Kingston Hospital NHS
NHS Foundation Trust

Quality Report 2016-17

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

Living our values *everyday*

CARING SAFE RESPONSIBLE VALUE EACH OTHER

Contents

PART 1

Quality Report 2016/17

1.0 Introduction from the Chief Executive

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

Delivering high quality care is at the forefront of everything we do at Kingston Hospital and this report covers how we have performed against the quality priorities set for 2016-17 and sets out what our quality priorities will be during 2017-18.

We were focused on delivering nine quality priorities during 2016-17, which had been agreed following consultation with our staff; members and governors; and patient groups. Out of the nine we have achieved or partly achieved eight and not achieved one. One of the two Patient Safety priorities we have achieved this year is a reduction in falls. Patients over 65 are vulnerable to falling in hospital because of their illness and frailty and a fall delays the patient's recovery. Over the last year we have implemented a new Falls Risk assessment and the falls rate has decreased to 5.11 per 1000 bed days, compared to 5.50 per 1,000 bed days in 2015/16.

The other Patient Safety priority, which was met in 2016-17 is to reduce use of agency staff by reducing vacancies. Having a permanent and sustainable workforce has such a positive benefit on both the care that patients receive, but also on everyone working for the organisation. Over the last year we have run a number of recruitment campaigns to ensure a continual supply of Band 5 Nurses and Nursing Assistants are available and we have also successfully recruited from overseas. The Trust now has 800 more permanent staff as at the end of 2016/17 than compared to 2015/16 and this has helped us to reduce our agency spend to 43% from 56%. As a result we are the second best performer in London regarding agency spend trajectory.

Improving End of Life Care has been a quality priority for the last two years and we have continued to make further improvements in 2016-17 and achieved the quality priority. Ensuring that our patients and their families have the best possible support and experience in the last days of life is so important and it will always be a key priority for the Trust. During the last year the Palliative Care team has run a comprehensive training programme to provide end of life training to 550 trained and untrained nursing staff and junior doctors. All dying patients now have an Individual nursing care plan and additional consultant and clinical nurse specialist resource has meant that we can provide a face to face service between 9am and 5pm seven days a week. During the year the Trust received the results of the CQC inspection undertaken in January 2016 and End of Life care was rated good in all domains with the exception of caring which was rated as outstanding.

For the last few years we have worked hard to involve staff, the local community, partners and stakeholders in decisions about our services and priorities for improvement and always listen to the feedback we receive when things have gone well and when we could have done better. As in previous years, we have involved them in helping to set our priorities for 2017-18, which are:

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

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
25th May 2017

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.

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

Kingston Hospital NHS Foundation Trust focuses on 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.*

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

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

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

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

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

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

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

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

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

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

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.*

National Reporting and Learning System (NRLS) – *The National Reporting and Learning System is a central database of patient safety incident reports which was set up in 2003. All of*

the incident information that is submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care. It also benchmarks Trusts on patient safety incident occurrences, as the data is split by incident categories, levels of harm and location of occurrence etc.

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

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

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

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

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

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

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

Sepsis Six (6): *The* ***Sepsis Six*** *is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. A training 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.

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

PART 2

4.0 Kingston Hospital NHS Foundation Trust Priorities for 2017/18

How were the priorities chosen?

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

The number of priorities selected is in line with those stipulated in the NHS Improvement document *Detailed Requirements for Quality Reports for Foundation Trusts 2016/17.*

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 2015/16 quality report – this should include performance in 2016/17 against each priority and, where possible, the performance in previous years.
- how progress to achieve these priorities will be monitored and measured; and
- how progress to achieve these priorities will be reported.

The dates of consultation are listed below:

- Clinical Quality Improvement Committee – 18th January 2017
- Council of Governors – 17th January 2017
- Governors' Quality Scrutiny Committee – 7th December 2016
- Kingston Hospital Monthly Team Brief – April 2017
- Quality Assurance Committee – 16th March 2017
- Trust Board Meeting (public) – 25th January 2017

The quality priorities long list was then put to a public vote during January 2017. 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 2017-18. A total of 314 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. Improve learning from incidents

The Trust encourages a culture of openness and reporting of incidents and near misses. The Trust wants a culture of high incident reporting and zero harm. An increase in incident reporting should not be taken as an indication of worsening patient safety, but rather an increasing level of awareness of safety issues amongst staff across the organisation. The information that is learnt from this reporting is used to improve patient and staff safety. Information about our incidents is reported to the National Reporting and Learning System (NRLS) so that nationally this information can also be learnt from. In selecting this priority, we will focus on making it simpler for staff to report incidents; increase the number of incidents/near misses reported; and undertake more improvement programmes as a result of incident and near miss analysis. We will also ensure that we are even more transparent with staff and the public in changes we have made arising from incident analysis.

2. Implement measures to reduce hospital acquired infections caused by gram negative Bacteria

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

3. Improve safety awareness for staff through human factors training

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

Improve the management of diabetes in the inpatient setting. This is important as the prevalence of diabetes in the UK continues to rise. This means that we are seeing more patients with type 1 and type 2 diabetes throughout our services. One of the areas of improvement we have identified through national clinical audits is how we manage diabetes for patients receiving inpatient care. We will therefore focus on improving this aspect of care and will include how we prevent and treat hypos (low blood glucose), documentation of foot risk and planning diabetes care during the perioperative period (around the time of an operation).

Domain 2: Clinical Effectiveness - Improve clinical outcomes for our patients

4. Develop the Trust's next three year (2017-2020) dementia strategy and implement year one

Over the last three years the Trust has focused on improving the care provided to patients with dementia, and support to their carers. This strategy has now come to an end and building upon this the Trust would like to develop a further strategy for the next three years. Successes over recent years include the opening of a new dementia friendly ward and the development of therapeutic activities for patients.

5. Increase seven day working provision

Emergency services are available every day in the hospital but access to senior doctors and to diagnostic tests is better Monday to Friday than at the weekend. This objective enables us to focus on the delivery of the four national priorities for the same standards to be available every day; namely to be seen by a consultant within 14 hours of arrival in hospital, every 12 hours whilst acutely unwell, and every day when needed thereafter. There should be access to emergency diagnostic tests within one hour, and within 12 hours in urgent cases seven days a week. Achieving these standards will mean that we avoid delays for our patients and may reduce the length of time they have to spend in hospital.

6. Commence Implementation of e-prescribing and electronic clinical records in the outpatient setting

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

Improve the efficiency of pathways of care for patients with long term ophthalmic conditions. The Trust treats over 50,000 people within the Royal Eye Unit, ophthalmology service at Kingston Hospital. With an ageing population the demand on ophthalmology services is increasing. Patients with chronic diseases such as glaucoma or macular degeneration are the most vulnerable and at greatest risk of irreversible loss of vision. These patients require long-term follow-up appointment checks and treatments. We know that we can do more to improve the efficiency of these services so that patients have timely access to appointments. This quality priority will therefore focus on making these improvements to ensure there is sufficient capacity and an improved experience of the appointments process for our patients.

Domain 3: Patient Experience - Listen and respond to patients' concerns

7. Understand and improve the experience of patients with mental health conditions using hospital services

One in four people in the UK experience a mental health problem each year. A high percentage of patients at Kingston Hospital will therefore have both a physical and mental health issue. This objective would therefore focus on better equipping our staff to be able to recognise and care for patients' mental health needs. This would include introducing mental health first aid training to key staff and more specialist training in key areas such as A&E, paediatrics and older peoples' wards. We would also undertake work to better understand the experience of patients with mental health services using our services. This objective will also involve us working collaboratively with colleagues from South West London & St Georges Mental Health Trust.

8. Improve the experience of patients using the emergency department

The Trust sees and treats over 110,000 patients a year through its two emergency departments – the main Emergency Department (which includes paediatric A&E) and the Royal Eye Unit Emergency service. Over the last year the Trust has made further improvements to the Emergency Department, in order to improve experience of waiting. This has included the opening of a new Clinical Decisions Unit in November 2016. We know from our CQC inspection in 2016, our A&E survey results and other sources of feedback e.g. complaints; and Friends & Family Test results that there are more opportunities to improve the experience of patients using these services. This objective therefore focuses upon improving the experience for patients in both the main Emergency Department and in the Royal Eye Unit.

9. Improve the experience of patients with haematological cancer

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

Understand & improve the experience of patients from the local Korean population, as a model for improvement for other 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. In order that we meet these needs, specific attention is required so that we can ensure our services are equally accessible, and no groups are 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. We know from census data that the local Korean population is estimated to be the highest in Europe. The Trust has started to engage more with the Korean community through its Governing Body, but we believe there is more that could be done. This objective would therefore focus on furthering this work and developing the approach to this as a model for future targeted work with other minority groups, the aim of which is to improve access and experience of services at the hospital.

Quality priorities for 2017/18

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

Domain: Patient Safety

Priority 1 - Improve learning from incidents

Goal	Aim	Actual Performance (2016/17)	KHT Data Available	Benchmarked/ Comparison
Safety	To build upon the work completed as part of the Trusts Sign up to Safety Pledges, by: Improving reporting rates of low harm patient safety incidents so that our reporting rate is within the second	Continued implementation of the Trusts Sign up to Safety pledges. There were 8550 patient safety incidents that were uploaded to the NRLS for the	Yes	The KHFT patient safety incident reporting rate is within the third quartile of our peers on the National reporting and Learning System (NRLS).

	quartile of our peers on the National reporting and Learning System (NRLS) by the end of Quarter 4 2017/18. Improving existing mechanisms for the identification and dissemination of learning from patient safety incidents; with complaints and claims etc.	period of 01/04/2016 – 31/03/2017		We were also ranked 136 out of 230 trusts in NHS England's 'Learning from mistakes league table'.

Measure:

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

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

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

Why we chose this indicator?

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

How will progress be measured?	NRLS data submissions and monitoring at the Clinical Quality Improvement Committee (CQIC).
How will progress be monitored?	Reporting to the Clinical Quality Improvement Committee (CQIC).
Lead Committee	Clinical Quality Improvement Committee (CQIC)
Lead Executive	Director of Nursing and Patient Experience

Priority 2 – Implement measures to reduce hospital acquired infections caused by gram negative bacteria

Goal	Aim	Actual Performance (2016/17)	KHT Data Available	Benchmarked/ Comparison
Safety	To meet the E. coli and other gram negative bacteria reporting and improvement requirements of Public Health England (PHE) and NHS Improvement (NHSI) in 2017/18	167 total cases reported, with 11 being Trust apportioned.	Yes	Not available at time of reporting

*****Data reported consists of hospital and community acquired Ecoli.*

Measure:

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

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

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

Why we chose this indicator?

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

How will progress be measured? Monthly data submission.

How will progress be monitored? Monthly reporting to Public Health England and Trust Infection Prevention Group Quarterly Reports.
Post Infection reviews will be completed on each Trust apportioned case.

	Monthly performance will be monitored by the Trust Board.
Lead Committee	Infection Control Group.
Lead Executive	Director of Nursing and Patient Experience.

Priority 3 - Improve safety awareness for staff through human factors training

Goal	Aim	Actual Performance (2016/17)	KHT Data Available	Benchmarked/ Comparison
Safety	Completion of Human Factors training by 20% (n=265) of clinical staff by the end of Quarter 4 of 2017/18. A nominated Human Factors lead in place for each Clinical Division by the end of Quarter 2 of 2017/18.	Nil	N/A	N/A

Measure:

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

Reference for data source: None

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

Why we chose this indicator?

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

How will progress be measured?	Training levels reported to the Clinical Quality Improvement Committee.
How will progress be monitored?	The development and roll out plan will be approved and monitored by the Clinical Quality Improvement Committee.

Lead Committee : Quality Assurance Committee

Lead Executive : Medical Director

Domain: Clinical Effectiveness

Priority 4 – Develop the Trust's next three year (2017-2020) dementia strategy and implement year one

Goal	Aim	Actual Performance (2016/17)	KHT Data Available	Benchmarked/ Comparison
Effectiveness	To develop the Trust's next three year dementia strategy and implement year one of the strategy.	The Trusts has opened its first dementia friendly ward. Developed a therapeutic activity programme, and a protected activity room is provided with a newly recruited permanent therapeutic activity coordinator. A new Dementia score card is in place to monitor harm and outcomes. The Trust has signed up to John's campaign and carers are welcomed outside of visiting times. There has been an increase in the dementia awareness and management training that is available to staff. Kingston carers network and Alzheimer's society have provided support to carers.	N/A	N/A

Measure:

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

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

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

Why we chose this indicator?

Over the last three years the Trust has focused on improving the care provided to patients with dementia, and support to their carers. This strategy has now come to an end and building upon this the Trust would like to develop a further strategy for the next three years. Successes over recent years include the opening of a new dementia friendly ward and the development of therapeutic activities for patients. This objective will enable the development of a new strategy to focus on areas for further development. We will commence delivery of the first year plans. Dementia remains an important concern for our local population given its prevalence and increasingly ageing population.

How will progress be measured?	Patient survey, carer survey, dementia scorecard, clinical audit, complaints Six-monthly progress reports to the Trust Board.
How will progress be monitored?	Bimonthly Dementia Strategy Delivery Group Monthly Dementia Environment of Care Advisory Group. Onward reporting to the Clinical Quality Improvement Committee and the Trust Board
Lead Committee	Dementia Strategy Delivery Group
Lead Executive	Director of Nursing and Patient Experience

Priority 5 – Increase seven day working provision

Goal	Aim	Actual Performance (2016/17)	KHT Data Available	Benchmarked/ Comparison
Effectiveness	To improve the provision of 7 day services in the Trust and improve quality of care for patients by having timely consultant ward reviews, every day, on every ward (including the acute assessment unit) The Trust will aim to meet the 4 priority standards as defined	As per the table below (audit conducted in March 2016 and Sept 2016)	Yes	National Audit of 7 Day Services results from September 2016 data table available below

	by NHS England			

Criteria	Results		Target	Standard met	Other Results		
	Number	%	%		KH compared to National Average	KH compared to London Region	March 2016
Patients reviewed within 14 hours of arrival by consultant	130/179	73%	90%	No	Weekday ↑ Weekend ↑	Weekday ↑ Weekend ↑	78%
Patients reviewed within 14 hours of admission by suitable consultant	149/179	84%		No	Weekday ↑ Weekend ↑	Weekday ↑ Weekend ↑	n/a
Suitable consultant once daily reviews	483/522	93%		Yes	Weekday ↔ Weekend ↑	Weekday ↑ Weekend ↑	56%
Suitable consultant twice daily reviews	27/32	84%		No	Weekday ↓ Weekend ↑	Weekday ↓ Weekend ↑	61%

*Key: ↑ = Higher than ↓= Lower then

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

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

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

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

Why we chose this indicator?

Emergency services are available every day in the hospital but access to seeing senior doctors and to diagnostic tests is better Monday to Friday than at the weekend. This objective would focus on delivery of the four national priorities to have available the same standards every day. These are; being seen by a Consultant within 14 hours of arrival in hospital, twice daily whilst acutely unwell and every day when needed thereafter, and access to emergency diagnostic

tests within one hour and urgent within 12 hours seven days a week. Achieving these standards will mean that we avoid delays for our patients and may reduce the length of time they have to spend in hospital.

How will progress be measured?	Via the Twice yearly national audit of seven day working.
How will progress be monitored?	Twice yearly national audit of seven day working.
Lead Committee	Clinical Quality Improvement Committee
Lead Executive	Medical Director

Priority 6 – Commence Implementation of e-prescribing and electronic clinical records in the outpatient setting

Goal	Aim	Actual Performance (2016/17)	KHT Data Available	Benchmarked/ Comparison
Safety	To improve patient safety, by undertaking a pilot to introduce electronic patient medication records in adult outpatients. Accurate and available electronic records for all patient encounters.	E-prescribing pilot lead clinician, and clinical specialty leads identified. CRS outpatient documentation templates uploaded/modified on CRS.	Yes	Pharmacy clinical and clerical intervention and incident data

Measure:

- Frequency of prescribed outpatient medication.
- Project evaluation questionnaires completed by clinicians and local CCGs.
- Boots Hospital Pharmacy data on clerical and clinical interventions.
- Ulysses Incident reporting data.
- Frequency of paper-free outpatient consultation records.
- Standardisation of outpatient workflows.
- Ulysses Incident reporting data related to record unavailability.

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

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

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

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

How will progress be measured?	Successful completion of the pharmacy pilot, with roll out of e-prescribing to all other adult outpatient specialties. Clinicians documenting outpatient notes in addition to clinic letters, which are already completed electronically and visible within the patient record on CRS.
How will progress be monitored?	Monthly monitoring of the quality measures of the pilot phase, which will be completed by the CRS Pharmacy Team. Weekly monitoring of electronic outpatient records created by outpatient clinicians and associated admin staff. An end of project report will be received by the Trust CRS Operations Group.
Lead Committee	Trust CRS Operations Group
Lead Executive	Medical Director

Domain: Patient Experience

Priority 7 – Understand and improve the experience of patients with mental health conditions using hospital services

Goal	Aim.	Actual Performance (2016/17)	KHT Data Available	Benchmarked/ Comparison
Experience	To understand the experience of patients with mental health conditions using Kingston Hospital; to increase staff awareness of the needs of patients with mental health conditions; and develop a programme of improvement	N/A	Yes in part; Incident, Complaints, Training and FFT. Benchmark data will be developed as part of the project.	N/A

Measure:

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

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

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

Why we chose this indicator?

One in four people in the UK experience a mental health problem each year. A high percentage of patients at Kingston Hospital will therefore have both a physical and mental health issue. This

objective would therefore focus on better equipping our staff to be able to recognise and care for patients' mental health needs.

How will progress be measured?

- Workforce / training data
- Patient experience data; FFT

How will progress be monitored? Project evaluation reported to HEE with oversight from the Project steering group and the new Trust Mental Health Steering Group.

Lead Committee: Trust Mental Health Steering Group

Lead Executive: Director of Nursing and Patient Experience

Priority 8 – Improve the experience of patients using the emergency department

Goal	Aim	Actual Performance (2016/17)	KHT Data Available	Benchmarked/ Comparison
Experience	To improve the experience of patients attending the main Emergency Department and the Royal Eye Unit Emergency Department	FFT rate for A&E and the REU for 2016/17 = 91.03% Total formal complaints for 2016/17 for A&E were 63, and 23 for the Royal Eye Unit	Yes	Not set

FFT:

Area	2015/16 Performance	2016/17 Performance	Benchmark/Target
Inpatient	93.00%	95.46%	96%
Outpatient	94.45%	93.31%	Not set
A&E	94.34%	94.34%	Not set
Maternity	95.37%	96.65%	Not set
Daycases	98.17%	98.33%	Not set

Measure:

- Report of improvements to physical environment of the emergency department
- Improved FFT response rate in main ED to 15% by Q4
- Consistent positive FFT feedback above 95%.
- Formal complaints rates.
- PALS data.
- Achievement of the following A&E 4hr target performance trajectories (which have been agreed with NHSI for 2017/18):

Q1	Q2	Q3	Q4
90%	**90%**	**90%**	**92.3%**

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

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

Why we chose this indicator?

The Trust sees and treats over 110,000 patients a year through its two emergency departments – the main Emergency Department (which includes paediatric A&E) and the Royal Eye Unit Emergency service. Over the last year the Trust has made further improvements to the Emergency Department, in order to improve the experience of waiting. This has included the opening of a new Clinical Decisions Unit in November 2016. We know from our CQC inspection in 2016, our A&E survey results and other sources of feedback e.g. complaints; and Friends & Family Test results that there is opportunity to improve the experience of patients using these services. This objective will therefore focus on improving the experience for patients in both the main Emergency Department and in the Royal Eye Unit Emergency Service.

How will progress be measured? FFT response rate
ED action plans from FFT feedback
Complaints/Compliments

How will progress be monitored? Monthly FFT reports
Service Line Scorecards
ED action plans from FFT feedback

Lead Committee: Patient Experience Committee

Lead Executive: Director of Nursing and Patient Experience

Priority 9 – Improve the experience of patients with haematological cancer

Goal	Aim	Actual Performance (2015/16)	KHT Data Available	Benchmarked/ Comparison
Experience	Improve the experience of patients with	KHFT scored above the national average	Yes	National Cancer

	haematological cancer.	on 5 of the 59 questions in the National Cancer Patient Experience Survey (NCPES) published in July 2016 (data collected June – September 2015). For the remaining 54 questions the Trust scored below average. The results of a local survey completed between April – June 2016 based on questions from the NCPES had similar results and identified a number of areas of focus.		Experience Survey (NCPES) Local Survey completed in response to the NCPES

Measure:

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

Reference for data source:

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

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

Why we chose this indicator?

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

How will progress be measured? National and local survey results.

	Relocation of the haematology service into the SWRU.
How will progress be monitored?	Survey results will be reported to Clinical Quality Improvement Committee Progress on the relocation of the haematology day unit to SWRU reported at the Investment Committee
Lead Committee	Clinical Quality Improvement Committee
Lead Executive	Medical Director

Part 3

5.0 Looking Back at 2016 /17

In February 2016 an online survey was conducted to identify the preferred quality priorities of Kingston Hospital NHS Foundation Trust Members and staff and other stakeholders with 304 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.

Last Year's Priorities:

Domain	Priority	Achieved
Patient Safety	1. Reduce falls in the hospital setting	Achieved
	2. Reduce avoidable harm from sepsis	Partly Achieved
	3. Reduce use of agency staff by reducing vacancies	Achieved
Clinical Effectiveness	4. Reduce readmissions in non-elective care	Partly Achieved
	5. Reduce length of stay	Partly Achieved
	6. Reduce patient reported pain	Partly Achieved
Patient Experience	7. Transform administration across the hospital	Not Achieved
	8. Improve end of life care	Achieved
	9. Improve patient experience of discharge	Achieved

Domain: Patient Safety

Priority 1 - Reduce falls in the hospital setting

Achieved

Goal	Aim
Safety	Prevent inpatient falls: Meet all 7 key commendations regarding care to avoid falls Achieve no red ratings in the National Inpatient Falls Audit and increase 2015 amber scores to green

Measure:

- Once the assessment has been implemented, the trust will be measuring the inpatient falls rate across the Trust, along with the completion rates of the falls risk assessment tool.

Reference for data source: National inpatient fall audit results.

Governed by standard national definitions? NICE Clinical Guideline 161 - Falls in older people: assessing risk and prevention and national inpatient falls audit measures.

Why did we choose this?

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.

What we said we were going to do?

- Increase the proportion of patients receiving a falls assessment/intervention against the 7 key recommendations regarding care to avoid falls.

- Continue to monitor the overall inpatient falls rate to identify any improvements and required changes to practice.

How did we do?

- A new Multifactorial Falls Risk assessment incorporating the 7 key recommendations from NICE Clinical Guideline 161, Falls in older people: assessing risk and prevention and other examples of best practice has been developed and approved for use in the Trust.

- The tool has been piloted on three wards and the tool is now being embedded across all areas.

- The repeat of the National Inpatient Falls Audit will happen in the Summer of 2017. The Trust has completed the key recommendations and expects to have made the improvements to previously red and amber rated scores.

- The Trusts 2016/17 falls rate has decreased to 5.11 per 1000 bed days, compared to 5.50 per 1,000 bed days in 2015/16.

Priority 2 - Reduce avoidable harm from sepsis

Partly Achieved

Goal	Aim	Actual Performance (2016/17)	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.	See table containing target data	Yes	No

Measure:

- Auditing of compliance with year 2 of the Sepsis Sign up to Safety targets.
- Medical staff reviews of patient records (mortality and morbidity reviews) identifying avoidable and unavoidable deaths.

Reference for data source: Clinical coding and clinical audit.

Governed by standard national definitions? Yes, NHS England Sepsis 6 bundle definitions.

Why did we choose this?

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 and improving processes, we can increase awareness of the condition and save lives.

What we said we were going to do?

Sepsis was a quality priority last year and we made a number of successful improvements. We have been focusing on achieving year 2 of the Sepsis Sign up to Safety plan as shown by the Table 1 which is in the next section.

How did we do?

These targets were achieved by the introduction of new trust guidelines, a robust education and training programme and working with teams to improve the processes to support staff to deliver timely and effective sepsis care. This year, we have also been promoting patient awareness through public information sessions and via a new page on the trust's internet site.

Table 1

Sepsis Six goals within 3 hours	Year 2 2016/17 target	Year 2 2016/17 achievement	Achieved (✔/✖)
Measure lactate levels	70%	67.9%	✖

Obtain blood cultures	60%	72.6%	✔
Administer broad spectrum antibiotics	90%	89.2%	✖
Commence IV fluids	70%	82.0%	✔

The two areas where we did not meet the target were:

1. Measuring lactate levels – The system for monitoring our performance on measuring lactate levels is reliant upon manual recording methods. To improve this we are exploring ways which will automate the process

2. Administration of antibiotics - We were short of this target by less than 1%. With the planned introduction of new Sepsis electronic alerts and screening at triage, alongside ongoing training and awareness campaign, we anticipate that we will see continued improvement in the timely screening & escalation of sepsis patients with a resulting improvement in treatment.

Priority 3 - Reduce use of agency staff by reducing vacancies

Achieved

Goal	Aim	Actual Performance (2016/17)	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 8.86% to 6.06% between 1st April 2016 and 31st March 2017. Turnover has reduced to 16.57%	Yes	No

Measure:

- Substantive establishment recruited and maintained at 95% supported by 5% temporary staffing.
- Overall reduction in vacancy target from 7% to 5% and a reduction in turnover. The target turnover was 17%.
- The temporary staffing target is 5% of spend, out of which, 40% is to be spent on agency and the remaining 60% on bank.

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

Governed by standard national definitions? No

Why we chose this indicator?

This indicator was chosen to address the high vacancy rates and introduce initiatives to reduce agency spend and recruit substantive appointments. In order to stabilise the workforce the turnover targets were increased to allow services to effectively achieve their vacancy rates. As part of the Lord Carter's review of efficient use of resources in the NHS, reducing agency costs is essential to avoid expenditure which could be reinvested in patient care.

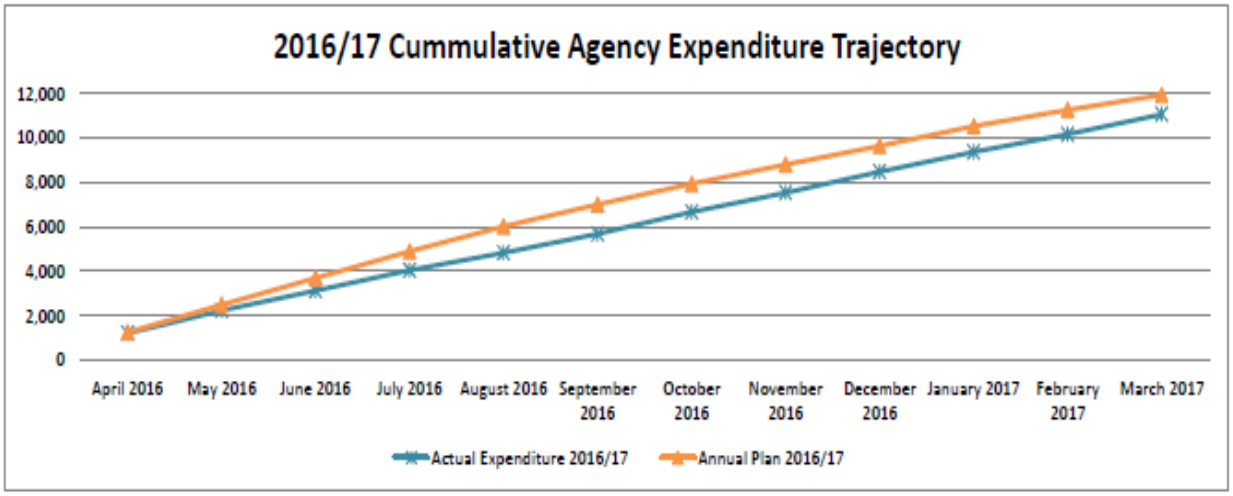
What we said we were going to do?

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

How did we do?

A number of innovative changes were introduced in the Trust last year to help address the reduction in agency staff. The active recruitment campaigns continue to rigorously recruit cohorts of Band 5 Nurses and Nursing Assistants, as well as seeking additional staff from overseas to fill vacant posts. An international recruitment campaign has successfully deployed a total of 125 Nurses for 2016/17.

The Trust now has in place 800 more substantial staff as at the end of 2016/17 than at the end of 2015/16 which has positively impacted the reliance on agency staff. The Trust currently has a 43% agency spend as 31st march 2017, which has reduced from 56%. As the below graph demonstrates the Trust spent £11.1m against a planned trajectory target of of £11.9m. The Trust is the second best performer in London regarding agency trajectory.



In addition our staff turnover rates have reduced throughout 2016/17 and are currently 16.57% which is below the target of 17% we had set. We will continue to focus on achieving further reductions to this during 2017/18.

The Trust Bank Office was successfully outsourced to Bank Partners in Feb 2017, with a strong focus on reducing agency staff, and increasing bank workers for vacant shifts. This new model will improve visibility of our temporary staff usage, as it will create a uniform and centralised system for booking temporary workers. In addition, the introduction of management information reports will allow the Human Resources leads to target areas that have high agency/bank usage and facilitate permanent recruitment.

A new collaboration programme called the South West London Bank Project which was launched early in 2016/17 will also aim to reduce the reliance on agency staff, by uniting local Trusts to drive down agency rates and volume. The project is planned for implemented in the spring of 2017 for nursing staff. A pan London project is underway to agree ceiling rates for medical locums, reflecting the challenges in controlling costs in this area.

A Workforce Pay Control Group was developed to support and advise managers with vacancy control, agency requests and temporary staffing usage. This Group review and authorise all recruitment activity across the Trust, and also monitor the agency spend. It is through this Group that the Trust has successfully reviewed and changed its overtime procedure, capped the medical locum rates and heavily scrutinised all recruitment requests.

The Safer Staffing Group continues to meet fortnightly to monitor the recruitment progress for nursing, midwifery, nursing assistants and midwifery support workers (MSW). The meeting also focuses on turnover/vacancy rates, roster management and agency/bank utilisation, and acuity data (level of nursing need per patient) for each of the inpatient areas.

The Trust will continue to align recruitment activity against temporary staffing spend, and with the support of Bank Partners and the South West London Bank Project, reduce the reliance on agency staff.

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

Partly Achieved

Goal	Aim	Actual Performance (Apr – Dec 2015/16)	KHT Data Available	Benchmarked/ Comparison
Effectiveness	Reduce non-elective readmissions following either elective or non-elective care in: A&E and Acute Assessment Unit (AAU), Respiratory; and Trauma & Orthopaedics	Kingston average percentages: A&E and AAU 16.5% (to Dec 2016) Respiratory 11.5% (to Dec 2016) Trauma and Orthopaedics 4.9% (to Dec 2016)	Yes	Peer average %: A&E and AAU 14.60% Respiratory 14.30% Trauma and Orthopaedics 4.30%

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? Yes, Hospital Episode Statistics (HES)

Why did we choose this?

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 nationally these areas provide good opportunities for improvements.

What we said we were going to do?

We said we wanted to reduce the times patients were re-admitted to hospital after being discharged, and decided to focus on emergency admissions in Trauma and Orthopaedics, our acute Medical Assessment Ward and the respiratory Ward. Each ward focussed on ensuring that:

- Discharge summaries were properly completed so that patients could go home and continue care with their GPs.
- Patients had their medication to leave hospital.
- Patients had the right information about their condition and plan. We tracked the rate of re-admissions in these areas in our monthly quality meetings so that we could track changes in the frequency of re-attendances.

How did we do?
We set a target to reduce re-admissions in these areas to the same level as our peer benchmark (within CHKS). We were able to make reductions in all these areas but were not able to reduce admissions to the benchmark in all three specialty areas. We met the reduction to national average in two of the three specialties selected. In the remaining one, we reduced readmissions but not to the benchmark level.

- Respiratory - We reduced readmissions from 11.50% to 11.30%* (Benchmark 14.30%).
- Acute assessment - We reduced admissions from 16.5% to 14.30%* (Benchmark 14.60%).
- Trauma and Orthopaedics we reduced readmissions from 4.90% to 4.70%* (Benchmark 4.30%).

**Figures are Apr – Dec 2016/17 compared to 2015/16 as full year data unavailable at time of reporting.*

We also undertook an audit with our commissioners to determine whether our emergency readmissions hospital wide could have been avoided. This identified that only 14% of the re-admissions could have been avoided.

Priority 5 - Reduce length of stay

Partly Achieved

Goal	Aim
Effectiveness	Reduce the length of stay for patients on Elderly Care, Respiratory and Cardiology wards

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 (HES).

Why did we chose this?

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.

What we said we were going to do?

- To ensure that discharge planning starts as soon as possible on admission and that plans are documented , and actioned such that the patients discharge is timely efficient and that the patient experience is optimised
- To ensure that patients are discharged home earlier in the day
- To ensure that patients receive information regarding their transfer to the discharge lounge and that the use of the discharge lounge is optimised
- To provide speciality inreach to AAU thereby ensuring that speciality clinical plans are commenced early.
- To ensure that patients are admitted to the correct inpatient speciality ward.

How did we do?

To support these aims, we have completed the following:

1. The Trust discharge policy has been reviewed and updated.
2. The patient choice policy has been reviewed and updated.
3. A patient leaflet on ‘preparation for discharge’ has been developed.
4. A patient booklet for patients with more complex discharge needs who are likely to require input from outside organisations and/ or are unable to return to their usual place of residence has been developed.

5. An electronic single referral form for inpatient wards to use when referring to community and adult social Care partners has been introduced, thereby reducing the use of paper forms and utilising the new patient tracking list (PTL).
6. Internal professional standards for clinical support services and diagnostic services have been developed.
    - An inpatient patient tracking list has been implemented to include the daily updating of the status of each patient.
    - The sharing of borough specific delays with partners.

7. In-reach is now provided by gastroenterology and cardiology and a business case to support in-reach by respiratory has now been approved and is in progress.
8. A discharge ward has been introduced to ensure that patients who are clinically optimised are transferred to a discharge area thereby allowing acute patients to be admitted to the relevant speciality ward.

Results

Whilst there is evidence of some reduction in length of stay e.g. Cardiology has reduced from 5 to 3.3 days for the first 9 months of the year, overall average length of stay (LoS) across the medical wards has remained unchanged. We have also seen an increase in the admissions of patients over 80 years of age whose length of stay has increased by 1.5 days.

Data show in the table below for period of Apr – Dec 2015/16 and 16/17. Further data will not be available until July 2017.

Period	Specialty	Length of Stay (Days) KHFT	Peer (Days)
Apr-15 - Dec-15	Cardiology	3.60	3.09
Apr-16 - Dec-16	Cardiology	3.30	3.50
Apr-15 - Dec-15	Respiratory	9.60	3.40
Apr-16 - Dec-16	Respiratory	10.70	3.50
Apr-15 - Dec-15	Elderly Care	26.10	13.80
Apr-16 - Dec-16	Elderly Care	20.80	14.60

Cardiology length of stay (LoS) reduced slightly from 3.6 to 3.3, and is now below the national benchmark of 3.5 days. The LoS for respiratory patients has not reduced since last year and remains higher that the peer benchmark. Further analysis has shown that the LoS when standardised for the severity of the patient's illness during the admission is similar to a standardised peer benchmark. Mortality indices for the patients at Kingston in this group compare favourably with national peers. In Elderly Care there has been a significant reduction in LoS by almost five days. However, it is still significantly above the national benchmark. Of note, the national benchmark in Elderly Care has increased during this period.

Priority 6 - Reduce patient reported pain

Partly Achieved

Goal	Aim
Effectiveness	To increase patient satisfaction with pain management

Measure:

- Patient satisfaction with pain management during inpatient or emergency care.
- Pain medication clinical audit results.

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

Governed by standard national definitions? No

Why did we choose this?

We know this is an area where we can make improvement 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 made 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 also wanted to ensure that we use the most effective interventions to manage pain well.

What we said we were going to do?

- Undertake a baseline assessment of our current inpatient pain management arrangements.
- Audit our documentation of pain management
- Monitor levels of patient pain satisfaction via complaints data and completion of a survey.

The Pain Management Group decided to focus on the assessment of pain in patients with dementia, delirium and confusion as a priority due to the fact it was identified as an unmet need, aligned with the dementia strategy and also the work that was being undertaken within the Trust on dementia.

How did we do?

A senior nurse “deep dive” of all inpatient areas was completed with the primary focus being to ask clinical staff (mainly qualified nurses and junior medical staff) about pain management practices and this was used as the baseline assessment. We asked:

- Whether a particular pain assessment tool was being utilised
- The process for documenting issues related to pain management
- Who staff would contact if they had difficulty managing pain both within and outside working hours.
- If training on pain management would be beneficial

The overall results were positive. The most significant observation from the deep dive identified from staff was some of the challenges around assessing pain in patients who have dementia, experiencing an episode of delirium or confusion.

Variation in the approach to pain management was identified, so a standardised tool was developed for use with patients. Reassessment of patient's pain levels following the administration of pain relief were identified as requiring improvement and staff training has been put in place to reduce variation and to ensure that patients are receiving adequate pain relief. This also answered staff requests for further updates on pain management.

In addition to the information obtained a "walk about" was attended by senior nursing staff, Governors and Non-Executive's asking patients directly about their pain management (if this was relevant).

Recommendations arising from this included:

- The monthly "deep dives" now include a question on pain management.
- Link nurses for pain management have been identified on many of the clinical areas.
- Working in collaboration with the palliative care and practice development team on training and updates for staff especially, Health Care Assistants.

A local audit on breast cancer post-surgery pain demonstrated that 90% received adequate pain relief. This audit was completed following the release of the National Cancer Patient Experience Survey, in July 2016, where the Trust achieved an overall improving cancer experience rate of 82% against the national average of 84%.

A quality improvement project on the introduction of fascia nerve blocks**,** to help control pain in patients presenting with a fractured hip, was completed during the year. At the start of this project in 2015, no patients were being offered this method of pain relief which provides significantly better pain control than opioid drugs. The work entailed changing the care pathway for the treatment of patients with a fractured hip, the provision of bespoke treatment 'packs' and training staff to carry out the pain relief procedure. The completed work was presented to the Trust's Clinical Quality Improvement Committee in August 2016 where it was reported that patients are now routinely being offered this form of pain relief as soon as they arrive in the A&E department. This improvement has been maintained with 96% of patients admitted to hospital with hip fracture over the past year offered these pain-relieving injections.

Additional training for staff in the recognition and management of pain have been timetabled to take place during 2017/18.

Domain: Patient Experience

Priority 7 - Transform administration across the hospital

Not Achieved

Goal	Aim
Experience	Transform patient administration and the delivery of outpatient services

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 did we choose this?

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. We therefore seek to improve the experience of the Trust's administration processes. We aim to reduce complaints by half through making the appointments process more straightforward.

What we said we were going to do?

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

How did we do?

Overall we have seen a reduction in the number of complaints and PALS contacts related to administration issues, however this did not quite achieve the 50% reduction in complaints we had set ourselves.

The number of administration related complaints decreased 38% between 1st April 2016 and 31st March 2017 as below:

Financial Year	No of Admin Complaints
2015-16	143
2016-17	88

The number of administration related PALS concerns decreased by 25% between 1st April 2016 and 31st March 2017 as below:

Financial Year	No of Admin related PALS Concerns
2015-16	1053
2016-17	787

In 2016/17, the most prominent three themes of PALS concerns raised were appointment administration concerns (accounting for 32% of the concerns received overall, which is a significant reduction on last year when they accounted for 46% of all concerns received.

Oral Surgery/ENT, Ophthalmology, and General Surgery/Urology received the most concerns about administration related issues predominantly about appointment administration.

We will continue during 2017/18 to make further improvements to our patient administration systems which will include:

- The service lines continue to monitor performance on phone calls, clinic letters and appointment letters timescales and reporting is undertaken via scorecards.
- An Administration Managers Forum is also in place where the service lines will continue to network to discuss any administration issues that have arisen and share solutions.
- A GP Queries email address (developed for GP's to raise non-urgent issues and concerns around patient administration) also continues to operate, and we will identify further learning from this.
- As a new appointment letter has been developed by the Outpatient Appointment Letter Improvement Group during 2016/17 and will be rolled out during early 2017/18. It is anticipated that this will reduce complaints levels during 2017/18 as it provides clearer information for patients.

Priority 8 - Improve End of Life Care

Achieved

Goal	Aim	Actual Performance (2014/15)	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. The CODE questionnaire was also used as an optional part of the National Care of Dying 4 audit, run by the Royal College of Physicians/Marie Curie in 2013. Although the Trust did not participate in the bereavement survey section of this national audit, it does provide some comparator information for this evaluation.

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? Yes NHS England

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 priority. 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.

What we said we were going to do?

1. Incorporate teaching on communication skills, Recognition of dying, symptom control and nutrition/hydration at the end of life in to regular teaching programmes and offer of bespoke training to wards/clinicians.

2. Support the role out of the of Individual Nursing Care Plan for dying patients by carrying out ward based teaching and undertake an audit to evaluate uptake and effectiveness.

3. Trial a memorial service for relatives/friends of people who have died in Kingston Hospital.

4. Develop a business case to identify additional funding to increase the specialist palliative care team for the provision of face to face 9am-5pm service from six days per week to seven.

5. Improve access and awareness of the Chaplaincy support throughout the Trust.

How did we do?

1. Sixty-two teaching sessions were carried out by the Palliative Care Team for trained and untrained nursing staff and junior doctors between 01/04/2016 and 31/03/2017. A total of 550 attended, and bespoke sessions were also provided for Allied Healthcare Professions.

2. The Individual nursing care plan for dying patients is used on all wards and several surveys/audits have been undertaken.

3. Two adult memorial services have been held, with both receiving very positive feedback. The first one took place on 25th May 2016, and the second one on 10th November 2016.

4. This service will continue to be held twice yearly, led by the hospital chaplaincy team and supported by the hospital palliative care team.

5. Funding for an additional whole time equivalent Consultant and Clinical Nurse Specialist were agreed by the Trust in April 2016, which enabled the face to face 9am-5pm 7/7 service to commence first weekend in November 2016.

6. A member of the chaplaincy team now attends the weekly hospital palliative care team multi-disciplinary team meetings following the appointment of a fixed term training chaplaincy post.

7. The Trust repeated the CODE Bereavement Survey in 2016 covering Jan-March '16. A 45% response rate was achieved (100 questionnaires were returned), compared with a 34% response rate in 2015. There are many very positive comments regarding the care received by dying patients and their loved ones in the last days of their life at Kingston Hospital and there is much to be proud of in the survey.

KHFT Bereavement survey which was benchmarked against National Audit Survey Results and the following progress was identified:

	2014/15 KHFT Score	**2016/17 KHFT Score**
Time to listen and discuss condition	Doctor Score: 79% (national score was 74%)	72%
	Nurse Score: 77% (national score was 74%)	75%
Did Doctors and nurses do enough to help relieve pain?	All of the time: 71% (National score 58%) Some of the time: 24% (National score 23%)	55% 37%
During the last 2 days involved in decisions about care and treatment.	Not involved' score: 16% (National score was 24%)	22%
Explanation of condition:	'Did not explain' score: 5% (National score was 12%	13%
-Spiritual needs were met by the healthcare team	'Strongly agree' score: 10% (national score 13%) 'Agree' score 30% (National score 26%)	12% 17%

During the year the Trust received the results of the CQC inspection undertaken in January 2016, which as is shown in section 12 of this report, End of Life care was rated good in all domains with the exception of caring which was rated as outstanding.

Priority 9 - Improve patient experience of discharge

Achieved

Goal	Aim	Actual Performance (2016/17)	KHT Data Available	Benchmarked/ Comparison
Experience	To ensure that the patient's discharge is timely, efficient and that patient experience is optimised	Year to Date Delayed Transfer of Care (DTOC) performance for 2016/17 = 6.18* 47 patients were discharged from the discharge lounge in April 2016. 70 were discharged in February 2017*	Baseline to be developed	Local DTOC target of 4% and national target 2.5%

*Data provided up to 28th Feb 2017 as data to 31st March 2017 data unavailable at the time of reporting.

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, London Quality Standards

Why did we choose this?

Local and National Health-watch feedback 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. 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.

What we said we were going to do?

- Reduce the number of delayed transfers of care and the number of internally reported delays to at least the local target of 4%.
- To ensure that discharge planning starts as soon as possible on admission and that plans are documented , and actioned such that the patients discharge is timely efficient and that the patient experience is optimised
- To ensure that patients are discharged home earlier in the day
- To ensure that patients receive information regarding their transfer to the discharge lounge and that the use of the discharge lounge is optimised
- Measure patient discharges before lunchtime.
- Friends and Family response from the discharge lounge

How did we do?

1. The Trust did not meet the 4% local target previously set. Delayed Transfers of Care (DTOC's) increased from October 2016 to November 2016 to 7% and then reduced to 6% in December 2016 and January 2017. Although in February 2017 DTOC reduced further to 5.3%, the rates remain higher than for the same period in 2015/16. However, further work on the patient tracking list and investment in the discharge team has enabled us to consistently reduce our internal delays. We hope to build on this with the simplified documentation pilot.
2. We are piloting, with all local CCGs, the use of simplified documentation to see if this can increase the speed that assessments are completed. We are also working with Yourhealthcare and Hounslow & Richmond Community Health on a discharge to assess model. We are also reviewing the impact of the discharge ward.
1. The Trust Discharge Policy has been reviewed and updated.
2. The Patient Choice Policy has been reviewed and updated.
3. A patient leaflet on 'Preparation for Discharge' has been developed.
4. A patient booklet for patients with more complex discharge needs who are likely to require input from outside organisations and/ or are unable to return to their usual place of residence has been developed.
5. An electronic single referral form for inpatient wards to use when referring to community and Adult Social Care partners has been introduced, thereby reducing the use of paper forms and utilising the new patient tracking list (PTL).
6. Internal professional standards for clinical support services and diagnostic services have been developed.
7. An inpatient patient tracking list has been implemented to include:
    - The daily updating of the status of each patient
    - The sharing of borough specific delays with partners

6.0 Other Improvements to Quality of Care at Kingston Hospital

Quality improvement projects overview

The topics for our Quality Improvement projects are chosen for a variety of reasons, where the Trust is either not performing at the standard it expects or because new ways of working show that patient care could be improved. Examples of both of these are given within this report. The Improvement work on chronic obstructive pulmonary disease (COPD) was partly instigated by the publication of the Trust's results in the COPD national clinical audit, which showed further improvement in patient care could be achieved. The example of the introduction of fascia nerve blocks in the treatment of patients with fractured hips, was chosen because this method of pain relief had been shown to be superior and in use at other hospitals. Quality improvement work is also initiated by the publication of national guidelines, the results of local clinical audit or monitoring and the internal reporting of incidents and complaints.

In the course of selecting our priorities each year, we focus on areas where there is improvement required, but in this section we want to highlight some of our other areas of focus and performance. For this report we have chosen to summarise our improvements within the 5 CQC domains – safe, effective, responsive, caring and well led.

SAFE

Increase incident reporting

We have continued to develop our use of internal and external information including our safety KPI tracking, Incidents and SIs, complaints, safety thermometer, extensive clinical audit programme and national audits to ensure that we are aware of and develop appropriate action plans and quality improvement projects targeted to our concerns.

Learning identified from our reported incidents and investigations has been discussed at specialty meetings, focussed patient safety meetings and committees. This information is also utilised by our Quality Improvement Group to help to inform our quality improvement projects. Staff are also given email feedback after reporting incidents and an investigation has been closed.

As a Trust we are aware of the benefits of involving patients, their families and carers in our incident investigations, and we actively share our Root Cause Analysis (RCA) reports accordingly and as per the wishes of our patients.

Trust-wide patient safety training has continued to raise awareness of incident reporting and investigation techniques throughout 2016/17, and there has been a 13% increase (n=677) in the number of patient safety incidents reported between 1st April 2016 and 31st March 2017 compared to the same period of 2015/16. The Trust aspires to have high levels of low harm incident reporting, as this demonstrates a no blame and pro-active safety culture.

We continually learn from all claims and Coroner's inquests, using this intelligence to identify further quality improvement projects and improve patient safety and experience, as well as, drive down the number of claims.

Duty of Candour

Duty of Candour means frankness, openness and honesty (being open). This regulation was added to the CQC Fundamental Standards of Quality and Safety in 2015 to ensure that healthcare providers, like hospitals, are open and honest with patients if there have been mistakes in their care that have led to significant harm.

We are continually developing our culture of open and honest conversations with patients and families when things do go wrong and when care has fallen below expected standards, and we support staff to do this.

We also seek out patient and carer involvement in our Serious Incident processes, discussing the findings of our investigations and actions.

Work undertaken by Kingston Hospital Foundation Trust on improving compliance with the Duty of Candour during 2016/17 includes:

- Providing multidisciplinary staff training,
- Raising awareness via discussions at staff forums,
- Updating the Trusts electronic incident reporting system to highlight where Duty of Candour could apply; and
- Introducing audits on patient safety incidents to monitor compliance with the Duty of Candour requirements.

Plans for 2017/18 include developing a patient information leaflet and a web page for staff, and continuing with Duty of Candour training.

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 in the second year of implementing the following 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. An update on the Trusts progress is given in Priority 2 of Part 3 of this document.

2. Reduce avoidable, hospital acquired grade 2, 3 and 4 pressure ulcers by 10% by March 2018. As part of the improvements in this area, we have improved communication between primary and secondary care, created an alert for inclusion within discharge summaries, and patient information leaflets are now included in the patients welcome packs given on admission. We continue to hold Tissue Viability Study Days for staff, and the investigations are overseen by the Pressure Ulcer Management Panel. Year-end figures show a further 3% reduction in the total number of patients with avoidable Trust acquired pressure ulcers, building on reductions made in prior years.

Through 2016/17, work has been undertaken to further underpin the management of the prevention of Trust acquired pressure ulcers. The time to investigate Trust acquired pressure ulcers has significantly reduced.

Improvements include:

- Development of a new Pressure Area Support Team (PAST) to assist in areas where numbers of pressure ulcers have developed with the aim of early identification and implementation of actions.
- A pressure ulcer action tracker is in place to provide assurance of the monitoring and completion of actions following pressure ulcer investigations.
- Daily MDT discussions regarding pressure ulcers are included as part of the RAG and 'Big 4'.

3. Reduce harm by introducing intrapartum fetal wellbeing assessment and management in high risk pregnancy. An update on how this is progressing is included in the Sign up to Safety in Maternity section below.

The Maternity Unit is taking part in Sign Up to Safety (SU2S) and aiming to reduce harm through the introduction of intrapartum fetal wellbeing assessment and management in high risk pregnancy.
A dedicated fetal surveillance midwife is running the SUT's project with two Consultant Obstetrician's to provide enhanced teaching on Cardiotocography (CTG) fetal heart rate 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:

- Audits and case note reviews completed and learning fed back to maternity staff.
- The maternity SUTS team have organised CTG master classes in addition to mandatory training and all midwives have attended.
- Midwives and Obstetricians complete an annual competency assessment.
- Weekly CTG reflection workshop held for all members of staff.
- Bed side teaching on daily basis to increase knowledge of interpretation of CTG.
- Reflection and reviewing performed on daily basis by SUTS midwife of cases with admission to the Neonatal Unit and emergency deliveries within the previous 24 hours.
- There is daily teaching for the band 7 midwives in the maternity unit.
- The SUT's midwife is presenting at an international conference in Sweden in May 2017.

Supervisors of Midwives Award - London Team of the Year 2016

The Trusts Supervisors of Midwives Team was recognised for this award due to the work undertaken on implementing service improvement projects that have a specific focus on raising standards and quality for local women and their families. The team have successfully raised the profile of Midwifery Supervision within the Maternity Unit: for example, the implementation of an *Advocacy and birth after thoughts service,* three years ago*.* The impact of this service has been

exceptional for women. The SoM team have worked consistently with local clinical governance structures to ensure that midwives' practice is safe and of the highest standards, by attending local and serious incident panels and instigating action plans to improve practice issues.

Some of the Kingston Supervisors of Midwives receiving their award.

Patient Safety Awards

The Trust has been shortlisted for three Health Service Journal Patient Safety Awards in maternity and urology, with the winners being announced on Tuesday 4th June 2017.

Maternity Department (Two award nominations)

- Training in cardiotocography to improve neonatal outcomes and reduce unnecessary intrapartum interventions.
- Improving the CTG monitoring and interpretation during pregnancy and labour which was a part of the Maternity Sign up to Safety project.

Urology

Cancer Services category - A long term quality improvement project to ensure that enough bladder muscle is gathered during a bladder tumour operation, which allows a better diagnosis of what stage the cancer is at and helps with deciding on the treatment.

Medicine Safety

All medication incidents are reported to the Medication Safety Officer and the CRS Pharmacy team. This has enabled the team to make changes to the electronic prescribing system to improve the safe prescribing and administration of drugs. Key changes in 2016-17 include,

- Development of a calculator available on all ward laptops to calculate gentamicin doses
- Powerplan to aid the safe prescribing of direct oral anticoagulants eg rivaroxaban
- IV aciclovir and IV aminophylline powerplans
- IV phenytoin powerplan with loading and maintenance doses
- An alert to prevent the co-prescribing of co-dydramol and paracetamol
- There has been an improvement in the scanning of patient wristbands and medication following the introduction of regular reports to the Senior nurses.

A Medicines Safety Newsletter is published bi-monthly.

As part of a CQUIN programme, Kingston hospital has collected data for Medicine Safety thermometer. Over the 2 year programme there has been an improvement in correlating our patients actual medications against those documented in our health records (otherwise known as medicines reconciliation), completed by a pharmacist within 24 hours of admission from 49% (Quarter 4 2015-16) to 74% (Quarter 3 2016-17). Following on from this audit there have been changes to the drugs available as stock on wards and how the information is accessed from the computer.

Medicine Storage and Security

The CQC inspection in January 2016 identified improvements required for the safe storage of medicines. A Quality Improvement Project was initiated by Nursing and Pharmacy with the aim of ensuring that:

- Medicines and prescription pads are securely locked away
- Temperatures are regularly monitored in areas where medicines are stored
- The use of patients own medicines is supported in accordance with Trust policy
- Controlled drugs are managed in accordance with Trust policy

The monthly audits commenced in inpatient areas in June 2016 and were rolled out to maternity, outpatients and departments in September and October.

The audits have shown continuous improvement in medicines storage and security.

The Trust's first Medicine Awareness Week was held in December 16. The aim of the week was to raise awareness of the importance of safe storage of medicines and to raise awareness on medication issues with a Medicines Awareness Trolley visiting ward and departments during the week (as pictured below). 132 nurses visited the trolley and there were 74 responses to the quiz.

Vital signs technology and Early Warning Score System

The Trusts have continued to deploy portable vitals monitors to measure patient observations (vital signs), manually record those measurements into the patient record and then manually calculate a NEWS (early warning score). The project funded by a grant from NHS Digital enabled the Trust to implement a solution for integration of Vitals Signs with Cerner Millennium via Welch Allyn medical devices. This work led to the Trust being shortlisted for a Nursing Times Award in the category of technology and data in nursing, and presentation of the project at the Cerner Health International conference in Kansas, United States of America in 2016.

A usual workflow would involve measuring observations, recording the results on paper, finding a device then transcribing the results into the clinical record. Vitals Link streamlines recorded patient observations directly into the clinical record at the point of care. The solution also supports NEWS score and sepsis alerting as the vitals signs data is run through an algorithm then presented to the Rapid response team via a dashboard.

The project has been implemented in the surgical wards, acute assessment unit, in the emergency department and the gynaecology ward. Further role out and spread is planned in 2017/18.

The project was delivered over 18 months in 3 key stages;

- Sepsis Algorithm designed (Sept 2015)
- Vitals Link tested and phased implementation (Sept 2015)
- RRT / Outreach Worklist and dashboard implemented (April 2016)

Timings of the observations recordings were taken pre and post implementation. Prior to implementation, the average time taken per set of observations is 4 minutes 18 seconds. Post implementation of Vitals Link;

The average time taken per set of observations is 2 minutes 49 seconds.

The average time saved per set of observations is 1 minute 29 seconds.

Therefore releasing time to care by;

- 26 minutes of nursing time per day
- 252 nursing hours per week
- 53% reduction in time taken to complete a set of observations
- 60% reduction in documentation time

Other benefits include

- Improve accuracy by eliminating transcription errors
- Immediate access to EWS
- Paper cost savings (4K pcm)
- Fewer delays from Observations to system time
- Fewer Incidents relating to data entry errors
- Increase in the number of patients seen by the outreach team (Rapid Response Team) as a result of receiving NEWS scores
- Speeding caseload review time by the Rapid Reponses Team by 25 minutes per shift.

EFFECTIVE

National Maternity Survey

The 2017 maternity survey is currently taking place for women who gave birth in February 2017. The findings of the last national maternity survey for women who gave birth in February 2015 were very positive, with Kingston Maternity unit ranked the best in London for care during labour. The areas which require improvement were 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 (Maternity Voices). 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.

Kingston Maternity Better Birth Pioneers with South West London Maternity and Neonatal Network

Kingston Maternity Unit is working closely with the South West London Maternity Pioneer Collaborative to pilot the National Maternity Review, Better Births. This initiative was launched in December 2016 as an 18 month pilot containing three work streams:-

- Continuity of Midwifery Care.
- Supporting choice through information and Personal Maternity Care Budgets (“My pregnancy and birth choices”).
- Testing the Market.

The overall aim of the pilot’s is to improve experiences of maternity care for women and their families through a personalised approach, whilst also improving clinical outcomes for women and their baby’s.

Diabetes inpatient management

An estimated 4.5 million people are living with diabetes in the UK, with around 700 people being diagnosed with diabetes each day, which is the equivalent of one person every two minutes. Since 1996, the number of people diagnosed with diabetes in the UK has more than doubled from 1.4 million to almost 3.5 million.

The Trust are aware that the care of patients with Diabetes needs to be improved along withenhancing the skills of our workforce.

Baseline data for Inpatient Diabetes Quality Improvement Project (QIP)
Summary results from National Diabetes Inpatient Audit 2016

Questions	2016 Kingston Hospital	2013 Kingston Hospital	2013 National average
Patient Experience (Patient survey)			
Patients reporting that all or most staff looking after them knew enough about diabetes to meet their needs while in hospital	60.8% (14)	59.6%	67.5%
Patients reporting that staff were definitely, or to some extent, able to answer their questions	87.5% (14)	83.9%	79.5%
Patients reporting that they were satisfied or very satisfied with the overall care of their diabetes while in hospital	78.3% (18)	89.3%	86.1%
Diabetes Management (Bedside audit)			
Treatment of all Hypoglycaemic episodes in accordance with local guidelines	15.4% (2)	-	-
Documentation of specific diabetic foot risk (for ulceration) examination in the first 24 hours of admission	5.6% (2)	16.3%	36.3%
Evidence of a plan for the management of the patient's diabetes in the perioperative period	33.33% (1)	-	-

In view of this we have implemented a Quality Improvement Project with representatives from all departments of the hospital with the project overview to improve in-patient care from HCA to Doctor.

The aim of this was to improve in-patient diabetes care, and the objectives were to:

- Ensure adequate knowledge of diabetes care and treatment for ward nurses, Health Care Assistants and doctors by providing specific training (time frames to be decided).

- Ensure staff are aware of available equipment and are able to use it correctly (nurses, HCAs and doctors) including yearly training for Point of Care Testing (POCT) equipment.

- Ensure safe discharge of patients with diabetes and on insulin in particular (through working with the Health Improvement Network (HIN).

- Make staff aware of what constitutes a 'diabetes incident' that should be reported.

This is an ongoing project that will continue during 2017/18, and we have already made changes to teach our clinicians additional skills.

1. We have provided 'hypo' boxes to all areas with appropriate resources to treat hypos and information on how to do it correctly. We have a training package up and running educating staff for this.
2. We are also now attending the Junior Doctors education programme to enhance their knowledge in areas of diabetes care and have provided them with quick reference cards.
3. A foot care programme about to be launched

Further initiatives are being planned to ensure patients are given the best standard of care in line with NICE and the National Service Framework which is monitored by the National Diabetes and Inpatient Audit (NaDIA).

Chronic obstructive pulmonary disease (COPD)

Improvement work on **chronic obstructive pulmonary disease (COPD)** by the Respiratory team over the past year has focused on collaboration with clinical teams in the community. A respiratory nurse and rapid access team from the community now regularly join Respiratory ward rounds to identify potential patients for discharge and ensure that services are in place. As part of this work, the respiratory team has developed a COPD discharge bundle which allows safer and more effective discharge to the community. We are also hoping to recruit a respiratory nurse to work with the in-patient teams to improve our management of patients admitted with respiratory problems, not only on the respiratory ward but in the Acute Assessment Unit too. The Trust will be monitoring improvement to patient care through the new continuous COPD national audit which started in February 2017.

We have identified the use of the discharge bundle is poor in non-respiratory teams due to high turnover of junior medical staff and as it is not a mandatory discharge document. We have identified a junior doctor champion in AAU, and have developed a business case for a specialist respiratory nurse to allow in-reach to AAU to ensure COPD patients are managed by specialist respiratory teams within 24 hours of arrival.

RESPONSIVE

Children and Young Person Board

The Children and Young Peoples Board was set up at the Trust to deliver improvement to the care of children and young people whenever they are seen in the Trust.

The Children and Young People's Board continues to meet four times a year and has representatives from all areas that see and treat children and young people, as well as a parent and young peoples representative.

New children's menu was implemented in October 2015 and in January 2017 there was food tasting session involving children, Paediatric nursing staff and paediatric dietician to look at refreshing the current children's menu.

Throughout the trust the local charity – Momentum have the following environments child and young people friendly:-

- The teenage room on Sunshine / Dolphin ward.
- 2 isolation cubicles on Sunshine ward.
- Waiting area on Paediatric Assessment Unit (PAU)/ Dolphin ward.
- The waiting area and an isolation cubicle in Paediatric A&E department.
- Play room in Royal Eye Unit (REU).
- Paediatric bay in the Day Surgery Unit including the Dental Area.
- The waiting area to the dental department (as pictured below).

The national children and young people's inpatient and day case survey has just been completed in December 2016 and Picker are currently correlating the data /results.

Inpatient survey results

July 2016 – December 2016

1. **Introduction**

Following the results of the National Inpatient Survey 2015 and proposed action plans as per report 'CQC Inpatient Survey Results 2015', the following Quality Improvement initiatives have taken place to enhance the Patient Experience in the last 6 months.

2. **Progress**

Ward Action Plans: All inpatient areas have produced bespoke action plans focussing on the following key themes; control of pain, communication, discharge and noise at night, which were identified as areas of care that needed improvement.

Each inpatient ward sister/representative has been invited to present and discuss their action plans and progress to the Patient Experience Committee.

The action plans have been circulated to all inpatient wards for review and discussion in order to ensure engagement, unveiling of ideas, consistency and ownership by staff.

Improvements have been carried out or are in the process of implementation with review on corresponding target dates. Some exceptions have resulted from barriers encountered that consist primarily of time, staff shortages or capital.

Pain: A Pain Management Group has been established that has set out a number of Projects, but is focused primarily on the assessment of pain in patients with communication difficulties and/or dementia, aligning with the trust dementia strategy.

Discharge: The Faster Flow, Safer Care and Discharge Programme was set up to ensure that patients leave hospital 'at the right time, with the right support and are discharged to the right place'. Detailed information about care and plans for discharge have been developed and delays in transfers improved. A Working Group has also been established to support the Emergency service.

Communication: The Trust is looking to provide focussed communication skills training for all staff. A number of companies are in the process of being scoped to assess the potential to develop a pan-organisation training scheme.

The delivery and review of Patient Information through the Patient Information Readers Panel (PIRP) has been changed to reflect an updated Policy. The guidelines offer a clear process which now conforms to the Accessible Information Standard.

Noise at Night: A 'How was your night?' survey has been carried out in a number of wards in order to ascertain the precise reasons for night disturbances. A ''Shhh!' campaign has been initiated which aims to encourage assessment and evaluation of ward areas and practices in order to help alleviate noise levels.

Friends & Family Test: The Trust has seen improvements to the majority of the FFT scores during 2016/17 as shown in the below table:

Clinical area	2015/16 - % of patients who would recommend to Friends & Family	2016/17- % of patients who would recommend to Friends & Family
Inpatients	93.00%	95.46%
Outpatients	94.45%	93.31%
Day cases	98.17%	98.33%
A&E	94.34%	94.34%
Maternity	95.37%	96.65%

The Trust is currently in the process of selecting a new system for patients to provide FFT feedback. One of the aims of this is to make it easier for patients to give this feedback and to increase the response rates even further. This will be implemented during 2017/18.

Training: Patient Experience will be introduced as a specific component on the Band 2 Nurse induction training schedule, in order to encourage and make aware the need for listening and responding to patients on their journey within the hospital.

The Quality Improvement Volunteers have proven to be a valuable asset in their continued participation of improvement initiatives and for their valued opinions as patient representatives at the PEC and PIRP meetings. Examples of some of the work completed include:

- Scoping the participation of patients and the public in Kingston Hospital's research portfolio;
- Working with patients to develop recommendations for Matron's on the theme of 'Dignity At Night';
- Commenting on Trust policies and information e.g. the Serious Incident Leaflet for Patients & Staff, and the Pressure Ulcers Patient Passport; and
- Membership of a number of Quality Improvement Volunteers' Forums e.g the Lay representative to Sign Up To Safety Steering Group and Sepsis Campaign.

Cancer performance and experience

The trust has continued to achieve all cancer targets in 2016/17, as shown in the table below, this is demonstrated with the green RAG grading. In quarter 3, the trust was reported as the best performing trust for the 62 day target in the country and the highest performing trust in London for the 62 day standard in January 2017. The trust has consistently achieved 10% higher than the reported national and local cancer performance against the 62 day standard.

In July 2017 we were successful with an NHS England bid to become 1 of 5 pilot sites for the 28 day faster diagnosis project, this pilot will shape the cancer targets for 2020, as from 2020 all patients are to wait no longer than 28 days after a GP referral for suspected cancer to hear if they do or do not have cancer. Test sites will help develop the rules for the new standard, and begin testing its implementation over the next year. This is a huge achievement, as a number of trusts across London expressed an interest in participating in this pilot and we were the only successful trust in London.

The Trust has an Improving Cancer Services Group, which consist of people who have either had cancer themselves or cared for a loved one with cancer. The group has successfully led on a number of real time patient feedback surveys including haematology, colorectal and breast. The results of these surveys have ultimately enhanced our service delivery and facilitated improvements in practice.

The trust has also been successful with a number of Macmillan bids which has enabled us to extend our palliative care service to a 7 day service, increase our acute oncology team and extend our counselling service to cover inpatient care.

Indicator	Standard	1 Apr 2016 - 28 Feb 2017	Red/Amber/Green (RAG)
All cancers: 62-day wait for first treatment from:			
- urgent GP referral for suspected cancer	greater than or equal to 85%	94.00%	
- NHS Cancer Screening Service referral	greater than or equal to 90%	96.30%	
All cancers: 31-day wait for second or subsequent treatment, comprising:			
- Surgery	greater than or equal to 94%	98.90%	
- 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%	99.70%	

Cancer: two week wait from referral to date first seen, comprising:			
- all urgent referrals	greater than or equal to 93%	98.20%	
- for symptomatic breast patients (cancer not initially suspected)	greater than or equal to 93%	98.70%	
Data source: National Cancer Database			

Proactive care of elderly patients in surgery (POPS) service

Following the publication of the NCEPOD report into Elective and Emergency Surgery in the Elderly: An Age Old Problem in 2010, and with more recent guidelines including those released in 2014 by the Royal College of Anaesthetists into Perioperative Medicine it has been increasingly recognised that geriatricians play an important role in the surgical pathway. The POPS service was introduced at Kingston Hospital in March 2016. We now provide twice weekly Consultant Geriatrician led multi-disciplinary team meetings to facilitate complex discharges and recognise those patients that require medical input on the surgical wards. There are regular Consultant Geriatrician ward rounds to support the Surgical teams in providing care for the complex older patients, focusing particularly on issues of frailty, including delirium and falls prevention and management. This has resulted in more timely discharge of our patients and improved confidence in our staff managing frailer surgical patients, which resulted in the POPS team being nominated for the Trust's team of the year awards.

We have also initiated a weekly preoperative multidisciplinary meeting attended by Consultants from POPS, Orthogeriatrics and Anaesthetics, as well as the preoperative nurses, to discuss patients with complex medical and social needs requiring future surgery. Early recognition and management of these complex patients in the surgical pathway will reduce the number of cancelled operations; enable us to provide higher quality inpatient care with a focus on frailty, delirium and falls; support timely discharge from hospital. In the future we hope to provide a specialist POPS Consultant led clinic to facilitate this service further.

CARING

Volunteering Report

The Trust has 450 volunteers who have committed to their roles for a two year period. Of these, 37% were recruited in the past year, 63% have been volunteering for the trust for 12 months or longer.

There are twelve established services delivered by volunteers including:

- Patient experience support in the Emergency Department
- Therapeutic Activities for patients with dementia
- Royal Eye Unit Patient Support and
- Paediatric Play Volunteers.

Volunteering roles are responsive to changes across the Trust, and these have included the provision of a new Main Outpatients' Navigator role, to help orientate patients around the newly refurbished department. The Trust established its Discharge Pathway Support Volunteering service at the beginning of 2016, to build on the pilot 'Hospital 2 Home' which now incorporates an approach to care planning that enables patients to access community and voluntary services, thereby ensuring that they are discharged from hospital to their home quicker.

Volunteering can opens doors to careers in midwifery, medicine, nursing and the health voluntary sector. The largest group of our volunteers are aged between 16 – 25 years (38%), with 16% being between the ages of 56 – 75 years. Over 10% of our volunteers are aged 75 – 95.

The pathway to becoming a volunteer has been substantially reduced to six weeks since the introduction of online recruitment. Volunteers also manage and book their volunteering online, giving them greater flexibility as this can be completed via a smart phone or tablet.

The volunteering achievements of changing lives and living the values through their contribution are celebrated via the annual Unsung Hero and Volunteering Values Awards. The 'Personal Impact' Award was won by Paul Horsecroft during 2016/17, and he is now a Trust Transport provider employee. Scott Whittington received the Unsung Hero Award, and was nominated by the Emergency Department Team for his approachability and manner with elderly patients and those with mental health issues during his weekly Friday night session.

We continue to be a sector leader in Volunteering in Public Services, with the Helping in Hospitals toolkit being launched in November 2016. This features the work and results of Kingston's volunteering programme. The social innovation charity Nesta named the Trust's "Hospital to Home Service" as one of its eight 'Not to be missed' impacts of 2016, and most recently, the Volunteering Service has been shortlisted as one of eight finalists in the 'Value in NHS Support Services' category in the Health Service Journal annual awards. The results will be available in May 2017, however, the recognition of being shortlisted is a huge achievement.

Patient and Public involvement Strategy

The Trust strategy to improve patient and public involvement (PPI) has led to greater inclusion of and collaboration with the public.

The scope of PPI activity is increasingly representative of the local demographic with a large number of voluntary organisations working collaboratively within the service lines: The Thomas Pocklington Trust (REU) National Deaf Association (ENT), Kingston Carers' Network (Care of the Elderly), Kingston Dementia Action Alliance (Dementia Strategy and umbrella network), Age UK Richmond (Care of the Elderly), Victim Support (Wolverton Centre), Momentum (Paediatrics).

There are also a number of new and established 'user groups' which combine expertise from inside and outside the hospital including: Cancer Board and Service User Group, Dementia Strategy Working Group, Patient Information Reader Panel, Paediatric Child and Parent Panel, Maternity Service User Panel, Vision Aid (REU), Macmillan (Sir William Rous Unit). Furthermore staff attend external groups including those led by Health Watch and the Learning Disability hospital interest group (HIG).

The annual patient led assessment of the care environment (PLACE) is representative of, and inclusive of, those with learning and physical disability. Recent findings led to improved signage for those with a visual impairment and informed the dementia environmental improvement programme.

The Trusts collaborative relationship with Healthwatch continues to provide valuable insights that inform improvements; information gathering exercises at discharge and outpatient appointments took place throughout November and December 2016, and the findings from these exercises will be available in May 2017.

There is some integration within the service line structures by volunteers who support PPI activity; supporting patients to express their views using the friends and facility test, and drawing on their insight as volunteers to represent the patient in service improvement projects.

Experienced patient advocates inform new and established influential groups including; the Patient Experience Committee, Children's and Young person's Board, Cancer Board and Nutrition Steering Group.

The public can hear of and comment on trust actively through the Annual General Meeting, the public Trust Board, associated published papers, the Hospital Oversight and Scrutiny Committee, via The Council of Governors the Members newsletter and increasingly, communications through social media (Twitter) and the website. Displays around the hospital inform patients and visitors of the trust's strategic priorities and response to patient feedback.

Patient and carer feedback methodology meets regulation with many areas exceeding FFT response rate targets. There is a need to further increase responses in the A&E and outpatient settings and a review of an alternative system to deliver this is currently taking place. Response rates through national surveys are in keeping with service activity. Feedback through FFT, Local surveys, National surveys, NHS choices, complaints and compliments are analysed and presented through the Patient Experience Committee and cascaded through service lines.

The Chaplaincy team have recently researched the faith practices of the local population to ensure the chapel offers services and support representative of the populations needs. By hosting engagement events for staff and the public the service seeks to develop a range of cultural, spiritual and wellbeing events though the year.

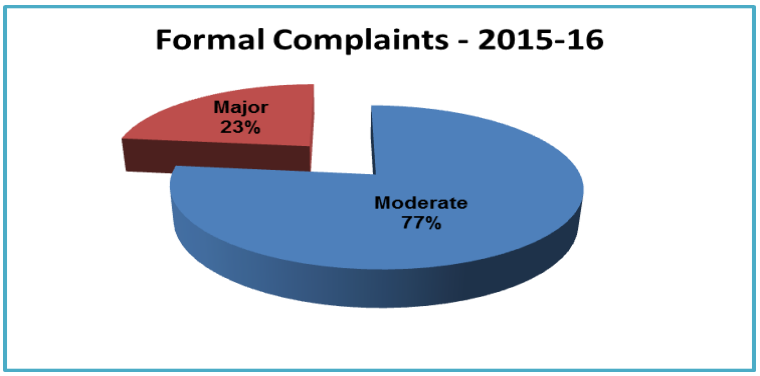
Supported by Your Healthcare and experts in supportive communication the Trust hosted an engagement event in February 2017 designed to enable the learning disability community to have a stronger voice.

There is still more to be achieved as the demographic of the locality evolves; engagement and collaborative working with local organisations is generally opportunistic. The specific focus in 2017/18 to ensure interactive (face to face) engagement is representative of the increasing Black Asian & Minority Ethnic (BAME) community and in particular the Korean community.

Complaints Performance

There has been a significant decrease in complaints during 2016/17 as shown in the table below, with the volume of complaints diminishing, and the proportion of those complaints that are graded as major remaining stable.

Total complaints 2015-16 (is this for 01/04/2015-31/03/2016? Yes)	Total complaints 2016-17 (1 Apr 16 to 31 Mar 17)
465	**391**



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. Our response rate for 2016/17 is currently is 81% (excluding March 2017 as the response rate cannot yet be measured for the complaints received in March 2017). Complaints can be made in writing or by email, and information about how to do this is on the hospital website.

The most prominent three themes of complaints this year were communication and care/treatment (accounting for 21% each of the total complaints received), and appointment administration (14%). In 2015/16, communication related complaints accounted for 22% of the complaints received, and appointment administration, and care and treatment 17% each.

The Trust undertakes a complaints survey and there is accessibility to complain through the Trust website which was introduced during 2016/17. A questionnaire is sent to complainants to understand their experience of the complaints process. The responses for 2016/17 showed that the majority of the complainants felt confident about making a complaint, and found it easy to complain. The majority of the complainants felt that we responded to their complaint well. About half of complainants felt that their complaint had made a difference. 59% of complainants responded that they feel very confident about making a complaint in the future. Improvements have been made to the process as a result of feedback e.g. simplification of the acknowledgment letter.

Patient Advice and Liaison Service (PALS)

There has also been a decrease in PALS cases during 2016/17 as shown in the table below

PALS Cases 2015-16	PALS Cases 2016-17
1582	**1467**

The most prominent three themes of concerns raised were appointment administration concerns (accounting for 32% of the concerns received which is a significant reduction on last year), communication concerns (25%), and care and treatment concerns (14%). In 2015/16, appointment administration concerns accounted for 46% of the concerns received, communication concerns 25%, and care and treatment concerns 10%.

Nutrition

The Trust Food and Nutrition Group have steered a number of key projects to improve nutrition during 2016/17.

Kingston Hospital undertakes an audit of nutrition and hydration twice a year to ensure patients are receiving the best care and provide assurance that our practice is compliant with the 'Essence of Care' nutrition benchmark and NICE guidelines 'Nutrition Support in Adults', as outlined in our local Nutrition policy. Improvements are noted compared with the 2015 audit. Current activity is focusing on improving the documentation of care supporting patients assessed as 'nutritionally at risk'; including the electronic recording of careplans and fluid balance charts.

A clinical audit carried out in February 2016 by the Gastroenterology team revealed that documentation of nasogastric tube insertion and placement checks is variable. In July 2016, new NPSA guidance was published containing five recommendations to be met by all organisations where patients are given nasogastric or orogastric tubes. In response:

- New Enteral Feeding Guidelines were approved and rolled out following review of current best practice and evidence base.
- A trial of the nasogastric tubes used by other organisations was completed to inform the commissioning of new tubes which allow increased x-ray visibility and have clearer markings.
- The electronic record system is being amended to record nasogastric tube placement and prompt staff in the safe management of a nasogastric tube.
- A quality improvement project will run through 2017/18 focussing on all adult inpatient areas including ITU and the emergency department, to ensure that care and decision making is now consistently delivered according to best practice, that staff access relevant training and that there are robust monitoring processes in place.

The Trust is complaint with NICE Quality Standards QS111 'Obesity in adults' which ensures providers have strategies in prevention and lifestyle weight management.

The continued drive to provide healthy and enjoyable food has meant that the Trust has worked closely with our onsite catering retailer ISS in order to improve the quality of the inpatient menu for both adults and paediatrics. The Trust holds regular and well attended Come Dine with Me sessions, including Volunteers, Clinical Staff and Healthwatch Patient representatives to taste and provide feedback on new food items that may go onto the inpatient menu. The menu is updated seasonally, with a Spring / Summer menu and an Autumn / Winter menu.

The work done to improve the quality of the inpatient food has been reflected in the Trust scores for Food in the annual PLACE inspection. Since 2015 the Trust has cored over 90% in the food element of the PLACE assessment, well above the scores for previous years. This is also consistently above the national average. In the PLACE cycles for 2015 and 2016 the Trust has ranked in the top ten for Acute Trusts in the London Commissioning region.

The Trust has also worked closely with our onsite retailers ISS, Pelican Rouge and RVS in order to achieve compliance with the Healthy Eating CQUIN, which is focused upon achieving a step change in the health of the food offered on site for visitors and staff. By working closely

with our onsite retailers the Trust has achieved compliance by January 2017, two months before the required completion of March 2017.

As part of the CQUIN the Trust worked with our onsite retailers and held well attended Healthier Product tasting sessions, with each retailer demonstrating a range of healthy products for staff to sample.

The Healthy Eating CQUIN also forms the basis for the Trust's Food and Drink Strategy, so that the continued drive to provide healthy and enjoyable food forms the basis of the Food and Drink Strategy.

The Trust Food and Strategy is reviewed annually, in order to maintain compliance with the latest legislation and policies.

The Trust has been featured in the London Hospital food campaign in March 2017 as a best practice example.

Mental Health

Throughout 2016/17 the Trust has strengthened relationships with mental health providers and support agencies leading to increased out of hours support by Children's Mental Health Services (CMHS), the appointment of a Consultant Liaison Psychiatrist and a new multi-agency Mental Health Steering Group which met for the first time in Quarter 4 of 2016/17. The Trust has delivered on a Dementia strategy providing a supportive care environment and range of therapies to patients with dementia. The psychiatry liaison service hosted by the Trust delivers mental health training to general health staff, and we have received funding or additional training during 2017/18. The Safeguarding Steering Group have delivered a programme of training to multi-professionals across the Trust in the application of the Mental Capacity Act and improved the e-documentation of safeguarding, and communication to safeguarding leads in the Local Authority, from triage in ED to wards and department; which includes vulnerable patients with mental health conditions.

Following a bid for funding, the Trust has received a grant in January 2016 from Health Education England to provide additional training to staff, including mental health first aid training. This will be provided in collaboration with South West London and St Georges Mental Health Trust.

Dementia

Environments

The Trusts first dementia friendly ward was opened and dementia friendly environments were established, including the refurbishment of Derwent Ward in November 2016, which included:

- **Use of colour for wayfinding and navigation-**to help patients find their way around the ward more easily.
- **Lighting**- new LED adjustable lights reduce glare and can adjust to time of day, one bay has human centric lighting that mimics natural daylight outside.
- **Flooring-** matt, non-shiny flooring has been replaced throughout with a homely wood effect floor with no harsh changes in colour.

- **Artwork-** images of the local area were used to help orientate patients to Kingston and images of nature to help calm patients.
- **Social Spaces-** 5 new social spaces have been introduced for patients and their families to sit away from their bed sides, including a homely day room with sofas and large armchairs.
- **Decluttering/increasing Storage**- by creating more storage, the corridors are now clear of equipment, allowing clear access for patients to walk around.

All public toilets across the trust have had their doors painted yellow with dementia friendly pictorial signage on each door to make toilets more visible to patients with dementia. All new toilets have contrasting toilet seats and grab rails and dementia friendly taps

Activities

We have developed a new activities timetable, and have recruited a permanent therapeutic activity coordinator enabling the following activities to be available to all patients:

- Breakfast club
- Lunch Club
- Hairdressing
- Bingo
- Memory games
- Exercise class
- Arts and Crafts
- Music group

The activities are very popular and are supported by dementia volunteers and students from Kingston University have been involved in running a music group. Patients enjoy spending time in the activities room on Derwent ward and often meet with relatives in there instead of at the bed side. All wards also have activity boxes with access to reminiscence materials for patients and the activity team are working with Remind me care to introduce digital reminiscence software via Ipads onto the ward.

Monitoring
Dementia score card in place to monitor harm and outcomes

Involving carers
There are now two chairs that fold out into beds for carers who wish to stay with their relatives on the wards. Two members of the trust have been asked to become ambassadors of John's campaign, a campaign to allow carers to stay with their relatives outside of visiting times and involve them in their care. The Trust carer's policy has been updated to include this.

Since December 2016 the Alzheimer's Society has supplied a dementia support worker one day a week to talk to carers and provide advice and support and refer them to their local support worker.

Kingston carers network and Alzheimer's society also provide support to carers.

Staff Skills
Dementia awareness training is now delivered to all clinical staff on corporate induction in a 45 minute session. This has been accredited by the Alzheimer's society dementia friends initiative, so that all staff trained can become dementia friends.

A full day on dementia management is delivered during the two week induction course for new band 2's and 5's and is open to other staff to attend.

Bespoke training sessions have been delivered to the following departments ED, Royal Eye Unit, Radiology, Audiology, Phlebotomy, security, Palliative Care, Out Patients.

WELL-LED

Health and Wellbeing Maternity Projects

Kingston Maternity Service were delighted to be one of two national winners of the NHS England Maternity Experience Challenge fund in March 2016 to fund 'Nobody's Patient' Project which built on the foundations of the original London SCN maternity experience initiative, focusing on the co-production of bespoke *WhoseShoes?*® user experience workshops scenarios. The new project took crowd sourced feedback from women and families experience of care in three sensitive 'seldom heard' groups and who often fall into 'gaps' between services:

- families with babies in NNU and paediatrics;
- severely ill women faced unexpectedly with a serious illness in pregnancy and the postnatal period;
- mid-trimester loss.

Successful test workshops involving staff and families were held in July and September 2016 at Kingston and St Georges. Numerous improvement pledges for action were made at the events, some examples of those already completed are:

- Introduction of diaries for babies to facilitate communication between parents & staff
- Rewording the letter sent out to parents when a risk investigation has been instigated to make it more user friendly.
- Naming the new 'High risk triage' the Oak room
- Changing the self-referral form to allow women a free text box to tell us what is important to them

We have produced 100 new scenarios & 14 new poems across these three seldom heard groups to use in the Whose Shoes? Game which are being disseminated to twelve other Trusts already familiar with the approach.

We are nearing completion of the new supplementary booklet which can be used in hospitals across London and beyond as well as developing a booklet of best practice case studies of co-produced solutions which can be replicated in other Trusts.

The project team led by Florence Wilcock consultant and Sam Frewin Project midwife have presented our work at a number of national maternity events including The Kingsfund, Mbrrace and NHS Expo. We are hosting an end of Project event on 22nd March 2017.

Staff Survey Results 2016

The 2016 staff survey results were published in March 2017.

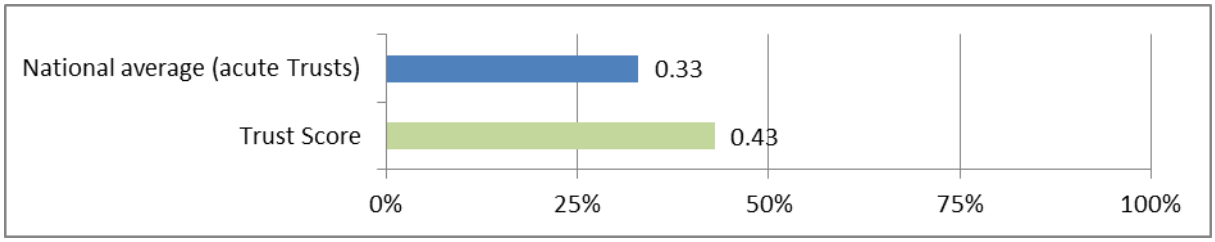
They show:

- Kingston Hospitals response rate increased from 46 to 51.1%.
- Over 50 of the Trust scores showed significant improvement including those around engagement, patient safety and quality of services.
- The Trust improved its overall performance to be ranked 36th out of 98 Acute Trusts nationally (up 6 places).
- Three areas for improvement were highlighted however in training, bullying(including discrimination) and health and wellbeing.
- The Trust has developed Board level plans to address these areas of deficit.
- A series of events for staff will be held in May to engage further on the survey and the Trusts plans for further improvement.

When benchmarked against the national survey the Trusts Top 5 questions were:

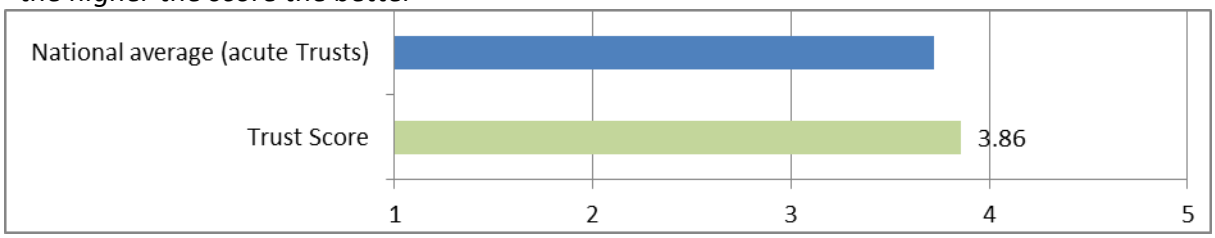
1. KF6: Percentage of staff reporting good communication between senior Management and staff

**the higher the score the better*



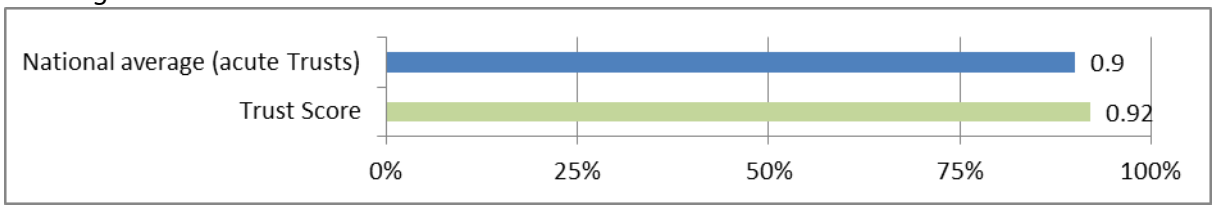
2. KF32: Effective use of patient / service user feedback

**the higher the score the better*



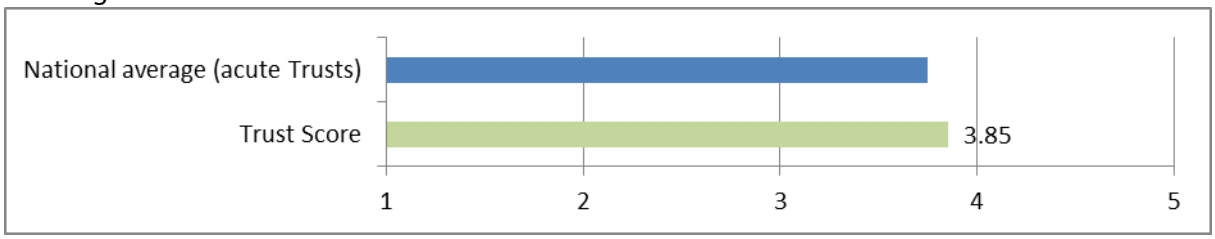
3. KF3: Percentage of staff agreeing that their role makes a difference to patients/service users

**the higher the score the better*



4. KF9: Effective Team Working

**the higher the score the better*



5. KF22: Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12months

**the lower the score the better*

The results of the staff survey show we have improved in 55 areas and we have scored in the top 20% of all acute trusts in 13 of those areas.

More staff have said they would recommend us to family or friends for treatment and this has risen from 68% to 75% and is the highest score in south west London. In addition, one of the biggest improvements is the score for the number of staff recommending the Trust as a good place to work, which has increased from 59% to 69% with the average score for acute trusts at 62%.

Furthermore, 92% of staff feel that their role makes a difference to patients and service users. The trust also has one of the highest scores for acute trusts for effective communication between staff and senior management. The results show improvement from 46% to 51% and the average score for acute trust is 41%.

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

Key Finding 21 % believing that the organisation provides equal opportunities for career progression or promotion	
Kingston Trust in 2016 Average score: 83	(median) for acute trusts: 87

**the higher the score the better*

Key Finding 26 % experiencing harassment, bullying or abuse from staff in last 12 months	
Kingston Trust in 2016 Average score: 27	(median) for acute trusts: 25

**the lower the score the better*

These results from both of these areas form part of the Trusts action plan in response to the staff survey and workforce race equality standards (WRES).

7.0 Overview of Services

During 2016/17 the Kingston Hospital NHS Foundation Trust provided and/or subcontracted 57 relevant NHS services, for adults and children in the following specialities:

Accident and Emergency

General Surgery

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

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

The income generated by the relevant health services represents 91.7% of the total income generated from the provision of relevant health services by the Trust for 2016/17.

8.0 Single Oversight Framework

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

There are five themes to the Single Oversight Framework:

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

Text in brackets indicates where NHSI is working increasingly collaboratively with the Care Quality Commission to monitor quality standards and delivery.

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

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

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

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

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

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

Ref	Metric	Q1	Q2	Q3	Q4	Target	Q1	Q2	Q3	Q4	YTD
k6.02	RTT 18 weeks - incomplete					92%	96.7%	95.9%	95.2%	94.9%	**95.7%**
k6.06	A&E 4 hour waiting time (all types)					95%	93.0%	92.5%	87.8%	87.0%	**90.1%**
k6.16	Cancer - Two month urgent referral to treatment wait (from urgent GP referral) - post local breach allocation					85%	94.1%	94.1%	93.4%	92.8%	**93.7%**
k6.17	Cancer - 62 day wait for first treatment following referral from an NHS Cancer Screening Service - post local breach re-allocation					90%	93.8%	95.2%	100.0%	95.0%	**96.3%**
	Cancer - Two month urgent referral to treatment wait (from urgent GP referral) - pre local breach allocation										
	Cancer - 62 day wait for first treatment following referral from an NHS Cancer Screening Service - pre local breach re-allocation										
k6.15	Cancer - 31 day second or subsequent treatment - surgery					94%	98.0%	98.1%	100.0%	100.0%	**98.9%**
k6.14	Cancer - 31 day second or subsequent treatment - drug					98%	100.0%	100.0%	100.0%	100.0%	**96.3%**
k6.13	Cancer - Patients receiving first definitive treatment within one month (31 days) of a cancer diagnosis					96%	99.6%	100.0%	99.6%	99.4%	**99.7%**
k6.11	Cancer - Two week wait					93%	97.7%	98.1%	98.8%	98.3%	**98.2%**
k6.12	Cancer - Two week referral to 1st outpatient - breast symptoms					93%	97.1%	100.0%	99.5%	97.8%	**98.6%**
k1.08	C.Diff due to lapses in care (YTD)					2.25	0	0	0	1	**1**
k1.07	Total C.Diff YTD (including cases deemed not to be due to lapse in care and cases under review)						2	5			**16**
	C.Diff cases under review						0	0			**0**

9.0 Monitor Risk Assessment Framework

The list of indicators for the period of 1 April 2016 – 30 September 2016 that apply to Kingston Hospital NHS Foundation Trust are included within the Single Oversight Framework.

10.0 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 2016/17, 33 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 97% (32/33) 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 2016/17 and for which the data collection was completed during 2016/17, are listed in Appendix 3 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 26 national clinical audits, applicable to Kingston Hospital, were published during 2016/17 and of these 26 were formally reviewed during 2016/17 (the remainder awaiting review). The actions we intend to take to improve the quality of healthcare are included in Appendix 4.

The reports of 140 local clinical audits were reviewed by Kingston Hospital NHS Foundation Trust in 2016/17. Examples of improvement actions taken as a result of national and local audit are shown in the table below.

Clinical audit results are discussed at clinical meetings in local departments and at wider meetings such as the Trust's annual Clinical Audit and Improvement Seminar. The results of both national and local clinical audits are used to drive local quality improvement. More detailed information about the actions we have taken from clinical audit will be available in our Clinical Audit and Effectiveness Annual Report, via the Medical Director's department, from July 2017.

National and local clinical audit results are used primarily by Kingston Hospital to improve patient care where gaps are found but are also used as assurance that the hospital is following best practice guidance. Four examples of how clinical audit results have provided assurance and improved care during 2016/17 are given in the boxes overleaf.

Clinical audit driving improvement	
National audit Results from the National Heart Failure audit highlighted some areas for improvement. The Trust implemented a Quality Improvement Project to increase the number of heart failure patients seen by a Heart Failure Team. The Team has been expanded by the appointment of two full time Heart Failure Nurse Specialists and a Consultant Cardiologist specialising in the treatment of heart failure. This has resulted in the creation of a Heart Failure referral pathway. Preliminary results suggest an improvement in the number of patients being seen by the member of the specialist team.	Local clinical audit In February 2016, the dermatology team carried out a local audit of current practice in the management of atopic eczema in patients under the age of 12 to assess practice against guidelines from the National Institute for Health and Care Excellence (NICE). Issues were identified with the documentation of information given to patients, and some aspects of assessment and treatment. A patient assessment proforma was developed to support clinicians in documenting their assessments, discussions and management plan to ensure that all patients were treated in accordance with best practice. A re-audit in September 2016 found marked improvements in the recording of assessments, treatment and information given to the patient. For example, in the re-audit 100% of patients had treatment

	tailored to deal with flare-up of their eczema compared to just 64% in the previous audit. The re-audit also showed large improvements in patients receiving a psychosocial wellbeing assessment (94% compared to 16%) and assessment of quality of life and trigger factors (100% compared to 66%).
Clinical audit providing assurance	
National audit The National Paediatric Diabetes audit (latest report published February 2017) continues to provide assurance that Kingston Hospital shows HbA1c results that are better than the national average. There has also been an increase in data completion rate.	Local clinical audit Oxygen is a drug which should be prescribed in all but emergency situations. Failure to administer oxygen appropriately can result in serious harm to the patient. The British Thoracic Society (BTS) national audit carried out in 2012 showed that at Kingston Hospital only 15% of patients had a prescription for the oxygen that they were receiving, and only 7% had a prescription that included a target range. In response to these results a quality improvement project was set up and succeeded in increasing the proportion of patients prescribed oxygen to 66% in the BTS national audit in 2015, in line with the national average. Oxygen prescribing is now monitored through a monthly local clinical audit and results have continued to improve. Since October 2016, results have been consistently above 70%. In February 2017, 75% of patients receiving oxygen, outside of emergency situations, had their oxygen prescribed, and all those patients had oxygen saturations within the prescribed target at the time of the audit.

11.0 Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 380 (portfolio studies only).

The Trust was involved in conducting 46 clinical research studies during 2016/17.

There were 128 clinical staff participating in research approved by a research ethics committee at the Trust during 2016/17. These staff participated in research covering 16 specialities.

12.0 Use of the CQUIN Payment Framework

A proportion of income for Kingston Hospital NHS Foundation Trust in 2016/17 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 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 2016/17 the Trust had a contract value of £181,554,668 for CQUIN activity (in the previous year, the value of this activity was £4,133,602). The table below illustrates how the Trust performed against the CQUIN schemes.

CQUIN	Contract Value	CQUIN Value	%Achieved	Value achieved
National Achievement	**£181,554,668**	£1,999,775	80%	£1,599,820
Local Achievement		£1,999,775	100%	£1,999,775
GRAND TOTAL:		**£3,999,550**	**91%**	**£3,599,595**

The table below summarises the different schemes that the Trust engaged in during 2016/17:

THEME	AIM	CQUIN ACHIEVEMENT
National CQUIN 1. NHS staff health and wellbeing	1a. Introduction of health and wellbeing initiatives.	100%
	1b. Healthy food for NHS staff, visitors and patients.	100%
	1c. Improving the uptake of flu vaccinations for front line staff with providers.	50%
National CQUIN 2. Identification and early treatment of Sepsis	2a. Timely identification and treatment for sepsis in emergency departments (a) Screening (b) Antibiotic administration	48%
	2b. Timely identification and treatment for sepsis in acute inpatient settings (a) Screening (b) Antibiotic administration	
National CQUIN 3. Antimicrobial resistance	3a. Reduction in antibiotic consumption per 1,000 admissions	100%

and antimicrobial stewardship.		
	3b. Empiric review of antibiotic prescriptions	100%
Local CQUIN 4. UEC Transition and transformation		100%
Local CQUIN 5. OBC/Joint care		100%
Local CQUIN 6. Medicines management		100%
TOTAL:		**90%**

CQUINS for 2017-18

The total value of 2017-2019 CQUINs is approximately £1.87 million.

Local CQUIN 2017/18

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

National CQUINs 2017/18

The national indicators are:

1. Improving staff health and wellbeing.
2. Reducing the impact of serious infections (Sepsis).
3. Improving services for people with mental health needs who present at A&E.
4. Offering advice and guidance (A&G).
5. NHS e-Referrals.
6. Supporting proactive and safe discharge.

National CQUIN Goals

CQUIN indicators	**Aims**
1. NHS staff health and wellbeing.	Introduction of health and wellbeing initiatives.
2. Reducing the impact of serious infections (Sepsis).	1. Early intervention of Sepsis 2a. Timely identification and treatment for sepsis in emergency departments (a) Screening (b) Antibiotic administration (c) Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72

	hours. (d) Reduction in antibiotic consumption per 1,000 admissions.
3. Improving services for people with mental health needs who present at A&E.	Reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable.
4. Offering advice and guidance (A&G).	A&G in the context of this CQUIN refers to structured, non-urgent, electronic A&G provided via telephone, email, or an online system. CCGs may agree with trusts how the local programme of A&G will operate, and the definition of an A&G response may include: • Virtual review of test results (e.g. ECG, bloods) and advice on next steps required • Supply of a suggested treatment or management plan to the GP (which may include carrying out further investigations in primary care) • Direct booking of diagnostic test (e.g. endoscopy) • Direct booking of intervention, where indicated • Advice on the appropriate clinic referral (reducing redirected appointments)
5. NHS e-Referrals	This indicator relates to GP referrals to consultant-led 1st outpatient services only and the availability of services and appointments on the NHS e-Referral Service. It is not looking at percentage utilisation of the system. All providers to publish ALL such services and make ALL of their First Outpatient Appointment slots available on NHS e-Referral Service (e-RS) by 31 March 2018 following the agreed trajectory.
6. Supporting proactive and safe discharge.	Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points from baseline (Q3 and Q4 2016/17). Inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rate.

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 2017-18	%of CQUIN quantum	Financial Value

Improving staff health and wellbeing	0.25%	£469,798
Reducing the impact of serious infections (Sepsis).	0.25%	£469,798
Improving services for people with mental health needs who present at A&E.	0.25%	£469,798
Offering advice and guidance (A&G).	0.25%	£469,798
NHS e-Referrals.	0.25%	£469,798
Supporting proactive and safe discharge	0.25%	£469,798

13.0 Care Quality Commission (CQC) Registration and Inspections

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

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

The CQC undertake announced and unannounced compliance visits to assess if the service is safe, effective, caring, is responsive to people's needs and is well-led. Since 2015-16 the CQC has undertaken new style announced compliance inspection visits.

The Trust was inspected by the CQC in January 2016, with eight of the Trust's services receiving a rating of 'Good' or 'Outstanding' for Caring, and five of the services being rated as 'Good' overall. The five rated as 'Good' were Surgery (including Theatres and Anaesthetics); Critical Care; Maternity and Gynaecology; Services for Children and Young People and End of Life Care.

The CQC rated Urgent and Emergency Services; Medical Care and Outpatients and Diagnostic Imaging as 'Requires Improvement'.

The Inspectors reported that '*people were treated with kindness, dignity, respect and compassion*', '*People who used the services and those close to them were involved as partners in their care*' and '*People were given appropriate and timely support and information to cope emotionally with their care, treatment or condition*.' The inspectors also reported that the organisation is well-led and found '*there was a clear vision and set of values, with quality and safety the top priority, which was understood by staff*.'

The Chief Inspector of Hospitals highlighted that '*Staff were observed to take the time to interact with people who used the service and those close to them in a respectful and considerate manner. They showed an encouraging, sensitive and supportive attitude towards people*.'

"We were impressed that staff across all levels of the organisation considered the culture of the organisation to be one focused on ensuring that patients received safe, high quality care. Staff were well versed in the values of the organisation and this came through when we met staff."

Despite five out of eight services being rated as 'Good' the Trust received an overall rating of 'Requires Improvement'.

A number of areas of outstanding practice were identified during the inspection including:

- The Wolverton Centre, for providing comprehensive sexual health services; for provision of service alerts for vulnerable patients, including young people, and those with a learning disability.
- A comprehensive dementia strategy, which enabled staff to support people living with dementia. A dedicated dementia improvement lead provided visibility and support to

staff, ensuring positive interventions were implemented. The carer's support pack, therapeutic activities and a memory café contributed to the enhancement of services.

- The Trust's engagement with 'John's campaign', promoted the rights of people living with dementia to be supported by their carers in hospital. To facilitate this, there was open visiting and a free car park for respective carers and relatives. Family members and carers were offered beds to stay overnight if needed.
- The specialist palliative care (SPC) team stood out as highly skilled and effective. They supported staff to provide good quality, sensitive care to patients at the end of life and to the people close to them.
- Staff of all disciplines demonstrated an impressive understanding of their role in addressing the needs of people at the end of life and of providing sensitive and compassionate care.
- The paediatric diabetes team were a top performer in the National Paediatric Diabetes audit 2014 to 2015 due to HbA1C rates being better than the England average.
- The trust participated in the Sentinel Stroke National Audit Programme (SSNAP), and achieved an A rating for the period January 2015 to March 2015.
- The Physiotherapists in the critical care unit had reduced the length of stay for their patients through the early implementation of rehabilitation.
- The engagement and involvement of volunteers was recognised as an invaluable team to support service delivery.
- Patient pathway co-ordinators in outpatients had impacted positively on the effectiveness of appointment arrangements.

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

The Trusts seven "Must Do" actions were:

1. Ensure that the Duty of Candour is adhered to by including a formal apology within correspondence to relevant persons and that records are kept
2. Ensure that individuals who lack capacity are subjected to a mental capacity assessment and best interest decisions where they require restraint and that this information is recorded in the patient record.
3. Make improvements to ensure medicines are not accessible to unauthorised persons; are stored safely, and in accordance with recommended temperatures
4. Make improvements to the systems for monitoring of equipment maintenance and safety checks in order to assure a responsive service..
5. Ensure the management, governance and culture in A&E, supports the delivery of high quality care.
6. Improve the quality and accuracy of performance data in A&E, and increase its use to identify poor
7. Ensure all identified risks are reflected on the A&E risk register and timely action is taken to manage risks, performance and areas for improvement

Detailed action plans have been developed with clinical teams and departmental heads in relation to the "must do" and "should do" actions identified. Good progress has been made in delivering the 7 must do actions. Work is ongoing to embed the actions taken and testing has been undertaken via audits, walkabouts and an internal self-assessment process has been commenced which will continue throughout 2017/18.

Good progress has also been made in delivering the "should do" actions. Of the 42 should do actions, 33 have either been completed or are planned to be completed in 2016/17. Key actions completed include improvements to pre-assessment, resolution of equipment issues highlighted by midwifery staff, improvements to the children's waiting area in the fracture clinic and establishment of a 9-5 face to face services seven days a week for specialist palliative care. 5 of the should do actions have plans which are due for completion in 2017/18, for example, greater privacy will be provided for inpatients attending the CT scanning unit as a consequence of a new Managed Equipment Service for radiology due to commence April 2017. There are a further 4 should do actions which have funding implications and require further discussion and resolution, the most significant of which relate to recommendations to review maternity capacity and to improve the environment in ICU.

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

14.0 Data Quality

The Trusts refreshed three-year Information Strategy and five-year Data Quality Strategy were both approved during the first quarter of 2016/17. This incorporated the recommendations from various national reports, 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' [Lord Carter, February 2016] and the 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry' [Robert Francis QC, February 2013], in respect of data quality and the use of information across services and the wider health economy.

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

Progress against Strategy - 2016/17

Progress made on the refreshed Strategy initiatives include:

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

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

Kingston Hospital NHS Foundation Trust submitted records to the Secondary Uses Service (SUS) throughout 2016/17. This data is included in nationally published Hospital Episode Statistics (HES) data. The Trusts Data Quality Group ensures performance meets and/or exceeds national performance. The percentage of records in the published data which included the patient's valid NHS number and General Medical Practice Code was:

DQ Indicator		KHT 2016/17 (Apr-Jan)	National 2016/17 (Apr-Jan)
Admitted Patient Care	% with Valid NHS number	99.4	99.3
	% with General Medical Practice Code	100	99.9
Out Patient Care	% with Valid NHS number	99.8	99.5
	% with General Medical Practice Code	100	99.8
Accident & Emergency Care	% with Valid NHS number	97.2	96.8
	% with General Medical Practice Code	100	99
Maternity - Births	% with Valid NHS number	99.9	99.1
	% with General Medical Practice Code	100	96.6
Maternity - Deliveries	% with Valid NHS number	99.8	99.8
	% with General Medical Practice Code	100	100
Data source: HSCIC SUS Dashboards			

15.0 Clinical Coding

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

As part of the internal clinical coding audit programme, and to comply with the Information Governance Toolkit Standard 13-505, two separate audits were undertaken by qualified and accredited auditors of the Clinical Coding team each across 200 Finished Consultant Episodes during 2016/17. The error rates reported for that period for diagnoses and procedure coding (clinical coding) were:

	KHT 2016/17

Total number of episodes examined: * 200 episodes in General Medicine * 200 episodes in General Surgery	General Medicine	General Surgery
Primary Diagnoses Incorrect	4%	2.50%
Secondary Diagnoses Incorrect	1.57%	4.66%
Primary Procedures Incorrect	4.23%	2.46%
Secondary Procedures Incorrect	3.19%	6%
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.

16.0 Information Governance Toolkit Attainment Levels

The Trust's Information Governance IG Toolkit Assessment Report overall score for 2016/17 was 80% (2015/16 was 80%; Green-Satisfactory) and was graded Green – Satisfactory across all Six Assurances.

The 2016/17 result is from version 14 of the Toolkit. As in previous years the evidence has been rolled over from previous versions to which we have added any new or revised policies and in-year evidence to support monitoring and compliance.

The Requirements have changed only slightly between versions. There are currently 45 requirements for Acute Trusts. The results by Assurance Level were as follows:

Assurance	2016/17 V14	2015/16 V13
Information Governance Management	80%	80%
Confidentiality and Data Protection Assurance	74%	74%
Information Security Assurance	73%	75%
Clinical Information Assurance	86%	86%
Secondary Use Assurance	100%	95%
Corporate Information Assurance	77%	77%

Overall Total	**80%**	**80%**

17.0 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 5th May 2017.

Indicator	Trust	National	Minimum	Maximum	Comment
Summary Hospital-level Mortality Indicator (SHMI) *October 2015 – September 2016*	0.9318	1	0.6516	0.986080271	Lower is better We are below the national average
Summary Hospital-level Mortality Indicator (SHMI) *October 2015 – September 2016*	0.8763	1	0.6897	1.1638	Lower is better We are below the national average
Latest Data Published	**March 2017**				

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

Kingston Hospital NHS Foundation Trust has taken the following action - enhanced medical leadership at Service Line level.

Indicator	Trust	National	Minimum	Maximum	Comment
Percentage of deaths with palliative care coded *October 2014 – September 2015*	25.5796	26.5867	0.1898	52.9080	We are below the national average Lower number is better

Percentage of deaths with palliative care coded *October 2015 – September 2016*	38	29.7497	0.3906	56.2682	We are below the national average Lower number is better
Latest Data Published	**March 2017**				

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

Kingston Hospital NHS Foundation Trust has taken the following action to improve this percentage – 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 *2011/12*	9.45%	10.03%	0.00%	14.94%	We are below the national average Lower number is better
Age <16 readmissions within 28 days 2012/13	No further data published				
Latest Data Published	December 2013				

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 *2011/12*	11.06%	11.45%	0.00%	22.76%	We are below the national average Lower number is better

Age 16+ readmissions within 28 days 2012/13	No further data published
Latest Data Published	December 2013

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
Trust's responsiveness to personal needs of patients *April 2014 – March 2015*	64.9	68.9	59.1	86.1	We are below national average Higher number is better
Trust's responsiveness to personal needs of patients *April 2015 – March 2016*	64.6	69.6	58.9	86.2	We are below national average Higher number is better
Latest Data Published	August 2016				

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 2015*	68	68	0	100	We are equal to the national average Higher number is better
Staff who would recommend Trust as a provider to friends and family *Staff Survey 2016*	69	59	41	79	We are better than the national average Higher number is better

Latest Data Published	March 2017

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

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

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

Indicator	Trust	National	Minimum	Maximum	Comment
% of patients admitted that were risk assessed for VTE *Jul 2015 – Sep 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 2016 – Sep 2016*	98.17%	95.57%	76.48%	100.00%	KHT above national average Higher number is better
Latest Data Published	March 2017				

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 – improved our existing mechanisms for the investigation and management of VTE's.

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 2014– March 2015*	12.2	15.1	0.0	62.2	KHT below national average Lower number is better
Rate per 100,000 bed days for C.diff reported within the Trust for patients >2 years old *April 2015– March*	13.3	14.9	0.0	66.0	KHT below national average Lower number is better

2016					
Latest Data Published	July 2016				

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 plan.

Indicator		**Trust**	**National**	**Minimum**	**Maximum**	**Comment**
Number and % of patient safety incidents *January 2016 – March 2016*	Number	2,292	425,007	300	12,784	There is no national average
	Rate per 1,000 bed days	31.8	7.76	3.6	170.8	
Number and % of patient safety incidents *April 2016 – June 2016*	Number	2,513	493,930	25	11,998	There is no national average
	Rate per 1,000 bed days	31.9	9.02	14.0	352.2	
Latest Data Published		**November 2016**				

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

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

Indicator		**Trust**	**National**	**Minimum**	**Maximum**	**Comment**
Number and % of patient safety incidents that result in severe harm or death *October 2015 – December 2015*	Number	14	2,381	0	128	There is no national average Lower number is better
	%	0.19	0.04	0.0	0.0	

Number and % of patient safety incidents that result in severe harm or death *January 2016 – March 2016*	Number	9	2,544	0	119	There is no national average Lower number is better
	%	0.11	0.05	0.0	4.45	
Latest Data Published		**November 2016**				

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

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

Indicator		Trust	National	Minimum	Maximum
Patient Reported Outcome Measures (PROMS) – Groin Hernia	**Participation rates for 1st questionnaire**	No Data	56.6%	0.0%	394.4%
	Participation rates for 2nd questionnaire	No Data	48.7%	0.0%	100.0%
	Health Gain (EQ-5D)	No Data	50.9%	0.0%	83.3%
	Health Gain (EQ-VAS)	No Data	40.5%	0.0%	83.3%
Latest Data Published March 2017					

Indicator		Trust	National	Minimum	Maximum
Patient Reported Outcome Measures (PROMS) – Hip Replacement	**Participation rates for 1st questionnaire**	No Data	87.4%	0.0%	693.8%
	Participation rates for 2nd questionnaire	No Data	37.4%	0.0%	100.0%
	Health Gain (EQ-5D)	No Data	89.7%	15.4%	100.0%
	Health Gain (EQ-VAS)	No Data	67.8%	15.4%	100.0%
	Oxford Hip Score	No Data	97.1%	71.4%	100.0%
Latest Data Published March 2017					

Indicator		Trust	National	Minimum	Maximum
Patient Reported Outcome Measures (PROMS) – Knee Replacement	Participation rates for 1st questionnaire	No Data	96.4%	0.0%	470.6%
	Participation rates for 2nd questionnaire	No Data	37.0%	0.0%	100.0%
	Health Gain (EQ-5D)	No Data	82.1%	12.5%	100.0%
	Health Gain (EQ-VAS)	No Data	59.4%	12.5%	100.0%
	Oxford Knee Score	No Data	94.4%	57.1%	100.0%
Latest Data Published March 2017					

Indicator		Trust	National	Minimum	Maximum
Patient Reported Outcome Measures (PROMS) – Varicose Vein	Participation rates for 1st questionnaire	No Data	33.8%	0.0%	331.6%
	Participation rates for 2nd questionnaire	No Data	39.1%	0.0%	100.0%
	Health Gain (EQ-5D)	No Data	53.1%	0.0%	88.9%
	Health Gain (EQ-VAS)	No Data	40.7%	0.0%	88.9%
	Health Gain Aberdeen Score	No Data	81.9%	42.9%	100%
Latest Data Published March 2017					

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 intends to take the following actions to improve this response rate and so the quality of its services – The Trust participated in this data from October 2016 onwards, therefore a part year of data has been submitted and the results were unavailable at the time of reporting.

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.

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

We have been engaged by the Council of Governors of Kingston Hospital NHS Foundation Trust to perform an independent limited assurance engagement in respect of Kingston Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and additional supporting guidance in the 'Detailed requirements for quality reports for foundation trusts 2016/17' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

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

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

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance issued by NHS Improvement.

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

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'; 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 2016/17' and supporting guidance and the six dimensions of data quality set out in the 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period 1 April 2016 to 22 May 2017;
- papers relating to quality reported to the Board over the period 1 April 2016 to 22 May 2017;
- feedback from Commissioners dated 19 May 2017;
- feedback from Governors dated 24 May 2017;
- feedback from local Healthwatch organisations dated 19 May 2017;
- feedback from Overview and Scrutiny Committee dated 19 May 2017;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 27 July 2016;
- the national patient survey dated 08 June 2016;
- the national staff survey dated 07 March 2017;
- the Care Quality Commission inspection report dated 14 July 2016;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 31 March 2017.

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

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Kingston Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Kingston Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and Kingston Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is narrower 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 2016/17' and supporting guidance.

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

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

Conclusion

Based on the work described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- 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 2016/17 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Grant Thornton House
Euston
London

25th May 2017

Appendix 1: National Confidential Enquiries

Programme type	Participated?	Study and number of cases submitted n=
Child Health Clinical Outcome Review Programme	Yes	Young People's Mental Health – 5 cases and organisational questionnaire Chronic neurodisability – 2 cases and organisational questionnaires
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	Perinatal mortality surveillance – 32 cases Maternal mortality surveillance – 0 cases
Medical and Surgical Clinical Outcome Review Programme	Yes	Cancer in Children, Teens and Young Adults – no cases selected, organisational questionnaire in the process of being completed Acute Non Invasive Ventilation – 2 cases and organisational questionnaire Acute pancreatitis – 5 cases and organisational questionnaire Mental health study – 5 cases and organisational questionnaire
Mental Health Clinical Outcome Review Programme	Not applicable	Not applicable – gap analysis on published report only

Appendix 2 – Other Confidential Enquiries

Programme type	**Participated?**	**Study and number of cases submitted n=**
Learning Disability Mortality Review Programme	Yes	Systems set up for reporting. Programme started 20th March 2017

Appendix 3: Eligible National Clinical Audits 2016/17 – Participation rates

National Clinical Audit	Participated?	Number of cases submitted
Acute Care		
1. Case Mix Programme (ICNARC)	Yes	100% (499/499 patient data) entered for April-Dec 2016. Data for Jan- March currently being entered / validated
2. Major Trauma Audit (TARN)	Yes	62.8-73.4% (176/244–285 from HES data)
3. National Emergency Laparotomy Audit (NELA)	Yes	100% (98/98)
4. National Joint Registry	Yes	100% (54/54)
5. Asthma (paediatric and adult) care in emergency departments	Yes	101% (101 cases submitted /100 recommended)
6. Severe Sepsis and Septic Shock	Yes	106% (106 cases submitted / 100 recommended)
Blood transfusion		
7. National Comparative Audit of Blood Transfusion audits: Patient blood management in scheduled surgery	Yes	100% (33/33)
Cancer		
8. Bowel Cancer (NBOCAP)	Yes	93% (165/178)
9. Lung Cancer (NLCA)	Yes	100% (97/97) for April 16 - Feb 2017. March data unavailable at the time of reporting
10. National Prostate Cancer Audit (NPCA)	Yes	100% (178/178) for April 16 - Feb 2017. March data unavailable at the time of reporting
11. Oesophago-gastric Cancer (NAOGC)	Yes	104% (52 cases)
Heart		
12. Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	100% (253/253)
13. Cardiac Rhythm Management	Yes	106 cases submitted (target unknown)
14. Coronary Angioplasty/National Audit of PCI	Yes	100% (1/1) organisational audit
15. National Cardiac Arrest Audit	Yes	16 cases to date (submission deadline is 02/06/2017)
16. National Heart Failure Audit	Yes	87% (386/445)
Long Term Conditions		
National Diabetes Audit (Adult): 17. Footcare 18. In-patient 19. Pregnancy in diabetes	 No Yes Yes	 Time constraint in taking patient consent 44 cases submitted plus 27/44 completed patient survey forms 6% (1/16)

20. National core	Yes	47 cases. (Target unknown)
21. National Diabetes Audit (Paediatric)	Yes	99% (159/161)
22. Inflammatory Bowel Disease (IBD)	Yes	2/128 (2%) – change in provider/software during year
23. National Chronic Obstructive Pulmonary Disease (COPD): Secondary care	Yes	100% (26/26 cases) Audit commenced Feb 2017
24. Adult Asthma	Yes	150% (30 cases submitted / 20 minimum required)
Older People		
Falls and Fragility Fractures Audit Programme (FFAP): 25. Fracture Liaison Service database 26. National Hip Fracture Database	 Yes Yes	 Facilities part of audit – organisation questionnaire only 100% (302/302)
27. Sentinel Stroke National Audit Programme (SSNAP) Clinical Audit	Yes	100% (178/178) Continuous audit, still submitting data for 16/17.
28. National Audit of Dementia	Yes	146% (73 cases submitted minimum of 50 required)
Other		
29. National Ophthalmology Audit	Yes	Data entered for February and March only due to software issues
30. Nephrectomy Audit	Yes	97% (30/31)
31. Stress Urinary Incontinence	Yes	67% (4/6)
Women and Children		
32. Neonatal intensive and special care (NNAP)	Yes	100% (409/409 cases)
33. Paediatric Pneumonia	Yes	66% (55/83)
Patient Reported Outcome Measures		
PROMS – Hernia and varicose veins only	Yes	The Trust participated in this data from October 2016 onwards, therefore a part year of data has been submitted and the results were unavailable at the time of reporting.

For Noting
The Trust does not take part in the Diabetes Transition audit - data is extracted for this from other Diabetes National Audits.

Although Rheumatoid and Early Inflammatory Arthritis and In-patient Falls were listed on the Quality Accounts for 2016/17, these audits did not run during this period.

Appendix 4: Actions to be taken following completed national clinical audits

National audit reports published in 2016/17	Date Report Issued	Report discussed during 2016/17	Actions Identified
Acute Care			
National Emergency Laparotomy Audit (NELA) Patient audit report	July-16	Yes	Monitor Critical Care Admission rate. Assessment of patients > 70 years by MCOP specialist. Improve documentation and reduce time to pre-op review by Consultant Surgeon (< 14 hours)
CEM - Vital Signs in Children (3560)	May-16	Yes	To re-adapt nursing levels and commence PEWS audit.
CEM - Procedural Sedation in Adults	May-16	Yes	Develop a proforma on CRS. Competency based training.
CEM - VTE risk in lower limb immobilisation	May-16	Yes	Write guideline and create CRS link to complete the VTE proforma.
National joint registry	Sept-16	Yes	No actions required
Blood Transfusion			
The National Comparative Audit of Lower Gastrointestinal Bleeding (LGIB) and the Use of Blood	May-16	Yes	No actions required
Red Cell and Platelet transfusion	Aug-16	Yes	Actions awaited
Cancer			
Oesophago-gastric Cancer (OGC) 2016 report	Sept-16	Yes	No actions required
National Prostate Cancer Audit 2016	Dec-16	Yes	Review of data completeness undertaken for the next data round
National Bowel Cancer Audit 2016	Dec-16	Yes	Review of data completeness undertaken for the next data round
National Lung Cancer Audit report 2016	Jan-17	Yes	Work with COSD re correct upload of KH patients. Review NCLA data to ensure reflective of KH activity / practice
Heart			
Heart Failure National Audit Report for 2014/15	July-16	Yes	Appointment of a Consultant Cardiologist specialising in the treatment of heart failure.
Heart Rhythm Management			

1) Report 14/15 2) Report 15/16	Aug-16 Feb-17	Yes Yes	Investigation into outlier status
Myocardial Infarction National Audit Project (MINAP)	Jan-17	Yes	Await publication of 16/17 results due in April 2017 as preliminary report shows great improvement
Long Term Conditions			
Rheumatoid & Early Inflammatory Arthritis – 2nd Report	July-16	Yes	Expand availability of urgent spaces in clinics. Appointment of Rheumatology Nurse Specialist. Article in GP newsletter to highlight need to refer patients within 3 days.
Inflammatory Bowel Disease (IBD) – National Clinical Audit of Biological Therapies	Sept-16	Yes	Set up local databases and virtual clinical for consultant / nurse discussions. Business case for a band 4 admin co-ordinator to ensure patient follow up.
National Diabetes Audit Core Report 1. Care processes and treatment	Jan-17	Yes	Explore electronic data capture and review data submitted for pump patients
Chronic Obstructive Pulmonary Disease (COPD): Secondary Care Clinical Audit – Supplementary Report	Feb-17	No Trust level data	Report forwarded to lead for information
National Diabetes Audit: Footcare Report	March-17	Yes	Improve taking of patient consent by giving consent forms for return by post.
National Diabetes Audit: Inpatient Audit 1) 2015 2) 2016	 June-17 March-17	 Yes Yes	 A Quality Improvement Project has been set up and is in progress
Older People			
Falls and Fragility Fracture Audit Programme a) National Hip Fracture Database b) FLS Facilities report	 Sept-16 May-16	 Yes Not applicable	 ASA scores reviewed for appropriateness. Training for staff on ASA scoring. KH does not have a Fracture Liaison Service
Sentinel Stroke National Audit Programme (SSNAP)			

1) January - March 2016 2) Organisational report 3) April - July 2016 4) Annual Report 15/16 (London) 5) August - November 2016	May-16 Sept-16 Oct-16 Oct-16 March-17	Yes Yes Yes	Actions have been taken to streamline the data collection process Action plan being drawn up
Women and Children			
BTS Paediatric asthma	Apr-16	Yes	A discharge sticker has been produced
National Neonatal Audit Programme 2016 report	Sept-16	Yes	Actions taken include improving compliance with breast feeding initiatives and improving documentation
National Paediatric Diabetes Audit 1) Report 2014/15 2) Report 2015/16	 June-16 Feb -17	 Yes Yes	 Improve staff allocation for data base and technical problem of data entry. Review data completeness for the next data round

Annexe 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 Report for 2016/17 by Kingston Hospital NHS Foundation Trust. The CCG is the lead commissioner for the Trust and this feedback represents the views of south west London CCG's (Richmond, Merton, Sutton, Wandsworth and Croydon).

The Quality Report provides information and a review of the performance of the Trust against quality improvement priorities set for the last year and gives an overview of quality for this period.
We were consulted with regarding the selection of priorities for the coming year and we are pleased to endorse the areas identified for improvement.

Through a variety of proactive and reactive mechanisms, we have the opportunity to review the quality of services at the Trust and we welcome the open and transparent engagement we experience with clinical and managerial staff.

Throughout the year, the Trust has provided progress reports on the achievement of the priorities selected and it is noted that 4 of the 9 priorities were achieved, and 4 of the 9 priorities partially achieved. It is highlighted within the report the progress achieved in the areas not fully delivered.
The rate of falls at the Trust has been a focus for the Trust for some time and it was pleasing to see the achievement of the goals set for last year. Similarly, the links between staffing levels and patient safety and the need to reduce agency costs are well understood and the Trust has been very successful in reducing vacancy rates, turnover rates and levels of agency usage. The increase of substantive staff (by 800 more) is commendable in light of the wider workforce market conditions the Trust is operating in. We would welcome continued attention to this area in the coming year given the concerns raised by staff and the Trust regarding future challenges for workforce.

The Trust did not achieve its ambitions to reduce administration related complaints by 50% and this area remains a concern for patients and General Practice – however it is noted that the overall trend is for less levels of complaint and this is commendable.

The section detailing other quality improvements are an indication of the successful focus on quality throughout the wider Trust than the areas selected as priorities and the Trust has received numerous national and regional recognition for these achievements. It is worth noting the progression of previously selected priorities features throughout this section, indicating a culture of improvement, sustainability and collaboration. The Trust has also been successful in achievement of a number of quality goals supported by the Commissioning for Quality and Innovation (CQUIN)

payment framework.

The Care Quality Commission (CQC) inspection and subsequent report was widely reported upon at the Clinical Quality Review Group (CQRG) and the Health Overview Panel (HOP) and the CQRG continues to receive periodic updates on the progress against the required actions. The CCGs would welcome continued progress reports at the CQRG and other forums during the coming year.

In terms of the future priorities it is welcome that Mental Health strategies to improve patient experience and in particular the focus on wider staff engagement and training.

Performance against a wide range of quality indicators have shown sustained improvements – notably in cancer performance and mortality rates. The CCG's are very proud of the achievements the Trust has made in terms of cancer performance in particular and the Trust and staff are to be congratulated for the excellent work in this area.

There are a number of areas where the Trust will need to continue to focus including hand hygiene, complaints response times, A&E four hour waiting times and single sex accommodation. We look forward to the coming year where our combined focus and partnership on A&E performance and reducing delays transfer of care will need to significantly improve above the performance over the last year.

Trust response

We thank Kingston Clinical Commissioning Group for their constructive feedback. The Trust is also pleased to share progress on wider improvement work and will continue to provide updates to the CCG. 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.

Kingston Hospital NHS Foundation Trust – Governor Feedback

I have reviewed the Trust's Quality Report for 2016/2017 on behalf of the Council of Governors 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.

There is a lot of very interesting and useful material but it is quite difficult to use given the prescribed format. What I would really have appreciated would be an executive summary and perhaps an organigram of committees involved in the quality assurance work of the Trust with names of key players.

The Governors Quality Scrutiny Committee has suggested that when priorities are not achieved an action plan to address outstanding actions could be developed and included in an appendix.

Overall I would say that it is an excellent report and that the Quality Account process has been very helpful in prioritising and focusing our discussions on Quality Assurance in the Trust.

Trust response

The Trust is grateful for the feedback received from the Council of Governors. There is now a contents page with page numbers, and an introduction by the Chief Executive has also been added

at the beginning of the report. The Trust looks forward to working closely with the Governors in the coming year to improve the services we provide to patients.

Royal Borough of Kingston upon Thames

Kingston Health Overview Panel- Comments on the draft KHT quality report 2016-17

The Health Overview Panel congratulates the Trust on the progress made in the past year in relation to the nine targets for 2016/17 and we welcome the honest approach to those few areas which require further attention. The reduction in the use of agency staff and increase in substantive staff, reduction in cancer waits, plus some progress with length of stay – particularly the 5 day reduction for elderly care - are very commendable but we note however that length of stay in Elderly Care is still high compared to peers. We were also pleased to learn that there has been a review of the discharge procedure, new patient/relative information about leaving hospital particularly where a patient has complex discharge care needs, the new e-referral form for referrals by wards to community and adult social care; the introduction of a discharge ward to help with bed utilisation. This demonstrates good progress with integration of care between the hospital and community. We also welcome that the hospital now routinely offers pain relieve as soon as patients arrive in A&E, particularly if they are likely to have a long wait.

We welcome the methodology and rigour in selecting the targets for the coming year to ensure these are relevant to service users and that other suggestions are carried forward in other Trust initiatives. We particularly endorse focus on areas which are of continuing interest to the Panel – hospital acquired infections, dementia, seven day working, e-prescribing, A&E and the experience of patients with mental health conditions.

Much has also been achieved outside of the Quality Report targets and we welcome details of progress made.

In particular we would like to commend the consistent achievement of performing well above the national **62 day cancer** target. We recognise the importance of focussing on the speed of diagnosis and treatment of cancers to enable better outcomes for patients.

We welcome the new initiative Proactive Care of elderly Patients in Surgery service – the **POPS service** – and the significant contribution to enabling more personalised care for elderly people with complex conditions both in identifying future care/surgery needs and for improved discharge from hospital. This is particularly important in Kingston where we have a high demographic of elderly people and will help support the joint working between health and social care.

We are pleased to see the progress with the **Patient and Public Involvement Strategy** and the extent of engagement - the large number of user groups, the Patient Experience Committee, the work of the Council of Governors and also that the insights from Healthwatch are a useful source of information.

The Health Overview Panel has shown interest in the role of **volunteering** at the hospital and it is good to see that volunteers continue to be recruited in significant numbers. The wide and important role of volunteers in a large range of hospital departments is described and the Panel particularly commends the importance of volunteers in the “Hospital 2 Home” initiative and the commendation from NESTA for this service together with the shortlisting of the overall volunteering service in the Health Service Journal’s annual award for the Value in NHS Support Services category.

The various links and involvement with a wide range of **voluntary organisations** is also commended. The Health Overview Panel has received presentations about local involvement with the Thomas Pocklington Trust (vision impairment) and the work undertaken with the Royal Eye Unit.

The reduction in the number of **complaints** is also to be commended together with the introduction of a complaints survey during the past year. It is especially good to learn that the majority of complainants felt that the Trust responded well to their complaint and that about half felt that making a complaint had made a difference.

We welcome the inclusion of the summary of ratings **by NHS Improvement and the CQC** and the list of areas of outstanding practice and progress against the "must do" areas. The Health Overview Panel has looked in detail at both the financial situation and the CQC inspection at meetings in May 2016 and September 2016. We identified that Kingston Hospital had as greater number of service areas rated as "good" compared with the other nearby district general hospitals.

Ann Radmore, Chief Executive, provided an update to our meeting in March 2017 and has agreed to give a further update in October 2017 when we hope to hear about improvements in the Trust's A&E performance and whether the additional funding (£0.96M) from the National Urgent Care fund is significantly helping here. We would also like to hear whether further progress is being made in reducing the average length of stay in elderly care and respiratory care as this is still much higher than at peer hospitals and what factors behind the longer ALOS at Kingston for these two specialties.

Overall we are pleased with the progress and performance at Kingston Hospital as described, taking into account the current challenges facing health and social care and congratulate staff on their personal contributions, their dedication and achievements.

Trust response

The Trust would like to thank Kingston Health Overview Panel for their feedback on the report and for acknowledging the progress we have made as a Trust. The Trust notes that Kingston Health Overview Panel are looking forward to hearing about progress in improving A&E performance as well as progress on reducing the average length of stay on both elderly care and respiratory care, later in the year. We will continue to work in partnership with Kingston Council to provide the best care for local people.

healthwatch Kingston Upon Thames healthwatch Richmond upon Thames

Healthwatch Richmond & Healthwatch Kingston's Response to Kingston Hospital NHS Foundation Trust Quality Accounts 2016-2017

Healthwatch Richmond considers the Trust's Quality Account (QA) for 2016/17 to be an accurate reflection of Kingston Hospital's achievements. The report is lengthy but does cover a wide range of topics, which are relevant and important for patient care. Once the report is finalised it would be useful to provide a shorter summary for the public to access. The explanations of terminology are

helpful and would benefit from being in a separate appendix for ease of reference. The use of tables to lay out data is helpful but not always easy to follow, some of the figures are embedded in the text and should be in the tables.

The Quality Report would be a lot easier to read and cross-reference if page numbers were added to the Contents list. The inconsistency in the numbering of the 2017/18 priorities is confusing – pp12 & 13 lists priorities that are numbered 1-9 (with no numbering next to the priority on long term ophthalmic conditions) whereas the summary list on p15 uses a different numbering system.

The QA gives a positive picture of ongoing improvements and is clear about where there is still room for improvement. Overall the continued excellent work on improvements by the hospital is encouraging.

Priorities 2017-18

Patient Safety

We welcome the continuation of the Sign up to Safety Campaign and the encouragement of a culture of openness in the reporting of incidents and near misses. The benefit of the involvement of families and carers in incident investigations is also a positive step.

The additional improving safety awareness for staff through human factors training will support learning from incidents and is to be encouraged.

The measures to reduce hospital acquired infections caused by gram negative Bacteria is an important continuation of the work to reduce hospital acquired infections and improve infection control. This builds on the work of the previous 2 years and we welcome the improvements that have taken place and the recognition that there is more to be done to reduce this avoidable condition.

Healthwatch Kingston (HWK) welcomes the priority given to 'Improving learning from incidents', not least because this is an area about which HWK has sought information during 2016/17. HWK has been pleased to receive a positive response to its questions but intends to continue to monitor developments during 2017/18. It is important that the whole organisation is involved in this process. The comparative rating of Kingston Hospital in respect of the NRLS and the 'Learning from Mistakes' league confirms that there is more to be done and we would like to be informed about the nature of the "additional feedback mechanisms" identified under 'Measure'. We also believe there is a case for incident data to be made public, or at least to be made available to local Healthwatches. We are surprised that this theme does not highlight the opportunity to cross-reference incident data with concerns raised by patients through PALS and the Complaints Procedure.

Clinical Effectiveness

The Trust has shown a clear commitment to their Dementia Strategy, an important initiative in the care of the growing number of patients who have dementia. We welcome this and the work they are doing supporting carers in conjunction with local support groups.

HWK is pleased to have contributed to the Kingston Hospital Dementia Strategy and their Working Group. We are pleased to see that Dementia care has improved greatly through this. Although the SEQUIN performance measures are improving, it has been recorded that not all Kingston Hospital patients over 75 are being tested to establish whether they qualify for further Dementia testing; this is important. The opportunity to track progress on the Dementia strategy through the six-monthly reports to the board is welcome. HWK would like to see the results of the 'Patient & carer

satisfaction using carer survey'.

The four priority standards to increase seven day working provision are currently only being met for consultant daily reviews. It is not clear how they will meet all the targets and we would encourage the Trust continuing to work towards this.

Healthwatch Richmond is pleased to hear of the success of e-prescribing and electronic clinical records in A&E and inpatients wards and supports the roll out of this to outpatients departments. The benefit in releasing staff time for patient care, a reduction in delays or loss of records and a reduction in medical prescribing errors should have a positive impact on the quality of care.

Improve the efficiency of pathways of care for patients with long term ophthalmic conditions
HWK is disappointed to see that, although this is listed (but unnumbered) as one of the priorities on p13, it is missing from the detail starting on p15. HWK is aware of concerns about the quality of appointment arrangements in the Royal Eye Unit and believes work on this area should indeed be a priority. HWK made an Enter & View visit to the Unit in August 2015 and found that the customer experience could be improved. Staff members were calling patients up for their appointment and then rushing back into the consultation room without ensuring the patient was aware. Patients with poor eye sight raised that they had trouble reading the small print in appointment letters and information leaflets. In response the REU committed to an action plan to ensure all staff members are briefed to provide a better call up service and the REU is working on their appointments system and with the REU volunteers to adhere to the Accessible Information standard legislation.

HWK also visited the Unit in November 2016 to learn about patient experience of communications on outpatient appointments. It was apparent that some patients need written communications to be provided in larger print and, although the signage has been improved, some patients were unclear where they should wait and the check-in machines were not working. It was also raised that people with reduced sight would benefit from better signage from the local train station and bus stop, a green line would be even better.

Patient Experience
Healthwatch Richmond is concerned about the services and support for people with mental health conditions both in hospital and in the community. We are supportive of these initiatives and welcome further information on the establishment of the multi-agency Mental Health Steering Group, the agreed improvement action plan and the patient experience data.

HWK particularly welcomes this priority. As part of facilitating the co-production of a new mental health strategy for Kingston, HWK received a significant amount of feedback from patients, 9 of whom commented on the fact that A&E is not sufficiently equipped, through its staffing and environment, to support people with mental health conditions.

HWK would like to see the Benchmark data that is going to be "developed as part of the project", the action plan that will be developed with SW London & St George's NHS Foundation Trust and the results of the "Patient experience mechanisms" that are proposed as a Measure.

The introduction of the new Clinical Decisions Unit to improve the patient experience of Emergency Services is a positive initiative and we will welcome information on its impact.

Regarding the Friends & Family Test score for 2016/17 as "91.03% t for A&E and the REU", it is unclear to HWK what this measure represents, we would welcome clarification on this.

The experience of patients with haematological cancer is concerning, with below average scores for 54 of 59 national indicators. This compares poorly with the Trust's care of patients with cancer in their specialist centre, the Sir William Rous Cancer Unit. We support the plan to move the service into the specialist unit and would welcome further information on the timescales involved.

Review of Priorities for 2016/17

Patient Safety

We welcome the decrease in the falls rate from 5.50 in 2015/16 to 5.11 2016/17 per 100 bed days and the plan to embed the Risk Assessment Tool across all areas. This should result in further reductions and we look forward to seeing the evidence for this in the National Audit in summer 2107.

It was disappointing that the targets were not all met for reducing the harm from sepsis and we support the plans for further action on this priority. Sepsis and septic shock have high mortality and morbidity rates and measures to reduce the risk are very important. The planned introduction of new Sepsis electronic alerts and screening at triage, together with training and awareness campaigns is to be welcomed.

The reduction in vacancy rates and turnover of staff is positive although the current turnover is not given. The reduction in agency spend from 56% to 43%, the 2nd best performance in London is to be commended. The initiatives being made through working with Bank Partners and the South West London Bank Project and the Workforce Pay Control Group have been a success. We support the Trust continuing these measures to reduce reliance on agency staff.

Clinical Effectiveness

The reduction of re-admissions in non-elective surgery to below the benchmark was achieved in A&E & AAU and Respiratory departments, but it was disappointing that this was not achieved for Trauma & Orthopaedics. It would be beneficial to explain why this happened and if there is any evidence of other factors, not focussed on, being important for this department. We would also welcome seeing these initiatives rolled out to other departments.

Reducing the length of stay (LoS) for frail and elderly patients, who weaken and have increased risks of falling or getting pressure sores or infections, is very important and there is clearly more work needed in this area. The reduction in Cardiology LoS is welcome and although there was a reduction for Elderly Care this was still well above the benchmark. It is worrying that the increase in the admission of patients over 80 has seen their LoS increase by 1.5 days and we would like to see further information on the factors contributing to this increase. This is not a priority for 2017/18 but this work is important to continue across the trust, particularly in the light of the increasing age of patients being admitted.

Pain relief is an area frequently raised in complaints. Dementia patients are particularly vulnerable to not receiving enough pain relief and there is a need to ensure the most effective interventions to manage pain are being used. The positive improvements for patients with dementia is welcome as is the introduction of fascia nerve blocks for hip fracture patients. The additional training for staff for 2017/18 is welcome and we would expect to see further improvements in pain management.

Patient Experience

GPs and patients have been clear in the need for improvements in administration, the 38% reduction in complaints about administration achieved is a good start but falls short of the 50% target. We support the further improvements planned for 2017/18 and would wish to see a focus on

the departments who receive the most concerns.

We are concerned that the initiatives to improve the patients' experience of discharge did not meet the 4% local target, which is higher than the national target of 2.5% and in some months there was actually an increase. We are aware that this is a complicated issue and we would like to see this work continued and more indication of the where the delays are occurring in the system and borough specific information.

The improvements in end of life care have shown positive results in the annual Bereavement Survey. All aspects evaluated performed favourable against national benchmarks and we support the continuation of these initiatives.

Healthwatch Richmond was pleased to read about all the other achievements the Trust has made over the last year in addition to their key priorities.

Trust response

The Trust would like to recognise the valuable feedback received from Kingston and Richmond Healthwatch. The report has been consequently updated in regards to formatting to ensure consistency and clarity in the document along with accurate signposting of information relevant to our priorities. Cross referencing of data to promote learning from incidents is within our work for 2017/18 and the priority has been expanded to clearly reflect this. Improving the efficiency of pathways of care for patients with long term ophthalmic conditions was put forward as an option for consideration as a priority, but not selected by the public for inclusion this year. The Trust will, however, continue to make focus on improvement in this area even though it is not a quality account priority. The Trust looks forward to continuing to work with Kingston and Richmond Healthwatch making sure we provide the best possible services to the local community.

LONDON BOROUGH OF RICHMOND UPON THAMES

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

Following on from the meeting held on Tuesday 9th May 2017, 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. We would like to take this opportunity to commend the Trust on a well laid-out and easy to read report, noting the limitations with regards to structure placed on the Trust. We were pleased to hear the progress that has been made against the Trust's 2016/17 priorities, particularly:

- The good progress made with the 'sign up to safety' campaign;
- The improvement to the care of children and young people whenever they are seen in the Trust;
- The drop in formal complaints;
- The opening of a dementia friendly ward;
- The introduction of wireless technology to reduce the administrative burden on nurses;
- The introduction of a discharge ward to reduce patients' length of stay;
- The 10% reduction in the use of agency staff which has saved £4million in nursing alone;
- The exceptional improvement in staff survey results; and
- The Trust's performance with regards to treating cancer patients.

As well as these achievements we also noted:

- That the target to reduce the length of stay had not been met in 2016/17. Although this target was ambitious, and progress has been made, this remains a priority for LBRuT.
- That the priority to reduce avoidable harm from sepsis was partially achieved but would not be a priority for 2017/18. We noted that the Trust is midway through a three year sepsis sign up to safety plan so it will still be a focus and the 2017/18 target to implement measures to reduce hospital acquired infections caused by gram negative bacteria would help reduce avoidable harm from sepsis. We will be interested to see whether or not these steps do contribute towards reducing avoidable harm from sepsis.

With regards to the Trust's 2017/18 priorities, we are particularly keen to see improvements in urgent and emergency services and are therefore pleased that this is reflected in your priorities. Although not directly linked to your 2017/18 priorities, we welcome the fact that you have targets in place to reduce the use of agency staff and to reduce staff turnover.

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 response

The Trust is grateful for the constructive feedback received from Richmond upon Thames' Health Services Scrutiny Committee, and particularly noting the Trust's achievements over the past year. The Trust appreciates the acknowledgement in regards to our continued work on reducing avoidable harm from sepsis through the 3 year Sign up to Safety project and will share our progress going forwards.

Annexe 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 01/04/2016 – 31/03/2017.
    - papers relating to quality reported to the Board over the period 01/04/2016 – 31/03/2017.
    - feedback from Commissioners, dated 18th May 2017
    - feedback from local Healthwatch organisations, dated 17th
    - feedback from Overview and Scrutiny Committee, dated 18th and 19th May 2017
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 27th July 2016
    - the 2015 national inpatient survey, dated 8th June 2016
    - the national staff survey, dated 7th March 2017
    - the Head of Internal Audit's annual opinion over the Trust's control environment, dated 31st March 2017

- 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

Sian Bates
Chairman
25th May 2016

Ann Radmore
Chief Executive
25th May 2016