environment in the Bereavement Offices, the relative room, the Chapel and the quality of patient information leaflets. The Trust has also successfully delivered each of the quarterly milestones for the full achievement of the CQUIN for EOLC (providing training and shared patient records with GP's and primary care).

The national audit for care of the dying patient in hospital has a number of recommendations which the Trust is working towards:

- Hospitals should provide a face-to-face specialist palliative care service – this is provided 6 days a week at the Trust
- Education and training in care of the dying should be mandatory for all staff caring for dying patients – this is included in mandatory training at the Trust
- All trusts should have a designated board member and a lay member with specific responsibility for care of the dying – the Chair of the Trust is the non-executive lead in this area and we have lay membership on our EoLC group
- Improving the discussion and recording of the decision that the patient is in the last hours or days of life. This should be made by the multidisciplinary team and documented by the senior doctor responsible for the patient's care. This should be discussed with the patient where possible and appropriate, and with family, carers or other advocate.

### **Healthwatch Forum and Healthwatch Visits**

Our local Healthwatch groups provide a user-led organisations for involving local people in the design and development of local health and social care services and help improve patient experience. They gather information and feedback from patients and service users about the experiences they have of health and social services, and use this to make improvements and influence the development of those services. They also provide reports

and updates about local services to Healthwatch England, a body that campaigns on national issues and raises concerns to the NHS and the Department of Health.

The Trust hosts a quarterly forum for all of the local Healthwatch groups that work with the Trust where senior representatives including the Director of Nursing & Patient Experience and Trust Chairman share details of how the Trust is performing and receives feedback regarding the local communities opinions of how the Trust is viewed.

One of the methods Healthwatch can use is Enter & View, which is a statutory function. This means that Healthwatch can visit any health or social care service or any that serves people in the local borough and observe how this service is delivered. During an Enter & View visit, Healthwatch will talk to patients or service users and members of staff and make observations of the environment to ensure it is safe and clean. After a visit, Healthwatch prepare a report which will list its findings and any recommendations. In April 2014, Kingston Healthwatch sent a small team of four people to visit Kingston Hospital and subsequently published a report with a number of very positive aspects and includes a number of recommendations, which the Trust responded to:

- Cleanliness – to check that cleaning equipment, such as mops and water for mopping, is regularly refreshed or replaced to maintain hygiene. We took action to ensure staff were reminded of this.
- Privacy for patients – we recognise that during busy times there might not be enough facilities to ensure the privacy of all patients, but there are ways of providing privacy on wards such as sound-proof partitions or cubicles
- Review staffing cover during Bank Holiday periods to ensure there are enough senior doctors to deal with urgent cases – we are progressing 7 day a week services which is reflected as a 2015/16 Quality Priority
- Provide family members of women in maternity with an ID badge or bracelet to give them access to the unit to ensure they are not left waiting for too long; this will also reduce pressure on staff – we considered this but the recommendation, but have not implemented this as it does not fit with our security and access requirements
- Better access to Wi-Fi or internet for those who are required to stay with family members for a longer time – we have introduced Wi-Fi for patients during 2014.

## 7. Overview of Services

During 2014-15 the Kingston Hospital NHS Foundation Trust provided and/or subcontracted four relevant NHS services, for adults and children as follows:

- Admitted patient care for planned and emergency treatment;
- Non-admitted patient care;
- Accident and Emergency; and,
- Critical Care.

The Trust has reviewed all the data available to it on the quality of care in 43 of these relevant health services.

These services covered the following specialities:

- |   |                            |
|---|----------------------------|
| • Accident and Emergency  | • Ear, Nose and Throat     |
| • Assisted Conception   | • Gastroenterology         |
| • Cancer  | • General Medicine         |
| • Cardiology  | • Genito Urinary Medicine  |
| • Care of the Elderly   | • General Surgery          |
| • Clinical Support Services – therapies related to an inpatient episode of care and/or referral for outpatient treatment(s) | • Gynaecology              |
| • Community Midwifery   | • HIV                      |
| • Community Paediatrics   | • Neonatal Care            |
| • Critical Care   | • Obstetrics               |
| • Diabetes and Endocrinology  | • Ophthalmology            |
| • Diagnostics (imaging and pathology)   | • Oral and Dental Services |
| • Dietetics   | • Orthopaedics             |
| • Digital Hearing Aids  | • Paediatrics              |
| • Direct Access – Pathology   | • Pain Management          |
| • Direct Access – Blood Transfusion   | • Parent Craft             |
| • Direct Access – Cytology (gynaecology)  | • Patient Transport        |
| • Direct Access –   | • Physiotherapy outpatient |
| Cytology (non-gynaecology)  | • Respiratory Medicine     |
| • Direct Access – Haematology   | • Rheumatology             |
| • Direct Access – Histopathology  | • Surgical Appliances      |
| • Direct Access – Immunology  | • Urology                  |

- Direct Access – Microbiology
- Direct Access – Radiology/Imaging

The income generated by the relevant health services reviewed in 2014/15 represents 87.1% of the total income generated from the provision of relevant health services by the Trust for 2014/15.

## 8. Monitor Risk Assessment Framework

Monitor is the regulator for Foundation Trust health services in England. They exercise a range of powers granted by Parliament which include setting and enforcing a framework of rules for providers and commissioners, implemented in part through licences they issue to NHS-funded providers.

As part of their role, Monitor has an assessment process which is called a Risk assessment framework. The purpose of the framework is to show through a rating system when there is poor governance at an NHS foundation trust.

The role of ratings is to indicate when there is a cause for concern at a provider. But it is important to note that they will not automatically indicate a breach of its licence or trigger regulatory action. Rather, they will prompt us to consider where a more detailed investigation may be necessary to establish the scale and scope of any risk. The risk rating for the Trust for the first three quarters of 2014/15 was green, the rating for quarter four remains to be confirmed. The table below shows our overall rating for the last year

Monitor Governance Risk Rating – Performance against national measures

Kingston Hospital NHS Foundation Trust regulatory rating 2014/15 (Monitor)					
	Annual Plan	Q1	Q2	Q3	Q4
Under the Compliance Framework (replaced by the Well Led Framework)					
Governance risk rating	Green	Green	Green	Green	TBC
Financial risk rating (COSSR)	3	3	3	3	3

Indicator	Threshold	Weighting	2013/14 Q1	Q2	Q3	Q4	2014/15 Q1	Q2	Q3	Q4
Maximum time of 18 weeks from point of referral to treatment in aggregate - admitted	90%	1.0	0	0	0	0	0	0	0	0
Maximum time of 18 weeks from point of referral to treatment in aggregate - non-admitted	95%	1.0	0	0	0	0	0	0	0	0
Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on incomplete pathway	92%	1.0	0	0	0	0	0	0	0	0
A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	1.0	0	0	0	0	0	0	1	1
All cancers: 62-day wait for first treatment from:		1.0	0	0	0	1	1	1	1	1
urgent GP referral for suspected cancer	85%									
NHS Cancer Screening Service referral	90%									
All cancers: 31-day wait for second or subsequent treatment, comprising :		1.0	0	0	0	0	1	0	0	1
Surgery	94%									
Anti cancer drug treatments	98%									
All Cancers: 31-day wait from diagnosis to first treatment	96%	1.0	0	0	0	0	0	0	0	1
Cancer: two week wait from referral to date first seen, comprising:		1.0	0	0	0	1	1	0	0	1
all urgent referrals	93%									
for symptomatic breast patients (cancer not initially suspected)	93%									
Clostridium (C.) Difficile - meeting the C. Difficile objective	24 per annum	1.0	1	1	1	1	0	0	0	0
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	1.0	0	0	0	0	0	0	0	0
Total Score			1	1	1	3	3	1	2	5

## 9. Participation in Clinical Audits Research

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.

National and local clinical audit results are used by Kingston Hospital to both assure itself of the quality of patient care and improve care where gaps are found. Four examples of how clinical audit results have provided assurance and improved care during 2014/15 are given in the boxes below.



Clinical audit providing assurance	
<p><b>National audit</b></p> <p>The paediatric epilepsy (Epilepsy 12) national audit provided assurance of comprehensive clinical care, including clinical examination, tests and investigations, treatment and the provision of information on lifestyle. Kingston Hospital scored above the national average for the majority of the criteria assessed. One issue raised at the time of the audit was the lack of an Epilepsy Nurse Specialist; the Paediatric Department have since recruited to this post.</p>	<p><b>Local clinical audit</b></p> <p>The National Institute for Health and Care Excellence (NICE) produce guidance with which hospitals are expected to comply. A clinical audit carried out to assess our practice compared to the NICE guidelines for pre-operative assessment and tests showed compliance with the guidance. The audit also revealed tests were not being repeated unnecessarily when the patient was admitted to hospital.</p>
Clinical audit driving improvement	
<p><b>National audit</b></p> <p>Kingston Hospital's results from the National Care of the Dying audit showed that more needed to be done to improve the experience of patients who die whilst they are in hospital. A wide-ranging action plan was developed after the national audit findings were published. This includes actions on staffing, training, recording of clinical information and communicating with relatives. A survey of bereaved relatives is now being undertaken to enable improved communication and support. Targeted re-audits of prescribing to ensure patients are comfortable in their last days and of nursing documentation to ensure holistic care have demonstrated improvements.</p>	<p><b>Local clinical audit</b></p> <p>The hospital's Pharmacy team undertake a number of clinical audits each year to ensure that drugs are being satisfactorily prescribed and administered. Two audits which were repeated during 2014/15 on two antibiotics (co-amoxiclav and gentamicin) showed improvements following actions that had previously been taken. Improvements included better targeted prescribing of co-amoxiclav and better dosing control for gentamicin, thus improving patient care.</p>

During 2014/15 37 national clinical audits and 3 national confidential enquiries covered relevant health services that Kingston Hospital NHS Foundation Trust provides. During that period Kingston Hospital NHS Trust participated in 97% (29/30\*) national clinical audits that have started to date and 100% per cent of national confidential enquiry programmes of the

national clinical audits and national confidential enquiry programmes, listed at Appendix A, which it was eligible to participate in.

\*Applicable audits that have not yet been started by the national centre are; British Thoracic Society Adult Bronchiectasis, British Thoracic Society Non-invasive ventilation, British Thoracic Paediatric Pneumonia, Ophthalmology, National audit of Dementia, National Parkinson's audit and Familial hypercholesterolemia.

The national clinical audits and national confidential enquiries that Kingston Hospital NHS Trust was eligible to participate in during 2014/15, and for which the data collection was completed during 2014/15, are listed in Appendix B 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 25 national clinical audits, applicable to Kingston Hospital, were published during 2014/15 and of these 20 were formally reviewed during 2014/15. The actions we intend to take to improve the quality of healthcare are included in Appendix C.

The reports of 133 local clinical audits were reviewed by Kingston Hospital NHS Foundation Trust in 2014/15. Actions that we intend to take, as a result of these, are available in our Clinical Audit and Effectiveness Annual Report (latest is available from Anne Jones, Head of Clinical Audit and Effectiveness).

Clinical audit results are discussed at clinical meetings in local departments and at wider meetings such as the Trust's annual Clinical Audit 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 2014.

## **10.Participation in Clinical Research**

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 209 (portfolio studies only).

The Trust was involved in conducting 48 clinical research studies during 2014/15.

There were 37 clinical staff participating in research approved by a research ethics committee at the Trust during 2014/15. These staff participated in research covering 14 specialities.

## **11.Use of the CQUIN Payment Framework**

A proportion of income for Kingston Hospital NHS Foundation Trust in 2014/15 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. The CQUIN goals for 2015/ 16 are yet to be finalised with the commissioners. 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 2014/15 the Trust had a contract value of £4,157,145 for CQUIN activity (in the previous year, the value of this activity was £3,820,249). The table below illustrates how the Trust performed against the CQUIN schemes.

<b>National CQUIN Achievement</b>				<b>83%</b>
<b>Local CQUIN Achievement</b>				<b>86%</b>
<b>GRAND TOTAL</b>		<b>£4,157,145</b>	<b>£3,537,770</b>	<b>85%</b>

The table below summarises the different schemes that the Trust engaged in:

<b>Theme</b>	<b>Aim</b>
<b>National CQUIN</b> 1. Friends and Family Test	(a) Implementation of staff FFT (b) Early implementation of FFT in OP & DC (c) Increased/Maintained response rate in AE & IP (d) Increased Response Rate in acute IP services
<b>National CQUIN</b> 2. NHS Safety Thermometer	Reduction in the prevalence of old & new Pressure Ulcers.
<b>Local CQUIN</b> 3. Dementia	(a) Find, Assess, Investigate & Refer (b) Clinical Leadership (c) Monthly Audit of Dementia carers
<b>Local CQUIN</b> 4. Better Care Fund / 7 day working	(a) Improve Patients Flow throughout Trust over 7 days (b) Increase Weekend Discharges (c) Discharge Earlier in the day (d) Discharge Lounge (d) Discharge to Assess
<b>Local CQUIN</b> 5. Food and Hydration	Improving focus on Food & Hydration, including clinical quality & patient feedback
<b>Local CQUIN</b> 6. End of Life Care	(a) Increase the roll-out of Coordinate My Care on wards. (b) Achieve a high level of training to enable clinicians to identify & care for patients in the last year of life
<b>Local CQUIN</b> 7. Patient Experience of Administration	Deliver improving patient administration action plan for, (a) GP email queries, Publishing outpatient waiting times for GPs, (b) Plans for all KHFT Outreach sites to have PAS/IT connectivity, and (c) GP Discharge letters for A&E, Daycases & Admitted Patient Care and OP (GP and Patients).
<b>NHS England CQUIN</b> HIV & NICU – Dashboards	Clinical quality Dashboards for HIV and NICU.

<b>NHS England CQUIN</b> NICU - Retinopathy of prematurity	Neonatal intensive care (NICU) – Retinopathy of prematurity (ROP) screening.
<b>NHS England CQUIN</b> HIV - Clinical Trials	To increase the number of patients enrolled into clinical trials (where they exist)

Further detail on the agreed CQUIN goals for 2014/15 (and their achievement) and for the goals in 2015/16, this can be obtained by contacting the Director of Finance at the Trust.

## **12. Care Quality Commission (CQC) Registration**

Kingston Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is approved. Kingston Hospital NHS Foundation Trust has the following conditions on registration - none. The Care Quality Commission has not taken enforcement action against Kingston Hospital NHS Foundation Trust during 2014/ 15.

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. In 2014/15 the CQC has been undertaking new style announced compliance inspection visits. The Trust has not as yet been subject to a new style announced visit, and did not receive an unannounced visit in 2014/15. To confirm compliance in all the areas of quality and safety, during 2014/2015, the Trust undertook self-assessments of performance against these five new key questions that the CQC asks of a Healthcare organisation.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The Quality Report is prepared each year by the Director of Nursing and Patient Experience and overseen by the Quality Assurance Committee. This group is chaired by a Non – Executive and attended by the Chief Executive. Any guidance issued by the Secretary of State related to the Health Act (2009) is reviewed in the 6 months leading up to the publication of the Quality Report. Such guidance would be appropriately incorporated into the Quality Report prior to finalisation.

### 13. Data Quality

The Trust has a five year Data Quality Strategy, of which 2014/15 was the fourth year. The strategy has a three themed approach to improving data quality in the Trust:

- People
- Reporting
- Systems

#### Progress against Strategy - 2014/15

During 2014/15 there have been a number of key actions undertaken toward improving data quality. The positive impact of some of these actions – particularly the system hardening and the self-service reporting of 18 weeks - is demonstrated in the KPI Dashboard.

#### Data Quality – NHS Number and General Medical Practice Code Validity

The Trust submitted records during 2014/15 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The following table shows the percentages of data that have valid NHS number and General Medical Practice code:

DQ Indicator		KHT 2014/ 15 (Apr-Mar)	National 2014/ 15 (Apr-Mar)
Admitted Patient Care	% with Valid NHS number	99.3%	99.2%
	% with General Medical Practice Code	100%	99.9%
Out Patient Care	% with Valid NHS number	99.5%	99.3%
	% with General Medical Practice Code	100%	99.9%
Accident & Emergency Care	% with Valid NHS number	97.0%	95.2%
	% with General Medical Practice Code	100%	99.2%
Maternity - Births	% with Valid NHS number	99.8%	99.2%
	% with General Medical Practice Code	99.9%	99.4%
Maternity – Deliveries	% with Valid NHS number	99.8%	99.6%
	% with General Medical Practice Code	100%	99.9%

## 14. 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.

A clinical coder – also known as clinical coding officer, diagnostic coder, medical coder or medical records technician – is a health care professional whose main duties are to analyse clinical statements and assign standard codes using a classification system. The data produced are an integral part of health information management, and are used by local and national governments, private healthcare organizations and international agencies for various purposes, including medical and health services research, epidemiological studies, health resource allocation, case mix management, public health programming, medical billing, and public education.

For example, a clinical coder may use a set of published codes on medical diagnoses and procedures, such as the International Classification of Diseases or the Common Coding System for Healthcare Procedures, for reporting to the health insurance provider of the recipient of the care.

A clinical coder therefore requires a good knowledge of medical terminology, clinical documentation, legal aspects of health information, health data standards, classification conventions, and computer- or paper-based data management, usually as obtained through formal education and/or on-the-job training

Clinically coded data is the basis for Payment by Results (PbR) and reference costs (it's through these data sets that the Trust receives its income from commissioners to run the hospital. It secures the recovery of the resources used to provide high quality patient care. It rewards efficiency, supports patient choice and diversity and encourages activity for sustainable waiting time reductions.

The Trust has a high level of accuracy in clinical coding. The last national PbR audit was carried out in May 2013 where it was found that the Trust had 2.5% of spells (3 spells) with an error that affected the price. This compares to the national average of 8% of spells with such errors. The Trust is in the best performing 25% of acute NHS Hospitals and Foundation Trusts. In 2013/14 the PbR assurance programme only audited 50 lowest performing Trusts in previous year. Kingston Hospital NHS Foundation Trust was not included in that sample. Kingston Hospital NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by Monitor and the error rates reported in the latest published audit for that period for diagnoses and procedure coding (clinical coding) were:

- Total number of episodes examined – 200
- Primary Diagnosis – 2.5 % incorrect
- Secondary Diagnoses – 2.9% incorrect

- Primary Procedures - 0.7%
- Secondary Procedures – 3.3% incorrect

At the time of writing the Trust is awaiting publication of the final report but do not anticipate any of the values presented to change from those in the draft report.”

During 2014/15 two internal Clinical Coding audits were undertaken and a third will be undertaken as part of the Clinical Coding internal audit programme. One of these audits shows that the Trust has maintained meeting IG Toolkit requirement level 3 (95% of primary procedures and diagnoses codes are accurate and 90% of secondary procedures and diagnoses codes are accurate). However IG audit carried out in January 2015 on General Medicine, Care of the Elderly, Cardiology and Respiratory met IG Toolkit requirements level 2 ( $\geq 90\%$  but less than 95% accuracy for primary diagnoses and primary procedures and  $\geq 80\%$  but less than 90% accuracy for secondary diagnoses and secondary procedures).

The audit sample of 200 Finished Consultant Episodes (FCEs) include admitted patient care data for the patients discharged in September. This was a transitional period for all medical wards moving from case notes to e-prescribing on CRS. Clinical information recorded in an electronic form was scattered in various folders hence difficult to find. This led to coding inaccuracy and omitted essential comorbidities.

The outcome was lower than expected standard of coding impacting on the IG Toolkit requirement, which dropped from level 3 to level 2. Continuous monitoring of quality of electronic clinical information indicated significant improvement since the time of this audit. It is important to note that:

- the results should not be extrapolated further than the actual sample audited and
- the services were reviewed within the sample

## **15. Information Governance Toolkit Attainment Levels**

The Trust’s Information Governance IG Toolkit Assessment Report overall score for 2014/15 was 81% (2013/14 was 82%; Green-Satisfactory) and was graded Green – Satisfactory across all Six Assurances.

The 2014/15 result is from version 12 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 changed only slightly between versions. There are currently 45 requirements for Acute Trusts. The results by Assurance Level were as follows:

Assurance	2014/15 V12	2013/14 V11
Information Governance Management	80%	86%
Confidentiality and Data Protection Assurance	81%	81%
Information Security Assurance	73%	73%
Clinical Information Assurance	80%	86%
Secondary Use Assurance	100%	100%
Corporate Information Assurance	77%	77%
<b>Overall Total</b>	<b>81%</b>	<b>82%</b>

## 16. National Data from the Health and Social Care Information Centre (HSCIC)

The tables below represent Kingston Hospital's performance across a range of indicators (as published on the Information Centre Website [www.hscic.gov.uk](http://www.hscic.gov.uk)). Many of these are also reported monthly at the public Trust Board meeting as part of the Clinical Quality Report. The data shown is correct as at 20<sup>th</sup> May 2015.

Indicator	Trust	National	Minimum	Maximum	Comment
<b>Summary Hospital-level Mortality Indicator (SHMI)</b> <i>October 2012 – September 2013</i>	0.9426	1	0.6301	1.1859	KHT below national average.  Lower number is better.
<b>Summary Hospital-level Mortality Indicator (SHMI)</b> <i>October 2013 – September 2014</i>	0.8728	1	0.5966	1.1982	KHT below national average.  Lower number is better.
<b>Latest Data Published</b>	<b>April 2015</b>				

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



The Kingston Hospital NHS Foundation Trust has taken the following action to improve this indicator and the quality of its services - enhanced medical leadership at Service Line level.

Indicator	Trust	National	Minimum	Maximum	Comment
<b>Percentage of deaths with palliative care coded</b> <i>October 2012 – September 2013</i>	27.6%	20.9%	0%	44.0%	KHT above national average.  Higher number is better.
<b>Percentage of deaths with palliative care coded</b> <i>October 2013 – September 2014</i>	36.7%	25.3%	0%	49.4%	KHT above national average.  Higher number is better.
<b>Latest Data Published</b>	<b>April 2015</b>				

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

The Kingston Hospital NHS Foundation Trust has taken the following action to improve this percentage and so the quality of its services – provision of a good palliative care specialist supports team and training for staff.

Indicator	Trust	National	Minimum	Maximum	Comment
<b>Age &lt;16 readmissions within 28 days</b> <i>2010/11</i>	8.30%	10.45%	0%	14.76%	KHT below the national average.  Lower number is better.
<b>Age &lt;16 readmissions within 28 days</b> <i>2011/12</i>	9.45%	10.26%	0%	14.94%	KHT below the national average.  Lower number is better.
<b>Latest Data Published</b>	<b>December 2013</b>				

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	Minimum	Maximum	Comment
<b>Age 16+ readmissions within 28 days</b> <i>2010/11</i>	12.01%	11.43%	0%	14.06%	KHT above the national average.  Lower number is better.
<b>Age 16+ readmissions within 28 days</b> <i>2011/12</i>	11.06%	11.45%	0%	13.80%	KHT below the national average.  Lower number is better.
<b>Latest Data Published</b>	<b>December 2013</b>				

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	Minimum	Maximum	Comment
<b>Trusts responsiveness to the personal needs of its patients</b> <i>April 2012 – March 2013</i>	69.8%	68.1%	57.4%	84.3%	KHT above the national average.  Higher number is better.
<b>Trust's responsiveness to the personal needs of its patients</b> <i>April 2013 – March 2014</i>	64.1%	68.7%	54.4%	84.2%	KHT below national average.  Higher number is better.
<b>Latest Data Published</b>	<b>May 2014</b>				

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.

Indicator	Trust	National	Minimum	Maximum	Comment
<b>Staff who would recommend Trust as a provider to friends and family</b> <i>Staff Survey 2013</i>	62	65 – All Organisations 67 – Acute Trusts	40 – Acute Trusts	94 – Acute Trusts	KHT below the national average.  Higher number is better.
<b>Staff who would recommend Trust as a provider to friends and family</b> <i>Staff Survey 2014</i>	60	65 – All Organisations 67 – All Acute Trusts	38 – Acute Trusts	93 – Acute Trusts	KHT below the national average.  Higher number is better.
<b>Latest Data Published</b>	<b>March 2015</b>				

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	Minimum	Maximum	Comment
<b>% of patients admitted that were risk assessed for VTE</b> <i>February 2014</i>	83.3%	96.0%	69.4%	100%	KHT below the national average.  Higher number is better.
<b>% of patients admitted that were risk assessed for VTE</b> <i>February 2015</i>	98.3%	96.0%	75.0%	100%	KHT above national average.  Higher number is better.
<b>Latest Data Published</b>	<b>May 2015</b>				

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 enhancing our computer system to make VTE assessment a mandatory field.

Indicator	Trust	National	Minimum	Maximum	Comment
<b>Rate per 100,000 bed days for C.diff reported within the Trust for patients &gt;2 years old</b> <i>April 2012 – March 2013</i>	15.8	17.3	0.0	30.8	KHT below the national average.  Lower number is better.
<b>Rate per 100,000 bed days for C.diff reported within the Trust for patients &gt;2 years old</b> <i>April 2013 – March 2014</i>	15.8	14.7	0.0	37.1	KHT above national average.  Lower number is better.
<b>Latest Data Published</b>	<b>December 2014</b>				

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 the following action to improve this rate, and so the quality of its services - by delivering its infection control action plan.

Indicator		Trust	National	Minimum	Maximum	Comment
Number and % of patient safety incidents <i>October 2012 – March 2013</i>	Number	1,585	515,998	631	11,495	We are above national average.  Lower number is better.
	Rate per 100 admissions	4.70	7.42	1.68	17.53	
Number and % of patient safety incidents <i>October 2013 – March 2014</i>	Number	2,505	553,072	301	12,152	We are above national average.  Lower number is better.
	Rate per 100 admissions	7.60	7.97	1.20	16.80	
Latest Data Published		November 2014				

Indicator		Trust	National	Minimum	Maximum	Comment
Number and % of patient safety incidents that result in severe harm or death <i>October 2012 – March 2013</i>	Number	14	3,175	0	114	Data relates to Small, Medium, Large and Teaching Acute Trusts.
	%	0.04%	0.05%	0.00%	0.44%	
Number and % of patient safety incidents that result in severe harm or death <i>October 2013 – March 2014</i>	Number	23	2,991	0	103	Data relates to Small, Medium, Large and Teaching Acute Trusts.
	%	0.07%	0.04%	0.00%	0.37%	
Latest Data Published		November 2014				

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.

Indicator		Trust <sup>1</sup>	National	Minimum	Maximum	Comment
Patient Reported Outcome Measures (PROMS)  Groin Hernia  <i>April-13 – March-14</i>	Participation rates for the first questionnaire	*	59.90%	0.00%	231.30%	
	Response rates for the second questionnaire	*	65.60%	42.00%	100.00%	
	Health Gain (EQ-5D)	*	0.085	-0.064	0.322	
	Health Gain (EQ-VAS)	*	-1.048	-11.833	18.167	

<b>Patient Reported Outcome Measures (PROMS)</b>  <b>Groin Hernia</b>  <i>April-14 – December-14</i>	Participation rates for the first questionnaire	No data	58.50%	0.00%	375.00%	
	Response rates for the second questionnaire	No data	52.60%	25.00%	100.00%	
	Health Gain (EQ-5D)	No data	0.084	-0.267	0.245	
	Health Gain (EQ-VAS)	No data	-0.502	-9.556	8.667	
<b>Latest Data Published</b>		<b>May 2015</b>				

<sup>1</sup> Indicates the figure has been suppressed (shown with an asterisk - '\*') to protect patient confidentiality as published by HSCIC.

The 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.

The Kingston Hospital NHS Foundation Trust intends to take the following actions to improve this response rate and so the quality of its services, by promoting the PROMS survey to patients.

Indicator		Trust	National	Minimum	Maximum	Comment
<b>Patient Reported Outcome Measures (PROMS)</b>  <b>Varicose Vein surgery</b> <i>April-13 – March-14</i>	Participation rates for the first questionnaire	No data	40.40%	0.00%	185.40%	
	Participation rates for the second questionnaire	No data	55.00%	32.80%	90.00%	
	Health Gain (EQ-5D)	No data	0.093	-0.096	0.468	
	Health Gain (EQ-VAS)	No data	-0.548	-12.045	19.143	
	Health Gain Aberdeen Score	No data	-8.701	-19.385	-2.721	

<b>Patient Reported Outcome Measures (PROMS)</b>  <b>Varicose Vein surgery</b> <i>April-14 – December-14</i>	Participation rates for the first questionnaire	No data	40.50%	0.00%	178.90%	
	Participation rates for the second questionnaire	No data	42.70%	23.30%	90.00%	
	Health Gain (EQ-5D)	No data	0.102	-0.040	0.277	
	Health Gain (EQ-VAS)	No data	-0.160	-14.429	9.400	
	Health Gain Aberdeen Score	No data	-8.823	-17.361	3.225	
<b>Latest Data Published</b>		<b>May 2015</b>				

The 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.

The Kingston Hospital NHS Foundation Trust intends to take the following actions to improve this response rate and so the quality of its services, by promoting the PROMS survey to patients.

### **17. Independent Auditors' Limited Assurance Report to the Directors of Kingston Hospital NHS Foundation Trust on the Quality Report**

#### **Independent auditor's limited assurance report to the Council of Governors and Board of Directors of Kingston Hospital NHS Foundation Trust on the Quality Report**

We have been engaged by the Board of Directors and 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 2015 (the 'Quality Report') and certain performance indicators contained therein.

#### **Scope and subject matter**

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

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

## **Respective responsibilities of the directors and auditor**

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' issued by Monitor.

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'
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's 'Detailed guidance for external assurance on quality reports 2014/15', and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2014/15'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual', 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 2014 to 27 May 2015
- papers relating to quality reported to the board over the period 1 April 2014 to 27 May 2015
- feedback from Commissioners, dated 18/05/2015
- feedback from local Healthwatch organisations, dated 18/05/2015
- feedback from Overview and Scrutiny Committee, dated 18/05/2015
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31 March 2015
- the national patient survey, dated 2014
- the national staff survey, dated 2014
- Care Quality Commission Intelligent Monitoring Report, dated 31/12/2015 and
- the Head of Internal Audit's annual opinion over the Trust's control environment, dated 31/03/2015

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



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

This report, including the conclusion, has been prepared solely for the Board of Directors and Council of Governors of Kingston Hospital NHS Foundation Trust as a body and the Board of Directors of the Trust as a body, to assist the Board of Directors and Council of Governors of 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 2015, to enable the Board of Directors and 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 Board of Directors as a body, 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
- analytical procedures
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- comparing the content requirements of the 'NHS Foundation Trust Annual Reporting Manual' to the categories reported in the quality report and
- reading the documents.

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

### **Limitations**

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in

materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual'.

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

## **Conclusion**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual';
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual'.

Grant Thornton UK LLP  
Grant Thornton House,  
Melton Street,  
Euston Square,  
London  
NW1 2EP

27 May 2015

## Appendix A: National Confidential Enquiries

Programme type	Participated?	Study and number of cases submitted
<b>Child Health Clinical Outcome Review Programme</b>	Programme not yet started	
<b>Medical and Surgical Clinical Outcome Review Programme</b>	Yes	Lower limb amputations - 1 case submitted but excluded as did not fit criteria GI bleed – 5 cases Sepsis – 4 cases Tracheostomy – 4 cases
<b>Maternal, Newborn and Infant Clinical Outcome Review Programme</b>	Yes	55/55 (100%)
<b>Mental Health programme</b>	Not applicable	

## Appendix B: Eligible National Clinical Audits 2014/15 – Participation rates

Shaded areas indicate national clinical audits where deadlines are after April 2015 and therefore the number of cases submitted is not yet available.

National Clinical Audit	Participated?	Number of cases submitted
<b>Acute Care</b>		
Adult Community Acquired Pneumonia	Yes	Still submitting data. Deadline May 2015.
Case Mix Programme (ICNARC)	Yes	
Trauma Audit and Research Network (TARN)	Yes	53%
National Emergency Laparotomy Audit (NELA)	Yes	100% (120/120)
National Joint Registry	Yes	0%
Pleural Procedures	Yes	14 (minimum 8 required) (175%)
<b>Blood transfusion</b>		
National Comparative Audit of Blood Transfusion audits: 1) Audit of patient information and consent		
2) Audit of transfusion in children and adults with Sickle Cell Disease		
<b>Cancer</b>		
Bowel Cancer (NBOCAP)	Yes	111% (152/137)
Lung Cancer (NLCA)	Yes	
National Prostate Cancer Audit	Yes	No cases April- September 2014 100% (54/54) for October 2014- March 2015
Oesophago-gastric Cancer (NAOGC)	Yes	
<b>Heart</b>		
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	57% (187/327) Still submitting data. Deadline May 2015 for this round
Cardiac Rhythm Management	Yes	94% (138/147)
Coronary Angioplasty/National Audit of PCI	Yes	1/1 (100%) organisational audit
National Cardiac Arrest Audit	Yes	35% (77/220)
National Heart Failure Audit	Yes	48% (179/374) Still submitting data. Deadline June 2015 for this round

Long Term Conditions		
Diabetes (Adult)		
Diabetes (Paediatric)	Yes	100% (160/160)
Inflammatory Bowel Disease (IBD) Biologics	Yes	100% (15/15)
National Chronic Obstructive Pulmonary Disease (COPD)	Yes	91% (68/75)
Rheumatoid and Early Inflammatory Arthritis	Yes	Still submitting data. Deadline end of April 2015.
Older People		
Falls and Fragility Fractures Audit Programme (FFAP) Hip Fracture database	Yes	92% (322/350)
Sentinel Stroke National Audit Programme (SSNAP) Organisational audit	Yes	1/1 (100%)
Sentinel Stroke National Audit Programme (SSNAP) Clinical Audit	Yes	98% (172/175)
Other		
PROMS – Hernia and varicose veins only		
Women and Children		
Neonatal intensive and special care (NNAP)	Yes	

## Appendix C: Actions to be taken following completed national clinical audits

National audit reports published in 2014/15	Date Report Issued	Report discussed during 2014/15	Actions Identified
<b>Acute Care</b>			
Emergency use of oxygen	Apr 2014	Yes	Oxygen policy revised and staff trained. Oxygen 'Awareness week' taking place in May 2015.
Severe sepsis and septic shock	Dec 2014	Yes	Various in line with Sepsis 'Sign Up to Safety' project, including review of guidelines and treatment goals.
Moderate or severe asthma in children	Jan 2015	Yes	Review of working practices has led to changes including ensuring routine blood pressure and peak flow measurement in triage. Triage streaming model altered.
Paracetamol overdose	Jan 2015	Awaiting discussion	
Adult critical care case mix programme (ICNARC)	Jan 2015	Yes	Recently joined this national audit. Quarterly reports being reviewed by ITU team.
Pleural procedures	Feb 2015	Due for presentation Jun 15	
<b>Blood transfusion</b>			
Use of Anti D	Nov 2014	Yes	Awaited
Patient information and consent	Nov 2014	Yes	Education of junior doctors regarding consent. Improve distribution of blood transfusion information leaflets to patients.
<b>Cancer</b>			
Bowel cancer	Dec 2014	Yes	No actions identified.
Lung cancer	Dec 2014	Yes	Awaited
<b>Heart</b>			
National cardiac arrest audit	Jul 2014	Yes	Further local in depth review of specific cases and peri-arrests.
Acute coronary syndrome or acute myocardial infarction (MINAP)	Dec 2014	Yes	Awaited

<b>Long term conditions</b>			
Inflammatory bowel disease ulcerative colitis audit	Oct 2014	Yes	Appointment of an Inflammatory Bowel Disease Nurse Specialist
Inflammatory bowel disease Biologics audit	Oct 2014	Yes	Training for ward nurses on nutritional requirements and referral.
National diabetes audit – outpatients	Oct 2014	Results sent to Diabetes lead	Awaited
Chronic obstructive pulmonary disease	Feb 2015	Yes	Preparation of business case for Respiratory nurse specialist. Various actions to improve discharge planning
National paediatric diabetes audit (2012/13 data)	Oct 2014	Yes	Requirement for additional administrative support for data input.
National paediatric diabetes audit (2013/14 data)	Mar 2015	Results sent to Paediatric team	Awaited
National diabetes audit (adults)	Feb 2015	Results sent to Diabetes lead	Awaited
<b>Older People</b>			
Sentinel stroke national audit programme	Dec 2014	Yes	No actions required – results good
Falls and fragility fracture programme – National hip fracture database	Sept 2014	Yes	No action required – results good.
<b>Women and Children</b>			
Heavy menstrual bleeding	Jul 2014	Yes	Results shared and discussed with local general practitioners to ensure treatment and referral pathway is clear. ‘One stop’ menstrual clinic to be considered. Preparation of management protocol and patient leaflet.
Paediatric asthma	Jul 2014	Yes	Staff informed to ensure information leaflet given to patients and recorded. Training for doctors on nebulisation.
Neonatal intensive and special care	Oct 2014	Yes	Action plan requires clarification
Epilepsy 12	Nov 2014	Yes within team Presentation due July 2015	Appointment of Epilepsy Nurse Specialist

## **ANNEX 1 – 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.

### **Kingston Hospital NHS Foundation Trust – Commissioner Feedback**

Kingston Clinical Commissioning Group has reviewed the Trust's Quality report for 2014-15 and recognises the Trust has continued to strive for care and service quality improvements. We recognise the quality improvements in many service areas during a challenging financial time along with national and local recruitment issues.

The monthly Clinical Quality Review Meeting with commissioners and senior Trust staff review service quality across the Trust. The Trust has presented openly its serious incidents and organisational learning from the Trust's Clinical Quality Improvement Committee to the CQRM.

We recognise the winter pressures in A&E and we commend the Trust on undertaking work to review of the quality of these service areas and the continued work on integration of services.

We acknowledge the Trust's concerted effort toward achieving the cancer standards and we are very supportive of the cancer action plan.

We welcome the 2015-16 priorities and look forward to continued improvements in service and care quality for the frail elderly, end of life care and the provision of 7 day working.

#### **Trust response and changes made as a result of the feedback above**

The Trust is grateful for the feedback received from Commissioners and looks forward to working closely with them in the coming year to improve the services we provide to patients.

### **Kingston Hospital NHS Foundation Trust – Governor Feedback**

The Governors have reviewed the Trust's Quality Report for 2014/2015 and acknowledge that the Trust has worked hard to improve the quality of care it provides to patients. The Trust has performed well across the quality domains that they focused on namely;

- Patient Safety
- Clinical Effectiveness
- Patient Experience

The Governors welcomed the opportunity to engage with the Trust in agreeing priorities within those domains. The opportunity to ask questions, to suggest ways in which sections could be



reframed and to suggest additional priorities within the domains represent very good practice. The Governors' Quality Scrutiny Committee was able to report, on an ongoing basis, to the Council of Governors (COG) and to give assurance to COG that the Quality Account process was both rigorous and consultative, engaging a wide range of stakeholders.

Governors welcome the Trust's identification of more areas for improvement and look forward to contributing to ongoing work in 2015/2016.

#### **Trust response and changes made as a result of the feedback above**

The Trust is grateful for the feedback received from the Council of Governors and looks forward to working closely with them in the coming year to improve the services we provide to patients.



#### **Healthwatch Kingston feedback on the Kingston Hospital Quality Report 2014/15**

Unfortunately Healthwatch Kingston did not receive a copy of the Quality Report in time to circulate to the Board of Trustees for discussion and comment. Nor was it able to carry out a wider discussion with active participants and members of Task Groups. The reason why the report was not received is unclear and action will be taken to ensure this does not happen next year. On behalf of Healthwatch Kingston, however, the Manager welcomes the opportunity to comment on Kingston Hospital's Quality Report 2014-15 which he considers to be a clear and concise document reflecting what works well, where improvements need to be made and aspirations for the future. It is reassuring to note the inclusion of the contribution Healthwatch Kingston has made to improving services following a visit in April 2014. Although it's not included in the Quality Report in July 2014 our staff team and volunteers visited the Royal Eye Unit and Day Surgery units to carry out surveys and make observations. Our recommendations included improving signage and seating in the waiting areas, along with consideration for colours that make life easier for visually impaired patients.

As the local independent consumer champion for health and social care services Healthwatch Kingston is committed to ensuring that the views of local people continue to shape and improve local service delivery. In so doing Healthwatch Kingston will work with Kingston Hospital NHS Foundation Trust to support an active patient and public involvement programme that is open and transparent and is seen to have a positive impact on service development.

Healthwatch Kingston will use its statutory rights in a number of ways to support a culture of continuous improvement at Kingston Hospital and to identify and address service deficits, gaps in provision or unsatisfactory performance. It will do so by:

- Obtaining the views of local people about their experiences of Kingston Hospital services;
- Conducting research to understand the needs of the local population;
- Collecting and recording evidence about how well service are performing, particularly the integration of health and social care services;
- Visiting hospital services through a planned "Enter and View" programme and speaking

with patients, service users, carers and staff;

- Developing effective community and stakeholder engagement, partnership working and feedback mechanisms;
- Writing reports and making recommendations about how hospital services should be improved as well as highlighting areas of good practice;
- Prioritising issues and developing theme based work plans; and,
- Making sure the voice of the consumer is heard by those who commission, deliver and regulate health and social care services.

Healthwatch Kingston has an established Hospital Services Task Group that has developed and implemented a work plan that sets out a number of priorities including gathering evidence, proposing actions and related outcomes. Kingston Hospital's Quality Report is considered to be a very important document by Healthwatch Kingston as it demonstrates the steps taken by the Trust to improve services and involve the local community in decisions about their treatment and care. As such Healthwatch Kingston will continue to monitor quality at Kingston Hospital and will pay particular attention to determining whether the Trust is able to meet its vision: 'Working Together to deliver exceptional, compassionate care each and every time.'

For 2015-16 Healthwatch Kingston's Hospital Services Task Group will be examining and scrutinising several important service areas at Kingston Hospital, including, ambulance services, A&E, weekend and holistic care, communications and appointments, aftercare and discharge arrangements. This programme of activities will pay careful attention to the Trust's priorities for 2015-16 as detailed in the Quality Report. To support Healthwatch Kingston in this role and to strengthen a partnership approach the Trust will be approached to provide relevant information that will demonstrate how well it is doing. Healthwatch Kingston will consider the Quality Report to be a live document and will request updates against each of its priority areas by requesting, for instance, performance reports, patient survey results, complaints data, PROMS, board papers and CQUIN activity. Healthwatch will also examine regional performance to compare the Trust against other similar hospital services such as information published by NHS London, Public Health England, Care Quality Commission and other regional and national reporting systems such as data from the Health and Social Care Information Centre.

In summary Healthwatch Kingston will use the Quality Report as a guide to ensuring that Kingston Hospital offers the best possible treatment and care for all its patients. It will request updates against each priority area if and when these have a bearing on the work of Healthwatch Kingston, specifically patient safety, cleanliness and environmental factors, involving people in decision making processes, discharge planning, waiting times and staff attitude. Healthwatch Kingston values the Trust's commitment to patients as set out in its vision and welcomes the opportunities for greater participation from local people such as the volunteering programme which could complement Healthwatch Kingston's aim to see increased patient involvement in decision making and service improvements. During 2015-16 Healthwatch Kingston will support the Trust in delivering against the targets set out in the Quality report and will seek opportunities to work more closely on issues that mean the most to local people in Kingston.

#### **Trust response and changes made as a result of the feedback above**

The Trust is grateful for the feedback received from the Healthwatch Kingston and looks forward to

working closely with them in the coming year to improve the services we provide to patients.

- The draft quality account was posted to Healthwatch Kingston at the same time as all other partners and will in coming years confirm receipt the following week.

### **Kingston Hospital Quality Account 2014/15 – Comments from RBK HOP**

This is a very good detailed report covering a wide range of quality areas which have been progressed by the Foundation Trust during the past year and builds on work undertaken in previous years. The information is well presented.

#### **Domain – Patient Safety**

##### Falls

It is good to see the reduction in falls and the follow through on learning about the causes of falls plus the range of initiatives including addition of alarms and coloured toilet seats in bathroom areas. We were very pleased to learn that Kingston Hospital performs very well compared to other London hospitals in this area. We recognise that continuing preventative initiatives is important for older patients at the hospital.

##### Incidents of hospital acquired infection

We congratulate the Trust on progress with reducing hospital acquired infection and the reductions in MRSA (zero cases) and MSSA cases. This is a tremendous achievement and we hope that very low levels continue in future years.

We welcome the planned initiatives in relation to CAUTIs and involvement in the South London Pilot.

##### Ward environment - dementia

We note the current budget challenges and that this has led to planned improvements in A&E not being made and hopes this can be achieved later. Perhaps consideration can be given to interim arrangements. We welcome the ward improvements around crockery and clocks etc. We congratulate the Trust on the HSJ/Nursing Times award in July 2014 for the Dementia Strategy.

#### **Domain – Clinical Effectiveness**

##### Displaying safe staffing levels

We trust that safe staffing levels as well as the numbers of staff present at any one time in a particular area are displayed.

Information about the nursing uniforms is helpful and we wonder if this information is on notice boards at entrance to wards?

##### Safer surgery for elderly including medicines review and frailty risk assessments

We look forward to learning more about progress in this area and wonder whether GP referral letters can provide some information about co-morbidities and medications.

##### Implementation of e-prescribing

We congratulate the Trust on the progress that has been made with the electronic patient record

system both in terms of notifying GPs and e-prescribing/other clinical documentation on all inpatient wards, intensive care and A&E and recognise the efficiencies and additional patient safety that this brings.

### **Domain – Patient Experience**

#### Increasing involvement in decision making

We recognise the value of involving patients in service re-design, and welcome the initiatives that are listed here.

#### Dementia strategy

We have followed the developments at HOP and value the work that has been progressed particularly involving and learning from families and carers plus the valuable links with the voluntary sector. We are especially pleased to learn of the steps that have been taken to enable carers and relatives to stay overnight near to relatives on wards. Hopefully this is helpful for nursing and clinical staff and helps with understanding the particular needs of patients.

#### Improved experience of hospital food

We particularly welcome the focus on this area and note that the possibility of toast is being progressed – this was something that we asked about previously.

We were pleased to learn in our discussions about the considerable improvements that have been made with catering and responding to patients' requests.

**Other quality initiatives:** this section covers a good range of important areas

Eliminating mixed sex accommodation – We welcome the fact that the Trust has had no cases where people have been in rooms/bays with members of the opposite sex. We trust that this will continue.

Technology – We welcome the successful award of £836K for patient observations devices recognising that this enables accuracy. How often do nursing staff observe the data to ensure the wellbeing of the patients? Is this information available to clinicians and nurses when doing ward rounds?

Nursing recruitment and retention – we note that this is difficult throughout London and are aware of the attractions of agency nursing in terms of remuneration. Housing costs are high in London. Does the hospital provide any housing for nurses and are there any plans to do so?

End of life care – we note that the Trust is working on a number of recommendations.

### **Priorities for 2015/16**

We welcome the plans to build on the achievements made previously in forming the targets for 2015/16 and the focus on reducing agency nurses, 7 day working and administration.

### **Trust response and changes made as a result of the feedback above**

The Trust is grateful for the feedback received from the Council and looks forward to working

closely with them in the coming year to improve the services we provide to patients.

- Information regarding staff uniforms is now displayed in each bay on wards
- GP letters often provide information regarding medications and co-morbidities, which is sometimes supplemented following the attendance at the hospital with new information (in the event of a new diagnosis or change of medication)
- Nurses review the observations immediately upon completion of the vital signs for the patient. In cases where this information indicates a deteriorating condition, there is an escalation process in place for staff to access additional senior nursing and medical support. Vital signs are reviewed during ward rounds.
- The trust has a limited number of on-site rooms for accommodation which is regularly reviewed



### **Healthwatch Richmond upon Thames feedback on the Kingston Hospital Quality Report 2014/15**

Healthwatch Richmond considers the Trust's quality account to be an accurate account of Kingston Hospital and clearly details the successes and failures at achieving targets for quality over the past year. A great deal of effort appears to have gone into improving service standards within the Trust and the commitment to improve them further is welcomed. The Trust has been candid in admitting failures to meet their targets and have provided clear reasons why these targets were missed.

We welcome the achievements in reducing falls as well as hospital acquired infections and it is encouraging to see that the Trust is taking steps to reduce the cause of E.coli infections. We were impressed with the Trust's approach to, and the progress made on, increasing patient involvement and engaging volunteers; although we would have appreciated seeing the results of the baseline measure on the impact of volunteering on patient experience in the quality account. We found it positive that the Trust has made improvements in the experience of patient carers, and we welcome a continuing increase in carer engagement, involvement and feedback levels in 2015/16. However, we found that there was very little information on the Trust's failure to provide a carers' hub or whether this will be a continuing target for the upcoming year. Additionally, we noticed that the written patient feedback comments are only analysed quarterly, and question why this is not more frequent (i.e. monthly), particularly considering that the "you said, we did" communications is monthly. More frequent analysis would be more timely and responsive to any "live" issues that arise.

The Trust is to be congratulated on winning the dementia care award, its approach to the volunteer programme, and on the success of the stroke audit. The target to make the hospital dementia friendly was ambitious and it is encouraging to see the steps that have been taken to ensure that this target will be achieved. We are pleased to see that the second year of the dementia strategy is a focus for 2015/16 and hope to see continual improvements in making the hospital more dementia friendly. We welcome the priority for reducing rate of harm to patients with dementia, but feel that the target (a reduction of 10%) could be more ambitious.

We found it concerning that the target for the safe surgery for the elderly was not met. It is not clear why this target had not been met and it is also unclear what recommendations the Trust will be focusing on to ensure this target is achieved. We also note that this target, despite not being achieved, is not part of the quality priorities for the coming year and we would wish to know how

the Trust will ensure that this target is achieved in 2015/16.

We welcome the Trust's engagement with Healthwatch: several of Healthwatch Kingston's recommendations have been implemented. We are also pleased to see one recommendation - on seven day services - reflected as a priority for 2015/16. In this context, it would be useful to see the summary data of current weekday and weekend mortality in the quality account as a baseline.

We note that the Trust has prioritised staff appraisal for the coming year, but we would welcome a higher target than the current 95%, as this is the actual performance in 2014/15. Similarly the target for mandatory training should be increased. Finally we welcome the priority on administration, although we feel there should be a further tier of targets to ensure that 100% of letters and discharge summaries are sent within 14 working days.

Overall we were pleased with the Trust's achievements over the past year. We support their aims for the coming 12 months and support achieving any missed targets from the 2014/15 period over the next year.

### **Trust response and changes made as a result of the feedback above**

The Trust is grateful for the feedback received from the Healthwatch and looks forward to working closely with them in the coming year to improve the services we provide to patients.

- The Trust priority to (as part of the Dementia Strategy was to "Design a 'carers hub', identify space, pursue sources of funding and partnerships to support, delivery model & outcomes" – it was not intended to have completed this work this year but it remains part of the overall Dementia Strategy implementation plan.
- Patient feedback is received in a wide variety of ways and in many cases (such as the Friends and Family test) the results are reviewed more frequently and often before the patient has left the Trust. A more comprehensive review is undertaken at quarterly intervals to capture broader themes and trends.
- The priority for setting trajectories to reduce the rate of harm to patients with dementia was not originally identified through the Dementia Strategy to have a target reduction in 2015/16 as we planned to establish the system to capture this information and set baselines ahead of reduction activities and trajectories in 2016/17. Based on feedback to the objective we decided to bring forward a harm reduction target into 2015/16 and therefore a 10% reduction for the final quarter of the year is deemed to be appropriate. We will of course review this in light of the baseline and ongoing strategy during 2016/17.
- The narrative relating to safer surgery has been clarified and it is intended that the additional investment in this area will prove helpful to achieve the recommendations in 2015/16. This area was not selected as part of 2015/ 16 priorities based on the choices made through the consultation process for priorities, however the Trust will continue to focus in this important area.
- The targets set for staffing and administration priorities have been agreed as a significant challenge for the Trust and clearly it is hoped that the targets are exceeded.

## **Richmond upon Thames' Health Scrutiny Committee response to Kingston Hospital NHS Foundation Trust's Quality Accounts**

Following on from the meeting held on Monday 11 May 2015, to discuss Kingston Hospital NHS Foundation Trust's (Kingston) Quality Account, 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.

### **The Report:**

We congratulate you on this clear, concise, well-written and well-evidenced document. In particular:

- The layout and structure of the report was logical, making the Account easy to navigate.
- The use of a traffic light system to indicate the progress for each priority made the Account easy to interpret and accessible to members of the public.
- The report was patient-focused, with a strong emphasis on improving outcomes for patients across the three domains.

Additionally, we applaud you for your timely response and actions. It is evidenced within the report that Kingston achieved most of the priorities set for 2014/2015. The LBRuT particularly noted the Trust's accomplishments in the following areas:

- The increased transparency and reassurance afforded through displaying safe staffing levels to the patients and the public (Priority 4).
- The work to ensure the implementation of e-prescribing/clinical documentation as part of becoming a paper light organisation (Priority 6) has exceeded expectations and will be built upon as a priority for 2015/2016.
- The extension and flexibility of visiting times as part of the implementation of Priority 8 (Dementia strategy – improvement in experience of patient carers). This shows compassion and understanding from the Trust towards the experiences of carers, patients and their visitors.
- The improvements in experience of hospital food (Priority 9), with overall patient experience improving as a result.

### **Suggestions:**

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 see incorporated in the final version, as we believe that these will further highlight the hard work and commitment which has taken place to improve the level of quality at Kingston. These are as follows:

- We noted that some areas such as A&E waiting times, DTOC, and Cancer are some of the indicators that have attracted a lot of attention as they were not met. It might be useful to highlight these in the report or include them in your priorities with some explicit reassurance about ongoing improvement work. Similarly, Priority 5- Safer surgery, Medicines review and Frailty risk assessment for Elderly was not met and we may need some explicit assurance about ongoing improvement work.
- We also noted that Children and Young People (CYP) and Maternity do not feature in your priorities but are aware about the importance of these services for our population. It might be useful to include them under the quality initiatives section outside the specific priorities.
- We acknowledge all the hard work Kingston has undertaken within their Dementia Strategy; however we noted that Priority 3 – Improvements in the inpatient ward environment – was only partly met. We appreciate the difficulty the Trust faced in funding the project in the current economic climate and are pleased to see the Dementia Strategy is an ongoing priority for 2015/2016.
- We are impressed by the Trust's plans for their new End of Life Care pathway for 2015/2016. In particular we approve of the Trust's focus on holistic care, including emotional and physical support for the patient and the family. We welcome the active engagement the Trust has undertaken with patients and their families to develop the programme. In taking this work forward, we recommend the interface between the Trust and the local community is reviewed to ensure this essential relationship is developed.
- Finally, the Outcomes Based Commissioning (OBC) framework captures in depth the perspective of Richmond patients and we would expect that the Trust takes account of this. Integration between hospital and community services to provide a seamless service around the patient's need is a recurrent theme and we would welcome commitment to work closely with partners to achieve this.

### **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. We also hope that our views and the suggestions offered are taken on board and acted upon and we are kept informed of your progress.

### **Trust response and changes made as a result of the feedback above**

The Trust is grateful for the feedback received from the Council and looks forward to working closely with them in the coming year to improve the services we provide to patients.

- The Trust met with representatives of the Council and explored the various priorities selected and assured that other areas (e.g. A&E and Cancer) would continue to be monitored as part of our performance framework and these areas appear as part of the Trust Board reports on performance which would enable monitoring of attainment.



## **ANNEX 2**

### **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 2014/15 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 1 April 2014 to 27 May 2015
  - papers relating to quality reported to the board over the period 1 April 2014 to 27 May 2015
  - feedback from Commissioners, dated 18/05/2015
  - feedback from local Healthwatch organisations, dated 18/05/2015
  - feedback from Overview and Scrutiny Committee, dated 18/05/2015
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31 March 2015
  - the national patient survey, dated 2014
  - the national staff survey, dated 2014
  - Care Quality Commission Intelligent Monitoring Report, dated 31/12/2015 and
  - the Head of Internal Audit's annual opinion over the Trust's control environment, dated 31/03/2015
- 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](http://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](http://www.monitor.gov.uk/annualreportingmanual)).

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

By order of the board

NB: sign and date in any colour ink except black

.....Date.....Chairman

.....Date.....Chief Executive