Kingston Hospital NHS
NHS Foundation Trust

Quality Report 2015-16

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

Living our values *everyday*

CARING SAFE RESPONSIBLE VALUE EACH OTHER

Pictures on front cover (clockwise)

Midwife of year winner (top left)

Therapy dog in action (top right)

Dementia activities session (bottom centre)

Contents

Part 1

Part 2

Part 3

Part 1

Quality Report 2015/16

1.0 Introduction from the Chief Executive

Quality is very much at the heart of everything we do at Kingston Hospital and I am proud of the many improvements we have made for our patients. These improvements have helped us to provide better care and experience for our patients and made them safer. This report is a review of how we have performed during 2015-16 and looks forward to what our quality priorities will be during 2016-17.

Over the last year we have seen over 113,000 patients in A&E, undertook nearly 390,000 outpatient appointments, cared for 31,000 admitted patients and delivered around 5,800 babies. All of our quality priorities support the care and treatment provided to all our patients.

We agreed on nine ambitious quality priorities for 2015-16 and we have achieved five and part achieved four. One of our effectiveness priorities was to increase the amount of time nurses have available to spend with patients by introducing electronic recording of vital signs. The initial roll out of new technology to record blood pressure and temperature automatically into the patient record has been a huge success and in one month 225 hours of nursing time has been released as a result of using this technology.

We also achieved the priority of improving the provision of seven day working in the Trust and to improve the achievement of the London Quality Standards. During 2015-16 the Trust made some essential investments in quality and reviewed the staffing structures. The improvements include the recruitment of three Emergency Surgeons to deliver improved emergency services; Recruited additional paediatric consultants to ensure presence between 8am and 10pm.

Providing the best End of Life care possible is a commitment of the Trust and the last year we achieved the quality priority of improve patients' and their relatives' experience of End of Life care. In a survey carers and patients reported having a better experience than the national average. for nurses and doctors having time to listen and discuss their condition. More people than the national average said they had confidence and trust all the time in the doctors caring for them and more people felt very involved with decisions about their care and treatment compared to the national picture.

Dementia care has continued to be focus for the whole Trust and I am particularly proud of the work being done to improve the care provided and also the lives of our patients with dementia. There are many elements to the work and it includes transforming the environment on our elderly care wards and providing therapeutic activities and support. During 2016-17 Derwent, one of our elderly care

wards, will be transformed into a dementia friendly environment and work will continue to implement the Dementia Strategy.

Sepsis is a national priority and at Kingston we have focussed a great deal of attention on making sure we recognise and treat patients with sepsis at the earliest opportunity. Recognition and management of sepsis is one of the Trust's 'Sign up to Safety' projects and we have a three year improvement project plan to ensure that we continue to see sustained improvements.

For the last few years we have worked hard to involve staff, the local community, partners and stakeholders in decisions about our services and priorities for improvement and always listen to the feedback we receive when things have gone well and when we could have done better. We have involved them in helping to set our priorities for 2016-17, which are:

Domain	Priority
Patient Safety	- Reduce falls in hospital setting - Reduce avoidable harm from sepsis - Reduce use of agency staff by reducing vacancies
Clinical Effectiveness	- Reduce readmissions in non-elective care - Reduce length of stay - Reduce patient reported pain
Patient Experience	- Transform administration across the hospital - Improve end of life care - Improve patient experience of discharge

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

Ann Radmore
Chief Executive
23rd May 2016

2.0 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:

Duncan Burton, Director of Nursing and Patient Experience at Duncan.Burton@kingstonhospital.nhs.uk or Lisa Ward, Head of Communications at 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.

3.0 Language and Terminology

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

Admission: *There are three types of admission:*

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

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

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

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

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

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

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

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

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

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

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

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

Friends and Family Test: *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).*

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

The National Institute for Health and Care Excellence (NICE): *provides national guidance and advice to improve health and social care. NICE's role is to improve outcomes for people using the NHS and other public health and social care services. Their main activities are:*

•Producing evidence based guidance and advice for health, public health and social care practitioners.

•Developing quality standards and performance metrics for those providing and commissioning health, public health and social care services.

•Providing a range of informational services for commissioners, practitioners and managers across the spectrum of health and social care

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.*

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

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

1. *Put safety first. Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.*
2. *Continually learn. Make their organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.*
3. *Honesty. Be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.*
4. *Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.*
5. *Support. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.*

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

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

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

Part 2

4.0 Kingston Hospital NHS Foundation Trust Priorities for 2016/17

How were the priorities chosen?

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

The number of priorities selected is in line with those stipulated in the Monitor document Detailed Requirements for Quality Reports 2015/16

The description must include:

- at least three priorities for improvement (agreed by the NHS foundation trust's board) indicating the relationship, if any, between the identification of these priorities and the reviews of data relating to quality of care referred to in the assurance statement.
- progress made since publication of the 2014/15 quality report – this should include performance in 2015/16 against each priority and, where possible, the performance in previous years
- how progress to achieve these priorities will be monitored and measured and
- How progress to achieve these priorities will be reported.

A long list of potential quality priorities was developed in consultation with stakeholders such as Healthwatch, Trust committees, commissioners and governors.

The dates of consultation are listed below:

Quality Assurance Committee	6th January 2016
Clinical Quality Improvement Committee	7th October 2015
Governors Quality Scrutiny Committee	16th December 2015
Trust Board meeting (public)	27th January 2016
Clinical Quality Review Group	16th March 2016
Kingston Hospital Monthly team brief document	5th February 2016
Healthwatch Forum	10th February 2016
Council of Governors	21 January 2016

The quality priorities long list was then put to a public vote during February 2016. Staff, volunteers, Trust members and the public were asked to vote on which priorities to select from the long list. Three priorities were voted for from each domain: patient safety, clinical effectiveness and patient experience. The priorities with the most votes were selected as the nine Trust Quality priorities for 2016-17. A total of 304 people completed the quality priorities survey. The long list (with the eventual priorities that were chosen underlined) is shown below. Those topics not selected as quality priorities in this Quality Account will be/or already are incorporated into wider trust quality and safety initiatives.

Domain 1 : Patient Safety – prevent harm

1. **Reduce use of agency staff by reducing vacancies.**

This is important because staff who are permanently 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. This was a priority last year.

2. **Reduce avoidable harm from sepsis.**

This is important because sepsis and septic shock have a high mortality and morbidity. If sepsis is recognised and patients receive antibiotics and fluids early in their treatment the outcome is improved and this will mean saving lives and reducing harm. It is therefore important that all our staff and our patients know about the risk of sepsis and that through education and we can increase awareness of the condition and save lives. This was a priority last year.

3. **Reducing falls in the hospital setting.**

Patients over 65 are vulnerable to falling in Hospital because of their illness, frailty and the unfamiliarity of the clinical setting. Falls usually delay patient's recovery and confidence and if injuries occur, such as hip fractures in the frail patients, the impact of this this can be very serious. By ensuring that the key recommendations of NICE to prevent falls in adults are implemented the number of falls should be reduced. This is important because many of the patient's at Kingston Hospital are over 65 and we need to ensure that patients don't have to spend a long time in hospital and that they are likely to return to their usual place of residence on leaving.

Improve completion of National Early Warning Score (NEWS) and escalation of the deteriorating patient. We measure vital signs such as pulse, blood pressure, temperature and breaths per minute in all of our patients whilst they are in hospital. The most unwell patients have their vital signs measured more frequently. We do this because these observations tell us whether patients are responding to their treatment or whether a different treatment is required. All observations must be completed and the right staff told if there is an abnormality in order that we give patients the best care.

Reducing Catheter Associated Urinary Tract Infections (CAUTI). CAUTIs are the most common cause of hospital acquired infections in the UK, accounting for up to 40% of all cases. Reducing these infections is important as they can lead to lead to pain, discomfort, loss of dignity, increased length of stay and can lead to sepsis. This priority would therefore focus on reducing these infections. It is sometimes necessary to catheterise patients for clinical reasons but we need to ensure that catheters are left in place for the shortest time possible, thus reducing the potential for infection.

Intrapartum fetal wellbeing assessment and management in high risk pregnancy. This is important because one of the ways we make sure that babies are safe during labour is to monitor their heartbeats and the mothers contractions with Cardiotocography (CTG). In order for this to be used effectively all the midwives and doctors need to be skillful in interpreting what the monitor is telling us. Misinterpretation of CTGs is one of the commonest mistakes that is seen in claims of harm to babies. Improving monitoring in labour will enable signs of distress to the baby to be managed safely and improve the outcome for babies. It also means that caesarean deliveries might be avoided when the monitoring shows the baby is healthy.

Reduce the risk of Hospital Acquired Thrombosis (HAT). This is a condition where patients

can get blood clots in the veins of their legs which causes swelling and pain but can also lead to a blood clot travelling to the lungs, which is dangerous. In hospital we assess everybody for their risk of getting this condition but some patients are particularly at risk and may need extra intervention. We need to reduce the risk of HAT by making sure that we analyse every time this happens so we can learn how to prevent the condition in more of our patients.

Domain 2 - Clinical Effectiveness - improve clinical outcomes for our patients

4. **Reduction in patient reported pain.**

This is important because it is an area where we can make improvement. We know this because our inpatient survey told us that we do not always recognise and treat pain effectively. We also know that patients with dementia are particularly vulnerable to not receiving enough pain relief. We will make it a priority to ensure all our staff know how to assess that pain is being managed effectively even when it is difficult for our patients to explain this to us. We will also ensure that we use the most effective interventions to manage pain well.

5. **Reduction in readmissions in non-elective care.**

We want to ensure that people don't have to stay in hospital any longer than is needed. But we must not send patients home too soon or without the right treatments to continue, or the right instructions about how to manage when they leave. We will make reducing the frequency that readmissions occur a priority, by making sure that we make the right plans with our patients so that they do not have to come back to the hospital.

6. **Reduction in length of stay.**

This is important because staying in hospital for longer than necessary can be harmful as well as inconvenient. This is especially true for frail and elderly patients who can become very weak in hospital and are at greater risk of falling or getting pressure sores and infections. We will work to make sure that we reduce any delays in hospital waiting for investigations and test results and that when it comes to the time to go home we have planned what is required and made sure that everything is ready at discharge.

Increase 7 day working provision. Emergency services are available every day in the hospital but they are not always the same as during the week. We will work to provide services that are important at weekends as well as week days if this means that our patients don't have to wait as long for their treatment and we will increase the number of senior doctors who are available to look after our patients, especially on our Acute Assessment Ward. This was a priority last year.

To work towards 'paperlight' using information technology and record management in Outpatients. This is important because; implementing electronic patient records and information technology solutions help reduce the amount of time staff spend on administrative tasks. This releases more time for them to provide patient care. It also allows us to introduce systems that support improved patient safety.

Hospital mortality index better than expected. This is a measure that compares results between hospitals. Kingston Hospital has a lower mortality index than many hospitals. We will look at our results in detail and the areas where we can make improvements we will take action to ensure that all areas of the hospital have a low mortality.

Domain 3 - Patient Experience - listen and respond to patients' concerns

7. **To transform administration across the hospital.**

One of the areas that patients and GP's have told us we need to improve on is our administration. This includes such things as how clear patient letters are, and the ease of making and changing appointments. This priority would therefore seek to improve the experience of the Trusts administration processes. This was a priority last year.

8. **Improve end of life care.**

There is only one opportunity to get the care at the end of a patient's life right for both them and their loved ones. This priority would therefore focus on making improvements in the care given to patients at the end of their life and the experience of their loved ones at this difficult time. This was a priority last year.

9. **Improve experience of discharge.**

Ensuring patients are discharged in a planned and timely way, with good communication with external parties is a critical to ongoing patient care. This priority would seek to increase understanding of patients experience of the discharge process and make improvements to that experience. This was a priority last year.

Improving the experience of patients with dementia in outpatient settings. As part of the Trusts Dementia Strategy we have significantly focused on improving the care of patients and their carers within inpatient settings. We will continue to do this, but we know that of the 350,000 patients that attend our outpatient settings each year also have a significant proportion that are affected by dementia. This priority would therefore focus on ensuring patients with dementia and their carers receive a positive experience of our services, and specific actions are in place to address their needs in these settings. This was a priority last year.

Improving the experience of children & young people. The majority of children and young people are seen and treated in specific children & young people's settings. Due to the specific nature of some outpatient and emergency services some children & young people have to be cared for within areas which predominately treat adult patients. For example places such as the Royal Eye Unit, A&E, our x-ray and CT departments, or our dental services. It is important that any child or young person coming to hospital receives the best experience wherever they are seen, and this priority would focus on ensuring this is the case.

Improve the experience of seldom heard groups and/or those with protected characteristics. There are groups in the communities that we serve that are seldom heard or who have additional needs that require specific attention so that our services are equally accessible, they are not disadvantaged or have a poor experience of our services. Examples of this include people with vision or hearing impairment, are lesbian, gay, bisexual or transgender or those from black, Asian or minority ethnic groups. This priority would therefore focus on identifying specific seldom heard and/or groups with protected characteristics that we could work with to ensure a positive experience of our services. If you have specific suggestions of seldom heard groups or those with protected characteristics that you believe warrant the specific attention of the Trust please can you provide below.

Quality priorities for 2016/17

The quality priorities for the forthcoming year are shown below. As well as new priorities we are also continuing to build on achievements in ongoing priorities in sepsis, administration, End of Life Care, reducing vacancies and discharge.

Domain	Priority
Patient Safety	1) Reduce falls in the hospital setting 2) Reduce avoidable harm from sepsis 3) Reduce use of agency staff by reducing vacancies
Clinical Effectiveness	1) Reduce readmissions in non-elective care 2) Reduce length of stay 3) Reduce patient reported pain
Patient Experience	1) Transform administration across the hospital 2) Improve end of life care 3) Improve patient experience of discharge

Domain: Patient Safety

Priority 1 - Reduce falls in the hospital setting

Goal	Aim	Actual Performance (2015/16)	KHT Data Available	Benchmarked/ Comparison
Safety	Prevent inpatient falls: Meet all 7 key recommendations regarding care to avoid falls Achieving no red ratings in the National Inpatient Falls Audit and increase 2015 amber scores to green	National inpatient fall audit results 2015 for Kingston Hospital Red: Scored 0-49% in the following • Dementia and Delirium • Blood pressure • Medication Review • Walking aids • Continence Care plan Amber Scored 50% - 79% in the following • Call Bells • Visual impairment	Yes	National inpatient falls audit results

Measure:

- Increase in the proportion of patients who received assessment/intervention for the 7 key recommendations regarding care to avoid falls.
- Continued monitoring for improvement in the overall inpatient falls rate.

Reference for data source: National inpatient fall audit results

Governed by standard national definitions? NICE guidance and national inpatient falls audit measures

Why we chose this indicator?

Patients over 65 are vulnerable to falling in hospital because of their illness, frailty and the unfamiliarity of the clinical setting. Falls usually delay patient's recovery and confidence and if injuries occur, such as hip fractures in frail patients. The impact of this this can be very serious. By ensuring that the key recommendations of NICE to prevent falls in adults are implemented the number of falls should be reduced. This is important because many of the patient's at Kingston Hospital are over 65 and we need to ensure that patients don't have to spend a long time in hospital and that they are likely to return to their usual place of residence on leaving. NICE guidance on falls prevention has strongly advised that we should not undertake falls assessment but instead identify all patients over 65 to be at risk. This was supported by the findings from the National Audit of Inpatient Falls report 2015 which strongly recommended for Trusts to stop using a fall risk prediction tool and instead put forward 7 'key indicator' recommendations for a multifactorial falls assessment:

1. Dementia and delirium – We recommend that all trusts and health boards review their dementia and delirium policies to embed the use of standardised tools and documented relevant care plans. Falls teams should work closely with dementia and delirium teams (if present) to ensure team working for these high-risk patients.

2. Blood pressure – We recommend that all patients aged over 65 years have a lying and standing blood pressure performed as soon as practicable, and that actions are taken if there is a substantial drop in blood pressure on standing.

3. Medication review – We recommend that all patients aged over 65 years have a medication review, looking particularly for medications that are likely to increase risks of falling.

4. Visual impairment – We recommend that all patients aged over 65 years are assessed for visual impairment and, if present, that their care plan takes this into account.

5. Walking aids – We recommend that trusts and health boards develop a workable policy to ensure that all patients who need walking aids have access to the most appropriate walking aid from the time of admission. Regular audits should be undertaken to assess whether the policy is working and whether mobility aids are within the patient's reach, if they are needed.

6. Continence care plan – We recommend that all patients aged over 65 years have a continence care plan developed if there are continence issues, and that the care plan takes into account and mitigates against the risks of falling.

7. Call bells – We recommend that all trusts and health boards regularly audit whether the call bell is within reach of the patient and embed the change in practice if needed.

How will progress be measured?	Clinical audit and review
How will progress be monitored?	Achievement of the project milestones
Lead Committee	Falls Group
Lead Executive	Medical Director

Priority 2 – Reduce avoidable harm from sepsis

Goal	Aim	Actual Performance (2015/16)	KHT Data Available	Benchmarked / Comparison
Safety	Eliminate all avoidable deaths from sepsis and septic shock, by implementing year 2 of the Sepsis Sign up to Safety plan	Measure lactate levels: 60% Obtain blood cultures prior to administration of IV antibiotics: 68.8% Administer broad spectrum antibiotics: 85.7% (Dec 15) Administer 30ml/kg Crystalloid for hypotension or lactate >4mmol: 33.3%	Yes	No

Measure:

- Improving the recognition and treatment of severe sepsis and septic shock through education and increased awareness. The targets for year 2 are shown below

Sepsis Sign up to Safety Plan targets

Sepsis Six goals within 3 hours	Year 2 16/17 target
Measure lactate levels	70%
Obtain blood cultures	60%
Administer broad spectrum antibiotics	90%
Commence IV fluids	70%

- Medical staff conducting review of patient records (mortality and morbidity review) identifying avoidable and unavoidable deaths

Reference for data source: Clinical Coding data and clinical audit

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

Why we chose this indicator?

Sepsis was a quality priority last year and we made a number of successful improvements. We are now focussing on achieving year 2 of the Sepsis Sign up to Safety plan. Sepsis and septic shock have a high mortality and morbidity. If sepsis is recognised and patients receive antibiotics and fluids early in their treatment the outcome is improved and this will mean saving lives and reducing harm. It is therefore important that all our staff and our patients know about the risk of sepsis. Through education we can increase awareness of the condition and save lives. We have already made improvements and more are planned in the next year.

How will progress be measured?	Via Clinical audit and review
How will progress be monitored?	Achievement of the project milestones
Lead Committee	Clinical Quality Improvement Committee
Lead Executive	Medical Director

Priority 3 - Reduce use of agency staff by reducing vacancies

Goal	Aim	Actual Performance (2015/16)	KHT Data Available	Benchmarked/ Comparison
Safety	Develop and implement targeted recruitment and retention strategies to recruit and retain permanent staff; and reduce the use of agency workers	Reduction in vacancy rates from 14% to 6.28 % between April 2015 and March 2016	Yes	No

Measure:

- Substantive establishment recruited and maintained at 95% supported by 5% temporary staffing.
- Overall reduction in vacancy rates from 7% to 5% and a reduction in turnover. (Targets for each staff group currently under review)

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

Governed by standard national definitions? No

Why we chose this indicator?

This is important because staff who are permanently 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. Staff retention is an essential part of developing staff roles and teams and providing consistent care to patients. High levels of vacancies and extensive use of agency staff can have a detrimental effect on patient satisfaction and staff morale. Increasing the number of substantively employed staff will be beneficial in terms of quality, stability and continuity. As part of the Lord Carter review of efficient use of resources in the NHS, reducing agency costs is important to avoid expenditure which could be reinvested in patient care.

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

Domain: Clinical Effectiveness

Priority 4 – Reduce re-admissions in non-elective care

Goal	Aim	Actual Performance (2015/16)	Benchmarked/ Comparison	KHT Data Available
Effectiveness	Reduce non-elective readmissions following either elective or non-elective care A&E and Acute Assessment Unit (AAU), Respiratory, Trauma & Orthopaedics	Kingston average % A&E and AAU 17.8 Trauma and Orthopaedics 4.9 Respiratory 14.5	Peer average %: A&E and AAU 14.3 Trauma and Orthopaedics 4.3 Respiratory 13.2	Yes *(Updated using CHKS, covers period Apr-15 – Jan-16)*

Measure:

- Reduction in non-elective readmissions following either elective or non-elective care by March 2017 on A&E and AAU, Trauma and Orthopaedics and Respiratory wards (achieve national average).

Reference for data source: Service Line dashboards and CHKS information system

Governed by standard national definitions? Hospital Episode Statistics definitions

We want to ensure that people don't have to stay in hospital any longer than is needed. But we must not send patients home too soon or without the right treatments to continue, or the right instructions about how to manage when they leave. We will make reducing the frequency that readmissions occur a priority, by making sure that we make the right plans with our patients so that they do not have to come back to the hospital. We have chosen these departments as they are the areas when compared to the national average that offer the most opportunity for improvement.

How will progress be measured? Monthly data collection

Audit of discharge plans

How will progress be monitored? Monthly Hospital performance reports and Service Line dashboards

Lead Committee Executive Management Committee

Lead Executive Chief Operating Officer

Priority 5 – Reduce length of stay

Goal	Aim	Actual Performance (2015/16)	Benchmarked/ Comparison	KHT Data Available
Effectiveness	Aim to reduce the length of stay for patients on elderly care, Respiratory and cardiology wards	Kingston average: Elderly Care 18.1 days Respiratory 9.3 days Cardiology 5.0 days	Peer average: Elderly Care 11.2 days Respiratory 5.8 days Cardiology 3.0 days	Yes *(Updated using CHKS, covers period Apr-15 – Jan-16)*

Measure:

- Reduction in length of stay for non-elective care by March 2017 on Elderly Care, Respiratory wards and Cardiology wards (achieve national average).

Reference for data source: Service Line dashboards CHKS information system

Governed by standard national definitions? Yes Hospital Episode Statistics definitions

Why we chose this indicator?

Staying in hospital for longer than necessary can be harmful and disruptive for patients. This is especially true for frail and elderly patients who can become very weak in hospital and are at greater risk of falling or getting pressure sores and infections. We will work to make sure that we reduce any delays in hospital waiting for investigations and test results and that

when it comes to the time to go home we have planned what is required and made sure that everything is ready at discharge. We have chosen these departments as they are the areas when compared to the national average, offer the most opportunity for improvement.

How will progress be measured? Monthly data collection

How will progress be monitored? Monthly Hospital performance reports

Clinical audit of discharge plans

Lead Committee Executive Management Committee

Lead Executive Chief Operating Officer

Priority 6 – Reduce patient reported pain

Goal	Aim	Actual Performance (2015/16)	KHT Data Available	Benchmarked/ Comparison
Effectiveness	To increase patient satisfaction with pain management	Baseline to be established based on previous national survey results -Children and young people Survey 2014: for parents and carers saying they thought staff did all they could to ease their child's pain Score: 8.4/10 -National Inpatient survey 2014: Hospital staff did all they could to help control their pain, if they were ever in pain Score 8.1/10 -Accident and Emergency Survey: 2014: Hospital staff did all they could to help control their pain, if they were ever in pain while in A&E 7.2/10 -Not having a long wait to receive pain relief if requested Score: 5.8/10	No	Yes (Awaiting 2015 results)

Measure:

- Patient satisfaction with pain management during inpatient or emergency care (baseline to be established)
- Pain medication clinical audit results (baseline to be established)

Reference for data source: Patient survey, complaints and clinical audit

Governed by standard national definitions? No

Why we chose this indicator?

This is an area where we can make improvement. We know this because our inpatient and other surveys told us that we do not always recognise and treat pain effectively. This issue has also been raised in complaints. We also know that patients with dementia are particularly vulnerable to not receiving enough pain relief. We will make it a priority to ensure all our staff know how to assess that pain is being managed effectively even when it is difficult for our patients to explain this to us. We will also ensure that we use the most effective interventions to manage pain well.

How will progress be measured? Patient survey

Clinical audit of pain medication

Complaints

How will progress be monitored? Regular reports to the Pain Management Group

Lead Committee Pain Management Group

Lead Executive Director of Nursing & Patient Experience

Domain: Patient Experience

Priority 7 – Transform administration across the hospital

Goal	Aim	Actual Performance (2015/16)	KHT Data Available	Benchmarked / Comparison
Experience	Transform patient administration and the delivery of outpatient services	Admin related complaints 2015-16 =143	Yes	No

Measure:

- 50% reduction in the number of complaints regarding patient administration

Reference for data source: Complaints received, Clinic reports

Governed by standard national definitions? No

Why we chose this indicator?

One of the areas that patients and GP's have told us we need to improve on is our administration. This includes such things as how clear patient letters are, and the ease of making and changing appointments. This priority would therefore seek to improve the experience of the Trusts administration processes. An analysis of our complaints shows that making and changing appointments is an area we need to improve. Improvements have been made during 2015 and it is important that these changes are sustained which is why we are aiming to halve complaints by making the appointment process clearer and easier.

How will progress be measured?

- Monitor complaints via service and type to assess where improvements are being made.

How will progress be monitored? Monthly reports

Lead Committee: Patient Experience Committee

Lead Executive: Chief Operating Officer

Priority 8 – Improve end of life care

Goal	Aim	Actual Performance (2015/16)	KHT Data Available	Benchmarked/ Comparison
Experience	To improve the experience of patients and their relatives of end of life care	KHFT Bereavement survey which was benchmarked against National Audit Survey Results* -Time to listen and discuss condition Doctor Score: 79% (national score was 74%) Nurse Score: 77% (national score was 74%) -During the last 2 days involved in decisions about care and treatment. 'Not involved' score: 16% (national score was 24%) -Explanation of condition: 'Did not explain' score was: 5% (national score was 12%) -Spiritual needs were met by the healthcare team 'Strongly agree' score was : 12% (national score was 13% 'Agree' score was 30% (national score was 22%)	Yes	Yes Care of the Dying Evaluation. National Audit Survey

*Trust used a standard validated self-completion questionnaire developed by Marie Curie: the Care of Dying Evaluation (CODE) survey. Data derived from the annual National

Bereavement Survey 'VOICES' 2013 in which Kingston data is included within overall results, has been used as a indicative benchmark.

Measure:

- Care of the dying survey results
- Improved staff confidence in communicating with patients and carers before, during and following the dying phase
- Improved use of spiritual support services.

Reference for data source: Bereavement survey

Governed by standard national definitions? No

Why we chose this indicator?

End of Life Care was a quality priority last year and we made a number of successful improvements. There is only one opportunity to get the care at the end of a patient's life right for both them and their loved ones therefore it is important that this is an ongoing prirotiy. This priority will therefore focus on making improvements in the care given to patients at the end of their life and the experience of their loved ones at this difficult time as well as supporting staff to provide the right care to patients and communicating effectively with carers.

How will progress be measured? Annual audit of bereavement survey

How will progress be monitored? End of Life Care Steering Group

Lead Committee Patient Experience Committee

Lead Executive Director of Nursing and Patient Experience

Priority 9 – Improve patient experience of discharge

Goal	Aim	Actual Performance (2015/16)	KHT Data Available	Benchmarked/ Comparison
Experience	To ensure that the patient's discharge is timely, efficient and that patient experience is optimised	Delayed Transfer of Care (DTOC) performance was approximately 5.8%	baseline to be developed	Local DTOC target of 4% and national target 2.5%

Measure:

- Reduction in the number of delayed transfers of care and the number of internally reported delays to at least the local target of 4%.

Reference for data source:

- Patient tracking list, feeding into daily DTOC and monthly submission.
- Business intelligence reports on time of discharge home.

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

Why we chose this indicator?

Local and National Healthwatch feedback has highlighted the importance of good discharge practices and the negative impact a poor discharge experience can have on patients and carers.

Discharge planning for many patients is complex and requires not only the timely implementation of medical and nursing care but also collaboration with other internal and external departments. E.g. social care, community nursing services. Transferring home following a period in hospital can cause concern to the patient. It is therefore critical that discharge planning is timely, that communication with patients, families and professionals is effective and that all services are in place before the patient leaves the hospital.

Effective discharge planning ensures that patients are discharged early in the day and that the hospital bed is then made available for another patient, improving patient flow from ED to AAU and from AAU to the Ward. This in turn improves the inpatient experience for the newly admitted patients.

How will progress be measured?

DTOC performance will be measured against the local target of 4%

Patients discharged before lunchtime will be measured

Friends and Family response from the discharge lounge

How will progress be monitored? Monthly DTOC submission

Monthly report on the timing of discharge

Monthly FFT report.

Lead Committee Patient Experience Committee

Lead Executive Chief Operating Officer

Part 3

5.0 Looking Back at 2015 /16

In December 2014 and January 2015 an online survey was conducted to identify the preferred quality priorities of Kingston Hospital NHS Foundation Trust Members and staff and other stakeholders with almost 140 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. We deliberately set challenging targets to further quality improvements for patients.

Last year's priorities:

Domain	Priority	
Patient Safety	- Improved recognition and management of sepsis in hospital	Partly Achieved
	- Implement patient safety elements of Year 2 of the Dementia Strategy	Partly Achieved
	- Reduce use of agency staff by reducing vacancies	Partly Achieved
Clinical Effectiveness	- Work towards paper-light systems using information technology and record management across the Trust	Achieved
	- 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	Achieved
	- Increased provision of 7 day working of key staff and services	Achieved
Patient Experience	- Transform administration across the hospital and make improvements in administration	Partly Achieved
	- Improve patients' and their relatives' experience of End of Life Care	Achieved
	- Improved discharge planning and processes	Achieved

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.

Domain: Patient Safety

Priority 1 - Improved recognition and management of sepsis

Partly Achieved

Goal	Aim
Safety	Eliminate all avoidable deaths from sepsis and septic shock

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 and Clinical Audit

Governed by standard national definitions? Sepsis 6 bundle definitions

Why did we choose this?

This indicator was chosen because sepsis and septic shock are treatable conditions that have a high mortality if not recognised promptly. 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 there are approximately 150,000 hospital admissions for sepsis each year with an average cost of £20,000 for each patient looked after.

What we said we were going to do?

We planned to achieve Sepsis 6 treatment bundle targets for 90% of patients by December 2018. We set a trajectory to achieve delivery in 2015 and each year to 2018. We planned to improve the recognition and treatment of severe sepsis and septic shock by providing education sessions across the Trust to ensure that staff are aware of the signs of sepsis, monitoring uptake by staff group. A coding mechanism would be introduced to facilitate identification and tracking of patients diagnosed with severe sepsis or septic shock in order to monitor compliance with timelines and recommendations for treatment set out in the Sepsis 6 recommendations.

How did we do?

The 3 target trajectory for our Sepsis Improvement plan is shown below

Sepsis 6 treatment bundle

Sepsis Six goals within 3 hours	*Target*	Year 1 target 1516	Year 1 achievement
Measure lactate levels	*95%*	**85%**	60%
Obtain blood cultures prior to administration of IV antibiotics	*70%*	**50%**	68.8%
Administer broad spectrum antibiotics	*95%*	**85%**	85.7%
Administer 30ml/kg Crystalloid for hypotension or lactate >4mmol	*90%*	**70%**	33.3%

In January 2015 we set the above trajectory as part of Sign up to Safety plan. In April 2015 a national CQUIN was introduced for sepsis which concentrated on sepsis screening and the prescribing of antibiotics.

The table below shows progress with further actions to improve recognition and treatment of sepsis

Action	Progress
Educating staff	GP training session held Staff reminded of the Mortality and Morbidity process Training and education programme includes: -Ward based training: Nurses/HCAs – 350 staff trained by Sepsis Nurse Specialist/Outreach Team -Sepsis simulation training – approx 120 staff trained -Training for each F1, F2, CT doctor intake -Sepsis training at nurse/HCA induction -Internal webpage hosts educational material -Posters in departments -Aide-memoire cards for clinicians
Coding of sepsis	Coding mechanism in place
Other actions:	Intranet information site for staff launched External webpage for public being developed

	Case note review of sepsis deaths Clinical guideline produced Competency framework developed with training for nurses to take blood cultures in the A&E Department Trialling of sepsis alert for electronic patient record Trial of designated sepsis nurse, sepsis bag/trolley in the A&E Department

Picture shows Staff in Sepsis simulation training scenario

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

Partly Achieved

Goal	Aim
Safety	Implementation of the patient safety element of year 2 of the Trusts Dementia Strategy: identify and monitor scale of harms (e.g. falls, pressure ulcers, etc) for patients with dementia and set year on year reduction targets for this group

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 did we choose this?

Improving care for patients with dementia is an important issue for Kingston Hospital reflected in the Trust's 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 compared to the national average. Patients with dementia are at an increased risk of harm whilst in hospital, such as falls, pressure ulcers and hospital-acquired infections.

What we said we were going to do?

In year 2 (2015/16) of the Dementia Strategy we planned to set up a system to identify incidents resulting in harm to patients with dementia. A baseline of such incidents was to be established in Q1 with the aim of reducing the rate of harm by 10% in Q 4. The Dementia Strategy Group will utilise these reports along with other measures such as the carers' FFT put in place in 2014/15 to track progress and develop further interventions to drive improvement. A targeted safety improvement programme was planned to be in place by September 2015.

How did we do?

We have put in place systems that enable us to easily identify through incident reports patients with dementia. A dementia score card is being developed to track specific harms alongside other information about patients with dementia including length of stay, late

transfers, re-admissions and discharge destinations. 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.

The incident data that has been collected so far has been analysed to look at which specific harms related to dementia require monitoring. The specific harm identified is predominantly patient falls. From mid-August to November 2015, 47% of incidents featuring dementia were accidents, of which 86 % were patient falls.

This work has already led to a number of improvements. Improvements are being made to toilet signage by painting the doors yellow and replacing signage with large pictorial signs will help patients find the toilet, which can often be a related to patient falls. The proposed improvements to Derwent ward including changes to flooring and lighting will impact on falls rates and falls with harm.

Dementia awareness training taking part across the trust will increase knowledge and awareness of how to assist patients with dementia that may in turn reduce falls with harm.

In addition the following has been achieved as part of year two or the dementia strategy

- Dementia service lead in post –as of Dec 2015
- Increased training provision of dementia awareness sessions
- Analogue clocks put up throughout wards with date and day
- Activities programme further established with full timetable running 5 days a week
- Signed up to John's campaign
- carer feedback sessions

We have only partly met this priority because we did not implement the monitoring until mid-August and therefore could not demonstrate an improvement by Quarter 4. However, now that harms for dementia patients are being recorded and better understood it will be possible to track and reduce these harms, for example by reducing falls. The Trust will continue to build on this work as part of the Dementia strategy year 3.

Priority 3 - Reduce use of agency staff by reducing vacancies

Partly Achieved

Goal	Aim	Agency Expenditure (KHFT data used) (2015/16)
Safety	To reduce agency usage by 10%	£18,009,200 (all staff groups) (15-16) £12,354,000 (14-15) Reduction in vacancy rates from 14% to 6.28 % between April 2015 and March 2016

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? No

Why did we choose this?

Kingston Hospital has to be able to respond to fluctuations in service demand by means of flexible staffing arrangements. The use of agency staff forms a key part of this flexibility; however, reliance on usage of agency staff can be costly. High levels of vacancies and extensive use of agency staff can have a detrimental effect on patient satisfaction and staff morale. Increasing the number of substantively employed staff will be beneficial in terms of quality, stability and continuity. Our own staff are more likely to be familiar with our policies, procedures, Trust values and have access to our programmes of work to improve patient safety.

What we said we were going to do?

We said we would increase recruitment to substantive posts and reduce the requirement to engage agency staff by 10%.

How did we do?

There has been an active recruitment process, including recruiting cohorts of band 5 nurse and nursing assistants, as well as seeking additional staff from overseas to fill vacant posts.

Investments made over the year had a positive impact on recruitment and retention with a significant reduction in vacancy rates from 14% to 6.28% between April 2015 and March 2016 and a small reduction in turnover. Investments included international recruitment campaigns, more practice development nurses to support new recruits, the Kingston Positivity Programme and training on a coaching approach to 1:1s and appraisals.

There is now an improved induction programme, including a buddy system, and feedback is sought from new starters to further improve service. In addition to filling vacant posts, there has been work to increase retention of existing staff by improving training, development and career opportunities, plus staff satisfaction and motivation. A positivity programme was launched and attended by 150 staff, and the inaugural #TeamKHFT Annual Awards were held.

Agency use is still a challenge, safe staffing numbers need to be maintained on the wards. Although we have not made the progress we had hoped in reducing temporary staffing usage, primarily reflecting substantive recruitment challenges and agency pricing issues effecting the NHS more widely, we have managed to reduce the amount we spent on agency staffing during the year. For the first half of the year we spent, on average, £1.6m per month on agency staffing. This average reduced to £1.4m per month for the second half of the year, a reduction of approximately 7%. The Trust is committed to reducing agency use and this will be a priority again for 2016/17.

The following activities have been undertaken to support recruitment:

- Linking with local partners
- Wholesale redesign of the in-house recruitment process in 2015/16. This has improved efficiency and improved lead times to recruit
- Ongoing investment in international recruitment which yielded significant numbers of new nurses in 2015/16
- A recently developed predictor tool which enables service lines and corporate departments to forward-plan recruitment, dovetailing with a range of incentives and bespoke approaches to help with recruitment of hard-to-fill post. Established vacancy control panel to ensure a reduction in agency spend and temporary staffing usage overall.
- Further investment is planned for e-roster roll out to ensure all staff are on the system and are rostered.

Domain: Clinical Effectiveness

Priority 4 - Work towards paper-light systems using information technology and record management across the Trust

Achieved

Goal	Aim
Effectiveness	Increase the amount of time nurses have available to spend with patients by introducing electronic recording of vital signs

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 the patients deteriorating condition

Reference for data source: Audit of patient safety alerts, system reports

Governed by standard national definitions? No

Why did we choose this?

The implementation of electronic patient 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. This application enables nurses to electronically record patient's vital signs observations at the bedside in real time. An alert mechanism enables medical and critical care teams to respond to deteriorating patients allowing for swift intervention and treatment.

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.

What we said we were going to do?

The initial scope of this project will focus on releasing nursing time to care and reducing the amount of time nurses take to obtain and record patient's vital signs. The system will cover 100 beds at the Trust initially, based on the funding secured via a national bidding process to support nurses' use of information technology to improve patient care.

We will establish a baseline prior to implementation of the project and set an improvement trajectory which will enable us to demonstrate reduced human error in recording vital signs and reduced time taken to respond to a deteriorating patient's condition.

How did we do?

During 2015 Kingston Hospital introduced new equipment the wards that enable patients' vital signs such as blood pressure and temperature to be recorded electronically. This is to help further improve patient care and free up nursing time so they have more time to spend with patients'.

The new Vitals Devices (Welch Allyn's) allow staff to send data when taking observations straight into an electronic patient record system called Care Records Service (CRS), the Trust's electronic patient system. This has allowed key nursing time to perform other tasks and improve the speed at which data is available to the clinical teams to review.

Staff can make faster decisions as they are alerted to abnormal and accurate readings immediately. The margin for error is greatly reduced by removing the need to transcribe information. The response from staff has been very positive.

As part of the roll out of the system the time saved has been monitored, and an average of 1.5 minutes of nursing time is saved for each set of observations taken on a patient. Based on the number of observations taken in one month (n=9,000) across these three wards, 225 hours of nursing time has been released in one month from this systems implementation.

With the deployment of the clinical record system (CRS) nursing documentation, has allowed focus on alternative methods of auditing the information directly from the system. The purpose of this is to release time from nurses collecting and inputting audit data. Since October 2015 the monthly documentation audit is now undertaken directly from the system.

We plan to extend this system into A&E during 16/17, and other areas as funding allows.

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

Achieved

Goal	Aim	Actual Performance (KHFT data used) (2015/16)
Effectiveness	To have a committed, skilled and highly engaged workforce who feel valued, supported and developed working together to care for our patients	88% Appraisal completed 86% Mandatory training (as of w/c 23.02.16)

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 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 2016
- 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? Yes

Why did we choose this?

The annual Staff Survey in 2014 demonstrated a reduction in employee engagement compared with previous years. Information from exit interviews, 100 day new starter surveys and the views expressed in "conversations with the Board" identified that development and recognition are important issues for staff.

Staff who are regularly trained and updated in core subjects (Mandatory Training) are better equipped to deliver safe care.

Giving feedback regarding performance, setting objectives, and creating personal development plans all lead to better staff engagement. Regular appraisals and one to one discussions with managers can improve staff commitment. This is a crucial part of our campaign to 'make a difference' and encourage positivity in staff.

What we said we were going to do?

80% of staff to have had an appraisal, agreed objectives and a personal development plan (PDP) by the end of September 2015 and 95% by the end of March 2016.

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

80% of staff will be 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.

How did we do?

We have achieved 86% total trust compliance for Statutory & Mandatory training by the following:-

- Compliance reporting available for all to view via the intranet. Individuals and managers are able to view compliance for all Statutory & Mandatory subjects.
- Dates available for the whole of 2016 for face to face classroom sessions of Pt manual Handling, Resuscitation, Fire and Conflict resolution.
- Specific 3 in1 sessions available for Manual Handling, Basic Life Support and Fire to allow staff to be released in one go
- Consultant specific session dates available throughout the year to allow for planning and reduction in clinic cancellations
- Training delivered within departments particularly specialised areas and training on governance protected time.
- Education Centre and HR Business Partners are working with service lines to monitor compliance and actions around low compliance
- Flexibility with training sessions and trial of different times/days

Mandatory training materials have been reviewed so that it is now delivered via various media (online, face-to-face and booklets**)** to improve accessibility and target resources to staff groups. Face-to-face training is delivered flexibly to enable front-line staff to attend whilst maintaining continuity of patient services.

We have achieved 88% for appraisals completed which is above target. We have been encouraging staff and managers to see the benefits of receiving feedback and having clear objectives as part of the appraisal process.

There are some very encouraging scores in our 2015 Staff Survey results showing an increase in the number of staff feeling that their immediate manager values their work and staff agreeing that their manager gives clear feedback on work. We attribute this to the following:

- All existing and new managers are encouraged to attend the Coaching Approach for one to ones and appraisals workshop; nearly 400 managers have already attended this workshop.

  There has also been active involvement by the HR Business Partners to ensure that each Service Line achieves their key performance indicators.

Unfortunately we could not measure any improvements in staff who say their appraisal left them feeling valued, as this question was changed in the staff survey. Therefore there are no comparable results available for this year in the national survey to this specific question. We have as a corporate objective to improve the day to day experience of staff at Kingston during 16/17.

Priority 6 - Increase provision of 7 day working of key staff and services

Achieved

Goal	Aim
Effectiveness	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) To have consultant ward reviews, every day, on every ward (including the acute assessment unit)

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

Benchmark: London Quality Standards audit results

Why did we choose this?

The Trust is making a significant investment in seven day working to ensure patients get the same level of care irrespective of the day of the week. To date, mortality of patients admitted at the weekend has been higher than that of patients admitted on a weekday. We also know that reviews of patients by senior doctors with the support other healthcare professionals and access to diagnostic tests would make the patient's stay more efficient and would probably reduce the time that a patient spends in hospital.

Fewer patients are discharged at the weekend making the hospital very busy at the beginning of each week with few empty beds; this slows down transfers out of the Emergency Department and makes the four hour standard very difficult to achieve.

What we said we were going to do?

This investment will enable consultant ward reviews seven days a week for all patients in the hospital by the end of the year. We will have increased numbers of therapists and pharmacists working in the hospital at the weekend as well as other support staff who are vital to achieving the right standards of care every day. Analysis of medical staff job plans will be undertaken to ensure daily ward reviews are included in the work profile for staff. Length of stay on inpatient wards will be monitored (including comparison of weekday and weekend admission/discharge rates).

How did we do?

During 2015/16 the Trust made some essential investments in quality which, alongside a review of staffing structures and adjustments to job plans, supported progress against achievement of the London Quality Standards including the delivery of 7-day services. The full year effect of a number of these initiatives will be realised in 2016/17. Initiatives include:

- Recruitment of 3 Emergency Surgeons to deliver improved emergency services, ensuring quality standards are delivered;
- Introduction of a dedicated 24/7 emergency surgeon rota;
- Recruitment of paediatric consultants providing consistent presence between 8am and 10pm every day. This enhanced consultant paediatrician cover also provided greater support to neonatology;
- Enhanced consultant geriatrician cover including surgical and elderly care patients undergoing orthopaedic procedures;
- 24/7 intensive care outreach from September 2015 and enhanced intensive care consultant cover enabling review of patients every 12 hours from January 2016;
- Enhanced consultant cover on the Acute Assessment Unit;
- Strengthened junior doctor arrangements and introduction of physician assistants on the medical wards;
- Enhanced consultant obstetric cover enabling 118 hours consultant presence per week from March 2016 and additional midwives to deliver a ratio of 1:30.5 midwives to births;
- Weekend pharmacy cover on the Acute Assessment Unit enabling early review of medication requirements and supporting 7-day multidisciplinary review;
- Weekend therapy support on the inpatient wards, enabling treatment plans to be in place within 24 hours and supporting 7-day multidisciplinary review;
- 7-day consultant radiologist presence in place since January 2016 with extended days during weekdays and outsourcing of CT reporting out of hours.

The Trust will continue to work towards the delivery of 7-day services with plans summarised below:

- Recruitment to vacant consultant geriatrician posts (stroke and general);
- Business Case and request to Macmillian for funding to progress to on-site 7 day palliative care provision from current 6 day a week provision.
- Review of staffing structure and job planning to support 7-day consultant cover on the medical wards.

Domain: Patient Experience

Priority 7 - Transform administration across the hospital and make improvements in administration

Partly achieved

Goal	Aim	Actual Performance (KHFT data used) (2015/16)
Experience	Patient letters and GP letters (discharge summaries & clinic outcomes) are sent in a timely fashion to support on-going care Patients find it easier to contact the Trust regarding their care and treatment	**2015/16 Total complaints 465** 2014/15 Total complaints: 472 **2015/16 Admin related complaints: 143** 2014/15Admin related complaints:113 **2015-16 Clinic letters (percentage of letters completed within 10 working days): 93.42%** 2014-15 Clinic letters: 84% **2015/16 Discharge summaries (sent to GPs following Day Surgery or Inpatient Episode, within 48 hours of discharge): 71.96%** 2014-15 Discharge summaries: 70% **2015/16 Discharge summaries (sent to GPs following A&E attendance, within 24 hours of discharge): 93.93%** **2015/16 Calls Answered: 82.49%** 2014/15 Calls Answered:74%

Measure:

- 30% reduction in the number of formal complaints a relating to
- administration
- >=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, Performance data, Call centre activity data

Governed by standard national definitions? No (benchmark data not available)

Why did we choose this?

It is recognised that Trust has faced significant challenges in establishing consistently excellent and sustainable approaches to patient administration. Following devolution of team structures out to the service lines in the autumn of 2013 there is still a high level of complaints regarding our administrative processes and the impact this has on patient experience.

What we said we were going to do?

We will build on work commenced in December 2014 with a new approach targeting the underlying issues to improve staff engagement and cohesion across multiple work streams.

A range of indicators have been established to monitor progress. We have chosen to monitor the following three areas:

- Patient experience as an indicator of improved administrative processes

- Letter and discharge summaries turnaround times as an indicator of both more effective processes and improved clinical effectiveness

- Effectiveness of call handling as an indicator of improved access for patients.

How did we do?

We improved on Calls Answered in person due to the successful implementation of the trusts new telephony system. There has been a number of changes within the administration team which has included role definition, reallocation of roles and responsibilities into the service lines. Now this change is imbedded we expect to see a reduction in the number of complaints relating to administration (current data shows the trend is reducing). Overall we have not reached our target with discharge summaries. Some areas are doing well such as A&E, however, work needs to continue with areas that are not meeting the target. We had expected to meet the clinic letter turnaround target, however, there have been a number of workforce challenges which delayed progress. Currently we are running a number of recruitment events and are optimistic this will make a significant improvement.

The Trust did not manage to reduce the number of complaints concerning administration, although the number of PALS contacts regarding administration has seen a reduction in year. A breakdown of the type of complaints for admin shows appointments are the main issue. Reducing complaints regarding appointments is a priority for 2016/17.

Type of complaints about administration

Top 3 Subjects	Total
Appointments	73
Communication (Incl. Consent)/information	26
Tests / Investigations	16

Top 5 Sub-Subjects	Total
Unhappy with appointment bookings	16
Appointment cancellation	15
Delay in appointment being allocated	15
Poor communication with patient, relative or carer	10
Test results / reports - failure / delay to receive	10

Priority 8 - Improve patients' and their relatives' experience of End of Life Care

Achieved

Goal	Aim
Experience	To establish a series of improvements for patients and their relatives based on their experiences and feedback

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

Benchmarks and KHFT data available

Reference for data source: Bereavement survey

Governed by standard national definitions? No

Why did we choose this?

End of Life Care helps people who are approaching death to live as well as possible until they die, and to die with dignity. It also includes support for their family or carers and includes palliative care. 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.

What we said we were going to do?

Following analysis of the themes identified by patients and their carers we planned to make improvements in the following areas by August 2015

- 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 did we do?

In a drive to gather representative feedback regarding the quality of care and level of support provided to the patient and their relatives or friend, the Trust used a standard validated self-completion questionnaire developed by Marie Curie: the Care of Dying Evaluation (CODE) survey. Data derived from the annual National Bereavement Survey 'VOICES' 2013 in which Kingston data is included within overall results, has been used as a indicative benchmark however caution must be exercised when drawing conclusions given the low response rates relevant to KHFT.

The anonymised CODE survey was sent to relatives/friends during October to December 2014; 2 months or more following a death. 239 (61%) relatives / friends agreed to participate in the survey with 80 (34%) questionnaires completed. Quantitative and qualitative data can be drawn from the CODE survey.

Care received from the nurses and doctors

Respondents were asked about the general care the patient received from the doctors and nurses and the environment in which this care was delivered. The questions apply to the last **two days** of his/her life and related to the doctors and nurses (including healthcare assistants and / or care agency staff) who were most involved with his/her care during this time. Overall the above results compare similarly with the National survey results. The results indicate

Benchmarks:

- A better experience with both Nurses (3% higher than the national average; 77% vs 74%) and Doctors (6% higher than the national average; 79% vs 73%) having time to listen and discuss their condition
- More people (8% higher than the national average; 68% vs 76%) said they had confidence and trust all the time in the Doctors caring for them.
- The Trust is not doing as well as other trusts regarding the privacy of the surrounding bed area (4% lower than the national average; 73% vs 77%)

Feedback from both the National Bereavement, Voices and a following adapted VOICES survey yielded a low return of 12% (n=18). Feedback was significantly higher when applying different methodology using a standard validated self-completion questionnaire developed by Marie Curie: the Care of Dying Evaluation (CODE) survey. The response rate form the CODE survey sent in Q1 2015 was 34% (n=80)

The control of pain and other symptoms
Respondents were asked their opinions regarding the management of symptoms the patient may have had and the care received during the last two days of his/her life. Local results are similar to the National audit, with slight improvement in symptoms managed all the time. Symptom control, however, remains an important area to focus on to improve overall experience for patients.

Communication with the healthcare team
Respondents were asked about the communication that they, their family members and friends received from the healthcare team who were most involved with his/her care in the last two days of his/her life. Overall the results compare favourably with the National audit with higher levels of satisfaction for explanations from the Healthcare Team. More people felt very involved with decisions about their care and treatment compared to the national picture.
The emotional & spiritual support provided by the healthcare team

Respondents were asked about the emotional and spiritual support that was provided to them and their family member or friend by the healthcare team in the last two days of his/her life. Overall the results equate to the national picture, however aaccess to Spiritual support in the Trust is one of the themes identified from the written comments from respondents. The Hospital Charity has approved in early 2016 an additional Chaplaincy post to support increased access to spiritual support. Recruitment to this is underway

Overall Impressions
Respondents were asked about their overall impression of the care the patient received in the last two days of life and their experiences during that time. Generally all comments were positive such as;

"The treatment and care received at Kingston was absolutely excellent. I cannot envisage how it could possibly have been better. The doctors and nurses were all absolutely superb. I shall never forget them and will always hold them in the highest regard."

Themes drawn from comments demonstrate there remains some variation in care and a continued need for improvement around general communication skills, communication around specific sensitive issues such as nutrition and hydration and communication

A detailed action plan is now being implemented which includes extending a targeted ward based teaching programme and an updated Individual Nursing Care Plan for dying patients which aims to provide a framework to support nurses to care better for dying patients.

Priority 9 - Improved discharge planning and processes

Achieved

Goal	Aim
Experience	Improvements in multidisciplinary assessment of complex patients

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 did we choose this?

This priority is based on implementation of the London Quality Standards. It focuses on improving multidisciplinary assessments for the complex patient and safe, timely and appropriate discharge from hospital for all patients. This builds upon the 2014/15 7 day working CQUIN to improve standards, patient outcomes and experience. Primary, community and social care partners are recognised as key to the delivery of consistently high quality discharges 7 days a week, therefore our Community partners have a similar CQUIN to support the integration of discharge teams and processes.

What we said we were going to do?

By Q4, there will be prompt screening of all patients with complex needs by the multidisciplinary team (including physiotherapy, occupational therapy and pharmacy).

By Q 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)

How did we do?

We have achieved both objectives. We have developed a tool called the Patient Tracking List Tool, which allows us to manage every “wait” a patient has, from the start of acute treatment until they are discharged as either a simple or complex discharge.

These plans are developed on the arrival on the ward, and are updated daily as a result of the daily patient (RAG) round. The DISCO IT system shows the discharge status of patients day-to-day and so used on the wards and at the daily bed meeting. It is also informs the weekly review of all “stranded” patients (i.e. whose length of stay is over 7 days) and at the weekly Delayed Transfer of Care discussion and agreement meeting with our health and social care partners. When estimated discharge dates have not been identified there will be clear reason/plan (with a review date) to ensure one is determined as soon as possible.

We recognise there is more to do in improving the experience of discharge and we are pleased this is a quality goal for 16/17.

6.0 Other Improvements to Quality of Care at Kingston Hospital

In the course of selecting our priorities and indicators 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. For this report we have chosen to summarise our improvements within the 5 CQC domains – safe, effective, responsive, caring and well led.

Safe

Sign up to Safety

Sign up to Safety is a national patient safety campaign. Kingston signed up in December 2014, submitting 3 Safety improvement Projects. Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty. The Trust is implementing 3 safety projects:

1. Eliminate all avoidable deaths from severe sepsis and septic shock by December 2018. 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.
2. Reduce avoidable, hospital acquired grade 2, 3 and 4 pressure ulcers by 10% by March 2018.
3. Reduce harm by introducing intrapartum fetal wellbeing assessment and management in high risk pregnancy

Maternity

The unit is taking part in Sign Up to Safety (SUTS) and aiming to reduce harm by introducing intrapartum fetal wellbeing assessment and management in high risk pregnancy
Two dedicated fetal surveillance midwives are running a project to provide enhanced teaching on Cardiotocography (CTG) interpretation. The aim of the project is to reduce poor outcomes related to misinterpretation of CTGs and to increase staff competency in CTG interpretation.
Progress so far:

- Successful bid submitted to NHSLA to secure funding for 1 year in the region of 250k.
- Audits and case note reviews completed.
- The maternity SUTS team have organised 2 Master classes and 120 midwives in total so far have attended.
- Development of competency Assessment for all staff.
- Weekly CTG reflection workshop held for all members of staff. Lunch and refreshment is provided to encourage staff to attend.
- Bed side teaching on daily basis to increase knowledge of interpretation of CTG.
- Reflection and reviewing performed on daily basis by SUTS midwives of cases with admission to the Neonatal Unit and emergency deliveries.
- There is daily teaching of the band 7 midwives in the unit.

Pressure Ulcer Prevention

No patient should develop pressure ulcers whilst in hospital and there has been a number of initiatives nationally and locally to prevent avoidable pressure ulcers over the past few years. Pressure ulcer prevention is one of the Trusts Sign up to safety improvement projects. The aim of the project is to reduce avoidable, hospital acquired grade 2, 3 and 4 pressure ulcers by 10% by March 2019.

- The pressure ulcer strategy (pictured below) was launched on the 19th November 2015 on International Stop Pressure Ulcer Day. A stand was set up at the main entrance Patient Information leaflets were available and were given out to staff and members of the public with verbal explanation about pressure ulcer prevention.
- Diagrams of the stages of pressure ulcers were also displayed on the display boards Patient Information leaflets have now been distributed for use on the inpatient wards.
- Pressure Area Management Policy and the Wound care Policy reviewed.
- A new Pressure Ulcer Investigation form has been devised which is used for all stages of ward acquired pressure ulcers.
- Training continues on the use of incontinence products in adult inpatient wards.
- The wound care study days have been re-commenced. They are running in December, and January and then every 2 months thereafter.
- Ward based training has commenced on Derwent ward. Hourly sessions cover identification and categorisation of pressure ulcers, preventative measures, identification of moisture lesions and accurate documentation. Training planned for AAU.

The impact of the work has been significant with an overall reduction in grade 2 pressure ulcers by 42.3%, and no stage 4 pressure ulcers reported in 2015 -16, compared to 3 in 2014 – 15.

The pressure ulcer strategy

Quality Improvement Projects

The Trust's Quality Improvement Project programme has continued to grow during the year, with progress monitored through the Quality Improvement Working Group. The programme includes the Trust's three Sign Up to Safety projects, as well as other topics led by various clinical teams.

One project completed this year concerned the prescribing of oxygen. A national clinical audit had shown that Kingston Hospital, along with most other hospitals in the country, did not always write a prescription for oxygen when required. This is important since oxygen is a drug and oxygen levels should be carefully monitored to ensure patients received neither too much nor too little oxygen. The project, led by a Consultant Respiratory Physician, entailed writing a new oxygen policy, providing education and training to clinical staff and producing visual reminders, such as 'oxygen magnets' for the patient's bed space. Our national clinical audit results have risen from 15% in 2013 to 66% last year. Oxygen prescribing is still being monitored to ensure that our results improve even further.

Duty of Candour

The Trust asked the internal auditors to carry out an audit of Duty of Candour to assess the systems we have been put in place, When patients have been harmed during care this is recorded on our incident reporting system and triggers the Duty of Candour process. Patients will receive an apology and then feedback on why this happened and support with aftercare and follow up. More guidance for patients and staff is now being developed to support patients through the process and ensure staff understand how to keep patients informed during an investigation.

Effective

CHKS Top 40 Hospital Award

In May 2015 the Trust was named as a CHKS Top 40 Hospital for the 15th year in a row, and is the only Trust to have achieved this.

Intensive Care Unit

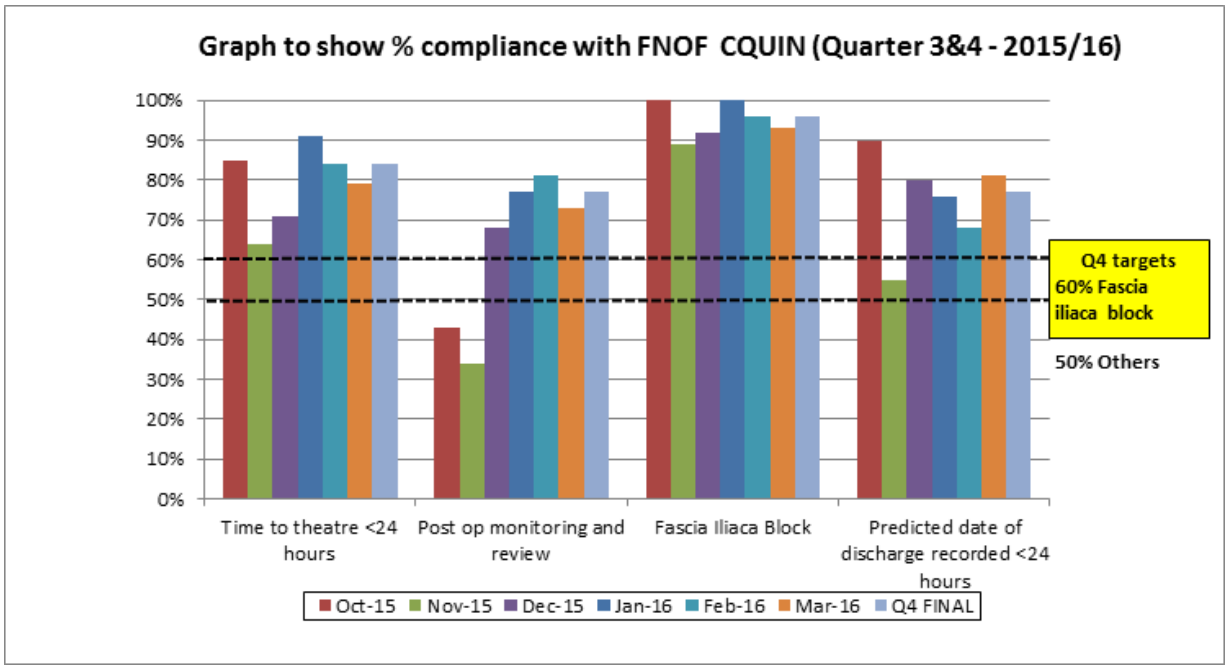
Within the Intensive Care Unit, a passive exercise machine has been introduced and provides early implementation for this group of patients and has reduced their length of stay.

During the autumn of 2015 the Trusts Outreach team was expanded to provide a 24 hour, 7 day a week service. This means patients who are identified as requiring additional support, due to deteriorating observations, have access to a critical care nurse 24/7. This enables a more rapid review of deteriorating patients and support to ward based staff.

Hip fracture pathway improvements

Trauma & Orthopaedics has worked to improve the hip fracture care pathway. On admission to the Emergency Department, patients will be routinely offered fascia iliaca block (FIB is a local anaesthetic block to reduce pain) as soon as possible after diagnosis of a hip fracture. Each emergency fractured neck of femur operation will be prioritised on a planned emergency trauma list and the operation undertaken within 24 hours of admission or diagnosis; and an estimated discharge date will be set within than 24 hours. Post operatively all patients will have hourly National Early Warning Scores (NEWS) for the first four hours, and will be reviewed by a doctor and the nurse in charge, within 4 hours of their return to the ward. Following implementation of our hip fracture pathway improvements the results in Quarter 4 were:

- 96 % of patients were offered an FIB.
- 84% of patients had their operation for their hip fracture within 24 hours .
- 77% of patients were received hourly NEWS and a review at 4 hours.
- 77% of patients had an estimated discharge date set.



Smoke Free Site

During 2015 we the Trust went Smoke Free across the site. It was important that we provide support to staff, patients and visitors via smoking cessation clinics and availability of treatments like Nicotine Replacement Therapy. Inpatients now have quick access to treatment and are offered a referral to a stop smoking specialist on discharge. The wards also stock nicotine replacement products. We worked closely with the Royal Borough of Kingston and the local community to ensure residents were informed and their concerns addressed. Where there used to be a smoking shed there is now a bike shed. We will build on this positive development to further promote healthy choices to staff, patients and visitors.

Caring

Dementia

In January 2016 the Alzheimer's Society launched its report 'Fix Dementia Care Hospitals' report from the Trust. Within the report the Trusts work on its dementia strategy and the subsequent changes that had been implemented were featured as a case study of good practice.

Picture of an Activities Session

End of Life Care

The End of Life Care team were one of the first to respond to the withdrawal of the Liverpool Care Pathway and developed a plan which informed the national approach to nursing and care at the end of life and has been adopted by a number of other organisations. The teams were shortlisted for a National Patient Safety award in July 2015.

Whose Shoes

The Trust has continues to hold Whose Shoes workshops during the year, to focus on improving the experience of patients and staff. This has included sessions in maternity, theatres, pediatrics and the day surgery unit.

Children & Young Persons survey

The National NHS Children's and Young person's (CYP) Inpatient and Day Case Survey 2014 at Kingston Hospital NHS Foundation Trust undertaken by the Picker Institute key findings showed:

- 91% of parents rated care 7 or more out of 10
- 93% of children and young people rated care 7 or more out of 10
- 90% of parents felt their child (aged 0-7 years) was always safe on the ward
- 89% of children and young people (aged 8-15 years) always felt safe
- 58% of parents of children aged 0-7 years stated there were definitely appropriate things for their child to play with on the ward, whereas 30% of young people aged 12-15 years felt there was a lot for their age group to do,
- 81% of parents always had confidence and trust in the members of staff treating their child (0-15 years)
- 88% of parents stated they were always treated with dignity and respect by the people looking after their child (0-7 years).

The survey results showed that the majority of our results were in line with the average for other trusts; with the following areas being significantly better than the Picker average in that the staff were always available when child needed attention, members of staff caring for the CYP worked well together as a team, staff were friendly and that parents felt they were listened too. Areas for improvement where our results were worse than the Picker average were that children did not completely like hospital food and Young People were not fully involved in decisions about their care and treatment.

The actions we have taken in response to this survey are that we have implemented a new menu with Children and Young Peoples involvement. A local charity have provided funding to refurbish the teenage room on the inpatient ward and free Wi-Fi is now available for all CYP in the Paediatric inpatient ward. We have actively engaged with Kingston Health Watch and a Young person's group have visited the Paediatric inpatient and A&E areas to provide feedback. FFT CYP questions are available, ensuring we are now receiving the feedback from CYP about their care. We have an established trust wide CYP board with representation from a young person a parent and all areas that see and treat children and young people.

Maternity Survey

The findings of the maternity survey for women who gave birth in February 2015 reported back in December 2015. As in previous surveys, Kingston Maternity unit was ranked the best in London for labour care. There are some areas which require improvement, particularly around continuity of care from the same midwife throughout pregnancy and the post natal period. An action plan has been developed which has been shared with the Maternity Services Liaison Committee. The ante natal and community midwifery teams have

been reconfigured to offer more continuity and further work is planned around IT access in community clinics and children centres to enhance continuity for women and midwives.

Neonatal Survey

The Trust commissioned Picker to undertake a survey of the experience of parents within the neonatal unit at Kingston Hospital. In response to this improvements have been made to the breast feeding facilities on the Neonatal Unit. Headphones are now available for parents during ward rounds, which allow parents to stay with their babies, and protect confidential discussions with other parents.

Responsive

Improving the hospital environment

In line with the Trusts estates plan, there has been continued development of the hospital for the benefit of patients and staff. One of the most significant of these projects was the complete replacement of the windows in Esher Wing. This has improved the experience of patients and staff in this building through better temperature control and the aesthetic created.

The 'Daisy room' was, thanks to charitable donations, opened in year. This provides a dedicated bereavement suite in the maternity unit.

Thanks to the work of Momentum the paediatric A&E waiting area has also been redecorated to create a friendlier environment for children & young people. Work has also commenced on the children's area of the Royal Eye Unit. This is part of improvements which are being taken forward as a result of the Trusts Children & Young Peoples Board, focus on improving care for children & young people wherever they are seen within the Trust.

The refurbishment of the main outpatients department is underway and unfortunately delays to the building programme have meant it was not completed in 2015/16 as planned. The new department will include a completely redesigned waiting area and a new location for phlebotomy to help improve the patient experience. This will open in 2016/17 and enable a better experience for patients using this service. The new purpose build transport lounge opened in March 2016 enhancing the experience of those patients waiting transport.

In April 2015 the Paediatric Assessment Unit (PAU) opened providing a 7 day service from 8am to 12pm each day.

Cancer

The Trust has made significant improvements in its cancer waiting time performance during 2015/16. In the last 4 months of 15/16 we have consistently been above the national average for 62 day treatment (2week wait) performance and currently (April 2016) the best performing Trust in London, on this indicator. We had no hundred day breaches for five consecutive months, which no other Trust in South West London achieved this.

Within the breast, dermatology and plastics services there has been significant improvements in the waiting times for patients with suspected breast cancer and the Trust is

now meeting all the national cancer waiting times targets. The department has also appointed Advanced Nurse Practitioners as part of service redesign.

Cancer targets

User involvement: We have re-invigorated our Cancer Service User Group and meet bi monthly with a number of ongoing projects including:

- Reviewing new cancer patient information
- Assisting with real time feedback
- Improving the Website
- Participating in the build and design of a Hematology Day Unit in the William Rous Unit

Indicator	Standard	2015/16 Performance	RAG*
All cancers: 62-day wait for first treatment from:			
- urgent GP referral for suspected cancer	greater than or equal to 85%	90.7%	
- NHS Cancer Screening Service referral	greater than or equal to 90%	97.7%	
All cancers: 31-day wait for second or subsequent treatment, comprising:			
- Surgery	greater than or equal to 94%	98.6%	
- Anti cancer drug treatments	greater than or equal to 98%	100%	
All cancers: 31-day wait from diagnosis to first treatment	greater than or equal to 96%	97.4%	
Cancer: two week wait from referral to date first seen, comprising:			
- all urgent referrals	greater than or equal to 93%	95.3%	
- for symptomatic breast patients (cancer not initially suspected)	greater than or equal to 93%	95.0%	
Data source: National Cancer Database			

**RAG stands for Red, Amber Green*

Complaints

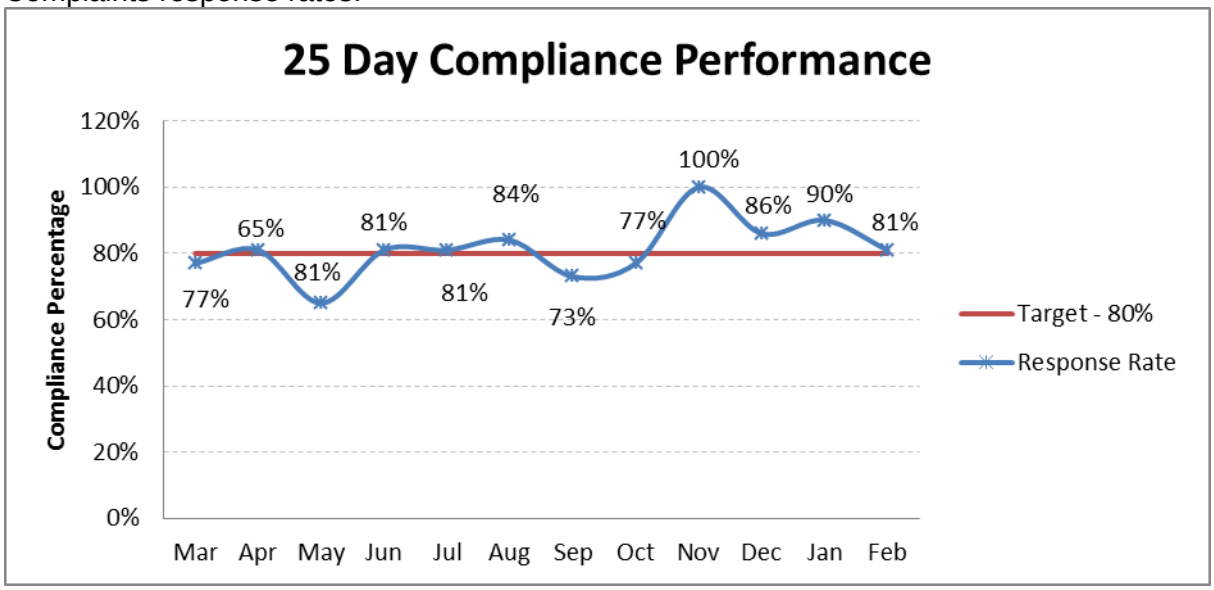
There has been a slight decrease in complaints during 2015/16 as shown in the table below.

Total complaints 2015-16	Total complaints 2014-15
465	**472**

We recognise that swift action is key to resolving complaints and, as such, we endeavour to respond to all complaints within 25 working days, or by the timeframe agreed with the complainant. There has also been a significant and sustained improvement in our response

rate, and the overall compliance for 2015/16 is currently 82%. *(excluding March 2016 as the response rate cannot yet be measured for the complaints received in March 2016).*

Complaints response rates:



Patient and Public Involvement Strategy 2016-18

Following a further period of engagement with key stakeholders the Strategy has been refreshed for 2016-2018. The refreshed strategy adds two further pledges to reach marginalised groups and help the public to navigate the multiple ways they could be involved with the Trust. Specific reference had been made to the importance of working with Healthwatch to support reaching marginalised groups particularly.

The PPI functions had been defined to assist understanding but also to identify further focus for groups with no voice or seldom heard. The six pledges from the previous strategy had also been updated and an additional pledge added.

Healthwatch Enter and View Visits 2015-16

We work closely with Healthwatch Kingston, Richmond and Wandsworth. A number of Enter and View visits by Healthwatch Kingston have taken place during 2015-16. A summary of the main findings, recommendations and actions are shown below:

Emergency Department (ED) - March 2015
The main focus of the visit was the patient's experience of the emergency department. This covered waiting times, reasons for attending, communication and quality of care. The overall feedback the Trust received was positive, with a view to return to the department within 6-8 months. Main recommendations included::

- Clear signage
- Information about waits
- Access to alternative toilet facilities

Actions taken following the visit include:

- Signage improved highlighting where alternative toilets can be found within the department.
- Introduction of clear information on expected waiting times on the ED Reception's patient information screen.
- Monitoring of hand sanitizers in the cubicles to ensure they are available.

Two further visits took place (one day/one evening) 25th & 26th February 2016 in the Emergency Department Reception and Minors. Again the overall feedback was positive and the recommendations from these visits are being devised into action plans.

Royal Eye Unit - July 2015

The focus of visiting the Royal Eye Unit (REU) was to gain an insight into the service being provided and how it is experienced by patients. Representatives from Healthwatch gathered information by talking to patients, completing patient questionnaires and recording observations about the environment. The overall feedback was positive. The main findings were:

- 87% of patients said their communications about appointments had been efficient. Patients commented they were happy with the timing of the letters they received and the information was clear.
- All of the patients asked said they found the reception staff and nurse they saw friendly and helpful.
- The majority of patients asked said the waiting area was comfortable and pleasant.

Main recommendations included:

- Clear communication with patients in reception.
- Communicate name and role to patients.
- Signage for the visually impaired.

Actions taken following the visit:

- A hospital wide project is looking at how we can improve signage for our visually impaired patients and visitors.
- The development of a volunteer network within the unit.

Paediatric wards and Paediatric Emergency Department - August 2015

The visit was led by children and young people. They were impressed by the wards and departments in terms of the decor, the cleanliness, the staff and the facilities. They were keen to give feedback on the new food menu and agreed that the new graphics were eye catching. The introduction of a more snack-based lunch option was popular.

The main recommendations following the visit were:

- Provide a more comfortable temperature on the wards and entry areas
- Improve lighting where possible in darker areas
- Provide newer toys to replace those that are old and dated
- Ensure hand sanitizer pumps are always full

Action and Follow up

There was a follow-up visit to Paediatric wards and Paediatric Emergency Department. This found that the Teenagers' Room and Children's Emergency Department were greatly improved with redecoration and the action items from their last visit in had been implemented.

Inpatient Wards – November/December 2015

Healthwatch Kingston and Healthwatch Richmond worked together to carry out these visits. They visited five inpatient wards. They chose specific wards based on information from PALS reports. They visited Blyth, Bronte, Hamble, Hardy and Keats. Their main focus was around the patient's experience of care, staff, decisions about care, cleanliness, food, and discharge arrangements.

The main feedback was positive. Overall the wards were clean and staff were friendly. The patient experience of care on the wards was good. Patients were generally satisfied with the meals.

The main recommendations following the visit were:

- Consider simplifying choice on menu cards and introducing fortnightly cycle
- Introduce wider range of wholemeal foods for vegetarians
- Ensure all patients are aware they can have hot drinks whenever they want
- Ensure that the full next of kin/patient representative information is accessible to staff at all points on a patient's journey, by modifying the formatting of the information on the IT system
- Ensure there is a room available for private discussions
- Inform/reassure elderly, vulnerable patients as early as possible about carers/help at home schemes upon discharge

Discharge from Hospital Report

Between July 2015 and January 2016, Healthwatch Richmond carried out an extensive project to look at how patients experience being discharged from local hospitals. The findings were published in April 2016. The main recommendations relevant to Kingston were:

- Ensure that patients are kept informed about their discharge.
- Information about Teddington Memorial Hospital is given to patients being transferred there.
- Provide patients who live alone with additional support to transition more successfully from hospital to the home.
- Improve communication between services, particularly with GP practices and community care staff.
- Review the provision of equipment for patients in the home.
- Provide more than 24 hours' notice to community nurses on equipment that they need to order for patients due to be discharged.
- Look at the length of time it takes for pharmacy to deliver medications to patients being sent home.
- Hospital to review the provision of non-emergency patient transport.

The Hospital has reviewed and responded to the recommendations and are working closely with other partners to look at the challenges we face around discharge and what improvements we can make to the process.

Improvements to hospital food

The Trust continues to make improvements to food for patients and feedback is now more positive. Here are some of the key improvements during 2015/16:

- Pictorial menus have been designed to assist patients with any kind of communication difficulty to make their own meal choices
- For those patients with dementia who are too restless to sit down and eat at mealtimes or for those who are no longer able to manipulate cutlery, we have introduced the Finger Food menu; this comprises a complete picnic meal in an easily portable box containing foods to trigger reminiscence

- Patient Food Discharge Packs are another innovation, designed for patients who are being discharged home to an empty house; these packs will supply sufficient foods for a 'no cook' meal together with beverages to help the patient settle back home
- The hospital runs a Lunch Club for in patients within elderly care
- Volunteer Dining Companions have continued to expand in numbers and they provide assistance with patient meals. All our Dining Companions are trained to a basic level and some go on to more specialist training run by speech & language therapists and dietitians. The higher level of training enables our Dining Companions to be able to assist feed some of our more vulnerable patients
- Launched a new specially designed menu for Sunshine and Dolphin Wards (Children & Young peoples wards) - for those children and young people who are able to leave the ward area, food vouchers are provided to enable them to eat in the Trust Restaurant with their family
- The maternity Unit has already launched a new plated meal service giving greater flexibility of meal timings to new mothers
- Toast is now available and cooked breakfasts are offered at the weekend

Picture of childrens menu launch

Well led

Volunteers

2015-2016 has been a year of realising the true impact of volunteers across the Trust. This is the culmination of the Trust's participation in the Centre for Social Action's 'Helping in Hospitals' programme with Nesta and the Cabinet Office. In 2016 the Trust welcomed the 1,000th volunteer into the Volunteering Programme. This has enabled established programmes such as Dining Companions, Dementia Volunteering, Chaplaincy, Welcoming and Hospital 2 Home Volunteering to flourish with regular coverage across the wards and departments that need their support. As a result, the Trust and volunteers can be certain their time is enhancing patient experience. This year, volunteers have helped to:

- Improve patient satisfaction at mealtimes by 5%
- Reduced anxiety amongst older patients at discharge by 48%
- Improved the mood and wellbeing of patients with dementia by 42%
- Connected more than 50% Hospital 2 Home patients to local charities and support groups

We are very proud to report that our Friends & Family Test has demonstrated a clear overall relationship between the support that patients receive from volunteering, and their overall satisfaction with their experience at Kingston Hospital.

The Trust has established relationships with Kingston College Access to Midwifery programme, Richmond College's Project Search, Esher College and sixth forms across local boroughs to create volunteering opportunities for young people and mature students aspiring towards careers in medicine, nursing, health care and health service administration. This has changed the way that we welcome younger volunteers aged 16 – 21 into the Trust who receive an unprecedented insight into hospital life through practical volunteering and intensive support from clinical and non-clinical staff.

Volunteers have influenced ongoing improvements and their unique perspectives are shaping the way the hospital is run. The Quality Improvement Volunteers have supported a wide range of projects including the Pressure Ulcers Strategy, Sepsis Awareness Campaign, Dignity at Night and helped to shape the Trust's Corporate Objectives. New forums such as 'Come Dine With Me' brings volunteers face-to-face with the staff and contractors who lead the Food & Nutrition Strategy to inform the ongoing improvement of menus and patient experience at mealtimes.

New volunteering programmes in A&E and the Maternity Unit see volunteers and staff working closely together to improve patient experience within a busy and often challenging clinical environment.

The Trust's Volunteering Service was awarded the Kingston Quality Mark accreditation from Kingston Voluntary Action. This is a new quality assurance tool devised by Kingston First, Kingston Voluntary Action Group and advised by Stay Well, Help the Hospices and Kingston Hospital as a way to:

- Reward and recognise good practice in volunteer management across the Borough
- Support small charities and organisations to follow best practice models with case studies and practical guidance
- Enable the public to make informed decisions about where they invest their time as volunteers
- Stand out as a Borough that celebrates volunteering as an asset of its community and way of life

Governance Review

A Well Led Review conducted by an independent organisation in November 2015 concluded that the Trust has sound governance processes and structures in place.

Foundation Trusts are required to carry out an independent review against Monitor's Well Led framework for governance every three years. The review is an assessment of the Trust's leadership and governance capacity across ten domains allied to the CQC inspection framework in four broad categories: strategy and planning; capability and culture; process and structure; and measurement. As 2016 marked the third year since Foundation Trust status was granted, KHFT commissioned Capsticks Governance Consultancy Service to carry out a Well Led review during the period September to November 2015. The review included observations of meetings, consultation with patients, staff and stakeholders, questionnaires and interviews with individual members of the Board. The key overall findings from the final report were "that Kingston Hospital NHS Foundation Trust is well led by the Board and that the governance processes and structures are sound and appear to be working well including those relating to performance management".

The review identified some areas of outstanding practice and many areas of good practice, with areas identified for further attention being primarily developmental. No material governance concerns were found. Capsticks highlighted that patient safety and quality were evident as the Trust's priority, saying "There is a strong quality culture led by the Board and leaders throughout the organisation prioritise safe, high quality, compassionate care". The evidence was based on observations at Board and Committee meetings, patient safety and quality featured strongly during interviews with Board members and as a key theme in discussions with staff.

NHS Staff survey

In the 2015 NHS staff survey published in February 2016, there were significant improvements in scores across a number of areas compared to the 2014 survey including recommending the Hospital for treatment and as a good place to work.
The Trust scored in the Top 20% of Hospitals across the country in a number of areas including:

- Staff reporting good communication between senior managers and staff;
- Number of staff receiving an appraisal;
- Support from immediate managers;
- Staff believe their role makes a difference to patients;
- Low levels of physical violence from patients, relatives and visitors;
- Staff feel able to contribute to improvements at work;

- Recognition of work by managers;
- Effective team working;
- Effective and fair processes for reporting incidents;
- Effective use of patient feedback.

We are also required to report on the following indicators from the NHS staff survey (2015)

Key Findings 26: % experiencing harassment, bullying or abuse from staff in last 12 months	
Kingston Trust in 2015 Average score: 29	(median) for acute trusts 26

Key Findings F21:. % believing the organisation provides equal opportunities for career progression / promotion	
Kingston Trust in 2015 Average score: 82	(median) for acute trusts: 87

We have continued to focus on improving the working lives of our staff from the Black, Asian and Minority Ethnic (BMAE) Community and also looking at why we have higher than average number of staff reporting they have been bullied or harassed by other staff. For 16/17 we have set a specific corporate objective to improve the day to day to experience of BMAE staff in the Trust.

Introduction of Schwartz rounds
In May 2015 the Trust held its first Schwartz Round. Developed by the Boston-based Schwartz Center for Compassionate Healthcare these are a multidisciplinary forum where staff come together once a month to discuss and reflect on the, the emotional and social challenges in their roles. Compassion from staff is essential to patient wellbeing. For staff to provide compassionate care, they need to feel supported in their work. Rounds are designed to provide this support. Rounds aim to improve relationships and communication in teams and between staff and their patients. The rounds are structured around themes with a small number of speakers talking about their experiences with a facilitator overseeing the round and getting feedback from the wider audience. There has been excellent feedback from staff that shows they find the session's valuable and thought provoking.

7.0 Overview of Services

During 2015/16 the Kingston Hospital NHS Foundation Trust provided and/or subcontracted 44 relevant NHS services, for adults and children as follows:

These services covered the following specialities:

Accident and Emergency
Assisted Conception
Cancer
Cardiology
Ear, Nose and Throat
Gastroenterology and Endoscopy
General Medicine
Genito Urinary Medicine

Care of the Elderly

Clinical Support Services – therapies related to an inpatient episode of care and/or referral for outpatient treatment(s)

Community Midwifery

Community Paediatrics

Critical Care

Diabetes and Endocrinology

Diagnostics (imaging and pathology)

Dietetics

Digital Hearing Aids

Direct Access – Pathology

Direct Access – Blood Transfusion

Direct Access – Cytology (gynaecology)

Direct Access –

Cytology (non-gynaecology)

Direct Access – Haematology

Direct Access – Histopathology

Direct Access – Immunology

Direct Access – Microbiology

Direct Access – Radiology/Imaging

General Surgery

Gynaecology

HIV

Neonatal Care

Obstetrics

Ophthalmology

Oral and Dental Services

Paediatrics

Pain Management

Parent Craft

Patient Transport

Physiotherapy outpatient

Respiratory Medicine

Rheumatology

Surgical Appliances

Urology

Trauma and Orthopaedics

The Trust has reviewed all the data available to it on the quality of care in 44 of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents 88.14% of the total income generated from the provision of relevant health services by the Trust for 2015/16.

8.0 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 may be cause for concern at an NHS foundation trust about financial sustainability or governance. It is important to note that the ratings will not automatically indicate a breach of licence nor trigger regulatory action. Rather, they will prompt Monitor 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 at the end of 2015/16 indicates no evident grounds for concern and that Monitor is not currently undertaking a formal investigation. 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 2015/16 (Monitor)					
	Annual Plan	Q1	Q2	Q3	Q4
Under the Compliance Framework (replaced by the Well Led Framework)					
Governance risk rating	Green	Green	Under review	Under review	To be confirmed
Financial risk rating (COSSR)	2	2	2	2	To be confirmed

In July 2015 Monitor's opened a formal investigation into the Trust's compliance with its licence in regards to Cancer, Finance and A&E. In December 2015 Monitor closed the investigation without formal regulatory action, which was replaced by informal monitoring and support to ensure ongoing sustainability in both finance and performance.

Monitor – Summary of operational performance

Indicator	Threshold	Weighting	2014/15				2015/16			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
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	1	1	1	1	1	1
All cancers: 62-day wait for first treatment from:		1.0	1	1	1	1	0	0	0	0
- 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	1	0	0	1	0	0	0	0
- Surgery	94%									
- Anti cancer drug treatments	98%									
All cancers: 31-day wait from diagnosis to first treatment	96%	1.0	0	0	0	1	0	0	1	0
Cancer: two week wait from referral to date first seen, comprising:		1.0	1	0	0	1	1	0	0	0
- all urgent referrals	96%									
- for symptomatic breast patients (cancer not initially suspected)	93%									
Clostridium (C.) Difficile (due to lapses in care) - meeting the C. Difficile objective	(2014/15) 24 per annum (2015/16) 9 per annum	1.0	0	0	0	0	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			**3**	**1**	**2**	**5**	**2**	**1**	**2**	**1**
Data source: KHFT Quarterly Monitor Returns										

9.0 Participation in Clinical Audits

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

At the start of 2015/16, 36 national clinical audits and 3 national confidential enquiry programmes covered NHS services that Kingston Hospital NHS Trust provides. During that period Kingston Hospital NHS Trust participated in 89% (32/36) 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 (Appendix 1) which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Kingston Hospital NHS Trust was eligible to participate in during 2015/16 and for which the data collection was completed during 2015/16, are listed in Appendix 2 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 23 national clinical audits, applicable to Kingston Hospital, were published during 2015/16 and of these 17 were formally reviewed during 2015/16 (the remainder awaiting review). The actions we intend to take to improve the quality of healthcare are included in Appendix 3.

The reports of 150 local clinical audits were reviewed by Kingston Hospital NHS Foundation Trust in 2015/16. Examples of improvement actions taken as a result of national and local audit are shown in the table below.

Clinical audit results are discussed at clinical meetings in local departments and at wider meetings such as the Trust's annual Clinical Audit 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 2016.

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 2015/16 are given in the boxes below.

Clinical audit providing assurance	
National audit The Trust has taken part in the National Bowel Cancer Audit for a number of years and the most recent report published in December 2015 contained results for 138 Kingston patients with	Local clinical audit Whilst the prescribing of drugs is usually within the remit of a doctor, a number of Kingston Hospital's nursing staff are able to prescribe drugs, having undertaken and passed a prescribing course. To

comparisons to the national average. Kingston's two year mortality rates (observed and adjusted) were both well below the national average of 22%, at 15% and 16.9% respectively. Our 90 day readmission rate was also much lower than the national average, with our adjusted rate 12.4% compared to the national average rate of 19.9%. The national audit data is reviewed regularly throughout the year by the Colorectal team.	ensure that this prescribing is carried out safely, a peer review audit was conducted by the nurses themselves during 2015 of over 100 prescriptions. The prescriptions were assessed for the type of drug prescribed, its dose, frequency and duration. The audit found that all nurse prescribers were prescribing within their capacities to a high standard, with good record keeping demonstrated.
Clinical audit driving improvement	
National audit Clinical data submitted to the National Emergency Laparotomy Audit has been used at Kingston by clinicians from Anaesthetics, Surgery and ITU to make substantial improvements to patient care over the past year. This involved the implementation of a clear care pathway for patients undergoing emergency laparotomy surgery, including increased consultant input and admission post operatively to ITU, as well as the appointment of new Elderly Care doctors for Surgery to ensure timely patient assessment. The 30 day mortality rate for Kingston hospital in 2015 was 5.9% compared to the national average of 11%.	Local clinical audit Handover of care between wards is very important for patient care, both in terms of safely and patient progress. The post natal wards have used local clinical audit to drive improvement over the past year in raising standards in patient handover. They performed audits monthly against the hospital's guideline on Handover of Care to track progress, increasing their use of the SBAR tool (Situation, Background, Assessment, Recommendation). Improvements were made through staff training and engagement.

10.0 Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 205 (portfolio studies only).

The Trust was involved in conducting 8 clinical research studies during 2015/16

There were 34 clinical staff participating in research approved by a research ethics committee at the Trust during 2015/16. These staff participated in research covering 8 specialities.

11.0 Use of the CQUIN Payment Framework

A proportion of income for Kingston Hospital NHS Foundation Trust in 2015/16 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 2016/17 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 2015/16 the Trust had a contract value of £4,133,602 for CQUIN activity (in the previous year, the value of this activity was £ 4,157,145). The table below illustrates how the Trust performed against the CQUIN schemes.

National CQUIN Achievement			60%
Local CQUIN Achievement			100%
*GRAND TOTAL	£4,133,602	£3,550,764	86%

*Provisional results as final data not available at time of publishing

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

Theme	Aim
National CQUIN 1. Acute Kidney Injury	AKI diagnosis and treatment in hospital and the plan of care to monitor kidney function after discharge, measured through the percentage of patients with AKI treated in an acute hospital whose discharge summary includes each of four key items of information listed below: 1. Stage of AKI 2. Evidence of medicines review having been undertaken 3. Type of blood tests required on discharge for monitoring 4. Frequency of blood tests required on discharge for monitoring
CQUIN achievement	55%
National CQUIN 2. Sepsis	Incentivise providers to screen for sepsis all those patients arriving in hospital via the Emergency Department (ED) for whom sepsis screening is appropriate, and to rapidly initiate intravenous antibiotics, within 1 hour of presentation, for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock.
CQUIN achievement	64%
National CQUIN 3. Dementia	(a) Find, Assess, Investigate & Refer (b) Clinical Leadership (c) Monthly Audit of Dementia carers
CQUIN achievement	40% Elements b & c fully achieved
Local CQUIN 4. South London Collaborative CQUIN Strategic Data Set	In line with commissioners' 5 year strategic plan, to establish a common process of collecting data for following strategic datasets (a) Children's dataset- PAU (b) AEC (Ambulatory Emergency Care) dataset

	(c) Integrated Care- A&E discharge (d) SWL Acute Data Set - Integrated Care 2 (DTOCs)
CQUIN achievement	100%
Local CQUIN 5. South London Collaborative CQUIN Inter-hospital Transfer	(a) Establish a SW London inter-hospital transfer network to coordinate and resolve issues relating to clinically indicated transfers (b) Establish means of monitoring and reporting compliance with IHT standards (c) Full achievement of each of the adult and paediatric inter-hospital transfer London Quality standards by the end of Q4 2015/16
CQUIN achievement	100%

CQUINS for 2016/17

The total value of 2016/17 CQUINs is approximately £3.99 million

Local CQUIN 2016/17

Local CQUIN goals for 2016/17 were not finalised with commissioners at time of publishing.

National CQUINs 2016/17

The national indicators are:

1. NHS staff health and wellbeing;
2. Identification and early treatment of Sepsis;
3. Antimicrobial resistance.

National CQUIN Goals

CQUIN Indicators	Goals
NHS staff health and wellbeing	**Goal:** Improve the support available to NHS Staff to help promote their health and wellbeing in order for them to remain healthy and well. **Rationale:** Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4bn a year – around £1 in every £40 of the total budget. Evidence from the staff survey and elsewhere shows that improving staff health and wellbeing will lead to higher staff engagement, better staff retention and better clinical outcomes for patients**.**

Identification and early treatment of Sepsis	**Goal:** Systematic screening for Sepsis of appropriate patients and where sepsis is identified, to provide timely and appropriate treatment and review. **Rationale:** Sepsis is potentially a life threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with around 32,000 deaths in England attributed to Sepsis annually. Of these it is estimated that 11,000 could have been prevented.
Antimicrobial resistance	**Goal:** Reduction in antibiotic consumption and encouraging focus on antimicrobial stewardship and ensuring antibiotic review within 72 hours **Rationale:** Reducing consumption of antibiotics and optimising prescribing practice by reducing the indiscriminate or inappropriate use of antibiotics which is a key driver in the spread of antibiotic resistance.

National and Local Indicator Values

Depending on provider performance, the CQUIN scheme is worth a maximum of 2.5%, payable in addition to the Actual Annual Value (AAV).
The AAV is the aggregate of all payments made to the provider for services delivered under the specific contract during the contract year, not including CQUIN and other incentive payments, and after any deductions or withholdings), subject to certain exclusions.

National Indicator	% of CQUIN quantum	Financial Value
NHS staff health and wellbeing	0.75	£1,199,865
Identification and early treatment of Sepsis	0.25	£399,950
Antimicrobial resistance	0.25	£399,950

12.0 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 2015/16.

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. During 2015-16 the CQC has been undertaking new style announced compliance inspection visits. The Trust was subject to a new style announced visit in January 2016.

In order to maintain registration as a healthcare provider, the Trust is required to demonstrate that it is meeting standards across five domains set out by the CQC:

- Safe
- Effective
- Caring
- Responsive
- Well led

During 2015-2016, the Trust undertook self-assessments of compliance with CQC standards to monitor the safety and quality of services. CQC compliance is considered at the Board to provide assurance.

The Trust was inspected by the CQC on the 12 to 14 January 2016. The Trust is awaiting receipt of the report.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period. The Trust did receive two outlier alerts from the CQC:

June 2015: Maternity Outlier Alert for Perinatal Mortality

- In response to the alert an analysis of case notes was done as well as the review by the maternity risk team and has not identified one clear cause of the raised perinatal mortality rate. Areas for improvement have been identified and these are being monitored via specific action plans. The response and the actions plans were accepted by the CQC. The maternity sign up to safety project features a number of these actions, see page 49.

September 2015 Mortality outlier alert for 'Septicaemia (except in labour)'

In response to the alert there was a review of case notes. The Trust is taking a number of actions around sepsis as outlined in our sign up to safety plan and Quality Priorities. The response and the actions plans were accepted by the CQC. The actions undertaken are shown in page 29/30 and are part of the actions taken for Priority 1 - Improved recognition and management of sepsis .

13. Data Quality

The Trust has a five year Data Quality Strategy, of which 2015/16 was the fifth year. The strategy has a three themed approach to improving data quality in the Trust:

- People
- Reporting
- Systems

The Trust will be consulting on, and subsequently publishing, both a refreshed 3 year Information Strategy and 5 year Data Quality Strategy during the first quarter of 2016/17. This will incorporate the recommendations from various national reports, 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' [Lord Carter, February 2016] and the 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry' [Robert Francis QC, February 2013], in respect of data quality and the use of information across services and the wider health economy.

The Trust also subscribes to the external CHKS benchmarking tool, which includes a data quality measurement component. Kingston Hospital NHS Foundation Trust was once again a winner of the CHKS Top Hospitals award in 2015. This award recognises the best performing CHKS client trusts across the UK and is based on the evaluation of 22 indicators of clinical effectiveness, health outcomes, efficiency, patient experience and quality of care.

Progress against Strategy – 2015/16

During 2015/16 there was a continual progression of actions undertaken towards improving data quality. One of these key developments was the creation and implementation of service and function specific data quality dashboards to support information assurance, primarily focussing on referral to treatment 18 weeks and Accident & Emergency. A further significant in-house development was an inpatient patient tracker list (iPTL), to support the identification of delays in patient pathways and those patients who are clinically optimised but remain in an acute facility (delayed transfers of care).

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

Kingston Hospital NHS Foundation Trust submitted records during 2015/16 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and General Medical Practice Code was:

DQ Indicator		KHT 2015/16 (Apr-Jan)	National 2015/16 (Apr-Jan)
Admitted Patient Care	% with Valid NHS number	99.4%	99.2%
	% with General Medical Practice Code	100%	99.9%
Out Patient Care	% with Valid NHS number	99.6%	99.4%
	% with General Medical Practice Code	99.9%	99.8%
Accident & Emergency Care	% with Valid NHS number	97.1%	95.3%
	% with General Medical Practice Code	100%	99.1%
Maternity - Births	% with Valid NHS number	99.9%	99.5%
	% with General Medical Practice Code	99.8%	99.6%
Maternity - Deliveries	% with Valid NHS number	99.8%	99.7%
	% with General Medical Practice Code	100%	99.9%
Data source: HSCIC SUS Dashboards			

We will be taking the following actions to improve data quality:

There is a data quality group to ensure performance meets and/or exceeds national performance.

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.

Kingston Hospital NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2015/16.

As part of the internal clinical coding audit programme, and to comply with the Information Governance Toolkit Standard 13-505, an audit has been undertaken by qualified and accredited members of the Clinical Coding team across 200 Finished Consultant Episodes during 2015/16. The error rates reported for that period for diagnoses and procedure coding (clinical coding) were:

	KHT 2015/16
Total number of episodes examined: * 130 episodes in General Medicine * 70 episodes in General Surgery	200

Primary Diagnoses Incorrect	2.5%
Secondary Diagnoses Incorrect	2.2%
Primary Procedures Incorrect	2.6%
Secondary Procedures Incorrect	1.1%
Data source: KHFT IG Audit, March 2016	

It is important to note that:

- The results should not be extrapolated further than the actual sample audited and;
- The services reviewed within the sample were General Medicine (130 records) and General Surgery (70 records).

15. Information Governance Toolkit Attainment Levels

The Trust's Information Governance IG Toolkit Assessment Report overall score for 2015/16 was 80% (2014/15 was 81%; Green-Satisfactory) and was graded Green – Satisfactory across all Six Assurances.

The 2015/16 result is from version 13 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 between versions. There are currently 45 requirements for Acute Trusts. The results by Assurance Level were as follows:

Assurance	**2015/16 V13**	**2014/15 V12**
Information Governance Management	80%	80%
Confidentiality and Data Protection Assurance	74%	81%
Information Security Assurance	75%	73%
Clinical Information Assurance	86%	80%
Secondary Use Assurance	95%	100%
Corporate Information Assurance	77%	77%
Overall Total	**80%**	**81%**

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). 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 March 2016.

Indicator	Trust	National	Minimum	Maximum	Comment
Summary Hospital-level Mortality Indicator (SHMI) *Oct 2013 – Sep 2014*	0.8728	1	0.5966	1.1982	Lower is better. We are below the national average.
Summary Hospital-level Mortality Indicator (SHMI) *Oct 2014 –Sep 2015*	0.9318	1	0.6516	0.986080271	Lower is better. We are below the national average.
Latest Data Published	**March 2016**				

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
Percentage of deaths with palliative care coded *Oct 2013 – Sep 2014*	26.9984	25.6840	0	50.8513	We are above the national average. Higher number is better.
Percentage of deaths with palliative care coded *Oct 2014 –Sep 2015*	25.5796	26.5867	0.1898	52.9080	We are below the national average. Higher number is better.
Latest Data Published	**March 2016**				

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 well embedded palliative care specialist support team and training and guidance for staff.

Indicator	Trust	National	Minimum	Maximum	Comment
Age <16 readmissions within 28 days *2010/11*	8.30%	10.45%	0.00%	16.05%	We are below the national average. Lower number is better.
Age <16 readmissions within 28 days *2011/12*	9.45%	10.03%	0.00%	14.94%	We are below the national average. Lower number is better.
Latest Data Published	**December 2013**				

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
Age 16+ readmissions within 28 days *2010/11*	12.01%	11.43%	0.00%	41.65%	We are below the national average. Lower number is better.
Age 16+ readmissions within 28 days *2011/12*	11.06%	11.45%	0.00%	22.76%	We are below the national average. Lower number is better.
Latest Data Published	**December 2013**				

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
Trusts responsiveness to the personal needs of its patients *April 2013 – March 2014*	64.1	68.7	54.4	84.2	We are below national average. Higher number is better.
Trust's responsiveness to the personal needs of its patients *April 2014 – March 2015*	64.9	68.9	59.1	86.1	We are below national average. Higher number is better.
Latest Data Published	**Aug 2015**				

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

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

Indicator	Trust	National	Minimum	Maximum	Comment
Staff who would recommend Trust as a provider to friends and family *Staff Survey 2014*	60	65	0	93	We are below national average. Higher number is better.
Staff who would recommend Trust as a provider to friends and family *Staff Survey 2015*	68	68	0	100	We are equal to the national average. Higher number is better.
Latest Data Published	**March 2015**				

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 including the implementation of the positivity programme.

Indicator	Trust	National	Minimum	Maximum	Comment
% of patients admitted that were risk assessed for VTE *Apr 2015 – Jun 2015*	98.50%	96.00%	86.10%	100.00%	KHT above national average. Higher number is better.
% of patients admitted that were risk assessed for VTE *Jul 2015 – Sep 2015*	98.60%	95.90%	75.00%	100%	KHT above national average. Higher number is better.
Latest Data Published	**December 2015**				

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 and raising awareness in staff.

Indicator	Trust	National	Minimum	Maximum	Comment
Rate per 100,000 bed days for C.diff reported within the Trust for patients >2 years old *April 2013 – March 2014*	15.8	14.7	0.0	37.1	KHT above national average. Lower number is better.
Rate per 100,000 bed days for C.diff reported within the Trust for patients >2 years old *April 2014 – March 2015*	12.2	15.1	0.0	62.2	KHT below national average. Lower number is better.
Latest Data Published	**July 2015**				

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 *Apr 2014 – Sep 2014*	Number	2,303		35	12,020	There is no national average .
	Rate per 1,000 bed days	33.8		0.2	196.30	
Number and % of patient safety incidents *October 2014 – March 2015*	Number	2,292		300	12,784	There is no national average
	Rate per 1,000 bed days	31.8		3.6	170.8	
Latest Data Published		**November 2015**				

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 and providing incident reporting training.

Indicator		Trust	National	Minimum	Maximum	Comment
Number and % of patient safety incidents that result in severe harm or death *October 2013 – March 2014*	Number	11		0.0	97	There is no national average Lower number is better
	Rate per 1,000 bed days	0.16		0.0	3.03	
Number and % of patient safety incidents that result in severe harm or death *October 2014 – March 2015*	Number	14		0	128	There is no national average Lower number is better
	Rate per 1,000 bed days	0.19		0.0	0.0	
Latest Data Published		**November 2015**				

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 and providing incident reporting training.

Indicator		Trust[1]	National	Minimum	Maximum	Comment
Patient Reported Outcome Measures (PROMS) **Groin Hernia** *April-15 – September-15*	**Participation rates for the first questionnaire**	-	56.4%	0.0%	442.9%	
	Response rates for the second questionnaire	-	43.0%	0.0%	100.0%	
	Health Gain (EQ-5D)	-	49.4%	0.0	0.1	
	Health Gain (EQ-VAS)	-	36.7%	-7.5	3.1	
Latest Data Published		**February 2016**				

[1] 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.

Kingston Hospital NHS Foundation Trust is taking the following action to improve this rate, and so the quality of its services: Implement an action plan to ensure PROMS returns are made.

Indicator		Trust	National	Minimum	Maximum	Comment
Patient Reported Outcome Measures (PROMS) **Varicose Vein surgery** *April-15 – September-15*	**Participation rates for the first questionnaire**	**-**	31.6%	0.0%	214.3%	
	Participation rates for the second questionnaire	**-**	29.0%	0.0%	87.5%	
	Health Gain (EQ-5D)	**-**	52.0%	0.0	0.1	
	Health Gain (EQ-VAS)	**-**	39.8%	-5.1	4.8	
	Health Gain Aberdeen Score	**-**	*	-13.3	0	
Latest Data Published		**February 2016**				

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.

Kingston Hospital NHS Foundation Trust is taking the following action to improve this rate, and so the quality of its services: Implement an action plan to ensure PROMS returns are made.

- Elective knee and hip replacements are done at the South West London Elective Orthopaedics Centre

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.

17. Independent Auditors' Limited Assurance Report to the 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 2016 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 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 2015/16**,** 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 2015/16

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 2015 to 19th May 2016
• Papers relating to quality reported to the Board over the period 1 April 2015 to 19th May 2016
• Feedback from Commissioners dated [20/05/16];
• Feedback from Governors dated [19/05/16];

• Feedback from local Healthwatch organisations dated [20/05/16];
• Feedback from Overview and Scrutiny Committee dated [20/05/16];• The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated [14 April 2016]
• The national patient survey dated [2015]
• The national staff survey dated [22/03/2016]
• Care Quality Commission Intelligent Monitoring Report dated [28/05/2015]; and
• The Head of Internal Audit's annual opinion over the Trust's control environment; and
• Any other information obtained during our limited assurance engagement.

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

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 2016, 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 2015/16' 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 2016:

- 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 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 2015/16' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2015/16'.

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

[19/05/16]

Appendix 1: National Confidential Enquiries

Programme type	Participated?	Study and number of cases submitted
Child Health Clinical Outcome Review Programme	Yes	Young People's Mental Health – taking part, study in early stages Chronic neuro-disability – taking part, study in early stages
Medical and Surgical Clinical Outcome Review Programme	Yes	Mental health Study – 5 cases Acute Pancreatitis - 5 cases and organisational questionnaire Sepsis – 4 cases and organisational Questionnaire Gastrointestinal haemorrhage – 5 cases and organisational questionnaire
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	Perinatal mortality surveillance – 38 cases Maternal mortality surveillance – 0 cases
Mental Health programme	Not applicable	

Appendix 2: Eligible National Clinical Audits 2015/16 – Participation rates

Shaded areas indicate national clinical audits where deadlines are after April 2016 and therefore the number of cases submitted is not yet available.

National Clinical Audit	Participated?	Number of cases submitted
Acute Care		
Case Mix Programme (ICNARC)	Yes	77% (558/721)
Trauma Audit and Research Network (TARN)	Yes	38% (104/276)
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Joint Registry – hips/knees	Yes	44 cases entered (target unknown)
Non-invasive ventilation	Although listed in the 2015/16 Quality Accounts, this audit has not taken place this year	
Emergency use of oxygen	Yes	410% (41 cases submitted/10 minimum requirement)
Procedural sedation in adults	Yes	78% (39/50)
Vital signs in children	Yes	200% (100 cases submitted /50 minimum required)
VTE risk in lower limb immobilisation	Yes	200% (100 cases submitted /50 minimum required)
National complicated diverticulitis	No	No indication was received that this audit had started
Blood transfusion		
National Comparative Audit of Blood Transfusion audits: Use of blood in haematology Patient blood management in scheduled surgery	 Yes Yes	 100% (40 cases) 100% (31 cases)
Cancer		
Bowel Cancer (NBOCAP)	Yes	117% (160/137)
Lung Cancer (NLCA)	Yes	100% (102 cases submitted/all eligible cases n=102)
National Prostate Cancer Audit	Yes	99% (174/176)
Oesophago-gastric Cancer (NAOGC)	Yes	124% (48 cases)
Heart		
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	100% (172/172)
Cardiac Rhythm Management	Yes	100% (122/122)
Coronary Angioplasty/National Audit of PCI	Yes	1/1 (100%) organisational audit.
National Cardiac Arrest Audit	Yes	49% (96/195)
National Heart Failure Audit	Yes	49% (130/263) – still entering data
Long Term Conditions		
National Diabetes Audit (Adult): Footcare In-patient Pregnancy in diabetes	 No Yes No	 Data has been collected but not yet submitted 44 cases submitted plus 34 /44 completed patient forms Requirement for patient consent for audit meant no data entered

National core	Yes	2015/16. Audit started March 2016. 83 cases – percentage not known
National Diabetes Audit (Paediatric)	Yes	100% (144/144) cases submitted
Inflammatory Bowel Disease (IBD)	Yes	100% (70/70)
National Chronic Obstructive Pulmonary Disease (COPD): Secondary care	Yes	Data entered in 2014 (no data collection in 2015/16)
Rheumatoid and Early Inflammatory Arthritis	Yes	35 cases – percentage not known
Older People		
Falls and Fragility Fractures Audit Programme (FFAP): Fracture Liaison Service database In-patient falls National Hip Fracture Database	 Yes Yes Yes	 Facilities part of audit – organisation questionnaire only 100% (30 cases) 92% (287/312) – still collecting data
Sentinel Stroke National Audit Programme (SSNAP) Clinical Audit	Yes	100% (163/163) – Continuous audit, still submitting data.
UK Parkinson's Audit	Yes	Organisational audit completed 100% (25 cases)
Other		
PROMS – Hernia and varicose veins only		No information yet received
National Ophthalmology Audit	No	Awaiting funding for IT system to allow participation
Women and Children		
Neonatal intensive and special care (NNAP)	Yes	100% (392 cases)
Paediatric Asthma	Yes	200% (40 cases submitted / 20 minimum required)
Paediatric Pneumonia	Although listed in the 2015/16 Quality Accounts, this audit has not taken place this year	

Appendix 3: Actions to be taken following completed national clinical audits

National audit reports published in 2015/16	Date Report Issued	Report discussed during 2015/16	Actions Identified
Acute Care			
Emergency use of oxygen	Dec 2015	Yes	Oxygen awareness week taking place in Kingston Hospital during Spring 2016
Adult critical care case mix programme (ICNARC)	Jan 2016	Yes	Data currently being reviewed in order to formulate action plan
Major Trauma Audit (TARN)	Nov 2015	Yes	Results circulated to A&E team.
National Emergency Laparotomy Audit	Oct 2015	Yes	Extensive action plan including appointment of new Emergency Surgeons and Consultant in Medicine for older people, direct post-operative admission to ITU and various policies and guidelines. Major improvement in patient care has been identified as a result of these actions.
National Joint Registry	Sept 2015	Yes	No Kingston Hospital data in this report, therefore no action plan required.
Blood transfusion			
Blood management in scheduled surgery	Oct 2015	Yes	A specific anaemia clinic is being considered.
Cancer			
Bowel cancer	Dec 2015	Yes	Results good, no actions required
Lung cancer	Dec 2015	Awaiting presentation in Respiratory	Action plan to be devised after discussion, if required
Prostate cancer	Nov 2015	Yes	No Kingston Hospital data in this annual report, since data entry did not begin until October 2014. Therefore no actions required at this stage.
Oesophago-gastric cancer	Dec 2015	Awaiting presentation in Gastroenterology	Results good. Actions may not be required.
Heart			
National cardiac arrest audit	Jul 15	Yes	Actions include ensuring staff complete cardiac arrest forms, reviewing location of cardiac arrests and presenting data to clinicians.

National Heart Failure audit	Oct 2015 (1314 data)	Yes	Cardiology Audit Assistant and Heart Failure Nurse Specialists appointed
Long term conditions			
Inflammatory bowel disease Biologics audit	Sep 2015	Yes	New IBD Nurse Specialist appointed
Yes	Results have been circulated to Diabetes team	Yes	Results have been circulated to Diabetes team
Yes	Results have been circulated to Diabetes team	Yes	Results have been circulated to Diabetes team
Yes	Actions to be taken link with the action plan for NICE Quality Standard 33, including review of patient pathway.	Yes	Actions to be taken link with the action plan for NICE Quality Standard 33, including review of patient pathway.
Mental Health			
Mental health in the ED	May 2015	Yes	Addition of a risk assessment tool as part of triage and ensure that psychiatric liaison notes are incorporated into the electronic patient record
Older People			
Sentinel stroke national audit programme	Dec 2015 (annual) Feb 16 (organisational)	Yes	Results good, no actions required.
Falls and fragility fracture programme In-patient falls National Hip Fracture database			
Assessing for cognitive impairment in older people	May 2015	Yes	Prepare specific dementia screening guideline for use in A&E. Review content of electronic patient record for this group of patients.
Women and Children			
Neonatal intensive and special care	Nov 2015	Yes	Actions including improving compliance with breast feeding initiatives and improving documentation
Management of the fitting child	May 2015	Yes	Training update for staff regarding blood test requirements, modify local guideline, consider simulation teaching session,

			and ensure patient/parent information is available in A&E.
National audit reports published in 2015/16			
Acute Care			
Emergency use of oxygen	Dec 2015	Yes	Oxygen awareness week taking place in Kingston Hospital during Spring 2016
Adult critical care case mix programme (ICNARC)	Jan 2016	Yes	Data currently being reviewed in order to formulate action plan

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

The Kingston Clinical Commissioning Group (CCG**)** welcomes the opportunity to provide a response to the Quality Account for 2015/16 submitted by Kingston Hospital NHS Foundation Trust.

The Quality Account provides information and a review of the performance of the Trust against quality improvement priorities set for the year 2015/16 and gives an overview of the quality of care provided by the Trust during this period. The priorities for quality improvement for the next 12 months are also set out which we were consulted upon and endorse.

The CCG supports the Trust's openness and transparency. We are committed to working with the Trust to achieve further improvements and successes in the areas identified within the Quality Account. This will be carried out through a number of both proactive and reactive mechanisms and collaborative and integrated working.

The challenging targets set by the Trust for 2015/16 were fully met for 5 of the 9 priorities and partially met in the remaining 4 areas.

The improved recognition and management of sepsis shows the positive steps the Trust has taken to improve performance in this patient safety area and we look forward to the sustained focus as part of the Trusts commitment to the "Sign up to Safety" campaign.

The significant progress made in reducing agency usage (in particular, the recruitment and training of staff to support reductions in turnover) is commendable in the current workforce climate.

The use of technology to release nursing time and improve the recording of patients vital signs is very innovative and we would welcome the planned expansion of the coverage in the Trust (as

funding allows).

Section 6 highlights other areas of improvement across the Trust in addition to the quality account priorities and the membership of the Clinical Quality Review Group (CQRG) in particular would wish to recognise the improvements seen in pressure ulcer prevention and the sustained improvement to food quality and support for patients at mealtimes.

Most notably, the performance achievements for cancer patients has seen the Trust move from a challenged and variable level of cancer target achievement to a position of high confidence in the pathways for patients. The performance over the last quarter and year end place it amongst the top performing Trusts in London and is to be commended.

Similar to the wider NHS, the Trust will need to continue its focus on emergency access (through Accident and Emergency) and build upon the programmes of partnership working already in place with Health and Social Care colleagues to support patients leaving the Trust to avoid any possible delays.

The CCG is supportive of the engagement model used with Commissioners, Governors and Healthwatch in the development of the quality priorities for 2016/2017 and wholly supports the goals and the improvements that the Trust plans to undertake over the next year.

The CCG looks forward to continuing to work with the Trust during the coming year, to build on the progress made and to provide support to initiatives that will improve the quality of care and outcomes.

Trust Response

We thank Kingston Clinical Commissioning Group for their constructive feedback. The Trust values the level of engagement from the CCG and looks forward to continuing the collaborative work being done to provide patients with the best care. The Trust and local partners are already working closely to avoid delayed transfers of care and ensure a safe and timely discharge for patients. The Trust intends to build on work during 2016-17 to improve the patients experience of discharge.

Kingston Hospital NHS Foundation Trust – Governor Feedback

The Governors have reviewed the Trust's Quality Report for 2015/2016 and acknowledge that the Trust demonstrates commitment to continuously improving the care it provides. The Governors welcomed the opportunity to engage with the Trust in agreeing priorities. The Trust was open to suggestions, comments and feedback on all aspects of the Quality Report and the priorities. In particular the governors felt that it is important the priorities have clear outcomes for patients and carers, are measurable and easy to understand by the public.

The Trust partly met 4 priorities last year and fully met the other 5 priorities. It is welcomed that the Trust will continue to take forward ongoing priorities in reducing vacancies, sepsis, discharge, administration and end of life care as well as new priorities on falls, pain, readmission and length of stay. These priorities represent areas that have a direct impact on how patients experience care.

The Governors' Quality Scrutiny Committee was able to give assurance to the Council of Governors (COG) that the Quality Account process was rigorous and inclusive, engaging a wide range of

stakeholders. The governors are looking forward to working with the hospital to ensure this year's priorities are a success in providing safe and effective care for patients.

Trust response
The Trust is grateful for the feedback received from the Council of Governors and looks forward to working closely with the Governors in the coming year to improve the services we provide to patients. The Trust acknowledges that the feedback from the Governors throughout the development of the Quality Account was valuable in making the priorities clearer and easier to understand.

healthwatch Kingston Upon Thames

Re: Quality Account 2015/16

Healthwatch Kingston welcomes the opportunity to comment on the 2015/6 Quality Account, a comprehensive document that describes another year of progress and a range of improved outcomes. Healthwatch has been able to visit the hospital on a number of occasions in the past year through the 'enter and view' process to see for ourselves how services are delivered and operated, enabling our members to see tangibly what the detailed account describes.

The principal monitoring exercise was the CQC inspection in January 2016 and we await with anticipation the Inspection Report, whilst noting the outlier alerts relating to perinatal mortality and sepsis. Measures to address these concerns have been developed and we look forward to being able to assess progress throughout 2016/7.

The account focuses on the key themes of safe, effective, caring, responsive and well led, and so Healthwatch will for the year ahead aim to consider how to reflect these themes in our own visits, just as the CQC and Monitor have for themselves in recent inspections.

Some specific highlights we welcome include:

- the progress made in reducing cancer waiting times
- good progress in the development of 7 day working in key areas such as paediatrics, medicine and surgery
- the general exceeding of clinical coding requirements
- higher recommendation rates to friends and family
- introduction of vital signs monitoring

The recent appointment of new permanent Chief Executive is welcomed and Healthwatch will look forward to meeting her and her senior team shortly.

Clearly the Quality Account is a substantial document with significant scope and much detail, produced in response to external reporting requirements. As the health service user and consumer focussed body for Kingston where a significant number of Kingston Hospital patients live, we will continue to scrutinise this and other reports to get to the heart of what is happening, celebrate what is going well and identify where practice could be improved. The Hospital's open and constructive approach to enabling us to carry out our work remains a very welcome feature of our strong relationship.

The Trust Response
The Trust is grateful for the feedback received from Kingston Healthwatch. We would like to recognise the valuable feedback from Kingston Healthwatch in developing and selecting the Quality priorities. We believe the work we do with our local Healthwatch groups is very important to providing safe and effective care for patients. We look forward to continuing to work with Kingston Healthwatch

Royal Borough of Kingston upon Thames

Kingston Hospital Foundation Trust Quality Account (2015/16) – Comments from Kingston Council's Health Overview Panel

This year's report provides detailed information about progress made in the past year. It clearly sets out what the Quality priorities set out to achieve and progress against these.

As well as reporting against the nine Quality Priorities agreed for 2015/16 it considers the themes which are examined both by Monitor and the Care Quality Commission in inspections. Evidence is therefore provided to demonstrate effective progress and outcomes against the following themes: Safe, Effective, Caring, Responsive and Well-led

We particularly commend the progress made in 2015/16 to improve the provision of 7 day working for paediatrics, surgery and medicine and in reducing the use of agency staff. We are pleased to see that further work on these two priorities will continue into next year. Progress on discharge planning is also commended. However, The Trust's performance in the national inpatient falls audit is a concern with the Trust being rated as red against five of the recommendations and amber against the other two. We very much agree that reducing falls in the hospital setting should be a priority for 2016/17 and look forward to progress being made by the Trust in their performance against these priorities. We also note that not all the targets set for 'Improved recognition and management of sepsis' were achieved and also look forward to progress being made in 2016/17.

We also note the new priorities of reducing length of stay and reducing re-admissions for people who have required emergency care (non-elective care). These (together with a wide range of other actions by the Trust and key partners) will assist in achieving a sustainable local health service in future years.

We note the strong participation in national clinical audit programmes. We also recognise the progress made in cancer waiting times in the past year and hope that this can be sustained and further progress made in 2016/17.

We also note that the Trust did receive CQC outlier alerts for perinatal mortality and sepsis. We recommend that perinatal mortality continues to be reviewed by clinical audit in 2016/17 and we endorse the continuing focus on sepsis as part of the nine quality priorities for the coming year. We were pleased to see the introduction of healthcare technology for vital signs monitoring when we visited A&E and other areas in December 2015 and note the Trust's success at attracting funding for this.

We look forward to seeing the CQC Inspection Report (of the planned visit in January 2016) in due course.

We are pleased to note that for all data quality indicators the Trust performed better than the national average. We hope further progress can be made on capturing palliative care coding for

deaths (and wish to point out that for October 2014 to September 2015 (page 72) the Trust performed below the national average but the comment incorrectly states it performed above) – which will link with the 2016/17 Priority Action to improve end of life care. We note the recent publication of CQC review of palliative care which details exemplar sites of good practice.

We were also pleased to see the progress on the indicator concerning staff who would recommend Trust as a provider to friends and family. KHFT now equals the national average and we hope that further progress can be made.

We are particularly pleased to learn of the permanent appointment of Ann Radmore as Chief Executive in May 2016 and believe this will be of great benefit to the Trust going forward.

Trust Response
The Trust is grateful for the constructive feedback received from Kingston Council Health and Overview panel. We have made the correction to the quality indicator on palliative care coding. Our Sign up to Safety Programme will focus on sepsis and maternity. We will continue to work in partnership with Kingston Council to provide the best care for local people.

healthwatch
Richmond upon
Thames

Commentary on Kingston Hospital NHS Foundation Trust Quality Accounts 2015-2016

Healthwatch Richmond considers the Trust's Quality Account (QA) for 2015/16 to be an accurate reflection of Kingston Hospital's achievements. Although the report is lengthy, it covers a good range of topics, all interesting and relevant. The QA is well laid out and easy to read, and the definitions of the unavoidable technical or medical terms are helpful. The use of tables with clear explanations is accommodating to the reader. The QA gives an encouraging picture of ongoing improvements and clearly details the areas where there is continued room for improvement. As a consequence, an encouraging picture of the hospital's excellent work emerges.

Considerable effort appears to have gone into nurse recruitment and commensurate reduction in the use of agency nurses. This is a priority the Trust has pledged to continue, in order to further improve services and achieve the London Quality Standards, including the delivery of 7-day services. We particularly welcome the on-going commitment by the Trust to ensure a consultant is available for ward reviews 7 days a week, and increase the numbers of pharmacists and therapists working at the weekends.

This action will allow a 7 day a week multi disciplinary review of patients. The local population will be reassured to learn of the recruitment drive and enhanced consultant cover, which will permit 24/7 access to a consultant in specialities such as paediatrics, obstetrics and emergency surgery. The Trust indicates that the full effect of these changes will be realised in 2016/17. We look forward to seeing evidence of improvements in patient service.

Healthwatch Richmond is impressed with the Trust's approach and the progress in increasing patient involvement, engaging volunteers and the wider stakeholder community, including Healthwatch. The Trust recognises the valuable role volunteers can play, and demonstrates this with initiatives such as Dining Champions and Dementia Volunteers. It is encouraging to read that volunteers have improved the mood and wellbeing of patients with dementia by 42%. With a high proportion of Kingston residents over the age of 65 years, this will provide reassurance.

The Trust has been candid in admitting failures to meet some targets and has provided clear reasons why this occurred and what action is being taken to continue improvement. Some of the CQUIN scores were well below 100%; this could have been explained in more depth.

The inclusion of statements of assurance about audits, information management and data quality is helpful. In each priority area, there is evidence of clear internal arrangements for managing and delivering the planned improvements with identified lead roles. The addition of information on how and why priorities were chosen is useful and further demonstrates the Trust's commitment to inclusion.

There appears to be some way to go in achieving the targets for prevention of sepsis over a 3-year period. This is concerning, given that this is a treatable condition if recognised promptly. We welcome the inclusion of this as a priority for 2016/17 and note the range of improvement measures being put in place by the Trust.

Similarly, the Trust has been open about partly achieving the target to identify and monitor harm to patients with dementia, as the monitoring systems were not put in place until August. Nevertheless there appears to be a system for recording incidents to identify dementia and track specific harms.

Monitoring of data shows that patient falls is a significant issue. We welcome the inclusion of reducing patient falls as a priority for 2016/17.

The Trust has achieved three targets in relation to the working conditions for staff. Significant for patients is the use of electronic recording of vital signs, freeing staff to spend more time with patients. This will also be a priority for 2016/17, as systems are rolled-out to A and E and other areas, subject to funding.

The Trust has performed better than planned in the area of staff appraisal and mandatory training. This is to be welcomed, given the implications for improved care. It is perhaps disappointing that this is not a priority next year, but the Trust has a corporate objective to improve staff experience during 2016/17.

It is concerning that the Trust has only partly achieved targets around improving patient experience. However, the new telephone system has helped improve the response to calls and this is welcome.

There seem to be no hard data about complaints, but the Trust says there is a trend to reduction over the year. We are pleased this is a priority for 2016/17.

There is evidence of achieving the target relating to improving end of life care for patients and their relatives, using an external survey technique. In some cases (care from doctors and nurses), the Trust has performed better than national averages. It is reassuring that this area remains a priority for next year and that the Trust has an action plan in place.

We are pleased the Trust has achieved the target for improving discharge planning and processes. Some more detailed figures would be welcome, but the tracking and reporting systems now in place should facilitate close management. It is pleasing that this is again a priority for next year.

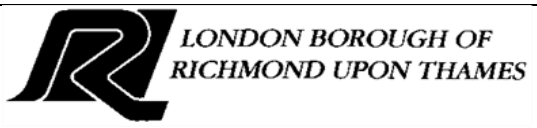
Healthwatch Richmond welcomes the Trust's pledge in its Patient Public Involvement Strategy to reach marginalised and hard to reach groups, in order to improve outcomes for the public.

Overall we think the Trust has achieved much over the past year, with a number of key areas being taken forward for further action, accompanied by a commitment to improving quality and patient outcomes in 2016/17.

Trust Response

The Trust would like to recognise that the valuable feedback from Richmond Healthwatch in developing and selecting the Quality priorities. We look forward to continuing to work with Richmond Healthwatch making sure we provide the best possible services to the local community. We welcome the comments on the CQUINS and will provide additional explanations in future years on performance. The Trust would like to note there is data on complaints in the report and a table of

the type of complaints regarding administration and we will consider how to make the information clearer in future years.



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

Following on from the meeting held on Thursday 19th May 2016, to discuss Kingston Hospital NHS Foundation Trust Quality Account, we welcome the opportunity to provide additional input, as the London Borough of Richmond upon Thames (hereinafter 'LBRuT') is committed to champion the interests of its residents by playing a full and a positive role in ensuring that the people living and working in LBRuT have access to the best possible healthcare and enjoy the best possible health. Whilst we appreciate that the version provided is a draft and the final version is yet to be approved we have a number of points we wish to raise and a number of suggestions we wish to proffer. We would like to take this opportunity to commend the Trust on a well laid-out and easy to read report. We were pleased to hear that considerable progress has been made in many quality areas over the past year. The LBRuT particularly noted the Trust's accomplishments in the following areas during 2015/16:

- Cancer performance is now one of the best in the UK;
- The volunteering programme has increased participation from 300 to 1000 volunteers, which has created additional capacity and featured highly in patient satisfaction feedback;
- A better patient experience, achieved through initiatives such as improvements in administration; a new 24/7 outreach team supporting very sick patients on the wards, and a new paper light system to release clinical time for patient care;
- The implementation of the Dementia Strategy, with Dementia Champions in place across the hospital and the opening of the first dementia friendly ward in November 2017;
- The progress made on 7 Day working. We were pleased to hear about the number of initiatives taking place, such as increased consultant cover; a focus on patient safety, including a paediatric consultant on site until 10.00PM every night; an increase in consultant obstetric hours; and an increase in the number of emergency surgeons cover by 3. We also welcome the extension of the palliative care service from 6 days to 7;
- The improvements to End of Life Care are also noted, evidenced by the Trust's Bereavement Survey measures which were better than the national average;
- The number of initiatives taken to improve outcomes for children and young people;
- The increased focus on the health and wellbeing of staff and patients, as demonstrated by the implementation of the national staff health and wellbeing CQUIN, and the complete ban on smoking on-site.

Suggestions:

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 hospital.

- LBRuT is keen to see a further improvement in Delayed Transfers of Care. We recognise the challenge of working across 5 boroughs, with 5 different systems and processes, and the recent problems with social care response which is being addressed as a priority by the Council. We welcome that a new single process to improve discharge is being developed and that there is much closer working between agencies on this issue;

 The Scrutiny Panel were pleased to note that reducing agency staff is a key quality indicator and recognise the benefits, in terms of cost reduction and improved patient care, of better rates of recruitment and retention. It might be useful to include the incentives you are offering to staff for better retention;

 The Trust may wish to reference the Outcomes Based Commissioning (OBC) approach in the Quality Accounts. We were pleased to hear that the OBC process was resulting in greater partnership working across primary care, community services and hospitals that service Richmond residents. It is also a key Health & Wellbeing Board priority to promote a more integrated patient experience;

 We welcome and appreciate the complete smoking ban in the hospital and the participation in the national health and wellbeing CQUIN for staff, but would also like the trust to focus on self-care and self-management in line with Richmond's Council and Richmond CCG's Prevention Framework, Better Care Fund and Better Care Closer to Home Strategy.

 Accident and Emergency performance was noted by the Panel as a local challenge. The Panel welcomed that this is recognised by the Trust and measures to improve this will be undertaken in municipal year 2016/17;

 The Panel noted that in the forthcoming year, the Trust will look to improve staff survey results, particularly those results reported by staff from minority ethnic groups who were less satisfied with the Trust than other staff. The panel further suggested to encourage patients and carers, such as older people/ people with dementia, those at the end of life and 'seldom heard groups' to participate in the patient satisfaction survey;

 Reduce falls in the hospital setting – Council is pleased to see this as a priority for 2016/2017 and would be keen to hear any feedback on how this reduction is achieved;

 Reduce avoidable harm from sepsis – In winter 2014, the Trust reported increased incidence of sepsis. It would be useful to know what learning the Trust has taken from this, to help achieve this priority.

Conclusion

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

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

Trust Reponses

The Trust is grateful for the constructive feedback received from Richmond Council Health and Overview panel. We have now indicated that the sepsis priority contains the actions we have taken in response to the CQC alert. As a result of feedback from Richmond Council Health and Overview Panel we have included in the report the work we have done to make the hospital site smoke free and reaffirmed our commitment to improving the wellbeing of staff patients and visitors. We are looking forward to further developing our partnership working as result of Outcomes Based Commissioning.

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 2015 to 19th May
- papers relating to quality reported to the board over the period 1 April 2015 to 19th May feedback from Commissioners, dated 19/05/2016
- feedback from local Healthwatch organisations, dated 20/05/2016
- feedback from Overview and Scrutiny Committee, dated 20/05/2016
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated [14 April 2016]
- The national patient survey dated 2015
- • The national staff survey dated 22/03/2016
- • Care Quality Commission Intelligent Monitoring Report dated [28/05/2015]; and
- • The Head of Internal Audit's annual opinion over the Trust's control environment; and
- the Head of Internal Audit's annual opinion over the Trust's control environment, dated [31/03/2016]

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

The directors confirm 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

Sian Bates
Chairman
23rd May 2016

Ann Radmore
Chief Executive
23rd May 2016

Picture: Staff reaffirming their commitment making sure patients always have a good experience of Kingston Hospital