Progress with 2015/16 Quality Goals

Executive Summary

Within the March 2015 update to the Trust Quality Strategy, 16 Quality Goals were set.

1. Implement year 2 of our dementia strategy
2. Make it easier to contact us and improve our correspondence with you
3. Improve End of Life Care
4. Deliver exceptional cancer services
5. Reduce Hospital Acquired Pressure Ulcers
6. Improve recognition and management of sepsis
7. Reduce catheter associated urinary tract infections
8. Develop our maternity staff to deliver even safer care for women in labour
9. Create an active Quality Improvement Programme
10. Make more services available at the weekend
11. Improve discharge planning so more patients can go home when they're ready
12. Make more of your medical notes electronic
13. Reduce agency staff by reducing vacancies
14. Improve staff happiness and motivation
15. Keep all staff up to date with mandatory training
16. A personal development plan, meaningful appraisal and clear objectives for all staff

The goals have been mapped against the Trust Values and include projects in all Domains of Quality; Safety, Efficiency and Experience. The Board will notice that good progress is being made in delivering these goals particularly in those that are also our Sign up to Safety Projects; sepsis, pressure ulcers and maternity.

The paper describes the key achievements in each area to date along with the next steps. Performance against the 9 Quality Account priorities will be published in the Annual Report. The Board should consider whether those projects that have a project plan beyond March 2016 should continue to be Quality Account Priorities for 2016/7.

Kingston Hospital NHS
NHS Foundation Trust

Caring Goals

Goal 1: Implement year 2 of our dementia strategy
Lead: Olivia Frimpong, Service Improvement Lead for Dementia

No	Key actions taken to date
1.	Commencement of roll-out of immediate impact programme across ward environments (e.g. clocks changed).
2.	Completed work with LSBU to design and implement a new training programme (due to commence at 2016) that will cover all staff across the trust. A nominated in-house team will receive training to allow them to deliver the programme themselves.
3.	A dedicated Service Improvement Lead for dementia has been recruited. The post holder will begin in November 2015.
4.	Signage across the hospital is currently being reviewed and consequently many signs are being moved down to eye level to make them more patient friendly for dementia patients.
5.	Dementia activities coordinator in post and regular programme of activities including memory lane lunch club, exercises classes, art therapy, memory café. Also regular one to one sessions both in the activities room and on the wards.

	Next Steps	Date for Completion
1.	Continue roll-out of immediate impact programme.	Ongoing action.
2.	Improving the bathrooms environments by introducing coloured grab rails, toilet seats, sink faucets, reviewing peddle bin usage etc.	March 2016
3.	Introduce pictorial aids with each signs to assist in way finding.	March 2016
4.	Complete drafting operational policy to give to designers for Derwent Ward refurbishment.	Timescales TBC
5.	Continue working with John's campaign to encourage relatives to stay with patients where possible by providing foldup beds in side rooms.	Ongoing action.

Goal 2: Make it easier to contact us and improve our correspondence with you
Lead: Nicky Felix, Associate Director of Patient Administration

Key actions taken to date	
1.	We have increased the number of telephone calls answered from 80% in Aug 14 to 83% in Aug 15
2.	Letters post OP appointment sent out at 10 working days form 54% in Aug 14 to 78% in Aug 15
3.	Number of PALS issues with admin as primary reason from 117 in Aug 14 to 77 in Aug 15
4.	First admin recruitment drive held in October to recruit to all vacant posts, 23 new staff recruited

Next Steps		Date for Completion
1.	The target for number of telephone calls answered set at 75%, to be increased to 85%.	March 2016
2.	The target for letters sent following OP appointments is currently set at 85%, therefore additional work is required to further raise this.	March 2016
3.	Further admin recruitment days planned for November and February to continue to fill all vacant posts	March 2016

Goal 3: Improve End of Life Care
Lead: Fergus Keegan, Deputy Director of Nursing

	Key actions taken to date
1.	On the 19th October 2015, a workshop was held at Kingston Hospital for an MDT forum to respond to the Trust Bereavement Survey Report that was agreed at the end of life care strategy group on 16/10/15. Attendance included a broad range of HCP and lay members. 6 themes for improvement were identified from the bereavement survey: 1. Access and awareness of Chaplaincy support 2. Communication within the MDT 3. Carer support 4. Promoting good pain management 5. Promoting assessment, communication and documentation of nutrition and hydration needs at the End of Life 6. Care after death
2.	Continuation of the bereavement survey that was conducted between October and December 2014, which returned a total of 80 responses from 239 participants.
3.	Engaged with Croydon Hospital following a response from their Chairman to learn from Kingston's End of Life Care process. Our survey format was subsequently shared.

	Next Steps	Date for Completion
1.	Repeat analysis of the responses received from the bereavement survey.	March 2016
2.	The results of the October workshop will be shared with all key stakeholders who attended or who wished to attend. It will be added as an addendum to the Bereavement Survey report.	November 2015
3.	The outcome of the October workshop will be discussed at the next End of Life Care Strategy Group, where some key actions to take forward will be agreed. This forms part of the on-going monitoring of outcomes from the Bereavement Survey report	January 21st 2016

Goal 4: Deliver exceptional cancer services
Lead: Sarah Evans & Nichola Kane

	Key actions taken to date
1.	We have recently finalised the completion of the Trust Cancer Strategy which details the Trust's approach to the delivery of its cancer services. Plans are currently in place to begin working towards the implementation of this strategy,
2.	The Trust has purchased a vacuum biopsy, which allows breast cancer patients to have their tissue biopsies conducted at Kingston Hospital. This provides increased choice to local patients who are no longer required to travel to the Royal Marsden for breast tissue biopsies.
3.	Cancer services have successfully managed an improvement in cancer performance, successfully meeting all cancer targets for Q2 of this year.
4.	Real-time feedback has been rolled out within urology, allowing the real-time collection of patient feedback regarding a range of topics (e.g. waiting times and their experience of clinics) via tablets situated in the waiting room area.
4.	Completed National Cancer Patient Experience Survey which has identified 5 key areas of improvement for cancer services to address.

	Next Steps	Date for Completion
1.	Continue implementation of the Cancer Strategy	Ongoing
2.	Continue development of plans to allow for the sustained delivery of improved performance. Plans are currently being developed and reported in to the Cancer Board.	Ongoing
3.	Real-time feedback to be implemented within gynaecology, followed by the William Rous Unit.	November 2015

Safe Goals

Goal 5: Reduce Hospital Acquired Pressure Ulcers
Lead: Lisa Cheek

	Key actions taken to date
1.	Development of a 3 year pressure ulcer prevention strategy to be launched in November 2015.
2.	Reduction in avoidable hospital acquired stage 2 pressure ulcers. 25 stage 2 pressure ulcers for April 14 to September 14 compared to 9 for the same period in 2015.
3.	The Trust has successfully reduced its number of moisture lesions.
4.	Involvement in the tender process for the new bed management contract which includes pressure relieving equipment.

	Next Steps	Date for Completion
1.	Launch pressure ulcer prevention strategy on national STOP pressure ulcer day. (19th November)	End November 2015
2.	New dates for formalised training for all staff will be available from 7th December 2015.	01/12/2015
3.	Continued work on management of incontinence products in ward areas.	Ongoing
4.	Involvement in the tender process for the new bed management contract which includes pressure relieving equipment.	Ongoing

Goal 6: Improve recognition and management of sepsis
Lead: Anne Jones

	Key actions taken to date
1.	Successful recruitment of a Sepsis Nurse Specialist who has actively begun working within the Trust.
2.	Commencement of sepsis simulation training sessions to provide training on sepsis management across the Trust.
3.	Electronic care records system (CRS) amended to provide sepsis 'alert' to trigger clinical intervention.
4.	Baseline audits have been successfully completed.

	Next Steps	Date for Completion
1.	Commence ward based clinical training for sepsis management	Ongoing
2.	Run sepsis training for general practitioners	01/12/2015
3.	Complete a patient awareness campaign to improve patient awareness of the signs of sepsis	TBD
4.	Repeat audits to provide information for the benchmarking of progress	Ongoing

Goal 7: Reduce catheter associated urinary tract infections
Lead: Fergus Keegan

	Key actions taken to date
1.	Working group established with engagement of senior nursing and medical staff, plus Your Healthcare
2.	Baseline and point prevalence audits completed
3.	Catheter passport format agreed: that developed by Kings and GSTT and adopted by Southwark and Lambeth community services will be adapted for local use
4.	Guideline development in progress with input from London HIN specialist nurse and KHNHSFT urology service
5.	Teaching session delivered by King's Continence specialist nurse at Infection Control Link Practitioner meeting on 25/09/2015

	Next Steps	Date for Completion
1.	There are multiple catheters, drainage bags and catheter - related products used in the Trust. Work is in progress (in consultation with London Health Innovation Network Lead Nurse) to review products and streamline what is used to maximise efficiency.	31st March 2016
2.	Roll out catheter passport using the format rolled out by other south London Trusts networks.	31st March 2016
3.	Finalise guideline and launch	31st March 2016
4.	Attend London Health Innovation Network learning event on 13.11.15	13th November 2015

Goal 8: Develop our maternity staff to deliver even safer care for women in labour
Lead: Vanessa Cole & Gabrielle Bambridge

	Key actions taken to date
1.	The recruitment of 2 Senior Midwives (Band 8a) and use of 2 PA per week of Consultants' time to support the 'Sign Up To Safety' Project (June –July 2015). The overall aim is to improve the birth outcomes for babies by enhancing midwives' and obstetricians' skills and competence in fetal surveillance both in the antenatal and intrapartum stages of pregnancy. The midwives spend 80% of their time within the clinical area.
2.	Commenced the rollout of an intensive teaching programme, using a multidisciplinary approach to the learning and development of maternity staff. There are dedicated teaching sessions each Friday whereby all maternity staff are invited to attend a case review. These presentation-led sessions allow staff to discuss, review and challenge all aspects of maternity care e.g. the appropriateness of interventions.
3.	In conjunction with this, a flexible teaching programme has also been initiated to support the delivery of ad-hoc teaching sessions within the clinical area, helping to up-skill and support junior midwives in their clinical decision-making.
4.	There are six master classes being provided up to May 2016 delivered and facilitated by an external consultant obstetrician to support staff in transitioning from a pattern recognition approach to a pathophysiological approach when interpreting cardiotocography (CTG). These classes aim to support maternity staff in the identification and avoidance of unnecessary interventions, appropriate and timely interventions leading to better health outcomes for women and their babies. To further monitor safety within maternity services all doctors and midwives undertake a competency test in fetal surveillance in labour. A learning and assessment framework has been formulated to ensure consistency in how knowledge is acquired and ensure a structured process to the annual assessment.
5.	An annual Practical Obstetric Multiprofessional Training (PROMT) day is provided and led by a consultant obstetrician and a senior midwife. This training includes the skills and drills practice within a simulated scenario.

	Next Steps	Date for Completion
1.	Publish a mid-year progress report to provide a complete update of project delivery against key milestones.	December 2015.
2.	Begin measuring the impact of the project against key performance indicators: 1. A reduction in avoidable admissions to the neonatal unit. 2. An increase in the number of staff receiving a pass mark in the annual assessment. 3. A reduction in the number of incidents where mis-interpretation of CTG was a contributory factor. 4. A reduction in babies born with Hypoxic Ischaemic Encephalopathy (HIE) over a five year period. 5. A reduction in legal claims over a 5 year period.	December 2015 & April/May 2016

Responsible Goals

Goal 9: Create an active Quality Improvement Programme
Lead: Anne Jones

	Key actions taken to date
1.	The Quality Improvement Programme (QIP) has been successfully launched, consisting of a range of Quality Improvement projects from within the Trust. These projects our monitored by the Quality Improvement Working Group and then report into the Clinical Quality Improvement Committee
2.	A range of projects have already been completed including; the Introduction of M pages for handover, the introduction of a Smoke Free site, establishing an IV line service and the implementation of Schwartz rounds. Quality improvement projects due to report shortly include work on oxygen prescribing and the introduction of fascia iliaca nerve blocks (pain relief) for patients with fractured hips.
3.	There are a range of ongoing projects working across key clinical areas, such as sepsis management, surgery in the elderly, , acute coronary syndrome (heart attacks) warfarin use and the monitoring and escalation of patients' vital signs (NEWS project).
4.	Staff education has commenced on the methodologies required to carry out quality improvement projects, including a booklet and classroom based teaching.

	Next Steps	Date for Completion
1.	Complete ongoing projects, produce project end reports and submit these to CQIC for review.	Varied; specific dates available within the Quality Improvement Tracker.
2.	Review PID for COPD project at working group with the view of launching COPD QIP	21st October 2015
3.	Review education opportunities for running Quality Improvement Projects and consider adding additional sessions to Education Brochure	January 2016
4.	Review and streamline QIP paperwork	January 2016

Goal 10: Make more services available at the weekend
Lead: Angela Clarke

	Key actions taken to date
1.	A dedicated pharmacist has been successfully appointed for the Acute Assessment Unit (AAU) to provide a pharmacy service on weekends. This ensure that flow of patients occur effectively with the support of medicine review and dispensing in a timely fashion as patients are reviewed by the medical team.
2.	Physiotherapy coverage for the inpatient wards has been expanded to deliver an increased physiotherapy service for patients at weekends. These staff help to assess and prepare patients to return home expediting as early a discharge as is medically possible.
3.	Outpatient pharmacy services are available 7 days per week through our partnership with Boots. This service allows patients to pick up medicines for minor ailments upon which the pharmacist has given advice, for patients who have seen the one site GP and for any patients who may have had a weekend OPD appointment. Toiletries etc are also available for patient who have been admitted.
4.	Patients attending A&E with a need to see a GP can be seen by a GP 10-10 Saturday and Sunday as well as evenings during the week. This service ensure that the A&E team can focus all their resources on acutely ill and injured patients.
5.	Saturday day surgery lists are being run in DSU giving patients more choice as to when to have a procedure and clinical more capacity to cope with their growing demand.
6.	Radiology provide access to all imaging modalities 7 days per week, this has been the case for some time and gives patients lots of flexibility as to when they attend for investigations

	Next Steps	Date for Completion
1.	Outsourced CT reporting contract to commence giving faster out of hours and weekend reporting times.	November 2015
2.	Review of TTO process for wards at weekends to evaluate where improvements could be made	November 2015
3.	Expansion of CT service for ward patients at weekend for both Saturday and Sunday so that more decision making can occur through	January 2016
4.	3 session days are being scoped for main theatre starting in the new year to expand capacity with and extended day format.	February 2015
5.	Pathology services fully combine across SWL at the end of November on the St Georges' site. This will facilitate increased levels of processing across the weekend and night times with improved turnaround times be achieved for both in and outpatients	November 2015

Goal 11: Improve discharge planning so more patients can go home when they're ready
Lead: Jenny Thomas

	Key actions taken to date
1.	Pilot of Patient Tracking List (PTL) completed on Bronte Ward in partnership with the ward matron, sister, ward manager and clinical lead. This work has led to an increased awareness of the causes of delays in flow.
2.	Regular feedback from the ward team has been used to refine the PTL process and generate a final specification of DISCO-based PTL finalised and agreed; Business Intelligence team working on completing the first model for review in early November 2015.
3.	Further ward-specific ward has been undertaken, including a complete refresh of patient documentation to improve communication with patients on the ward via a one-page discharge leaflet and welcome card, introduction of SAFER standards to provide greater consistency at board rounds, the completion of a volunteer-led discharge audit to gather patient feedback regarding the discharge process and the introduction of EDD dates on all patient boards.
4.	Review of all patients whose LOS exceeds 10 days has been re-launched on a bi-weekly basis with all 6 health & social care partners, so that active case management and planning can occur. Regular reporting is now possible and can be reviewed across the Trust in a real time basis.
5.	A robust reconciliation process for the measurement and count of DToCs has also been re-launched with all six health & social carer partners, so that a weekly position can be agreed and reported on a cumulative monthly basis (for total days delayed in month) into Unify returns, as well as for month–end snapshot count purposes.

	Next Steps	Date for Completion
1.	Refine and complete the DISCO-based PTL prior to rollout across 13 inpatient wards.	November 2015
2.	Progression of ward-specific process improvement working with the Bronte trio as initial pilot area.	February 2016
3.	Merger of existing LOS review processes with those that will be supported by the new PTL information to be reviewed once the latter is fully operational	February/ March 2016
4.	Interpretation of rules for DToC declaration is being supported with a clarification visit from Liz Sargeant, ECIP, on November 23rd2015. New processes in place to inform the October return, with fully streamlined reporting from the November return onwards.	November 2015

Goal 12: Make more of your medical notes electronic
Lead: Peter Donohue

	Key actions taken to date
1.	Clinical Documentation Implemented across all inpatient medical and surgical wards on CRS. All staff received training prior to the go-live date, along with a 2 week support model on pharmacy and nursing intensive support, plus a further week of back support from the change team. Areas excluded are; outpatients, Coombe Wing, day surgery and paediatric inpatients.
2.	Vital signs integration phase 1 implemented in Kingston Surgical Centre in Q3 2015. All patient observations are now electronically uploaded on to CRS. These observations include blood pressure, pulse, respiratory rate and temperature.
3.	E-Prescribing implemented across all live sectors. As with CRS rollout, all staff received training, a 2 week support model and a further week of back support from the change team. Areas excluded are; outpatients, Coombe Wing, day surgery and paediatric inpatients.

	Next Steps	Date for Completion
1.	Care plan requests submitted to Cerner as part of the Documentation improvement on CRS to streamline current care plans and improve the relevance of the existing templates.	First trial due to go ahead in November 2015
2.	Finalise scoping of the next stage of rollout for the clinical documentation and e-prescribing projects, due throughout 2016. Areas being targeted are outpatients, Coombe Wing, day surgery and paediatric inpatients.	Early scoping currently underway, with timescales due to be finalised over coming months.
3.	Provide stabilisation programme to all areas; support team are currently undertaking competency work within the Trust across several workstreams to and establish a BAU Model.	Coombe wing and Paediatrics are sectors remaining to go live, provisionally 2016 TBC

Value Each Other Goals

Goal 13: Reduce agency staff by reducing vacancies
Lead: Terry Roberts

	Key actions taken to date
1.	Overseas recruitment is currently taking place with a focus on nursing staff. We are currently appointing approximately 14 new nurses per month. An additional cohort of UK recruitment has also generated success in reducing Band 5 nursing vacancies from 157 to 108 vacancies. This is complemented by cohort recruitment for Nursing Assistants.
2.	Retention work is currently underway to reduce staff turnover. Examples of methods used to reduce turnover of Nursing Staff are; improvement of the induction and on-boarding process; assignment of 'buddies' to new starters and questionnaires sent to new starters after 100 days in post to gather direct feedback for improvement, career planning to ensure opportunities for development are available and giving managers the skills to manage positivity. Furthermore, the HR Business Partners are working closely with service lines to establish why staff are leaving to try and support the service lines in taking action to reduce their turnover. A programme of actions are taking place to address the high turnover in admin areas these includes: •intensive training for all admin staff and their managers, •customer service training, •standard operating procedures have been written for each service line to ensure admin staff are clear on their duties and where to seek help. •regular admin walkabouts to check in with admin teams •monthly admin workshops to provide peer support and training •action plans to support admin teams who are struggling. •creation of career progression post
3.	Teams submitted bids for money to improve staff facilities and programme of work due to commence by end of November

	Next Steps	Date for Completion
1.	Monitor commissioning of new recruitment in all staff groups to ensure that target in achieved	Ongoing
2.	Use the newly introduced Monitor price cap to reduce agency staffing costs, whilst continuing to look at filling vacancies	November 2015

Goal 14: Improve staff happiness and motivation
Lead: Lisa Ward

	Key actions taken to date
1.	Positivity programme launched across the Trust and workshops attended by 150 staff
2.	First #TeamKHFT Annual Awards ceremony to be held on 3rd December 2015
3.	Teams submitted bids for money to improve staff facilities and programme of work due to commence by end of November

	Next Steps	Date for Completion
1.	A full review of the positivity programme will be performed, with next steps agreed following the finalisation of the review.	March 2016
2.	The #TeamKHFT event will be held and evaluated.	3rd December 2015
3.	Facilities programme of work will commence and new equipment shall be purchased	28th February 2016

Goal 15: Keep all staff up to date with mandatory training
Lead: Debbie Norton

	Key actions taken to date
1.	Compliance reports visible for all to see via the intranet.
2.	Majority of subjects training accessed via the Statutory & Mandatory Training booklet available on the intranet.
3.	Reduction in amount of subjects delivered face to face free sessions
4.	To support compliance extra sessions for the face to face sessions and working with service lines to support planning and release of staff for training

	Next Steps	Date for Completion
1.	Long term review of delivery of Statutory & Mandatory Training to web based eLearning for staff to access from anywhere via tablet/phone as well as computer for suite of eLearning modules	Ongoing. End date depends on resource availability, however targeting completion at end of 2016
2.	Long term working with service lines to plan for release of staff for training to reduce DNA rates and adhere to policy around non-compliance and attendance of training	April 2016
3.	Flexibility of face to face sessions with different start times, 3in1 sessions for ease of staff to be released	April 2016
4.	Ensure both individuals and managers monitor compliance	April 2016

Goal 16: A personal development plan, meaningful appraisal and clear objectives for all staff
Lead: Audrey Linton

	Key actions taken to date
1.	As at the end of September 89% of appraisals taken place; it is predicted that we will reach be at 90% before end of November.
2.	Over 300 managers have undertaken training to support them in developing a more coaching approach to conducting one to ones and appraisals.
3.	Throughout the Trust, a total of 427 Development & Training Plans have been completed by managers.
4.	To support compliance extra sessions for the face to face sessions and working with service lines to support planning and release of staff for training
5.	Weekly reporting to EMC of compliance rates.

	Next Steps	Date for Completion
1.	Divisional Directors to ask managers to ensure appraisal dates set for all staff	October 2015
2.	New staff to received objectives within 3 months of their employment	Ongoing
3.	HRBPs working with Service Lines to ensure all new starters have set objectives.	Ongoing