Quality Account 2011-12
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South West London Acute Commissioning Unit

PART 5

Statement of Directors’ Responsibilities in respect of the Quality Account

Independent Auditor’s Limited Assurance Report to the Directors of Kingston Hospital NHS Trust on the Annual Quality Account

Glossary of Terms
PART 1: Statement on Quality from the Chief Executive

I am delighted to introduce you to the Trust’s third annual Quality Account. The Quality Account provides information on quality achievements in the last year and identifies quality priorities for the coming year. Much of the content and the order in which it is presented are set by guidance and Act of Parliament. Within that framework we have attempted to present you with sufficient information to assess our performance. Please be assured that Kingston Hospital continues to seek out ways of improving the service we provide.

As a medium sized district general hospital we provide a full range of diagnostic and treatment services. There are approximately 320,000 people living in South West London and North Surrey who could use our hospital.

For centuries, the town of Kingston-Upon-Thames has served as the regional centre for the surrounding population. Residents from areas such as Wimbledon, Richmond, Epsom and Esher have historically travelled to Kingston for business, shopping, legal affairs at the courts and for their Hospital care. Kingston also has a university and college drawing people in from further afield and a vibrant night time economy. There are excellent travel links and most importantly, historic flows mean that people from the surrounding area look at Kingston as their regional centre.

Within this catchment area are groups both affluent and disadvantaged. We also serve a mix of ethnic groups including large Korean and Tamil communities around Kingston. We continue to develop our services to be responsive to the needs of our diverse population. Kingston is a popular local hospital and its services have a very good reputation.

The Quality Account talks openly about the care we provide. It describes what we do well and also where we need to do more. Areas of significant improvement have included:

- Reducing falls by almost half;
- Reducing the occurrence of pressure ulcers;
- Improving the assessment of patients at risk of developing blood clots; and,
- Reducing re-admissions after emergency treatment.

We also lowered our rate of re-admission following planned treatment but not as much as we had hoped. Nor did we reach our target for improving the care of patients with dementia. So, we have put in place plans to remedy this in the coming year. Although we have made real progress in reducing the overall number of patients falling while in hospital, we are concerned about the unprecedented increased harm a small number of patients have suffered following a fall. Actions have been identified which are being overseen by the Medical Director and Director of Nursing & Patient Experience.

After an extensive consultation process, the Trust has set three priorities for 2012-13.

Our first priority is to focus on our most ill patients, those needing the highest levels of treatment and attention. We want to make sure that early signs of deterioration are recognised and acted upon. To support this we plan to improve communication within and between teams when a patient’s condition is causing concern and make sure that we respond appropriately.
Our second priority is to maintain a high standard of care at night and over the weekend. We believe that improving our staffing levels at night and at weekends will help us achieve this.

Our third priority will be communication with our patients. This is a two-way process that requires us to listen and respond appropriately. You have told us, in no uncertain terms, that you want to have an active role in your own care. Good communication is integral to this. As the Trust seeks Foundation Trust status, we will continue to put you, the patients, at the centre. That is the only way to fulfil our vision to be the hospital of choice for our local community, recognised for excellent and innovative emergency, surgical, acute medicine and maternity services, delivered by caring and valued staff.

I hope you find this Quality Account useful. To make this easier to read, we have developed a shorter summary version.

If you have any feedback or suggestions on how we might improve our Quality Account, please do let us know by emailing enquiries@kingstonhospital.nhs.uk or writing to our Patient Advice Liaison Service at:
Kingston Hospital NHS Trust
Galsworthy Road
Kingston-upon-Thames
Surrey
KT2 7QB.

You can also ask for a paper copy of the Quality Account and/or the summary version from the Trust by contacting the Communications Team, on 0208 934 3843.

To the best of my knowledge the information contained in this document is accurate.

Kate Grimes
Chief Executive
27 June 2012
PART 2a: Priorities for Improvement in 2012-13
PART 2a: Priorities for Improvement in 2012-13

Introduction

We asked the public and our staff for their views on what our quality priorities for 2012-13 should be (described in more detail later in this document). The Trust then decided to focus on one priority in each of the three domains of quality identified by Lord Darzi in “High Quality Care for All”, (2007). These are Patient Safety; Effectiveness of Care; and, Patient Experience.

When establishing the priorities for 2012-13 the Trust considered if any of the priorities from 2011-12 should be taken forward.

As can be seen in Part 3: Looking back at 2011-12, the Trust has done well against many of the priorities set last year. We achieved the targets for reducing falls, reducing grade 2 pressure ulcers, providing better pain control and reducing emergency readmissions following an emergency admission.

The Trust has also made significant progress against the target for reducing grade 3 & 4 pressure ulcers, increasing venous thromboembolism (VTE) assessments and taking actions to improve patient experience.

The Trust will work to ensure that the achievements secured over the past year are sustained going forward.

Although we did not fully achieve our ambitions in reducing emergency readmissions following elective admission and improving care for dementia patients, it was decided not to take these areas forward into the 2012-13 Quality Account priorities. This is because quality improvements in these areas will be progressed through the NHS Operating Framework 2012-13 and Commissioning for Quality and Innovation (CQUIN) framework, and therefore inclusion as Quality Account priorities as well would represent an unnecessary duplication. Both these areas will have quality targets set and monitored in 2012-13 under those frameworks.

The Trust has therefore selected three new priorities for 2012-13, as follows:

<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>Theme</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety</td>
<td>Recognising when a patient’s condition is deteriorating and taking swift clinical action</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Effectiveness</td>
<td>Reduction in variations in care out of hours</td>
<td>2</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Improving communication with our patients</td>
<td>3</td>
</tr>
</tbody>
</table>

The ranking attributed to each of these priorities is based upon the feedback from patients and staff.

The next few pages describe the three quality priorities that the Trust Board has agreed to focus on in 2012-13. There are explanations about why these are important for the Trust, and what the Trust is planning to do to improve quality in these areas.
PART 2a: Priorities for Improvement in 2012-13

Patient Safety: Recognise when a patient’s condition is deteriorating and take swift clinical action

Lead: Jane Wilson, Medical Director

Monitoring: Patient Safety Committee

Why did we choose this?
Every day more than a million people are treated safely and successfully in the NHS, but the evidence tells us that in complex healthcare systems things will and do go wrong, no matter how dedicated and professional the staff. And when things go wrong, patients are at risk of harm.

Analysis of 576 deaths reported to the National Patient Safety Agency’s (NPSA) National Reporting and Learning System (NRLS) over a one year period (2005) identified that 11% were as a result of deterioration not recognised or acted upon (66 cases). (National Patient Safety Agency)

Overall the Trust’s patient outcomes are excellent with a Hospital Standardised Mortality Ratio (HSMR) well below the expected rate nationally, but the Trust knows it could do better in the areas of recording patient’s observations and escalating the care needed.

Audits undertaken in the Trust show that the completeness of patient’s vital signs observations and the timeliness of their recording can be improved. Delays arising from not recognising early signs of deterioration and not responding to these appropriately can also be reduced. Currently some patients may become more unwell and need admission to intensive care, when earlier intervention could have prevented this from happening.

Hospitals that have good systems in place to recognise deterioration in a patient’s vital signs increase the chances of survival following cardiac arrest. Prompt recognition of cardio-respiratory arrest and the instigation of resuscitation techniques can double the chance of survival (Resuscitation Council (UK) 2005).

How have we performed to-date?
The Trust performs extremely well in many of the patient safety measures. The HSMR mortality measure is at 82.2 for 2011. This represents 172 less deaths than expected for the year (770 versus 942).

The Trust uses observation charts to help to track a patient’s condition. The results of these Early Warning Score (EWS) audits show that the Trust has improved performance in some months, but not on a consistent basis.

EWS – Full sets of observations:

Nurses and doctors should be measuring all of the patient’s observations all of the time where required. The charts help staff to identify when a patient’s condition is not improving or needs to have higher levels of treatment provided. The audit also shows that there are times when abnormalities are recorded but staff do not act on the information.
PART 2a: Priorities for Improvement in 2012-13

The results of this audit are shown in the graph below.

EWS – Episodes not escalated:

During the third quarter of the year, we will embed the changes that we have planned and continue measuring the improvements we expect to find.

During the last quarter, we expect to show that the number of incidents that have occurred, where patient’s observations were not acted upon, have reduced (compared to our baseline data).

How will we measure progress?
The Trust, through the Acute Response Group, will monitor the action plan and measures of success which include:

- The Standardised Hospital Mortality Indicator (SHMI);
- Relevant Patient Safety Indicators;
- The number of episodes when a patient has deteriorated and appropriate action was not taken evidenced through the EWS audits;
- Results of the audit of admissions to Intensive Care Unit; and,
- Indicators of deterioration at ward level will be monitored to ensure appropriate action has been taken.

Why did we choose these measures?
Methods of collection are established and their patterns of data collection are consistent over time. They will demonstrate our performance, and any improvement.

Benchmarking against other hospitals may not be a valid approach because of differences in patient population, resource availability and/or severity of illness. Therefore, benchmarking based on improvement within the Trust is considered most appropriate.

What are we going to do?
Aim: To increase the early recognition and treatment of deteriorating patients.

The training of staff in recording observations and acting on them will be enhanced and monitored for effectiveness.

- During the first quarter of the year, we will collect, analyse, and review data on the patients who are admitted to the intensive care unit, and initiate root cause analysis of any incidents where failure to take appropriate action resulted in an admission to the Intensive Care Unit (ICU). Audits of cardiac arrest and peri-cardiac arrest calls will be undertaken. The information generated from this will identify the improvement actions to be taken. An action plan will be developed.

- In the second quarter of the year, the issues identified will be used to develop a series of actions and measures to identify the ways we can improve our performance and begin measuring and reporting performance.
PART 2a: Priorities for Improvement in 2012-13

Effectiveness of Care: Reduce variations in care out of hours

Lead: Jane Wilson, Medical Director
Monitoring: Clinical Effectiveness Committee

Why did we choose this?
The Trust needs to deliver a safe and high quality service for patients seven days a week, twenty four hours a day.

In London, data shows that the probability of dying as a result of many emergency conditions is significantly higher if the admission is at the weekend. Outcomes for patients in London vary considerably across different hospitals. A variety of outcome measures, such as mortality rates, length of stay, and re-admission rates provide an indication of the quality of a service and enable comparisons between services across London.

The Trust has introduced a number of projects which have improved the ways of working together: better access to diagnostic tests; increased the number of consultant ward rounds; and, the scheduling of emergency operations.

The result of this is a reduction in the overall mortality rate, length of stay and emergency readmissions. However, the difficulty in delivering good continuity of care across all hours is recognised and effective handover is crucial to the quality and safety of patient care.

The Trust operates a “Hospital at Night” team. The team co-ordinates handover and clinical tasks required for all patients out of hours. The Trust has not fully encompassed all of the principles of a comprehensive team and needs to make sure that the right skill mix and staffing levels are in place in the hospital at night time. In particular, the role of the team and the leadership of the team could support more co-ordinated multi-disciplinary handover.

How have we performed to-date?
Throughout the last year the Trust has been working to improve care in the hospital 24/7.

The Medical Assessment Centre has been relocated and this has led to improvements in length of stay and patient flow through the hospital. Senior clinical staff are now more involved in patient pathways at an early stage. They have better access to the necessary diagnostics to ensure that length of stay, complication rates and readmissions are within best practice guidelines.

The weekend has traditionally seen a reduction in services to support care delivery. In order to improve care delivery the Trust has made good progress in:

- Reviewing consultant job plans to include weekend ward rounds; and,
- Increasing accessibility to diagnostics and therapies.

The latest mortality figures, length of stay, and readmissions rates for weekend and weekdays show that there is no significant variation between patient’s outcomes between weekday and weekend admissions. In many areas, the Trust is significantly better than the level that could be expected.

What are we going to do?
The Trust will continue to introduce changes that will see consultant led patient care in emergency situations and during an extended working day and the work the Trust has done so far has helped with inpatient reviews and discharge planning.

Aim: To improve clinical leadership and handover processes out of hours in order to improve the effectiveness of the care that patients receive.
• In the first quarter of the year, we will collect, analyse and review data on the patients who are cared for, admitted and discharged out of hours, including the outcomes for these patients compared to those who are admitted or discharged during week days.

• In the second quarter of the year, the issues identified will be used to develop a series of actions that can improve our performance.

• During the third quarter of the year, we will embed the changes that we have made and begin assessing their impact.

• During the last quarter of the year we expect to show that the care for patients across the 24 hour, 7 day period has come closer together and that there are reductions in the variability of outcomes for these patients.

How will we measure progress?
The Trust will continue to review mortality rates, lengths of stay and emergency readmission rates. It will track weekend to weekday variations to ensure that the good performance is sustained.

The handover completeness (communication of patient demographics/ diagnosis/ tasks required) along with the perception of staff regarding usefulness of the handover will help to identify areas for improvement.

This will include monitoring of the training for Healthcare Assistant in handover processes.

Through quarter one the Trust will seek to identify more sensitive measures of quality regarding leadership of the hospital at night team.

Why did we choose these measures?
Although the Trust performs very well in terms of variations in outcomes for patients (mortality, length of stay and readmissions) and whilst these are very useful in identifying areas of local focus, the Trust currently does not collect data which is sensitive enough to identify the subtle variations in handover and completeness of tasks allocated.
PART 2a: Priorities for Improvement in 2012-13

Patient Experience: Improving communication with our patients

Lead: Jenny Parr, Director of Nursing & Patient Experience

Monitoring: Patient Experience Committee

Why did we choose this?
Our principal partners are the patients, their carers, their relatives and designated friends. Alongside them, we often work with social care organisations to support our patient’s well-being. We work together recognising the diverse needs, preferences and choices of our partners.

Medicines management plays an important role in preparing patients, and their carers, for transfer/discharge, and has an impact on the recovery and/or management of their condition(s) following discharge. The use of medication is increasing and many patients will be taking a number of different medicines, quite appropriately, to manage their condition. The risk of drug interactions increases with additional medication. A high proportion of hospital admissions and readmissions, quoted as between 5% and 17% (Source: Macmillan Cancer Support, 2010, Office for National Statistics, 2009), are due to adverse reactions to medicines or incorrect medicine taking.

Engaging patients and carers in discussions about medication, and ensuring that decisions about treatment are shared, can improve both the management of the condition and improve a patients’ experience of care. Patients benefit from having information about their condition and treatment options. They also need support to understand, interpret, and translate that information. The results of national patient surveys for inpatients and outpatients have not shown improvement in this area over recent years.

Specific areas where patients report the need for improvement include: involvement in decisions about treatment and discharge; being informed of who to contact if worried; understanding the purpose and side effects of medicines; and, being kept informed of delays.

Despite reductions in the absolute number of complaints regarding attitude and communication, the Trust acknowledges the need for further improvement. Results from the Patient Experience Tracker used during the past 12 months have not demonstrated improvement in the involvement of patients in decisions about treatment or discharge.

How have we performed to-date?
The Trust has been successful in obtaining feedback from large numbers of patients. This has been used in developing and delivering improvement actions. The Trust held a number of listening events for approximately 70 patients. These events provided the Trust with important information from patients that it has used to re-define the Trust’s values, make new commitments to patients, and develop new standards.

Patient’s views have been collected routinely by using feedback tablets, available in wards and outpatient settings, for patients to comment on their experience. Local surveys of patients have been conducted across a number of services, and used to develop quality improvement initiatives.

A Patient Assembly has been established to provide a patient and community perspective on the Trust’s plans and strategies. Patient Assembly members are also representatives on some Trust committees.

A new patient feedback system called the Net Promoter Score (NPS) is being implemented. This allows patients, in all service areas, to complete a comment card, about the service they have just received.
What are we going to do?

Aim: We aim to help patients recognise that they have had more personalised care.

- In the first quarter of the year, we will collect, analyse and review data on the patients by using a variety of systems including Net Promoter Score.
- In the second quarter of the year, the issues identified will be used to develop a series of actions and to identify the ways we can improve our performance. This will include areas such as making information about waiting times visible and updated, developing patient leaflets, and piloting the checkout sheet from the outpatients clinic.
- During the third quarter of the year, we will embed the changes that we have planned and begin measuring the improvements we expect to find.
- During the last quarter of the year, we would expect to show through our Net Promoter Scores that patient reports of how effective communication is have improved in outpatient and inpatient areas. These results should also be seen in the results of national inpatient and local outpatient surveys.

For patients with particular needs (e.g. sensory impairment, dementia, etc.) the Trust will work with the Learning Disability Link Nurses Group and other teams to improve the effectiveness of communication.

How will we measure progress?

As part of the national inpatient survey there are a number of questions which describe different elements of the overarching patient experience theme, "responsiveness of personal needs of patients”.

We will conduct local audits to establish how we are improving based on these questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
</tr>
<tr>
<td>Q2</td>
<td>Did you find someone on the hospital staff to talk to about your worries and fears?</td>
</tr>
<tr>
<td>Q3</td>
<td>Were you given enough privacy when discussing your condition or treatment?</td>
</tr>
<tr>
<td>Q4</td>
<td>Did a member of staff tell you about medication side effects to watch for when you went home?</td>
</tr>
<tr>
<td>Q5</td>
<td>Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?</td>
</tr>
</tbody>
</table>

We will analyse the responses we get from patients to check that we are improving the patient experience and use the scores to track our performance. Net Promoter Scores will be gathered at ward and department level. The Trust will undertake a local survey of outpatients.

Why did we choose these measures?

Effective communication benefits the patient in a variety of ways. It supports a patient’s confidence that the right decisions have been made. Good communication allows the patient to be an active partner in their care and future well-being. The nationally recognised benchmarking, arising from the patient survey, is a one-off annual event but we will also conduct in year surveys.

The Net Promoter Score system allows a more localised assessment, based on the different wards and services we provide and also offers us a quicker and timelier way to identify local improvement drivers.
PART 2a: Priorities for Improvement in 2012-13

Quality Strategy Targets

In March 2012, the Trust Board approved a Quality Strategy, which brought together a number of previous documents, which dealt with aspects of quality. This will be monitored through the Trust’s Quality Assurance Committee.

Quality underpins the Trust’s vision which is that local people choose Kingston Hospital because they recognise it as delivering excellent care services. The Quality Strategy describes how the safety and effectiveness of care will be enhanced whilst continuing to improve patient experience over the next five years against a backdrop of financial constraint. The Trust has placed quality as its primary corporate objective. All staff have this as a key personal objective so that patients receive safe and high quality care.

The Trust has been working to deliver quality care at Kingston for some time. The Trust has a demonstrable track record of continuous improvement and good results while continuing to ensure that its finances are well managed. It is vital to have a strategy to ensure that quality is protected in the current environment of change and financial constraints. The Quality Strategy draws together the key elements from individual strategies (Patient Safety and Patient Experience), and updates them to produce a cohesive approach to delivering care.

The delivery of quality care relies upon having the right culture throughout the Trust. The quotation “culture eats strategy for breakfast” (Drucker) recognises the need to build a culture that supports strategy implementation. The Trust has recently engaged staff in developing core values of “caring, safe, responsible and valuing each other”. Put simply, the quality vision is designed to create the right environment for all staff so that they, in turn, can deliver the appropriate care for patients.

The Quality Strategy details a range of actions that the Trust will take to deliver quality care.

Capabilities & Culture
Our culture puts quality first throughout the Trust from the wards to the Board and in all the Trust’s supporting and administrative areas.

The action plan will aim to improve the visibility of the leadership by the whole Trust Board with respect to quality improvement. Quality key performance indicators (KPIs) will improve and the staff survey will demonstrate improvements in key questions related to incident reporting and quality of care being seen as a top priority.

The workforce will be fit for purpose and all staff will demonstrate behaviour which is consistent with the Trust’s values all of the time to deliver compassionate care consistently.

The action plan will aim to embed the values throughout the employee lifecycle, reinforcing expectations of how staff should interact with each other and patients and equip staff with the skills to “live the values everyday”. Improvement will be seen in the numbers of staff who undertake training in these areas, the staff survey will demonstrate improvement in questions relating to appraisal and management feedback, and the Net Promoter Score will demonstrate improvement.

Processes & Structures
A robust systematic approach to governance and risk management, which permeates right through the Trust and creates and maintains reliable processes and continuous learning.

Evidence of challenge regarding quality will be visible in the minutes of meetings throughout the Trust. WHO and Internal Audit results will improve. Escalation of risks and awareness of gaps in control will be visible from ward to ward.
Trust Board. A range of assurance mechanisms will be used including internal and external audit.

Communication systems must be effective and accurate, and thus maximises the capacity of information technology to share information efficiently within and outside of the Trust.

The action plan will aim to ensure the risk of incidents relating to the handover of care between organisations and individuals is reduced. Incidents will be monitored and learning shared.

Patients and the public will be involved, heard from, and are responded to.

The numbers of patients or public involved on committees will increase. The patient and public contribution will be visible at all levels of the Trust.

Mechanisms will be developed to enable the Trust to place itself at the forefront of publishing accessible and useful information on the quality and outcomes of the services delivered for patients.

Outcomes will be available on the Trust website for patients to see. The contribution of patients and the public to the development of the Quality Account, its priorities and the publication of outcomes will be evident in the work plan of the Patient Assembly and the stakeholder commentary of the Quality Account. HealthWatch and LiNKS members will be active partners in developing and presenting useful information.

Having captured patients’ ideas on improving efficiency and redesign of services, services will be made fit for purpose.

The Patient Assembly work plan will identify programmes of work and demonstrate increased involvement. Patient feedback will be used to improve those services where patients have been involved in redesign.

Innovative solutions will be used to ensure that delivering efficient services enhances quality.

Actions will improve staff satisfaction and reduce sickness. The patient’s experience will be improved as length of stay and harm events (pressure ulcers and falls) will reduce. Resources will be used more efficiently. Project evaluations will monitor the quality impact and measures of improvement.

The impact of any service development or service change is assessed to ensure that the quality and equality of the service or care delivered is not compromised.

Post implementation reviews will be scheduled and the learning will be built into future plans. Patient and staff experience and quality KPIs will be maintained or improved. The quality impact and measures of improvement will be monitored regularly.

Measurement
Systematic flows of information are used between frontline staff and the organisational leaders to achieve high reliability and enhance quality.

Performance relating to national standards will improve, exception reporting and forecasting will be used and lead to evidence of actions at all levels. Quality KPIs will improve.

Quality standards are set, monitored and published to drive quality improvement.

The performance of the Trust with respect to national standards will be visible within and externally to the Trust. Action plans will be developed at the right level to address areas for improvement.

Continuous Improvement
The Trust seeks to continuously improve by setting challenging goals, building on successes and evaluating achievements, and taking lessons and implementing best practice from world-wide exemplars.

Clinical audit results will demonstrate improvement year on year. Lessons will be shared at the annual Clinical Audit Seminar, and departmental governance meetings.
PART 2b: Statements Relating to the Quality of NHS Services Provided
PART 2b: Statements Relating to the Quality of NHS Services Provided

Note: The format, content and wording of this Part of the Quality Account is mandated and cannot be changed by the Trust.

Review of Services

During 2011-12 the Trust provided and/or subcontracted four NHS services, for adults and children as follows:

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

These services covered the following specialities:

- Accident and Emergency;
- Assisted Conception;
- Cancer;
- Cardiology;
- Care of the Elderly;
- Clinical Support Services – therapies related to an inpatient episode of care and/or referral for outpatient treatment(s);
- Community Midwifery;
- Community Paediatrics;
- Critical Care;
- Diabetes and Endocrinology;
- Diagnostics (imaging and pathology);
- Dietetics;
- Digital Hearing Aids;
- Direct Access – Pathology;
- Direct Access – Blood Transfusion;
- Direct Access – Cytology (gynaecology);
- Direct Access – Cytology (non-gynaecology);
- Direct Access – Haematology;
- Direct Access – Histopathology;
- Direct Access – Immunology;
- Direct Access – Microbiology;
- Direct Access – Radiology/Imaging;
- Ear, Nose and Throat;
- Gastroenterology;
- General Medicine;
- Genito Urinary Medicine;
- General Surgery;
- Gynaecology;
- High Cost Drugs;
- HIV;
- Neonatal Care;
- Obstetrics;
- Ophthalmology;
- Oral and Dental Services;
- Orthopaedics;
- Paediatrics;
- Pain Management;
- Parent Craft;
- Patient Transport;
- Physiotherapy outpatient;
- Respiratory Medicine;
- Rheumatology;
- Surgical Appliances; and,
- Urology.
The Trust has reviewed all the data available to them on the quality of care in all of these services. The income generated by the NHS services reviewed in 2011-12 represents 87% of the total income generated from the provision of NHS services by the Trust for 2011-12.

Participation in Clinical Audits

During 2011-12, thirty eight out of fifty one national clinical audits and four out of five national confidential enquiries covered NHS services that the Trust provided.

During that period, the Trust participated in 92% of national clinical audits (thirty five audits) and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries, which it was eligible to participate in.

National Clinical Audits

The national clinical audits that the Trust was eligible to participate in and those it did participate in, during 2011-12, are detailed below together with the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.

Note: The requirement to submit cases is a minimum number the Trust must submit. Trusts are encouraged to submit as many cases as possible, hence the higher than 100% percentages against some audits.

<table>
<thead>
<tr>
<th>National Clinical Audit</th>
<th>Participated?</th>
<th>Number of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peri &amp; Neonatal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal intensive and special care (NNAP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatric pneumonia</td>
<td>Yes</td>
<td>63 cases</td>
</tr>
<tr>
<td>Paediatric asthma</td>
<td>Yes</td>
<td>145% - At least 20 cases to be submitted, 29 cases actually submitted</td>
</tr>
<tr>
<td>Pain management in children</td>
<td>Yes</td>
<td>100% - 50 cases</td>
</tr>
<tr>
<td>Childhood epilepsy</td>
<td>Yes</td>
<td>50% - At least 58 cases to be submitted, 29 cases actually submitted</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Yes</td>
<td>99% - At least 125 cases to be submitted, 124 cases actually submitted</td>
</tr>
</tbody>
</table>
### PART 2b: Statements Relating to the Quality of NHS Services Provided

<table>
<thead>
<tr>
<th>National Clinical Audit</th>
<th>Participated?</th>
<th>Number of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency use of oxygen</td>
<td>Yes</td>
<td>800% - At least 1 case to be submitted, 8 cases actually submitted</td>
</tr>
<tr>
<td>Adult community acquired pneumonia</td>
<td>Yes</td>
<td>1,320% - At least 5 cases to be submitted, 66 cases actually submitted</td>
</tr>
<tr>
<td>Non-invasive ventilation</td>
<td>Yes</td>
<td>133% - At least 15 cases to be submitted, 20 cases actually submitted</td>
</tr>
<tr>
<td>Pleural procedures</td>
<td>Yes</td>
<td>200% - At least 15 cases to be submitted, 30 cases actually submitted</td>
</tr>
<tr>
<td>Cardiac arrest</td>
<td>Yes</td>
<td>72% - At least 107 cases to be submitted, 77 cases actually submitted</td>
</tr>
<tr>
<td>Severe sepsis &amp; septic shock</td>
<td>Yes</td>
<td>100% - 30 cases</td>
</tr>
<tr>
<td><strong>Adult critical care</strong></td>
<td>No</td>
<td>The Critical Care Unit currently uses the Ward Watcher system to collect clinical information, although a business case has been made to participate in the Adult Critical Care National Audit</td>
</tr>
<tr>
<td>Potential donor audit</td>
<td>Yes</td>
<td>100% ITU – 47 cases</td>
</tr>
<tr>
<td>Seizure management</td>
<td>Yes</td>
<td>100% - 20 cases</td>
</tr>
<tr>
<td><strong>Long Term Conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>No</td>
<td>The re-tendering process for this national clinical audit has not resulted in the reduction of data to be collected, as had been hoped. The large data set makes collecting this data difficult within existing resources</td>
</tr>
<tr>
<td>Heavy menstrual bleeding</td>
<td>Yes</td>
<td>Audit still in progress</td>
</tr>
<tr>
<td>Chronic pain (National pain audit)</td>
<td>Yes</td>
<td>Organisational survey submitted. Patient data due to be submitted during 2012-13</td>
</tr>
<tr>
<td>Ulcerative colitis &amp; Crohn’s disease (Inflammatory bowel disease)</td>
<td>Yes</td>
<td>100% - 20 cases (Ulcerative colitis)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% - 20 cases (Crohn’s disease)</td>
</tr>
</tbody>
</table>
### National Clinical Audit

<table>
<thead>
<tr>
<th>National Clinical Audit</th>
<th>Participated?</th>
<th>Number of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parkinson’s disease</td>
<td>Yes</td>
<td>100% - 20 cases</td>
</tr>
<tr>
<td>Adult asthma</td>
<td>Yes</td>
<td>320% - At least 5 cases to be submitted, 16 cases actually submitted</td>
</tr>
<tr>
<td>Bronchiectasis</td>
<td>No:</td>
<td>A large number of national clinical audits in respiratory medicine prevented participation in the bronchiectasis audit, although the Trust did participate in all other respiratory national audits</td>
</tr>
<tr>
<td>Elective Procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip, knee and ankle replacements (National Joint Registry)</td>
<td>Yes</td>
<td>27% - At least 22 cases to be submitted, 6 cases actually submitted</td>
</tr>
<tr>
<td>Coronary angioplasty (Cardiac interventions)</td>
<td>Yes</td>
<td>Organisational survey submitted, no patient cases required</td>
</tr>
<tr>
<td>Elective surgery (National PROMs programme)</td>
<td>Yes</td>
<td>50 patients participated between October 2011 and March 2012</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute myocardial infarction &amp; other ACS (MINAP)</td>
<td>Yes</td>
<td>30 cases submitted</td>
</tr>
<tr>
<td>Heart failure</td>
<td>Yes</td>
<td>100% - 324 cases</td>
</tr>
<tr>
<td>Acute stroke (SINAP)</td>
<td>Yes</td>
<td>100% - 29 cases</td>
</tr>
<tr>
<td>Cardiac arrhythmia</td>
<td>Yes</td>
<td>100% - 139 cases</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung cancer (NLCA)</td>
<td>Yes</td>
<td>100% - 112 cases</td>
</tr>
<tr>
<td>Bowel cancer (NBOCAP)</td>
<td>Yes</td>
<td>87% - At least 153 cases to be submitted, 133 cases actually submitted</td>
</tr>
<tr>
<td>Oesophago-gastric cancer (AUGIS)</td>
<td>Yes</td>
<td>22 cases to-date. Closing date is in 2014</td>
</tr>
<tr>
<td>Trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip fracture</td>
<td>Yes</td>
<td>348 cases</td>
</tr>
</tbody>
</table>

**Part 2b: Statements Relating to the Quality of NHS Services Provided**

This table summarizes the participation and case submission rates for various national clinical audits and clinical procedures. The data includes participation status, case submission rates, and specific numbers for different conditions and procedures.
### PART 2b: Statements Relating to the Quality of NHS Services Provided

<table>
<thead>
<tr>
<th>National Clinical Audit</th>
<th>Participated?</th>
<th>Number of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe trauma (TARN)</td>
<td>Yes</td>
<td>77 cases to-date. Deadline for submission is June 2012</td>
</tr>
</tbody>
</table>

#### Blood transfusion

<table>
<thead>
<tr>
<th>Blood transfusion</th>
<th>Participated</th>
<th>Number of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedside transfusion</td>
<td>Yes</td>
<td>100% - 14 cases</td>
</tr>
<tr>
<td>Medical use of blood</td>
<td>Yes</td>
<td>105% - At least 40 cases to be submitted, 42 cases actually submitted</td>
</tr>
</tbody>
</table>

#### Health Promotion

<table>
<thead>
<tr>
<th>Health Promotion</th>
<th>Participated</th>
<th>Number of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk factors (national health promotion in hospitals)</td>
<td>Yes</td>
<td>100% - 30 cases</td>
</tr>
</tbody>
</table>

#### End of Life

<table>
<thead>
<tr>
<th>End of Life</th>
<th>Participated</th>
<th>Number of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care of dying in hospital</td>
<td>Yes</td>
<td>100% - 30 cases</td>
</tr>
</tbody>
</table>

### National Confidential Enquiries

The national confidential enquiries that the Trust was eligible to participate in and those it did participate in, during 2011-12, are detailed below together with the number of cases submitted to each enquiry as a percentage of the number of registered cases required by the terms of that enquiry.

<table>
<thead>
<tr>
<th>Programme type</th>
<th>Clinical Outcome Review Programme</th>
<th>Participated?</th>
<th>Number of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Surgical</td>
<td>Peri-operative care of surgical patients</td>
<td>Yes</td>
<td>Organisational questionnaire returned. 100% - 6 cases</td>
</tr>
<tr>
<td></td>
<td>Review of organisational and clinical aspects of children’s surgery</td>
<td>Yes</td>
<td>Organisational questionnaire returned. No case data to submit</td>
</tr>
<tr>
<td></td>
<td>Cardiac arrest</td>
<td>Yes</td>
<td>Organisational questionnaire returned. 100% - 4 cases</td>
</tr>
<tr>
<td>Mental Health</td>
<td>National Confidential Enquiry into Suicide and Homicide</td>
<td>Participation not required by acute trusts but actions taken in response to report recommendations</td>
<td></td>
</tr>
<tr>
<td>Maternal, Infant &amp; Perinatal</td>
<td>Maternal and perinatal mortality</td>
<td>Yes</td>
<td>Perinatal mortality 100% - 24 cases</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>There were no maternal deaths during the period.</td>
</tr>
</tbody>
</table>
### Review of National Clinical Audit Reports Issued in 2011-12

For a number of reasons, during 2010-11 the Trust did not participate in 10 of the 38 required national clinical audits and therefore did not receive local results on which to take action. These are detailed in the table below. During 2011-12, the Trust prioritised participation in national clinical audits and took part in 35 out of a possible 38, plus all the National Confidential Enquiries.

The reports of 28 national clinical audits were reviewed by the Trust in 2011-12 and the Trust intends to take the following actions to improve the quality of healthcare provided:

<table>
<thead>
<tr>
<th>National Clinical Audit undertaken in 2010-11 where the report was published in 2011-12</th>
<th>Date Report Issued</th>
<th>Actions Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peri &amp; Neonatal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal intensive and special care (NNAP) – 2010 data</td>
<td>October 2011</td>
<td>The aims of this audit are to assess whether babies receive consistent care across the NHS in England and to identify areas for improvement. The audit shows improved results for the Trust with all babies born under 28 weeks (100%) having their temperature taken within one hour of birth (national results = 84%). 66% of babies under 33 weeks born at the Trust were receiving their mother’s milk at discharge from the Neonatal Unit, compared to 44% nationally. Communication with parents is key but is not well documented in the babies’ notes. A new form to document this communication has been implemented at the Trust.</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatric pneumonia</td>
<td>October 2011</td>
<td>This audit showed that investigation and management of pneumonia in children at the Trust appears very similar to national data. However, some changes to practice were raised, including targeting chest x-rays, consideration of changing first-line antibiotic choice and not performing chest physiotherapy in this particular group of patients.</td>
</tr>
<tr>
<td>Paediatric asthma</td>
<td>Didn’t participate in audit – report not reviewed</td>
<td></td>
</tr>
<tr>
<td>Paediatric fever</td>
<td>April 2011</td>
<td>This audit concentrated on children presenting to the Accident &amp; Emergency Department with fever. The Accident &amp; Emergency team have run further educational sessions on the recognition of fever in young children and highlighted the importance of the early administration of analgesia.</td>
</tr>
<tr>
<td>Childhood epilepsy</td>
<td>Not yet published – due June 2012</td>
<td></td>
</tr>
</tbody>
</table>
## PART 2b: Statements Relating to the Quality of NHS Services Provided

<table>
<thead>
<tr>
<th>National Clinical Audit undertaken in 2010-11 where the report was published in 2011-12</th>
<th>Date Report Issued</th>
<th>Actions Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes paediatric audit 2009-10</td>
<td>July 2011</td>
<td>As a result of the findings of this audit, the Paediatric Team are writing a policy for the management of children with a high HbA1c level. Such children would be more at risk of long term complications of diabetes and the level needs to be controlled where possible. This policy will set out how often such children should be reviewed in clinic and how the hospital will work with other services, such as schools</td>
</tr>
</tbody>
</table>

### Acute Care

<table>
<thead>
<tr>
<th>Emergency use of oxygen</th>
<th>Didn’t participate in audit – report not reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult community acquired pneumonia</td>
<td>October 2011</td>
</tr>
<tr>
<td>Non-invasive ventilation</td>
<td>October 2011</td>
</tr>
<tr>
<td>Pleural procedures</td>
<td>Didn’t participate in audit – report not reviewed</td>
</tr>
<tr>
<td>Cardiac arrest</td>
<td>Didn’t participate in audit – report not reviewed</td>
</tr>
<tr>
<td>Vital signs in accident &amp; emergency majors</td>
<td>April 2011</td>
</tr>
<tr>
<td>Adult critical care</td>
<td>Didn’t participate in audit – report not reviewed</td>
</tr>
<tr>
<td>National Clinical Audit undertaken in 2010-11 where the report was published in 2011-12</td>
<td>Date Report Issued</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Potential donor audit</td>
<td>December 2011</td>
</tr>
</tbody>
</table>

### Long Term Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Report Status</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heavy menstrual bleeding (1st Annual Report)</td>
<td>May 2011</td>
<td>Any actions required will be taken once the audit is complete. Patient recruitment to the audit took place during the period February 2011 to January 2012 and the Trust was one of the top five recruiters. Women who completed the baseline questionnaire a year ago are currently being sent postal follow-up questionnaires.</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Didn’t participate in audit – report not reviewed</td>
<td></td>
</tr>
<tr>
<td>Chronic pain</td>
<td>November 2011</td>
<td>The Trust has considered the National Pain Audit (Phase 1 Organisational) and considers that it is compliant with the generalised recommendations. The patient reported outcomes part of the audit started in March 2012.</td>
</tr>
<tr>
<td>Parkinson’s disease</td>
<td>Didn’t participate in audit – report not reviewed</td>
<td></td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>Didn’t participate in audit – report not reviewed</td>
<td></td>
</tr>
<tr>
<td>Adult asthma</td>
<td>Didn’t participate in audit – report not reviewed</td>
<td></td>
</tr>
<tr>
<td>Bronchiectasis</td>
<td>Didn’t participate in audit – report not reviewed</td>
<td></td>
</tr>
</tbody>
</table>

### Elective Procedures

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Date</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip, knee and ankle replacements (National Joint Registry)</td>
<td>September 2011</td>
<td>The report has been noted by the Orthopaedic Department. The report contains no recommendations and therefore no action has been taken by the Trust.</td>
</tr>
<tr>
<td>Coronary angioplasty (Cardiac interventions)</td>
<td>October 2011</td>
<td>The Trust submits data on the number of procedures only. We do not receive any recommendations from this audit.</td>
</tr>
</tbody>
</table>
# PART 2b: Statements Relating to the Quality of NHS Services Provided

<table>
<thead>
<tr>
<th>National Clinical Audit undertaken in 2010-11 where the report was published in 2011-12</th>
<th>Date Report Issued</th>
<th>Actions Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective surgery (National PROMs programme)</td>
<td></td>
<td>Information from the Patient Reported Outcomes Measures programme for hernia repair is due to be presented to the Trust’s Audit &amp; Clinical Effectiveness Committee.</td>
</tr>
<tr>
<td><strong>Cardiovascular Disease</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute stroke (National Sentinel Stroke Audit 2010)</td>
<td>May 2011</td>
<td>At the presentation of this audit to the Clinical Audit Group it was noted that the service had been recently reconfigured across the sector. At an inspection of the stroke service at the Trust in November 2011, the hospital achieved 100% in nearly all applicable criteria for stroke treatment.</td>
</tr>
<tr>
<td>MINAP 2011 (10th Report)</td>
<td>September 2011</td>
<td>Report not reviewed yet</td>
</tr>
<tr>
<td>Heart failure (April 2010 to March 2011)</td>
<td>January 2012</td>
<td>The Trust is acting on a number of the main recommendations from this report, including ensuring that patients with heart failure have input from a consultant cardiologist and specialist nurse. A further consultant cardiologist post is being advertised and the specialist nurse service has been reorganised to provide heart failure services on the wards. A special blood test to diagnose heart failure is being trialled on our wards.</td>
</tr>
<tr>
<td><strong>Renal Disease</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal Colic</td>
<td>April 2011</td>
<td>Following this audit, the Accident &amp; Emergency team are considering the use of a triage tool for patients presenting with the symptoms of renal colic and will be incorporating training on renal colic into education sessions for doctors and nurses.</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel Cancer 2011 Report (Covers patients diagnosed August 2009 – July 2010)</td>
<td>November 2011</td>
<td>The report lists twelve recommendations, of which the Trust is fully or partially compliant with ten. The non-compliant recommendations relate to further in-depth or extended audit, rather than clinical concerns. The partially and non-compliant recommendations will be discussed further at a forthcoming Multidisciplinary Team meeting.</td>
</tr>
</tbody>
</table>
### National Clinical Audit undertaken in 2010-11 where the report was published in 2011-12

<table>
<thead>
<tr>
<th>National Clinical Audit undertaken in 2010-11 where the report was published in 2011-12</th>
<th>Date Report Issued</th>
<th>Actions Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung Cancer 7th Annual Report 2011 (Covers patients diagnosed in 2010)</td>
<td>December 2011</td>
<td>The report has been discussed by the Lung Cancer Multidisciplinary Team. Most of the actions to be taken relate to ensuring good data quality by close cooperation between the Lung Cancer Multidisciplinary Team and the Cancer Data Manager. This regular review will also ensure that, where standards may not have been achieved, action can be taken immediately.</td>
</tr>
<tr>
<td>Trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip fracture</td>
<td>July 2011</td>
<td>The Trust is used as a case study in the 2011 report. Data from the national Hip Fracture Database has been used to plan service developments which have resulted in time to surgery for patients with hip fractures falling from 41 hours to 30 hours and in-patient stay reducing from 18 days to 14 days.</td>
</tr>
<tr>
<td>Falls and non-hip fractures 2010 (3rd Round)</td>
<td>May 2011</td>
<td>The results of this audit showed that the Trust is providing a good service for patients with hip fractures, but that there was room for improvement in the treatment of patients with other fractures. The actions already implemented have included an Accident &amp; Emergency admissions ‘bundle’, ensuring that patients have a multi-factorial falls and bone health risk assessment and improved communication with community services. To meet other recommendations outlined by the report, it was recommended locally that a fracture liaison/falls prevention coordinator be appointed but this has not yet been implemented.</td>
</tr>
<tr>
<td>Severe trauma (TARN)</td>
<td>Self generated</td>
<td></td>
</tr>
<tr>
<td>Psychological Conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia 2011 (1st Round)</td>
<td>December 2011</td>
<td>The results of this audit are currently under discussion.</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>O negative blood use</td>
<td>April 2011</td>
<td>The Trust’s results for this national audit were good and no additional actions were required to ensure compliance with the recommendations made.</td>
</tr>
</tbody>
</table>
### PART 2b: Statements Relating to the Quality of NHS Services Provided

<table>
<thead>
<tr>
<th>National Clinical Audit undertaken in 2010-11 where the report was published in 2011-12</th>
<th>Date Report Issued</th>
<th>Actions Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platelet use</td>
<td>April 2011</td>
<td>The internal hospital guidelines for using platelets (a component of blood) are to be reviewed by the haematology team.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Clinical Audit undertaken in 2011-12 where the report was published in 2011-12</th>
<th>Date Report Issued</th>
<th>Actions Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peri &amp; Neonatal</td>
<td>Not yet published</td>
<td></td>
</tr>
<tr>
<td>Neonatal intensive and special care (NNAP) – 2011 data</td>
<td>Not yet published</td>
<td></td>
</tr>
</tbody>
</table>

Children

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric pneumonia</td>
<td>Not yet published</td>
<td></td>
</tr>
<tr>
<td>Paediatric asthma</td>
<td>Not yet published</td>
<td></td>
</tr>
<tr>
<td>Pain management in children</td>
<td>December 2011</td>
<td>This audit focused on how hospital Accident &amp; Emergency Departments manage children who present with pain. The Accident &amp; Emergency team are currently drawing up local pain management guidelines for children. Educational sessions are planned to ensure that children receive rapid assessment and pain relief where necessary.</td>
</tr>
<tr>
<td>Childhood epilepsy</td>
<td>Not yet published – due June 2012</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Not yet published – due October 2012</td>
<td></td>
</tr>
</tbody>
</table>

Acute Care

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency use of oxygen</td>
<td>December 2011</td>
<td>Initial report findings have been discussed at the Acute Response Group and are due for formal presentation in May 2012 at the Medicine Grand Round where an action plan should be agreed.</td>
</tr>
<tr>
<td>Adult community acquired pneumonia</td>
<td>Still collecting data – report due late 2012</td>
<td></td>
</tr>
<tr>
<td>Non-invasive ventilation</td>
<td>Still collecting data – report due late 2012</td>
<td></td>
</tr>
</tbody>
</table>
### National Clinical Audit undertaken in 2011-12 where the report was published in 2011-12

<table>
<thead>
<tr>
<th>Audit Area</th>
<th>Date Report Issued</th>
<th>Actions Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pleural procedures</td>
<td>December 2011</td>
<td>The audit showed some good practice and the Trust’s results were in line with national findings. There was room for improvement where patients are having pleural procedures carried out and a dedicated procedure room is currently being constructed on the Acute Admission Unit.</td>
</tr>
<tr>
<td>Cardiac arrest</td>
<td>Audit still in progress</td>
<td></td>
</tr>
<tr>
<td>Severe sepsis &amp; septic shock</td>
<td>April 2012</td>
<td>This audit showed that documentation of care could be improved, for instance the administration of oxygen and fluids. The A&amp;E team will be discussing possible changes to their current clinical notes at their next clinical governance meeting, in particular adding a specific section on systemic inflammatory response syndrome (SIRS).</td>
</tr>
<tr>
<td>Adult critical care</td>
<td>Didn’t participate in audit – report not reviewed.</td>
<td></td>
</tr>
<tr>
<td>Potential donor audit</td>
<td>Not yet published – due December 2012</td>
<td></td>
</tr>
<tr>
<td>Seizure management</td>
<td>December 2011</td>
<td>The results of this national audit are due to be discussed at a forthcoming A&amp;E clinical governance meeting.</td>
</tr>
</tbody>
</table>

### Long Term Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Date Report Issued</th>
<th>Actions Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Didn’t participate in audit – report not reviewed.</td>
<td></td>
</tr>
<tr>
<td>Heavy menstrual bleeding</td>
<td>Not yet published – due 2013-14</td>
<td></td>
</tr>
<tr>
<td>Chronic pain (National pain audit)</td>
<td>Not yet published</td>
<td></td>
</tr>
<tr>
<td>Ulcerative colitis &amp; Crohn’s disease (Inflammatory bowel disease)</td>
<td>February 2012</td>
<td>The report has only recently been received and has been sent to the Gastroenterology team for discussion.</td>
</tr>
<tr>
<td>Parkinson’s disease</td>
<td>Not yet published – due Summer 2012</td>
<td></td>
</tr>
<tr>
<td>Adult asthma</td>
<td>January 2012</td>
<td>The audit resulted in an asthma ‘bundle’ being devised to ensure consistent care and treatment for patients.</td>
</tr>
<tr>
<td>Bronchiectasis</td>
<td>Didn’t participate in audit – report not reviewed.</td>
<td></td>
</tr>
</tbody>
</table>
## PART 2b: Statements Relating to the Quality of NHS Services Provided

<table>
<thead>
<tr>
<th>National Clinical Audit undertaken in 2011-12 where the report was published in 2011-12</th>
<th>Date Report Issued</th>
<th>Actions Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip, knee and ankle replacements (National Joint Registry)</td>
<td>Not yet published – due September 2012</td>
<td>Information from the Patient Reported Outcomes Measures programme for hernia repair is due to be presented to the Trust’s Audit &amp; Clinical Effectiveness Committee.</td>
</tr>
<tr>
<td>Coronary angioplasty (Cardiac interventions)</td>
<td>Not yet published – due October 2012</td>
<td></td>
</tr>
<tr>
<td>Elective surgery (National PROMs programme)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute myocardial infarction &amp; other ACS (MINAP) 2012 (11th Report)</td>
<td>Not yet published – due September 2012</td>
<td></td>
</tr>
<tr>
<td>Acute stroke (SINAP)</td>
<td>August 2011</td>
<td>The Trust is continuing to actively participate in both the SINAP (first 72 hours of hospital admission after acute stroke) and London Minimum Data Set data collection. However, only small numbers of patients who have a stroke are directly admitted to the Trust (most go to specialised stroke units) and therefore the numbers we enter into the audit are small. The stroke team have concentrated on ensuring that acute stroke care is delivered as soon as possible to these patients and they have done this through education of clinical staff and keeping guidelines updated.</td>
</tr>
<tr>
<td>Cardiac arrhythmia</td>
<td>Not yet published – due November 2012</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung cancer (NLCA)</td>
<td>Not yet published – due end of 2012</td>
<td></td>
</tr>
<tr>
<td>Bowel cancer (NBOCAP)</td>
<td>Not yet published – due November 2012</td>
<td></td>
</tr>
<tr>
<td>Oesophago-gastric cancer (AUGIS)</td>
<td>Audit still in progress</td>
<td></td>
</tr>
<tr>
<td>National Clinical Audit undertaken in 2011-12 where the report was published in 2011-12</td>
<td>Date Report Issued</td>
<td>Actions Identified</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Trauma**

- Severe trauma (TARN): Self generated

**Blood Transfusion**

- Bedside transfusion: October 2011
  - This audit is due to be discussed at the next meeting of the Trust’s Blood Transfusion Committee.
- Medical use of blood: Not yet published – interim report received, but final report outstanding

**Health Promotion**

- Risk factors (national health promotion in hospitals): Autumn 2011
  - Following the audit, a health promotion screening tool was developed to assess patients who may be at risk from obesity, smoking or excess alcohol use. Such patients are offered referral to a suitable health promotion adviser.
  - Written information has been produced and is routinely distributed to patients. Relevant clinical staff are being trained to deliver health promotion advice.

**End of Life**

- Care of dying in hospital: December 2011
  - The Trust’s results were very good, generally scoring above the national average. Training for ward nurses will be updated to include issues such as ensuring relatives are given sufficient information and that GPs are informed that their patient has been placed on the Liverpool Care Pathway.
  - Releasing ward nurses to attend these training sessions has been difficult in the past year but this should be made easier when vacant nursing posts are filled.
PART 2b: Statements Relating to the Quality of NHS Services Provided

Review of Local Clinical Audit Reports
The reports of 112 local clinical audits were reviewed by the Trust in 2011-12 and the Trust intends to take the following actions to improve the quality of healthcare provided, as a result of the following example set of audits:

<table>
<thead>
<tr>
<th>Local Clinical Audit</th>
<th>Actions Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Care</td>
<td></td>
</tr>
<tr>
<td>Medicines reconciliation</td>
<td>This CQUIN audit reviewed the practice of undertaking a medicines reconciliation review for new patients admitted to hospital. This review involves pharmacists ensuring that the medicines patients are being prescribed in hospital correspond to those they were taking prior to admission. The hospital had been set a target to ensure that at least 65% of appropriate in-patients received such a review. The audit showed that 72% of patients received a pharmacist’s review, exceeding the target and the audit result for the previous year (62%). It has raised the profile of medicines reconciliation in the Trust.</td>
</tr>
<tr>
<td>Acute Medicine and A&amp;E</td>
<td></td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>During the past year a ‘bundle’ of care has been devised for patients who are being discharged from hospital with a diagnosis of chronic obstructive pulmonary disease (COPD). The aim of the care ‘bundle’ for this chronic disease, is to provide patients with optimal information and community support to keep them healthier and therefore avoid further hospital admissions. The care bundle includes referral to smoking cessation services, self management plans and referral to rehabilitation programmes where necessary. The Trust was set targets for the role out of this new initiative and clinical audit was undertaken to monitor the role out and drive quality improvement. By March 2012, 52% of patients with a diagnosis of COPD were being discharged with a COPD ‘bundle’, exceeding the target set for the Trust of 50%.</td>
</tr>
<tr>
<td>Surgery and Critical Care</td>
<td></td>
</tr>
<tr>
<td>Prescribing of anti-emetic medicine to prevent post-operative nausea and vomiting</td>
<td>Experiencing nausea and vomiting after surgery is common but can be preventable. An audit was undertaken to measure whether patients were being given appropriate anti-emetic medication. The junior doctors involved in this audit collected data from anaesthetic and drug charts and talked to patients about their experiences. The audit resulted in the Trust guidelines for post-operative nausea and vomiting being updated based on new evidence for treatment to ensure that patients will receive the most effective treatment. Education was also provided for staff on the importance of treating patients who may be more likely to experience nausea and vomiting following surgery, for instance patients who have major surgery that require strong opiate pain killers.</td>
</tr>
</tbody>
</table>
## Local Clinical Audit

### Women and Child Health

**Treatment of children in the Accident & Emergency Department with urinary tract infections**

A repeat clinical audit was carried out to measure whether the Trust had improved its compliance with guidelines from the National Institute for Health Clinical Excellence (NICE). These state that infants and children presenting with an unexplained fever of above 38°C should have a urine sample tested within 24 hours.

A particular problem had been difficulty in obtaining a urine sample from young children in the short period they are in the Accident & Emergency Department.

Parents are now given a pot as soon as they arrive so that they can collect the urine whilst waiting for doctor assessment. As a result, more children with a fever of above 38°C now have a urine test carried out so that a urinary tract infection can be ruled out or treated without delay.

### Nursing

**Nutrition**

Thorough clinical audits on nutrition take place twice every year at Kingston Hospital to assess the level of service that we provide to our patients at mealtimes. Recent results show that we provide a pleasant mealtime environment and assess patients for their risk of malnutrition. Actions taken in the last year include providing patients with alcohol hand-wipes and ringing a bell on each ward to highlight the start of the mealtime to ensure patients can enjoy their meal without interruption. The recent audit has shown that we do not score so well when it comes to documenting and implementing special measures for at-risk patients and patient notes are now being checked monthly to ensure this improves.

### Hospital-wide

**Health promotion**

During the year, the Trust concentrated on the issue of health promotion as part of the Commissioning for Quality and Innovation (CQUIN) initiative. The aim of the Health Promotion CQUIN was to inform patients of the help and support they could receive towards improving their general health, by stopping smoking, reducing alcohol consumption and losing weight.

By carrying out a series of quarterly clinical audits during the year, and acting on these results, we were able to maintain or improve our performance.

For instance, the proportion of patients with a specific range of presenting complaints attending the Accident & Emergency Department who were screened for alcohol consumption rates rose from 14% to 50% over the year, and the proportion of staff trained to deliver health promotion screening and advice rose from 15% to 60%.

The Trust has also demonstrated that it has maintained a consistently high level of screening and health promotion advice to in-patients over the year.
Within the Trust the results of clinical audits, both national and local, are used to drive local quality improvement. Clinical audit results are discussed at clinical meetings in local departments and at wider meetings, such as the Trust’s annual Clinical Audit Seminar.

Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2011-12, that were recruited during that period to participate in research approved by a research ethics committee, was two hundred and fourteen.

Participation in clinical research demonstrates the Trust’s commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest treatment possibilities and active participation in research leads to successful patient outcomes.

The Trust was involved in conducting thirty eight clinical research studies in Health Services Research, Metabolic & Endocrine Medicine, Paediatrics, Reproductive Health & Childbirth, Diabetic Medicine and Cancer Care during 2011-12.

There were eleven clinical staff participating in research approved by a research ethics committee at the Trust during 2011-12. These staff participated in research covering five medical specialities.
Use of the CQUIN Payment Framework

A proportion of the Trust's income in 2011-12 was conditional on achieving quality improvement and innovation goals agreed between the Trust and the South West London Acute Commissioning Unit through the Commissioning for Quality and Innovation payment framework.

Eight schemes were agreed with the Commissioning Unit, with each scheme set to deliver specific quality and innovation improvements in line with national and local targets. We have used the following symbols to indicate how well we have done:

- Met the target
- Good progress but more to do
- We did not meet the target

<table>
<thead>
<tr>
<th>CQUIN and rationale</th>
<th>Target Measure</th>
<th>Achievement</th>
</tr>
</thead>
</table>
| **VTE:** Venous Thromboembolism (VTE) is a significant cause of mortality, long-term disability and chronic ill health. It was estimated in 2005 there were around 25,000 deaths from VTE each year in hospitals in England and VTE has been recognised as a clinical priority for the NHS by the National Quality Board and the NHS Leadership Team | % of all adult in-patients to have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool | ✓
| Quarter 1: 75% | Quarter 2: 80% | Quarter 3: 85% | Quarter 4: 90% | Full payment of £250,500 received |
| **Patient Experience:** The indicator is a composite, calculated from 5 survey questions which are known to be important to patients and where past data indicates significant room for improvement across England. The questions cover: | 1 point increase in index based score | ×
| Involvement in decisions about treatment/care; | | Score decreased by 0.3 (from 64.5 to 64.2) | £125,250 possible payment lost |
| Hospital staff being available to talk about worries/concerns; | | |
| Privacy when discussing condition/treatment; | | | |
### Part 2b: Statements Relating to the Quality of NHS Services Provided

<table>
<thead>
<tr>
<th>CQUIN and rationale</th>
<th>Target Measure</th>
<th>Achievement</th>
</tr>
</thead>
</table>
| • Being informed about side effects of medication; and,  
  • Being informed who to contact if worried about condition after leaving hospital | | |

**Patient Experience – Personal Needs:** The aim of the patient experience strategy is to change the culture of the Trust so that the patients perspective drive delivery of care, design and redesign, governance and decision making of the Trust so that our teams can deliver a caring respectful, safe high quality experience

- Produce action plan with quarterly milestones for implementation of local patient experience strategy
- Achieve milestones as laid out in the action plan

- Action plan produced and all milestones achieved
- Full payment of £62,625 received

**Patient Experience – Personal Needs:** Level of patient complaints in Ophthalmology has been increasing and some operational issues have been identified

- Produce action plan with quarterly milestones for implementation of local Ophthalmology patient experience strategy
- Achieve milestones as laid out in the action plan

- Action plan produced and all milestones achieved
- Full payment of £62,625 received

**End of Life Care:** In England around half a million people die each year, nearly two thirds over the age of 75. For the majority, death is preceded by a period of chronic illness such as heart disease, cancer, stroke, chronic respiratory disease, neurological disease or dementia. In London there were 50,265 deaths in 2007, representing 0.66 per cent of the population

Nationally, the Department of Health published the End of Life Care Strategy, implementation of which is an attempt to create a joined up service, encourage healthcare practitioners to adopt robust and tested procedures to ensure effective end of life care and to ensure that,

- Development of hospital based end of life care registers in agreed specialities
- Implementation plan completed
- Report on indicators 2 to 5 to include performance against agreed standards
- End of year report on indicators 2 to 7 and results of tracking patients preferred place of care and/or death

- All actions completed
- Full payment of £400,800 received
### Statements Relating to the Quality of NHS Services Provided

<table>
<thead>
<tr>
<th>CQUIN and rationale</th>
<th>Target Measure</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>wherever possible, peoples’ wishes as to the care they receive at the end of life are respected</td>
<td>Form designed and action plan completed</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Chronic Obstructive Pulmonary Disease (COPD) Discharge Bundle:</strong> London spends over £100m on COPD per year with an average of £5,000 per year per inpatient. There is an admission rate of 140 per 1,000 patients on the Quality and Outcomes Framework (QOF) registers across London. In quarter 1 2009-10 COPD was the second highest cause of emergency admission. In 2008-09 the total number of bed for emergency hospital admissions for COPD as a primary diagnosis was 91,140. Average length of stay in London is 6.8 days ranging from 8.0 in Havering to 4.7 in Kensington and Chelsea. Nationally 15% of patients admitted to hospital with COPD die within 3 months and a quarter die within a year of admission. It is this significant unwarranted variation and use of urgent care which the consultative national strategy aims to address and which the NHS London Respiratory programme intends to reduce in London.</td>
<td>Target percentage of COPD patients to have a completed bundle</td>
<td>Form designed and action plan completed</td>
</tr>
<tr>
<td><strong>Improving Acute Oncology Services:</strong> The National Chemotherapy Advisory Group (NCAG) report (2009) recommended that all hospitals with an Accident &amp; Emergency department should establish an Acute Oncology Service but little progress has been made. There would be a reduced inpatient stay in patients suffering complications of treatment if there is an inpatient review available by a member of the Acute Oncology Service during the report on progress of Acute Oncology Service, 80% of staff recruited. Acute Oncology Service to be in place and a plan/progress report to be produced. Target percentage of patients admitted via Accident &amp; Emergency due to complications of chemotherapy reviewed by a member of the Acute Oncology Service team within 1 working day of admission.</td>
<td>Report on progress of Acute Oncology Service, 80% of staff recruited</td>
<td>✓</td>
</tr>
</tbody>
</table>

Staff all recruited on schedule |

Service in place and plan/progress report produced |

Target percentage for each quarter achieved |

Full payment of £175,350 received |
### PART 2b: Statements Relating to the Quality of NHS Services Provided

<table>
<thead>
<tr>
<th>CQUIN and rationale</th>
<th>Target Measure</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>working week, or 7 days a week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This should reduce bed days as outlined in the Cancer Reform Strategy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greater awareness of complications of therapy should also lead to reduced complications and improved patient experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Improving Acute Oncology Services:</strong> The NCAG report (2009) recommended that all hospitals with an A&amp;E department should establish an Acute Oncology Service but little progress has been made. There would be:</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>• More appropriate use of further diagnostic tests;</td>
<td>Report on progress of Acute Oncology Service, 80% of staff recruited</td>
<td></td>
</tr>
<tr>
<td>• Less unnecessary biopsies;</td>
<td>Acute Oncology Service to be in place and a plan/progress report to be</td>
<td></td>
</tr>
<tr>
<td>• Faster signposting to potentially curative treatment; and,</td>
<td>produced</td>
<td></td>
</tr>
<tr>
<td>• A reduced inpatient stay inpatients admitted as an emergency with previously undiagnosed cancer if there is an inpatient review available by a member of the AOS during the working week, or 7 days a week</td>
<td>Target percentage of patients admitted as an emergency with previously untreated cancer reviewed by a member of the Acute Oncology Service team within 1 working day of admission</td>
<td></td>
</tr>
<tr>
<td><strong>Quality in Discharges:</strong> GPs need to receive the discharge summaries in a timely manner to ensure effective treatment of their patients</td>
<td>Progress towards discharge summaries sent electronically to all GP practices</td>
<td>✔</td>
</tr>
<tr>
<td><strong>Quality in Discharges:</strong> GPs need the complete information on a patient's hospital stay to treat them safely and</td>
<td>Target percentage of discharge summaries audited containing all the information required</td>
<td></td>
</tr>
</tbody>
</table>

Staff all recruited on schedule
Service in place and plan/progress report produced
Target percentage for each quarter achieved
Full payment of £175,350 received

Timetable achieved
Available to all Docman enabled GP practices by year end
Full payment of £175,350 received
### Part 2b: Statements Relating to the Quality of NHS Services Provided

<table>
<thead>
<tr>
<th>CQUIN and rationale</th>
<th>Target Measure</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Correctly</strong></td>
<td><strong>Medicines Management:</strong> Patients with heart failure are high users of acute care and readmissions. Development of a local registry for heart failure patients with details from the national heart failure registry template will allow primary care to support these patients</td>
<td>Only 2 out of 4 fields fully complied on audit £137,775 received out of a potential £175,350</td>
</tr>
<tr>
<td><strong>Medicines Management:</strong> Medicines Management: Patents with heart failure are high users of acute care and readmissions. Development of a local registry for heart failure patients with details from the national heart failure registry template will allow primary care to support these patients</td>
<td><strong>Achievement</strong></td>
<td><strong>Targets achieved</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Medicines Management:</strong> Medicines Management: British Thoracic Society (BTS) NICE guidance – medicines adherence Assessment of patient’s competency to use a new inhaler device using trainer devices prior to use of the inhaler for patients new to inhalers or identified as at risk of incorrect use. Any risks identified are communicated to primary care This scheme supports the work being undertaken by primary care clinicians in this patient group</td>
<td><strong>Target percentage of patients admitted, in quarters 2, 3 and 4, with heart failure as primary diagnosis who are on audit register</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Medicines Management:</strong> Medicines Management: Part of the national Quality, Innovation, Productivity, Prevention (QIPP) agenda for Medicines. NICE recommends that long acting insulin analogues have a specific but limited place in therapy. They are substantially more expensive than conventional insulins, but their use has increased enormously over the past few years Any decision to start an insulin analogue needs to be balanced carefully against the lack of long-term safety data and increased prescribing</td>
<td><strong>Target percentage of Type 2 Diabetes patients referred to a hospital diabetes specialist assessed as requiring to start a long or intermediate acting insulin are started on neutral protamine Hagedorn (NPH) insulin and percentage reduction in primary care data and education programme delivered by Trust staff</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Medicines Management:</strong> Medicines Management: Part of the national Quality, Innovation, Productivity, Prevention (QIPP) agenda for Medicines. NICE recommends that long acting insulin analogues have a specific but limited place in therapy. They are substantially more expensive than conventional insulins, but their use has increased enormously over the past few years Any decision to start an insulin analogue needs to be balanced carefully against the lack of long-term safety data and increased prescribing</td>
<td><strong>Target percentage of Type 2 Diabetes patients referred to a hospital diabetes specialist assessed as requiring to start a long or intermediate acting insulin are started on neutral protamine Hagedorn (NPH) insulin and percentage reduction in primary care data and education programme delivered by Trust staff</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Targets achieved</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Full payment of £62,626 received</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Target not met in all quarters</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>£33,818 received out of a potential £62,626</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Target percentage for each quarter achieved</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Full payment of £62,626 received</strong></td>
</tr>
</tbody>
</table>
### PART 2b: Statements Relating to the Quality of NHS Services Provided

<table>
<thead>
<tr>
<th>CQUIN and rationale</th>
<th>Target Measure</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>costs. In addition, people with glycaemic control problems should be properly assessed for underlying causes before these newer, more expensive insulins are considered</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medicines Management:</strong> Technical patient safety solutions for medicines reconciliation on admission of adults to hospital’ NICE and National Patient Safety Agency (NPSA) 2007</td>
<td>65% of adult patients to receive a Level 2 Medicines Reconciliation review within 24 hours of admission</td>
<td>✔ Target achieved in each quarter Full payment of £62,625 received</td>
</tr>
<tr>
<td><strong>Health Promotion:</strong> Public Service Agreement (PSA) target of reducing smoking prevalence and gap between social classes Morbidity and mortality of cancer, COPD, CVD attributable to obesity, smoking, alcohol consumption Choosing Health – Department of Health White paper on Public Health priority areas: Reducing smoking; reducing obesity and improving diet; increasing physical activity; and, encouraging sensible alcohol intake. World Health Organisation Health Promoting Hospital Programme recommends that hospitals are used as a setting for broad health promotion activity. They have proposed a broad set of indicators to measure the health promotion activity of a hospital and provided an evidence base for their use. This indicator is the simplest indicator which captures whether a hospital has been active in health promotion for all of their patients</td>
<td>Action plan for percentage of adult medical and surgical inpatients screened for smoking, alcohol and obesity and Accident &amp; Emergency patients screened for alcohol Target percentage of adult medical and surgical inpatients screened for smoking, alcohol and obesity and Accident &amp; Emergency patients screened for alcohol</td>
<td>= Action plan produced Target percentage for each quarter achieved, except smoking in quarter 4 £56,364 received out of a potential £75,152</td>
</tr>
<tr>
<td>Action plan for percentage of patients receiving health promotion advice or referral Target percentage of patients receiving health promotion advice or referral</td>
<td>= Action plan produced Target percentage for each quarter achieved except in quarter 3 £91,850 received out of a potential £100,200</td>
<td></td>
</tr>
<tr>
<td>Action plan for percentage of clinical staff given level 1 health promotion training Target percentage of clinical staff given level 1 health promotion training</td>
<td>= Action plan produced Target percentage for each quarter achieved Full payment of £75,152 received</td>
<td></td>
</tr>
</tbody>
</table>
### Neonatal Community Nurse Provision

Well organised, effective and sensitive neonatal care can make a lifelong difference to premature and sick new born babies and their families. Getting this early care right is the responsibility of the NHS at all levels.

<table>
<thead>
<tr>
<th>Target Measure</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment</td>
<td>Not met</td>
</tr>
<tr>
<td>Discharge pathways developed</td>
<td></td>
</tr>
<tr>
<td>Final year end corrected gestational age at discharge</td>
<td></td>
</tr>
<tr>
<td>Average length of stay of babies born at less than 30 weeks</td>
<td></td>
</tr>
</tbody>
</table>

Not met  
£10,008 possible payment lost

### Two Year Outcome Assessment

Availability of information born under 30 weeks gestational age will allow monitoring and support from London Specialist Commissioning Group.

A shortened length of stay in specialist care should also be possible.

<table>
<thead>
<tr>
<th>Target Measure</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimate of number of babies eligible for inclusion</td>
<td>Not met</td>
</tr>
<tr>
<td>Number of appointments sent for MDT follow up, year to date and projected to year end</td>
<td></td>
</tr>
<tr>
<td>Number of babies entered onto Standardised Electronic Neonatal Database (SEND) for two year outcome follow up</td>
<td></td>
</tr>
<tr>
<td>Number of follow up appointments completed and percentage achieved for follow up</td>
<td></td>
</tr>
</tbody>
</table>

Not met  
£1,112 possible payment lost

### HIV

Effective outcomes in HIV rely on involvement of patients in respect of optimal treatment, improved morbidity and preventing onward transmission.

Involved patients are more able to play a part in self managing their condition.

Whilst patients can choose whether to involve GPs in their care, ensuring the primary care needs of HIV positive patients is becoming an increasing issue as HIV patients are living longer and are at increasing risk of co-morbidities.

<table>
<thead>
<tr>
<th>Target Measure</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of HIV patients involved in decision about their care</td>
<td>80% reported involved</td>
</tr>
<tr>
<td>Full payment of £2,779 received</td>
<td></td>
</tr>
<tr>
<td>70% of Trust HIV patients diagnosed since 2000 to be registered and disclosed to a GP</td>
<td>Achieved</td>
</tr>
<tr>
<td>Full payment of £5,559 received</td>
<td></td>
</tr>
<tr>
<td>90% of patients consenting to GP letters about whom a letter has been sent</td>
<td>Achieved</td>
</tr>
<tr>
<td>Full payment of £5,559 received</td>
<td></td>
</tr>
</tbody>
</table>

Further details of the agreed goals for 2011-12 and for the following 12 month period are available electronically at: [http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html](http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html)
The Trust is required to register with the Care Quality Commission and its current registration status is registered without compliance conditions.

The Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2011-12:

Full Unannounced Inspection: The Trust met 100% of the standards set out by the Care Quality Commission in a full unannounced inspection of the Trust undertaken in November 2011.

The full Care Quality Commission report highlighted the Trust as being compliant across all 16 standards that the government says patients have the right to expect. After speaking with patients, staff and stakeholders and observing the running of the Trust for two days, 14 inspectors agreed that the Trust met all essential standards including:

- Treating people with respect and involving them in their care;
- Providing care, treatment and support that meets people's needs;
- Caring for people safely and protecting them from harm;
- Quality and suitability of management; and,
- Staffing.

Patients echoed this when interviewed by the Care Quality Commission during their inspection. The report includes quotes from these satisfied patients including: "they treat you as a person here," and "the care has been exemplary, I can't fault them". Many patients even said that they preferred Kingston Hospital to other hospitals that they could have gone to, and one patient remarked; "we made a deliberate and positive choice to use this hospital because of the standard of service provided".

The report demonstrates that the Trust is continuously striving to deliver high quality services and that patients treated at the Trust receive safe and appropriate care that meets their needs.

Dignity & Nutrition Inspection: Following an inspection on dignity and nutrition in October 2011, the Trust was named as one of only 45 Trusts out of 100 inspected that were deemed fully compliant and met two key standards relating to dignity and nutrition:

- Standard one: privacy and dignity – respecting and involving people who use services; and,
- Standard five: nutrition – respecting and involving people who use services and meeting the nutritional needs of patients.

During their spot check, the Care Quality Commission inspected two of the Trust's medical wards and found that the patients were treated with kindness and respect, and that their privacy was maintained. During their visit they found that the patients were able to make informed choices and were involved in planning their care and treatment.

The inspectors also found that patients were able to make informed choices about their meals and drinks. Patients were aware that the Trust caters for special diets and that each individual patient's nutritional needs were assessed and monitored. The report highlighted that people were given the support they require by staff to make sure they have a balanced diet and enjoy their meals.

The Trust was also commended on the interaction with patients during mealtimes, the assistance offered to patients who were
unable to feed themselves and the quality of
the food they were given.

Termination of Pregnancy Regulations
Inspection: In March 2012, the Trust had an
unannounced visit from the Care Quality
Commission to investigate if the Trust was
compliant with Termination of Pregnancy
regulations.

The inspector reviewed a sample of patient
notes and spoke to staff about the Trust’s
processes.

Verbal feedback was received by the Chief
Executive, Medical Director and Director of
Nursing & Patient Experience on the day of the
visit. The Trust was found to be fully compliant
with the standards required.

The Trust has recently received the final report
from the Care Quality Commission and the
Trust has been confirmed as compliant with
the standards required.

The Trust intends to take the following
action to address the conclusions or
requirements reported by the Care Quality
Commission.

Full Unannounced Inspection
Outcome 04: People should get safe and
appropriate care that meets their needs and
supports their rights

• Audit of the implementation of patient sign
off of care plans to be undertaken; and,

• Review, and potentially amend, nursing
assessment documentation to include a
section for patients to sign to indicate that
the information gathered within the
documentation is accurate and reflective
of their needs.

Outcome 05: Food and drink should meet
people’s individual dietary needs

• Evaluate the benefit and cost of moving to
a menu pre-ordering system;

• Audit local support provided and establish
action plans to address areas for
improvement; and,

• Roll out of pictorial menus to all areas.

Outcome 09: People should be given the
medicines they need when they need them, in
a safe way

• All registered nurses to be written to
regarding their responsibilities for
medicine security;

• All fridge and store room locks to be
replaced and/or upgraded;

• Lockers to be provided for inpatients to
store own drugs; and,

• Procedures for self-medication to be
developed and implemented.

Outcome 13: There should be enough
members of staff to keep people safe and
meet their health and welfare needs

• Implement the recommendations of the
establishment review;

• Include data from e-rostering on vacancies
and use of temporary staff in the ward
scorecard;

• Audit implementation of 2-hourly rounding;
and,

• Continue with Releasing Time to Care
Programme modules.

Outcome 14: Staff should be properly trained
and supervised, and have the chance to
develop and improve their skills

• Ongoing monitoring of implementation of
new arrangements, including attendance
at drop in sessions.

Dignity & Nutrition Inspection: No
recommendations raised.

Termination of Pregnancy Regulations
Inspection: No recommendations raised.
The Trust has made the following progress by 31 March 2012 in taking such actions.

Full Unannounced Inspection
Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights
- All new care bundles now include a section for the patient to sign to indicate their collaboration and agreement to the care plan.

Outcome 05: Food and drink should meet people’s individual dietary needs
- Quarterly reviews with wards now in place, to ensure patients’ needs and preferences are being met;
- Clear signage in place behind all patient beds to indicate how assistance can be provided; and,
- Trial of pictorial menus on the Stroke Unit has commenced and feedback is being collated.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection
- Improved signage of hand gels in the maternity unit introduced.

Outcome 09: People should be given the medicines they need when they need them, in a safe way
- Audit activity increased to six monthly (previously annually);
- Strategy for regular communication as a result of audit findings implemented; and,
- Medicines Management Policy updated to reflect the emphasis on supporting patient choice.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs
- Role of supervisory Sister introduced on all inpatient medical wards;
- Skill mix on medical wards increased to 65:35 trained to untrained staff;
- Team nursing introduced across all inpatient medical wards; and,
- First two modules of the Releasing Time to Care Programme completed (knowing how we are doing, well organised ward).

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills
- Changes to the arrangements for professional clinical supervision have been made, including increased advertising of group sessions to hard to reach groups (e.g. staff working nights); and,
Data Quality

In March 2012 the Trust approved a refreshed Data Quality Strategy, as part of its commitment to high quality data. The provision of high quality data and information underpins the delivery of efficient and effective clinical care. When done well, this:

- Enables an accurate record of care events, and the resources required to deliver them, which leads to improved clinical care by management of patient pathways and assessment of clinical efficacy, and resource use;
- Enables consistent interpretation, and therefore consistent action;
- Reduces the bureaucratic burden, so releasing staff time for the delivery of front line services;
- Enables better quality planning to take place;
- Enables better organisational performance through the provision of performance information;
- Safeguards revenue and minimises disputes between the Trust and our partners; and,
- Supports the wider health community by the provision of information to support local, regional, and national policy development through the production of accurate statutory returns.

To deliver these benefits, it is important that the scope of the Data Quality Strategy covers more than just clinical activity. However, whilst the long term strategy is to have all key systems within the strategy’s scope, the immediate focus will be on the Care Records Service as the Trust’s key operational system.

Therefore the aims of the Strategy are to deliver high quality data and information quality by:

- Ensuring that the benefits of good data quality are articulated and communicated;
- Driving personal responsibility for data quality, rather than relying on a central function to correct problems;
- Ensuring that organisational resource use can be aligned effectively with output; and,
- Outlining a plan that moves the Trust’s data quality agenda forward to deliver the benefits.

To do this the Strategy, over the next five years, will focus on the following themes:

- Organisation & Staff: This will focus on driving individual responsibility for owning data quality, delivered through the communication of benefits of data quality and the production of reports that allow colleagues to monitor data quality more proactively. In addition, the central data quality function will develop and manage a robust assurance framework;
- Reporting: This area will review and ensure that systems can produce the required monitoring of data quality issues to support identification of problems and allow them to be fed back to the individual concerned. In addition, data quality KPI's will be developed and integrated into the Trust’s performance management process so that the area has the required level of senior management involvement;
- System Management: A review will be carried out to identify the Trust's key systems and what, if any, data quality risks are associated with them. Once this is complete then a plan will be developed to mitigate and then remove any risks that
are considered significant. Finally, a master data and information management process will be implemented to ensure consistency of information interpretation and support process automation; and,

- One Version of the Truth: A key enabler in the delivery of high quality data is the provision of one source of information to avoid duplication and the production of contradictory information. The Trust has invested in a data warehouse to provide the capability for this, and this work will continue with more data sets being integrated and the improvement of access for staff to the information.

In the short term the Trust will be taking the following actions to improve data quality:

Organisational/staff actions:
- Monitoring and correcting of data errors through the further development of exception reports and by the implementation of an appropriate central assurance process;
- Increase data quality benefit awareness with colleagues to ensure individual commitment; and,
- Ensure that robust processes are in place so that identified data issues can be fed back to the individual(s) concerned to stop reoccurrence.

Reporting actions:
- Through system development ensure that there is a robust audit process in place that can clearly identify the person or teams who created the error and that the appropriate feedback process is in place;
- Provide a suite of error reports for operational staff to monitor their own data quality on a self-service basis; and,
- Support the integration of Data Quality KPI’s into new reporting/performance management processes including adding them on the divisional dashboards and executive reports.

System management actions:
- Carry out a key system review which will identify the data quality risks, based on the size of the risk and the systems significance, and then develop and implement plans to mitigate and then remove them;
- Based on the key system review develop and implement data feeds into the Trust data warehouse enabling standardised and consistent error reporting of Trust systems other than the Care Records Service, such as Critical Care, Pathology, Radiology, etc.;
- Formalise existing processes and bring them together into a comprehensive Care Records Service Risks Management process;
- Investigate and request proposals for changes to system software to reduce the risk of users creating errors (system hardening), this may require additional funding; and,
- Design and implement an organisational master data and information management process to manage key data items and business information rules to ensure consistent interpretation and process automation.
NHS Number & General Medical Practice Code Validity
The Trust submitted records during 2011-12 to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics which are included in the latest published data (to March 2012). The percentage of records in the published data:

Which included the patient’s valid NHS number was:
- 98.9% for admitted patients (2010-11: 98.3%) (National percentage 2011-12: 98.8%);
- 99.1% for outpatient care (2010-11: 98.5%) (National percentage 2011-12: 99.1%); and,
- 96.4% for accident and emergency care (2010-11: 95.4%) (National percentage 2011-12: 93.4%).

Which included the patient’s valid General Medical Practice Code was:
- 100% for admitted patients (2010-11: 100%);
- 100% for outpatient care (2010-11: 100%); and,
- 100% for accident and emergency care (2010-11: 100%).

Information Governance Toolkit Attainment Levels
The Trust’s Information Governance Assessment Report overall score for 2011-12 was 82% (2010-11: 81%) and was graded Green – Satisfactory (2010-11: Green – Satisfactory).

The 2011-12 result is from version 9 of the Information Governance Toolkit, whereas the 2010-11 result used version 8. There was very little difference between the two versions. Evidence from version 8 was rolled over into version 9 and we have added to this, for instance updating policies and procedures and adding in-year evidence of monitoring. The results by assurance area were as follows:

<table>
<thead>
<tr>
<th>Assurance Area</th>
<th>Overall Score</th>
<th>Number of Indicators by Level in 2011-12 (2010-11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010-11</td>
<td>2011-12</td>
</tr>
<tr>
<td>Information Governance Management</td>
<td>86%</td>
<td>86%</td>
</tr>
<tr>
<td>Confidentiality and Data Protection Assurance</td>
<td>81%</td>
<td>81%</td>
</tr>
<tr>
<td>Information Security Assurance</td>
<td>73%</td>
<td>73%</td>
</tr>
<tr>
<td>Clinical Information Assurance</td>
<td>86%</td>
<td>80%</td>
</tr>
<tr>
<td>Secondary Use Assurance</td>
<td>91%</td>
<td>100%</td>
</tr>
<tr>
<td>Corporate Information Assurance</td>
<td>77%</td>
<td>77%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>81%</td>
<td>82%</td>
</tr>
</tbody>
</table>

Mandatory Information Governance Training in the Trust this year has slightly exceeded the level of staff trained in 2010-11. This was deemed reasonable by the Information Governance Policy Team from the Department of Health in their Information Governance Assurance Deep Dive Exercise, undertaken in December 2011.
Clinical Coding Error Rate

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.

Clinically coded data is the basis for Payment by Results (PbR) and reference costs. It secures the recovery of the resources used to provide high quality patient care. It rewards efficiency, supports patient choice and diversity and encourages activity for sustainable waiting time reductions.

Following three successful Payment by Results audits, (2007-08, 2008-09 and 2009-10), the Audit Commission made a decision to audit only hospitals with high rates of errors and Healthcare Resource Group (HRG) code changes.

As the Trust has historically been in the top 5% of hospitals for coding accuracy, the Trust was not subject to the Payment by Results clinical coding audit during 2011-12 by the Audit Commission.

The Information Governance Clinical Coding Audit carried out on 200 (2010-11: 200) Finished Consultant Episodes (FCES) in General Medicine in January 2012, showed consistency in the high quality of coded data. This audit met the criteria for Level 3 Information Governance toolkit requirements (the highest level).

The table below demonstrates the Trust has consistently achieved a high level of clinical coding accuracy and, since the introduction of Payment by Results in 2006, has remained within the top 5-10% of hospitals in the country for coding accuracy.

<table>
<thead>
<tr>
<th></th>
<th>2008-09*</th>
<th>2009-10*</th>
<th>2010-11**</th>
<th>2011-12**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Diagnosis Incorrect</td>
<td>6.3%</td>
<td>1.7%</td>
<td>1.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Secondary Diagnosis Incorrect</td>
<td>11.4%</td>
<td>1.8%</td>
<td>9.5%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Primary Procedures Incorrect</td>
<td>4.1%</td>
<td>1.8%</td>
<td>3.3%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Secondary Procedures Incorrect</td>
<td>6.1%</td>
<td>1.6%</td>
<td>8.8%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Episodes changing HRG</td>
<td>4.0%</td>
<td>1.3%</td>
<td>4.0%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

* Audit Commission Payment by Results Audit results

** Information Governance Clinical Coding Audit results
PART 3: Looking back at 2011-12
### Summary

Performance against our Quality Account priorities for 2011-12 can be summarised as follows:

<table>
<thead>
<tr>
<th>PATIENT SAFETY</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Priority One</strong></td>
<td>To reduce patient falls to less than the 4.8 falls per 1,000 bed days National Patient Safety Agency benchmark, by March 2012</td>
</tr>
<tr>
<td>• 46% reduction in inpatient falls (935 to 502)</td>
<td></td>
</tr>
<tr>
<td>• Average of 3.5 falls per 1,000 bed days over 2011-12</td>
<td></td>
</tr>
<tr>
<td><strong>Priority Two</strong></td>
<td>To reduce the number of hospital acquired grade 2 pressure ulcers from the baseline 2010-11 figure by 30% (43 grade 2 pressure ulcers) by March 2012</td>
</tr>
<tr>
<td>• 39% reduction in grade 2 ulcers (142 to 86)</td>
<td></td>
</tr>
<tr>
<td><strong>Priority Three</strong></td>
<td>To reduce the number of hospital acquired grade 3 and 4 pressure ulcers by 70% (16 patients) by 30 March 2012</td>
</tr>
<tr>
<td>• 52% reduction in grade 3 &amp; 4 ulcers (23 to 11)</td>
<td></td>
</tr>
<tr>
<td><strong>Priority Seven</strong></td>
<td>To meet the 95% risk assessment target set last year</td>
</tr>
<tr>
<td>• 91.9% of patients assessed in March 2012 (above CQUIN and contractual level)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLINICAL EFFECTIVENESS</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Priority Four</strong></td>
<td>To reduce the pain patients feel after operations</td>
</tr>
<tr>
<td>• Now &gt;80% of patients assessed</td>
<td></td>
</tr>
<tr>
<td>• Standardisation of documentation</td>
<td></td>
</tr>
<tr>
<td>• Pain Link Nurse programme introduced</td>
<td></td>
</tr>
<tr>
<td>• Groups were invited to trial new forms</td>
<td></td>
</tr>
<tr>
<td><strong>Priority Five</strong></td>
<td>To eliminate emergency readmissions occurring within 30 days of discharge following an elective admission</td>
</tr>
<tr>
<td>• Emergency post elective readmissions reduced to 1.8% in March 2012 from 2.2% in April 2011</td>
<td></td>
</tr>
<tr>
<td><strong>Priority Six</strong></td>
<td>To reduce all other readmissions within 30 days of discharge</td>
</tr>
<tr>
<td>• Emergency post emergency readmissions reduced to 9.9% in March 2012 from 10.6% in April 2011</td>
<td></td>
</tr>
<tr>
<td><strong>Priority Seven</strong></td>
<td>To improve the care to our patients who suffer from dementia</td>
</tr>
<tr>
<td>• Increased education of junior doctors</td>
<td></td>
</tr>
<tr>
<td>• 81% of patients aged 65 and over had memory assessment</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PATIENT EXPERIENCE</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Priority Seven</strong></td>
<td>To ensure that we listen to you and address your concerns and improve the way we communicate with you</td>
</tr>
<tr>
<td>• Delivered all objectives in plan</td>
<td></td>
</tr>
<tr>
<td>• Defined the trust’s values, held listening events for patients, attitude and communication related complaints reduced</td>
<td></td>
</tr>
</tbody>
</table>
This section should assure commissioners, patients, and the public that the Trust is regularly scrutinising each and every one of its priorities, concentrating on those that need the most attention.

We have used the following symbols to indicate how well we have done against the various priorities and targets we report on:

- **Met the target**
- **Good progress but more to do**
- **We did not meet the target**

**Review of the 2010-11 Quality Account by the Audit Commission**

The Audit Commission undertook a ‘dry run’ audit of the 2010-11 Quality Account and made recommendations to help the Trust be in a better position for the requirement for a formal audit, which commenced from 2011-12.

Guidance from the Department of Health required the Audit Commission to:

- Review the Trust’s arrangements for satisfying itself the Quality Account was fairly stated and followed relevant requirements; and,
- Test two performance indicators included in the Quality Account.

In reviewing the management arrangements, the Trust was found to have clear governance arrangements with good systems and processes for producing the Quality Account. On reporting arrangements, the Audit Commission recommended that the Trust provide an earlier draft of the Quality Account to stakeholders, to further improve engagement in identifying and agreeing priorities.

Stakeholders have been involved in the process of selecting the priorities for 2012-13 and received a first draft of the Quality Account for comment before the end of April 2012.

In testing indicators on clostridium difficile and numbers of patients with pressure ulcers the Audit Commission made two recommendations with regards to pressure ulcers, both of which the Trust has taken action to address.

**Internal Audit**

Internal Audit also reviewed the arrangements for producing the 2010-11 Quality Account. The audit opinion was Substantial Assurance with no issues found with the adequacy of controls, and only one recommendation made around the effectiveness of controls.

The recommendation, regarding including an explanation of how performance indicators for each priority were selected, has been addressed in Section 2a of this Quality Account.
PART 3: Looking back at 2011-12

Progress against 2011-12 Patient Safety Priorities

The Trust has a strong patient safety culture and continues to strive to be a safer hospital, working towards avoiding preventable deaths and minimising harm.

The Trust regularly receives national alerts on patient safety issues and the performance of medical equipment. During 2011-12 121 alerts were issued, of which 37 were relevant to the services provided or equipment used by the Trust.

Of these 121 alerts, 1 alert was issued in 2010 and should have been completed by November 2011. Although most of the action required in the alert was completed in time, a Medication Treatment Guideline is still outstanding.

The Trust completed all the actions recommended, or relevant to the trust, for 118 alerts within the required timescales. There are 2 alerts that have just been received and we are in the process of assessing their relevance to the Trust.

Two Hourly Ward Rounds

Nursing Rounds are a proactive intervention where nurses (or a combination of nurses and other healthcare workers) do bedside rounding with patients at regularly scheduled intervals.

There have been a number of studies, both in the UK and abroad, which have shown that nursing rounds are associated with significant increases in patient satisfaction and with equally significant reductions in the use of call bells and in the frequency of falls, pressure ulcers and complaints.

As part of our suite of strategies to improve patient experience and quality of care, the Medical and Surgical Divisions introduced two hourly rounds for patients on the inpatient wards to ensure that we promptly address care, comfort needs and monitor privacy and dignity issues.

During these rounds the nurses ask the patients if they require repositioning, have any pain, require the use of the toilet, need a drink or want anything explained. In addition to this, the nurses explain to the patient and relatives the plan for the next two hours, ensure that the call bell, personal items and drinks are close at hand as well as take the opportunity to review infusions, oxygen, drains, catheters and update relevant charts.

Patient rounding brings improvements to patient care, patient experience and patient safety.

Frontline Focus Fridays

Over the last 18 months the Trust has embedded an approach to strengthen nursing and midwifery visibility and leadership through frontline focus.

Every Friday, the Director of Nursing & Patient Experience and other senior nurses now dedicate time to monitor direct clinical care leadership at ward level and meet to discuss the environment, area of focus, Trust policies as well as results of audit clinical professional standards. The approach provides opportunities to learn from clinical audit undertaken by local leaders and translate this learning into practice improvements quickly.

Over the past year, the nursing and midwifery professions have used this approach to provide evidence for Care Quality Commission inspections, environmental checklists, development of ward scorecards and the nursing assurance framework. The group provides a regular update to the Executive Management Committee and is now a key vehicle for driving performance and change at a local level.

Attendance at the meetings has been encouraging, with approximately 18 staff attending the hour long sessions, including representatives from Heads of Nursing and
Midwifery, Ward Sisters, Infection Control, Practice Development, Midwifery, Estates and ISS (our cleaning and catering contractor). Attendance is dependent upon availability of staff to leave the clinical area.

The topics vary from week to week and are identified through either a rolling programme planned in advance or, on occasion, covering matters arising from day to day activity.

The forum serves not only to deliver focused sessions on topics (for example falls/pressure ulcer care/infection control) but have also raised awareness of some areas which require attention (such as nutrition/screening programmes and health promotion). A key strategy has been the inclusion of the wider team in the Trust to address areas which require a more collaborative approach, such as environmental standards of cleaning.

Infection Control

There were 2 hospital acquired MRSA bacteraemia in 2011-12. The Trust will be expected to have no more than 1 hospital acquired MRSA bacteraemia for 2012-13.

There were 18 cases of C. difficile in 2011-12 against a target of 17. From 1 April 2012, the Trust commenced more sensitive testing of C. difficile to comply with new Department of Health guidance. This may have an impact on the numbers of C. difficile positive patients reported, and will make comparison from this to next year difficult. Next year’s target has been set at 15 cases.

18 Week Performance

At the start of the year the Trust had problems with the 18 week referral to treatment target.

As a result, the patient waiting list has been comprehensively validated resulting in a clear picture of the areas where there were capacity issues that needed to be addressed. The impact of this was that the Trust improved its performance over the remainder of the year.

Overall in 2011-12 the Trust met the target for 90% compliance for admitted patients and 95% compliance for non admitted patients. This means the Trust is in a good position to achieve these targets in each speciality as required for 2012-13 and ensure an overall position of 92% compliance for all patients to be seen and treated within 18 weeks.

Royal Eye Unit

Due to some performance issues within the Royal Eye Unit, in 2011-12, increased support was provided in order to ensure a high quality and effective service. Priority areas were identified and a detailed action plan developed. This included the appointment of new consultants to establish greater capacity within the sub specialities of Ophthalmology.

Four areas were highlighted for action:

- 18 week position;
- Clinical incidents;
- Complaints; and,
- Numbers of patients treated.

The patient waiting list has been comprehensively validated resulting in a clear picture of the areas where there were capacity issues that needed to be addressed. Clinical incidents identified due to the waiting list issues have been investigated and action taken.

The number of complaints within the Unit was high and mostly related to administrative issues and delays to appointments. Access to the Unit through the phone lines was poor and also generated a significant number of complaints. Whilst significant progress has been made, the administrative issues are not fully resolved and remain a high priority. Regular governance and business meetings take place and additional resource will remain in place until the outcomes of the action plan are delivered.

Changes to the clinic templates were implemented to provide additional clinics (increasing the number of patients treated) and to fully utilise the newly appointed consultants.
PART 3: Looking back at 2011-12

**Never Events**
A never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

During 2011-12 there were two never events at the Trust. No harm was caused to either of the patients involved. Both incidents were investigated and a full root cause analysis undertaken. These were reported through the appropriate committees to the Trust Board and the Strategic Health Authority. Learning from these events has been incorporated into revised operating procedures.

**PRIORITY ONE: Reduce Falls**
Aim: To reduce patient falls to less than the 4.8 falls per 1,000 bed days National Patient Safety Agency benchmark, by March 2012.

Why did we choose this?
Patient falls are among the most common occurrences reported in hospitals and are a leading cause of death in people aged 65 years or older. As many as half of those who fall, may suffer moderate to severe injuries that reduce mobility and independence. This increases the risk of premature death.

<table>
<thead>
<tr>
<th>What were we going to do?</th>
<th>What did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure risk assessments are completed on all patients and take steps to identify causes and actions.</td>
<td>Audited regularly to check compliance.</td>
</tr>
<tr>
<td>Implement the falls action plan. If performance drops we will take remedial actions.</td>
<td>Action plan implemented.</td>
</tr>
<tr>
<td>Implement ward score card to provide transparency of levels of performance and strengthen accountability.</td>
<td>Ward score cards are produced monthly.</td>
</tr>
<tr>
<td>Implement hourly rounding.</td>
<td>Two hourly rounds implemented on all wards.</td>
</tr>
<tr>
<td>Benchmark internally, developing local action plans to achieve local target reductions.</td>
<td>Benchmarking undertaken and action plans developed and implemented.</td>
</tr>
</tbody>
</table>

How did we measure progress?
Regular reporting of the number of falls to ward, divisional and Trust Board meetings.

Monthly reporting to NHS London High Impact Actions, a London benchmarking exercise that enables a comparison to be made of the Trust’s performance against other London Trusts.

Monthly reporting of statistics to the local LINks and HealthWatch.

The Falls High Impact Actions action plan is monitored at the Patient Safety Committee.

How did we do?
We achieved our target for this priority.
A number of initiatives were implemented over the year. Raising awareness and implementing an educational strategy proved to be very effective. Alongside this, two hourly rounding, consistent, regular monitoring of falls, and the purchase of innovative equipment designed to provide a mechanism to alert staff of potential risk, have all been successful. The nursing assessment documentation now incorporates a falls risk assessment and, where indicated, nurses should be using a variety of strategies to reduce the risk. Despite the progress made there were five falls in 2011-12 where patients sustained head injuries and subsequently died.

Since then, the Medical Director and Director of Nursing & Patient Experience have led a review of each case to establish if there were any common issues or events related to these episodes and to consider what actions should be put in place to minimise the likelihood of recurrence. A task and finish group has since been established led by the Medical Director and Director of Nursing & Patient Experience until these actions are completed.

**PRIORITY TWO: Reduce Pressure Ulcers**

**Aim:** To reduce the number of hospital acquired grade 2 pressure ulcers from the baseline 2010-11 figure by 30% (a reduction of 43 incidents) by March 2012.

**Aim:** To reduce the number of hospital acquired grade 3 & 4 pressure ulcers by 70% (a reduction of 16 incidents) by 30 March 2012.

**Why did we choose this?**
Pressure ulcers can cause serious pain and severe harm to patients. The cost of treating all hospital acquired pressure ulcers in the UK is estimated to be between £1·4billion and £2·1billion each year, amounting to approximately 4% of total NHS expenditure. In the majority of cases pressure ulcers can be prevented if we follow simple measures.

<table>
<thead>
<tr>
<th>What were we going to do?</th>
<th>What did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure risk assessments are completed on all patients and take steps to identify causes and actions.</td>
<td>Audited regularly to check compliance.</td>
</tr>
</tbody>
</table>
PART 3: Looking back at 2011-12

<table>
<thead>
<tr>
<th>What were we going to do?</th>
<th>What did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reinforce the pressure ulcer care plan across all wards.</td>
<td>Regular focus with senior nursing staff.</td>
</tr>
<tr>
<td>Ward Sisters will investigate the cause of serious pressure ulcers, develop action plans</td>
<td>Now occurring.</td>
</tr>
<tr>
<td>to drive improvement, and present these to Director of Nursing &amp; Patient Experience.</td>
<td>Action plans are signed off by the Director of Nursing &amp; Patient Experience.</td>
</tr>
<tr>
<td>Implement ward score card to provide transparency of levels of performance and strengthen</td>
<td>Produced monthly.</td>
</tr>
<tr>
<td>accountability.</td>
<td></td>
</tr>
<tr>
<td>Strengthen the High Impact Action Skin group.</td>
<td>Patient Safety Committee monitors outputs.</td>
</tr>
<tr>
<td>Develop a patient information leaflet.</td>
<td>Done.</td>
</tr>
<tr>
<td>Develop and implement a skin care bundle.</td>
<td>Now in use.</td>
</tr>
<tr>
<td>Benchmark internally, developing local action plans to achieve local target reductions.</td>
<td>Benchmarking undertaken and action plans developed and implemented.</td>
</tr>
</tbody>
</table>

How did we measure progress?

Regular reporting of the number of pressure ulcers to ward, divisional and Trust Board meetings.

Monthly reporting to NHS London High Impact Actions, a London benchmarking exercise that enables a comparison to be made of the Trust’s performance against other London Trust.

Monthly reporting of statistics to the local LINks and HealthWatch.

The Skin High Impact Actions action plan is monitored at the Patient Safety Committee.

How did we do?

We achieved our target for reducing grade 2 pressure ulcers. Whilst making significant progress, we did not hit the reduction target we had set ourselves for grade 3 & 4 pressure ulcers.

The number of patients with hospital acquired grade 2 pressure ulcers has decreased by 39% against a target of 30% and is now running below the 2011-12 target.

There were a total of 86 grade 2 pressure ulcers in 2011-12, down from 142 in 2010-11.
PART 3: Looking back at 2011-12

The Trust undertakes internal benchmarking through the ward scorecards which are produced monthly. These are reviewed at the monthly Nursing and Midwifery Advisory Committee with the Heads of Nursing.

All grade 3 or 4 pressure ulcers are investigated and the findings are presented to the Director of Nursing & Patient Experience and reported at the Executive Management Team meeting.

The learning from investigations has raised awareness across the Trust and there has been an increased focus on education and prevention strategies for staff within the Accident & Emergency Department.

The nursing assessment documentation follows this through and a care bundle has been developed to assist staff in planning patient centred care. An information leaflet has been produced to raise awareness of risks and preventative strategies targeted at patients and carers.

The High Impact Action Group has been strengthened and meets monthly with the Matrons, Tissue Viability Specialist Nurse and Risk Managers.

PRIORITY THREE: Increase VTE Assessment

Aim: To meet the 95% risk assessment target set last year.

Why did we choose this?
Venous Thrombo-embolism (VTE) is one of the commonest causes of death in this country. Safe and effective methods of prevention of VTE have been known for many years but the importance and scale of VTE as a public health and patient safety issue has remained largely unrecognised. VTE risk assessment is about saving lives and avoiding long term ill health.

<table>
<thead>
<tr>
<th>What were we going to do?</th>
<th>What did we do?</th>
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</thead>
<tbody>
<tr>
<td>Ensure that all relevant staff are trained to undertake and record all risk assessments on the Care Records Service.</td>
<td>We trained all our doctors to be able to undertake a VTE risk assessment. All completed risk assessments are now recorded on the Care Records Service.</td>
</tr>
</tbody>
</table>
PART 3: Looking back at 2011-12

<table>
<thead>
<tr>
<th>What were we going to do?</th>
<th>What did we do?</th>
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<tbody>
<tr>
<td>Report any in-patient VTE and undertake a root cause analysis of why this happened.</td>
<td>All patients who experience a VTE are now investigated to understand why.</td>
</tr>
<tr>
<td>Develop an action plan to drive improvement.</td>
<td>An action plan was developed and implemented.</td>
</tr>
</tbody>
</table>

How did we measure progress?
Reports from the Care Records Service are reviewed on a weekly basis, by ward and Consultant, together with records of training undertaken.

The action plan was monitored and VTE incident reports were analysed at the Patient Safety Committee.

How did we do?
We achieved our CQUIN and contractual target of at least 90% of patients receiving a VTE assessment upon admission to the hospital. However we did not achieve the stretch target of 95% that we set as a Quality Account priority last year.

In March 2012 91.9% of patients (4,556 patients) received a VTE assessment upon admission.

The Trust has made a concerted effort to ensure that all patients who are admitted to hospital have a VTE assessment. All assessments are recorded on the Care Record Service. The Trust will continue to monitor this area closely to ensure that this performance is sustained.
Progress against 2011-12 Clinical Effectiveness Priorities

New Supervisory Role for Ward Sister
In the changing landscape of health and social care, quality and patient outcomes are key to ensuring sustainable models of care. This makes the ward sister and team leader role pivotal.

The Royal College of Nursing (RCN) report “Breaking down Barriers, Driving up Standards”, (2009), discussed the importance of the role of the ward sister. The report highlighted the urgent need for work to be done to strengthen and support this role for the delivery of high-quality nursing and care. The Royal College of Nursing recommended that all ward sisters and team leaders become supervisory to clinical practice in order to redress the balance. Current pressures and competing priorities had rendered the role of the ward sister almost impossible, resulting in excessive workloads and extra unpaid hours worked every week.

During 2011, the Trust undertook a nursing skill mix review, led by the Director of Nursing & Patient Experience. This was to provide the Trust with a clear understanding of the current nursing establishment in relation to patient activity/volumes and staffing levels.

As part of the outcomes of the review, the Medical Division has introduced the role of the supervisory ward sister (matching the system already in place in the Surgery Division). This revised role means that the ward sister is now in a supervisory capacity rather than delivering direct patient care on the ward, which has had a very positive effect for patients and the ward team as a whole. The new role has enabled better coordination of the nursing team, support and supervision and direction of care delivered by less experienced nurses, as well as supporting reductions in length of stay in hospital.

Releasing Time to Care (Productive Ward)
The Division of Acute Medicine & Emergency Care has been implementing the releasing time to care programme since 2010-11. Over this time ward teams have addressed a variety of issues including the ward environment, management of resources and capturing ‘bright ideas’ from front line staff who have both the knowledge base and close contact with our patients. The Trust is harnessing these in-house skills for the benefit of both staff and patients so that those who work in the ward will be empowered to shape their environment and maximise effective patient care.

Feedback to date has shown that the programme is well received and is now being rolled out across other areas of the Trust.

PRIORITY FOUR: Better Pain Control

Aim: To reduce the pain patients feel after operations.

Why did we choose this?
In November 2010, the Department of Health (DH) identified that the National Confidential Enquiry Patient Outcome and Death (NCEPOD) report claimed hospitals were failing to address pain issues adequately particularly in elderly patients.

Pain is counterproductive in the restrictions it places upon our ability to perform normal activities. In hospital, particularly following surgery, pain can contribute to the development of complications such
as chest infections and VTE. The stresses it places on the body can also increase the risk of heart attack and delay wound healing. The human cost of this is not measurable, but it clearly impacts on a patient’s recovery and increases length of stay.

Our patients identified pain management in the Inpatient Survey as something we needed to focus on.

<table>
<thead>
<tr>
<th>What were we going to do?</th>
<th>What did we do?</th>
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<tbody>
<tr>
<td>We are aiming to improve the assessment and management of pain through a series of interventions which include:</td>
<td>The Campaign Against Pain task group was set up to implement better pain control for patients.</td>
</tr>
<tr>
<td>• An analysis of the opportunities and barriers to effective pain management;</td>
<td>An average of 87% of all patients now have their pain assessed every day (end of March 2012 audit).</td>
</tr>
<tr>
<td>• Establishment of a designated group;</td>
<td>A standardised assessment tool has been developed and the vital signs chart incorporates pain as the 5th vital sign.</td>
</tr>
<tr>
<td>• Routine monitoring of pain as the 5th vital sign alongside temperature, pulse, blood pressure and respiration;</td>
<td>An audit cycle has been developed to monitor the effectiveness of this newly developed assessment strategy and resultant care plans.</td>
</tr>
<tr>
<td>• Ensure that pain is included in the review of nursing documentation and included as a question within hourly rounding;</td>
<td>A patient information booklet is being developed alongside a network of Pain Link Nurses, who will act as a ward level resource.</td>
</tr>
<tr>
<td>• Develop a Pain Link Nurse on medical and surgical wards alongside a supporting educational development programme;</td>
<td>The Campaign Against Pain task group is researching available benchmarking information and tools.</td>
</tr>
<tr>
<td>• Production/re-launch of prescribing guidelines;</td>
<td></td>
</tr>
<tr>
<td>• Develop a patient information leaflet; and,</td>
<td></td>
</tr>
<tr>
<td>• Identify means to benchmark ourselves against other trusts and undertake this.</td>
<td></td>
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</tbody>
</table>

How did we measure progress?
We audited the effectiveness of planned interventions to address pain, as recorded in the nursing documentation, as well as undertaking an annual audit of nursing documentation.

We measured and analysed what patients said on our inpatient survey.

Delivery against actions detailed in our action plan was monitored by the Patient Experience Delivery Board.

How did we do?
We achieved our target, as demonstrated by an improved score in the national patient survey:

<table>
<thead>
<tr>
<th>Question: Staff did everything they could to control pain (response: yes definitely)</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>68%</td>
<td>64%</td>
<td>68%</td>
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A local audit undertaken in March 2012 (102 respondents) shows that when comparing with the standards, 87% of patients had been asked whether they had experienced pain in the previous 24
hours by either a doctor or nurse. This was an improvement of 4% compared to the last audit. 70% of patients were reassessed by a nurse after taking analgesia to see if it had worked, a 10% increase from the previous audit.

**PRIORITY FIVE: Reduce Readmission Rates**

*Aim:* To eliminate emergency readmissions occurring within 30 days of discharge following an elective admission. ✗

*Aim:* To reduce all other readmissions within 30 days of discharge. ✓

**Why did we choose this?**

Feedback says that patients only want to be in hospital when it is absolutely necessary. Patients also say that if they can be treated at home or within the community they would prefer this to a hospital environment. Wherever possible, the Trust wants to ensure that it has good discharge arrangements in place to avoid readmissions.

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<thead>
<tr>
<th>What were we going to do?</th>
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<tr>
<td>Continue to ensure Consultant job plans in the Accident &amp; Emergency Department facilitate cover for the department through extended hours service until 22.00 during the week and for 6 hours per day at the weekend.</td>
<td>We have increased the number of Consultants in the A&amp;E. Job plans have been reviewed as part of the 2012-13 job planning round.</td>
</tr>
<tr>
<td>Ensure that every patient potentially requiring readmission is discussed with a Registrar before being referred to a specialty or sent home.</td>
<td>A Registrar or Consultant reviews all referrals.</td>
</tr>
<tr>
<td>Ensure that every patient is sufficiently recovered to enable recovery to continue safely at home or in the community.</td>
<td>The Trust continues to work towards no patient transfers or discharges after 22.00.</td>
</tr>
<tr>
<td>Ensure that every patient has a robust discharge plan that is communicated to and understood by patient and family member/carer. Discharge planning will include senior level supervision from both nursing and medical staff.</td>
<td>Additional focus will be placed on this as part of the 2012-13 priorities.</td>
</tr>
<tr>
<td>Ensure discharge summaries are completed and sent to GPs.</td>
<td>Audited to ensure compliance with the requirement to complete and send.</td>
</tr>
</tbody>
</table>

**How did we measure progress?**

Conversions (the number of people seen in Accident & Emergency and subsequently admitted) were monitored on a daily basis by Accident & Emergency Consultants.

Readmissions were monitored and reported to the Contract Monitoring Group.

The patient experience of discharge was monitored via the results on the National Inpatient Survey.
Involvement in discharge was audited via an audit of ward sister’s documentation and discharge summaries were audited on an annual basis.

How did we do?
The Trust did not completely eliminate emergency post elective readmissions, but it did significantly reduce the percentage from 2.2% in April 2011 to 1.8% in March 2012.

The Trust also reduced emergency post emergency readmissions from 10.6% in April 2011 to 9.9% in March 2012. This performance is monitored through the weekly Executive Team meeting, and monthly at the Trust Board meeting.

Emergency post elective readmissions have reduced from 2.2% of all elective admissions in April 2011 (33 patients out of 1,500 patients admitted) to 1.8% of all elective admissions in March 2012 (38 patients out of 2,064 patients).

Emergency post emergency readmissions have reduced from 10.6% of all emergency admissions in April 2011 (153 patients out of 1,443 patients admitted) to 9.9% of all emergency admissions in March 2012 (159 patients out of 1,599 patients admitted).

Readmission rates are a good measure of how well a treatment or procedure went. If it went well (good outcome) then this reduces the risk of having to return to hospital for further treatment.

The Accident & Emergency Department at the Trust has an excellent track record of managing admissions and has one of the lowest conversion rates in the country. The reductions in readmission rates have helped to maintain that record and the Trust will be looking to sustain and, hopefully, build on the improvements in readmission rates in future years. This will include an increasing focus on the time of discharge for patients.

PRIORITY SIX: Improve Care for Dementia Patients

Aim: To improve the care to our patients who suffer from dementia.
PART 3: Looking back at 2011-12

Why did we choose this?
People with dementia deteriorate physically and psychologically when they are in hospital. The Alzheimer’s Society believes that better care for patients with dementia who are admitted to hospital could improve outcomes, reduce complications, reduce complaints, and lower the average length of stay of these patients by a week. The National Dementia Strategy recommends good quality early diagnosis and intervention, ‘person-centred care’, and an emphasis on staff training. A national audit of people with dementia being cared for in acute general hospitals was undertaken in 2010. The aim of the audit was to establish a baseline of service provision and to act as a driver for service improvement.

What were we going to do?
- Early brief cognitive assessment of all patients aged 65 and over admitted to Kingston Hospital, in order to identify those who have memory loss, confusion, or dementia;
- Increase staff education and training to include all newly qualified staff, all trained nurses and healthcare practitioners, and junior medical staff and maintain record of training programmes;
- Develop a care plan for patients with delirium which enables individualised care to be identified, delivered and evaluated; and,
- Ensure person-centred care including help with eating and drinking is delivered to patients with dementia focussing on the areas highlighted in the Healthcare for London Dementia Plan.

What did we do?
- We put a training programme in place, led by the Dementia Lead for the Trust
- Training has been provided to Nurses on all wards, including the Acute Assessment Unit, so that they can conduct mini-mental test score
- A care plan is now in place, developed by a Consultant in Elderly Care

How did we measure progress?
The Trust undertook local audits, training records audits and a record keeping audit with the outcomes of all audits reviewed by the Audit & Clinical Effectiveness Committee.

As part of Frontline Focus Fridays the Essentials of Nursing Care are audited.

How did we do?
The Trust is aware that it has not fully achieved its ambitions in improving the care of patients with dementia.

The care for patients with dementia has a raised profile throughout the Trust. The new nursing assessment documentation highlights the mini memory assessment and follows this through with a section that focuses on cognition. The Trust is currently developing a care bundle to implement alongside this to assist staff in planning person centred care.

In 2012-13 the Trust has a CQUIN target around the care of patients with dementia which will be reported on quarterly to Commissioners.
The Trust is committed to involving patients and the public in the development and improvement of the Trust's services (see Section 4 for Statements from our Partners on the Quality Account). As part of this commitment, the Trust approved a new Patient Experience & Public Involvement Strategy in March 2011. The Strategy has been developed to enhance organisational values so that the patient’s perspective drives delivery of care, governance, and the decision making of the Trust. Through this Strategy we want hospital teams deliver a caring, respectful, safe and high quality experience all of the time.

As part of the Strategy, and to ensure the patient’s perspective drives delivery of care, the Trust has set up a Patient Assembly. Patient Assembly members are invited to sit on Trust committees and forums to represent patients’ views on matters raised by the Trust. The main roles of the Patient Assembly are to:

- Represent the views of patients and members;
- Ensure that the Trust is responsive to any relevant views raised by the Patients Assembly;
- Assist the Trust to seek views from traditionally hard to reach groups and enable feedback to those groups;
- Establish an annual work plan;
- Participate in activities to improve the patient environment and ensure feedback;
- Consider feedback on patient experience and proposed actions for improvements; and,
- Receive presentations and updates from the Trust and other stakeholders.

The Patient Assembly met for the first time in February 2012. The Patient Assembly is continuing to recruit its membership and aims to have approximately twenty members to support the Trust in its work once fully recruited.

The Patient Assembly will meet quarterly, and the meeting is attended by the Director of Nursing & Patient Experience or the Deputy Director of Nursing.

**Patient Experience Trackers**

There were 29 Patient Experience Tracker handsets used throughout the Trust in 2011-12. The trackers have enabled the Trust to continue encouraging patient engagement in feeding back their experiences. The patient usage of the trackers is reported weekly and the responses are analysed every month.

**Net Promoter Score Pilot**

As part of the Trust’s Patient Experience & Public Involvement Strategy, the Trust is piloting the Net Promoter Score. This is a simple patient experience measure, which allows the Trust to obtain real-time, rapid feedback from every patient using Trust’s services.

Patients are given a card at the end of their care episode which can be completed and left in card return boxes, or returned by post. The card asks the question ‘how likely are you to recommend the service that you received today to a friend or family member?’ The patient is asked to score between ‘0’ and ‘10’ by ticking a box. The patient is then invited to write a comment on the main reason for their score in a box.

The data from these cards will be analysed for each ward and outpatient department on a monthly basis and reports will be produced to provide detailed feedback for staff that can be used to drive improvements.

**Living Our Values Everyday**

The Trust held a series of successful listening events called ‘In Your Shoes’ in November
2011, where patients were invited to share their experiences of using Trust services. Around 70 patients attended and discussed their experiences on a one to one basis with a member of staff. Themes were then discussed in small groups. The information provided by patients was carefully documented and analysed to produce valuable learning.

The information from these events has been used to develop "patient commitments", which are statements about the care and treatment the Trust commits to deliver. The learning has also further clarified the Trust's values and staff behavioural standards, and will be cascaded through the Trust in staff training, team development sessions, and staff performance appraisals.

Listening sessions were also held for staff to listen to each other’s experience of working at the Trust, and the learning from these sessions has also been used to improve patient and staff experience.

**Inpatients' Survey**
The Trust received the results of the 2010 inpatient survey in May 2011.

The survey highlighted that the Trust was in the top 20% of hospitals for providing single sex wash facilities, staff keeping noise to a minimum at night and for providing clear written information to patients about what to do once they are discharged from hospital.

The Trust had also improved in a number of areas compared to the previous year's survey, including reducing waiting times before being admitted to a bed, asking patients about the quality of the care they are receiving and providing information about what to do if they are concerned about their condition.

Although the Trust did not perform as well as it would have liked in some areas, a survey carried out subsequently showed that the Trust was making improvements in some of these areas.

Since the survey took place, the Trust has put in place a Patient Experience & Public Involvement Strategy to ensure the patient perspective drives delivery of care and that patients receive a high quality service all of the time. In addition to this, the Trust is using patient experience trackers to help identify any issues, so that action can be taken to make improvements. The Trust is also reviewing its discharge process to reduce delays and to more involve patients and their families in the process.

The Trust now has two hourly nurse rounds to ensure all patients are visited on a regular basis, giving them an opportunity to ask any questions, as well as have their needs assessed and responded to.

The Trust is continually striving to improve all areas of inpatients experience, particularly those areas in which the Trust did not perform to the high quality standards it aims to provide.

**Outpatients' Survey**
The national Outpatient Department survey, took place in June 2011. A total of 850 patients were surveyed with 406 completed questionnaires returned, giving a response rate of 48%.

Since the last Care Quality Commission survey took place in 2009 the Trust has significantly improved in some areas. These include reducing how long patients have to wait to receive an appointment date as well as the length of time they spend waiting to be seen in the outpatients department.

There were some areas in which the Trust did not perform as well as expected. These included:

- The hospital environment and facilities (cleanliness of the department);
- Tests and treatment (effective provision of information to patients about tests);
- Seeing a doctor and other professional (information provided by the doctor, and
PART 3: Looking back at 2011-12

time to communicate problem with the doctor); and,

- Overall impression of the department (the management of the problem patients sought help for, the care received, and whether patients were treated with respect and dignity).

The Trust already had a number of initiatives in place to make improvements to the patient experience in outpatients. This included:

- Holding ‘listening events’ in autumn 2011 for patients so that they could feedback any concerns they may have;
- Setting up a new Outpatients Improvement Group to look at patient feedback, to make any changes; and,
- The kiosks pilot in outpatients.

The Outpatient Improvement Group is developing an action plan which will address and monitor patient experience closely.

Patient Environment Action Team (PEAT) survey

The Trust performed well in the Patient Environment Action Team (PEAT) survey result published in September 2011. This is a voluntary programme, yet 100% of the eligible NHS organisations covering 1,222 hospitals took part in 2011. PEAT assessments aim to provide a snapshot of standards across a range of non-clinical activities that impact on the patient in hospital, from cleanliness to signage and includes assistance with eating and drinking.

Hospitals are scored in three categories excellent, good and unacceptable. The Trust scored:

- Good (90.67%) in Environment (59.7% of organisations scored Good in 2011);
- Excellent (95.65%) in Food (69.4% of organisations scored excellent in 2011); and,
- Good (94.98%) in Privacy and Dignity (40.5% of organisations scored Good in 2011).

Patient Advice & Liaison Service (PALS)
The Trust welcomes and encourages feedback on its services from, or on behalf of, patients and the Patient Advice and Liaison Service (PALS) is happy to receive such comments.

The PALS provide information and help to resolve concerns that a patient or their family may have. The team aims to sort out problems and concerns quickly in order to help get matters resolved for the patient.

Staff work hard to ensure that any investigations are thorough and that the outcomes reflect the seriousness of the issues that patients and their relatives or carers have raised. Concerns received from or on behalf of patients in no way prejudice how they are treated and are seen as a valuable way of improving services for patients and carers.

The top five concerns raised through the PALS this year were:

- Communication problems: such as difficulties patients experience not being able to contact a department by telephone, or being unable to leave a message;
- Treatment issues: such as delays in commencing treatment, or patients unhappy with the outcome of treatment;
- Administration issues: such as letters for cancelled clinics not being printed, and delays in referral letters being processed;
- Waiting times: for example delays in being given a follow up appointment, and delays in clinics due to overbooking of appointment slots; and,
- Staff attitude problems: such as staff not responding to requests for assistance, or staff being dismissive of patients’ concerns.

The percentage of patients who had a concern and then proceeded to a formal complaint (i.e.
they were not happy either with the way the PALS managed their concern, or felt that the issue needed to be raised again through the formal process) was just under 4%.

This reflects the comprehensive way that concerns brought to the PALS are responded to. It is encouraging that the majority of concerns are dealt with promptly and conclusively without escalation.

Complaints
Over the course of 2011-12, the Trust received 433 formal complaints, an 8% reduction on the 469 complaints received in 2010-11.

The top five issues complained about were:
- Communication with patients and relatives;
- Medical treatment;
- Appointment problems;
- Delays and failures in diagnoses; and,
- Discharge errors.

The Trust’s complaints performance and response times are monitored by the Risk Management Committee, which reports to the Trust Board via the Quality Assurance Committee. The response rate for the year was 72% completed within 25 working days. There has been considerable focus on improving the timeliness of complaint responses.

Next Stage of Complaints
Once local resolution has been exhausted, complainants can refer any outstanding issues to the Health Service Ombudsman, where an assessor will review the complaint investigation and the subject of the complaint.

There have been three referrals to the Ombudsman in 2011-12. To date, the Ombudsman has declined to take on two of the cases, and is considering the third. This is a positive reflection of the robustness of our complaints process.

Learning from Comments & Compliments
Through close working between the PALS and complaints team and the clinical divisions, the Trust aims to resolve issues at an early stage whenever possible and also to learn from the feedback we receive.

Some examples of actions taken as a result of complaints are:
- Review of pain relief given to patients in the Hysteroscopy clinic. All patients are asked to give routine feedback of pain relief given for each procedure;
- New telephone triage proforma introduced in the Maternity Unit. The form is then updated each time the patient contacts the Unit in early labour;
- Expansion of the Consultant team in the Royal Eye Unit in order to increase the availability of clinic appointments; and,
- All patients over 65 years and all patients with a learning disability attending the Accident & Emergency Department undergo a falls risk assessment using the established screening tool.

Patient Stories
This year, the Trust launched a new initiative to improve the patient experience and help the Trust learn from complaints. Each month the Director of Nursing & Patient Experience presents a ‘patient story’ to the Trust Board.

The stories are chosen to reflect issues highlighted in the recently published outpatient survey results. Senior members of staff from the area concerned also attend to answer any questions, discuss actions that have been taken, and to show how improvements are being made.

The purpose of presenting patient stories to the Trust Board is to:
- Connect better with patients, relatives and frontline staff on an emotional level;
- Understand the impact of the experience on the patient and their perspective on
why it happened, and how it could be avoided in future;

• Appreciate the human aspects of harm and errors and develop an open culture to learn from errors; and,

• Make the experience of the patient personal to the Trust at all levels, recognising that ‘this experience happened here’.

Nursing & Midwifery Quality Scorecards
Quality indicators facilitate an understanding of a system and how it can be improved, thereby monitoring performance against agreed standards or benchmarks. They provide a mechanism whereby care providers can be accountable for the quality of their nursing services.

The report State of the Art Metrics for Nursing: A Rapid Appraisal (Kings College, London, 2008), reviewed the status of the evidence base on nursing metrics. The recommendations within this report helped frame the development of the Trust’s Nursing Quality Ward Scorecard.

During the course of the year, the nursing leadership team have adapted the Nursing Quality Ward Scorecards and these now serve as a very useful “heat map” of the Trust. They allow senior nurses, at a glance, to see how they compare to other wards and their previous performance. Most importantly support the development of local action plans to address issues identified.

The scorecards are reviewed at the Divisional level meetings, the Nursing and Midwifery Advisory Committee and the Trust Risk Management Committee.

Eliminating Mixed Sex Accommodation
In January 2009, the Secretary of State for Health announced an intensive drive to eliminate mixed sex accommodation within the NHS.

The NHS Operating Framework for 2010-11 required all providers of NHS funded care to confirm whether they are complaint with the national definition ‘to eliminate mixed sex accommodation except where it is in the overall best interest of the patient, or reflects their patient choice’.

The Trust has a zero tolerance approach to patients being placed in mixed sex accommodation for any reason other than one that is clinically justified. The Trust has a number of measures to support local delivery of this commitment.

Matrons report, measure, and analyse any mixed sex breaches monthly. These are then investigated and integrated into Trust and Divisional scorecards, which are reviewed at the Trust Board and the monthly Risk Management Committee. We also highlight the number of complaints relating to mixed sex accommodation at our Patient Experience Committee.

In 2011-12 we have created two single sex wards and undertook building works in five wards in the hospital’s Esher Wing to improve the proximity to toilets and showers for some side rooms. In addition to this, the Day Surgery Unit has completed building works to improve the privacy and dignity of patients.
PRIORITY SEVEN: To Listen and Communicate Better with our Patients

Aim: To ensure that we listen to you, improve the way we communicate with you and address your concerns.

Why did we choose this?
The “Patient Experience” lies at the heart of our work. At the Trust we want to create a culture where we engage with you, improve communication and subsequently deliver the highest quality patient-centred care. Staff at the Trust aim to ensure all patients are treated with dignity, compassion, courtesy, and respect. Our complaints, the National Inpatient Survey, and our local survey show us we need to improve in this area.

<table>
<thead>
<tr>
<th>What were we going to do?</th>
<th>What did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement our Patient Experience Strategy year one action plan which includes:</td>
<td>Outputs from the “listening events”, held with Trust patients and stakeholders, have been used to re-define Trust values, standards, and patient commitments. These values promote compassionate, dignified and respectful care.</td>
</tr>
<tr>
<td>• Defining with you a set of expected behaviours so that we deal with you in a compassionate and respectful way;</td>
<td>“Listening events” have been completed, for patients, carers, visitors, and staff. The Net Promoter Score pilot is being implemented across the Trust between March and June 2012.</td>
</tr>
<tr>
<td>• Introduce new ways in which we engage with patients, carers and visitors and identify areas for improvement. This will include “listening events”;</td>
<td></td>
</tr>
<tr>
<td>• Introduce “patient story” to Board meetings;</td>
<td>Patient stories have been introduced at Board meetings.</td>
</tr>
<tr>
<td>• Feedback patient experience to staff and identify the training needs that should be met.</td>
<td>The outcomes of the “listening events” have been fed back to staff at the Patient Experience Delivery Board meeting and the Patient Experience Committee. A human resources organisational development plan has identified plans to implement this learning in staff training and appraisal plans.</td>
</tr>
<tr>
<td>• Establish a customer service skills course for all frontline staff.</td>
<td>A team development session has been devised as part of the Living Our Values Everyday project. Eight pilot sessions have been delivered in the Trust attended by approximately 60 staff in total. Pilot sessions have been delivered to Ambulatory Care, Human Resources, Astor Ward, Estates and Facilities, PALs and Complaints, and other managerial and administration staff.</td>
</tr>
</tbody>
</table>
### Key components of the team development session curriculum are:

- Introduction to the Trust values, commitments, and service standards;
- Understanding and reflecting on patient’s experience of negative and positive service;
- Rationale and importance of the team development sessions;
- The Communication model – a template for looking at factors influencing how we communicate, and how we can improve our communication with others;
- How to work better with colleagues including use of feedback;
- How to turn a negative work experience into a positive one through using problem-solving techniques, and managing attitudes better; and,
- Identifying which behavioural changes can be taken forward into future practice.

Once formally launched the course will be delivered to all frontline staff.

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### How did we measure progress?

The Trust has continued to implement a range of interventions to respond to the needs of patients using our services, particularly those needs for information, respect of privacy and dignity, and involvement in care decisions.

The Trust used the Patient Experience Tracker in 2011 to provide a rapid patient feedback system at the point of care, in clinical settings. Clinical staff received regular reports on patient feedback. They developed action plans to make improvements based directly on patient feedback.

In 2012, the Trust started to pilot the Net Promoter Score. This provides patients, in both ward and outpatient clinic settings, with the opportunity to provide feedback using a brief postcard survey to score and comment on the service they received. Following analysis of this data, staff will develop action plans in order to be able to bring about improvement in care delivery and patient experience.

### How did we do?

The results for the 2011 Inpatient Survey were published in April 2012.

These showed that the Trust was performing about the same as most other Trusts on the majority of the questions in the survey. But compared to the 2010 survey the Trust showed significant improvement on four questions:

- Experience of sleeping accommodation, that was not shared by members of the opposite sex;
- Experience of bathroom and toilet facilities that were not shared by members of the opposite sex;
As noted earlier the Trust did not achieve the improvement it was hoping for on the five questions that form the basis of the CQUIN payment. The following table shows that of the five CQUIN questions, two demonstrated improvement in 2011 and three worsened.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>6.5</td>
<td>6.8</td>
</tr>
<tr>
<td>44</td>
<td>Did you find someone on the hospital staff to talk to about your worries and fears?</td>
<td>5.3</td>
<td>5.2</td>
</tr>
<tr>
<td>46</td>
<td>Were you given enough privacy when discussing your condition or treatment?</td>
<td>7.9</td>
<td>7.8</td>
</tr>
<tr>
<td>65</td>
<td>Did a member of staff tell you about medication side effects to watch for when you went home?</td>
<td>4.7</td>
<td>4.9</td>
</tr>
<tr>
<td>70</td>
<td>Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?</td>
<td>7.8</td>
<td>7.4</td>
</tr>
</tbody>
</table>

Improvement on these questions is a Quality Account priority for the Trust for 2012-13. An action plan is currently being developed, however the ‘Big Five’ project is designed to improve these areas.
### National Priorities & Core Standard Metrics for 2011-12

The following table is presented to the Trust Board on a monthly basis, as part of the Trust’s commitment to quality at the heart of everything we do.

Additional narrative around clinical quality and safety is provided in an accompanying written report, prepared by the Medical Director and Director of Nursing & Patient Experience.

Copies of the full report are available on the Trust website as part of Trust Board papers.

### Outcomes and Effectiveness

<table>
<thead>
<tr>
<th>Outcomes and Effectiveness</th>
<th>RAG rating</th>
<th>2010-11</th>
<th>2011-12</th>
<th>Overall Performance to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative Risk of Mortality (taken from Dr Foster)</td>
<td>All HSMR Diagnoses</td>
<td>&lt;=100</td>
<td>101-105</td>
<td>&gt;105</td>
</tr>
<tr>
<td></td>
<td>Surgical specialties</td>
<td>&lt;=100</td>
<td>101-105</td>
<td>&gt;105</td>
</tr>
<tr>
<td></td>
<td>Medicine Specialties</td>
<td>&lt;=100</td>
<td>101-105</td>
<td>&gt;105</td>
</tr>
<tr>
<td>Average Length of Stay (taken from Dr Foster)</td>
<td>Trust Average Length of Stay (Emergency Only)</td>
<td>Actual</td>
<td>6.8</td>
<td>6.5</td>
</tr>
<tr>
<td></td>
<td>Expected</td>
<td>6.8</td>
<td>7.4</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>6.8</td>
<td>7.4</td>
<td>6.9</td>
</tr>
<tr>
<td></td>
<td>Expected</td>
<td>6.8</td>
<td>7.4</td>
<td>6.9</td>
</tr>
<tr>
<td>Paediatrics (All inpatients)</td>
<td>Actual</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
</tr>
<tr>
<td></td>
<td>Expected</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
</tr>
</tbody>
</table>

#### 30 Day Readmission Rate

<table>
<thead>
<tr>
<th>Number of Emergency Readmissions following elective admission - 30 days</th>
<th>0</th>
<th>315</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Emergency Readmissions following elective admission - 30 days</td>
<td>1.4%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Number of Emergency Readmissions following emergency admission - 30 days</td>
<td>&lt;1307</td>
<td>1742</td>
</tr>
<tr>
<td>% Emergency Readmissions following emergency readmission - 30 days Reduction of 25%</td>
<td>10.1%</td>
<td>10.6%</td>
</tr>
</tbody>
</table>

#### Other

| A&E - Percentage of A&E Attendances for Cellulitis + DVT that end in Admission | 25.6% | 21.5% | 26.1% | 21.7% | 25.4% | 24.1% | 16.2% | 24.5% | 26.6% | 24.8% | 21.20% | 18.40% | 22.9% |
| Reduce the number of Intensive Care Unit patients who are readmitted into ICU after fit for transfer | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 |
PART 3: Looking back at 2011-12

### Green Achieve

<table>
<thead>
<tr>
<th>Green Achieve</th>
<th>Amber Underachieve</th>
<th>Red Fail</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Apr</td>
<td>May</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.2</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20.4</td>
<td>21.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&lt;=4.8</td>
<td>&gt;4.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.1</td>
<td>2.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20.4</td>
<td>21.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.1</td>
<td>2.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&lt;=4.8</td>
<td>&gt;4.8</td>
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<tr>
<td></td>
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<td>1.1</td>
<td>2.7</td>
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<td></td>
<td></td>
<td>0.0</td>
<td>0.0</td>
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<tr>
<td></td>
<td></td>
<td>20.4</td>
<td>21.5</td>
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<td>2.7</td>
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<td>&lt;=4.8</td>
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<tr>
<td></td>
<td></td>
<td>1.1</td>
<td>2.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

### Patient Safety

#### Number of patients with pressure ulcers (Grade 2)
- 2010-11: <=10
- 2011-12: <10

#### Number of patients with pressure ulcers (Grade 3-4)
- 2010-11: >0
- 2011-12: >0

#### Number of Patient Safety Incident Falls
- 2010-11: 938
- 2011-12: 502

#### PSI Patient Falls per 1000 G&A bed-days
- 2010-11: <=4.8
- 2011-12: <=4.8

#### Number of Serious Untoward Incidents
- 2010-11: 32
- 2011-12: 46

#### Number of Never Events
- 2010-11: 2
- 2011-12: 0

#### E. coli Bloodstream Infections
- 2010-11: 2
- 2011-12: 0

#### Hand Hygiene
- 2010-11: >=95%
- 2011-12: 70% to <85%

#### Caesarean Section Rate
- 2010-11: <=26%
- 2011-12: <=26%

#### Induction Rate
- 2010-11: <=20%
- 2011-12: <=20%

#### Normal Delivery Rate
- 2010-11: >58%
- 2011-12: >58%

#### Caesarean Section Rate - Primip
- 2010-11: <=26%
- 2011-12: <=26%

#### Preventive care of hospital acquired VTE - % patients risk assessed
- 2010-11: Q4>90%
- 2011-12: 94.9%

#### % of 3rd and 4th degree tears
- 2010-11: <5%
- 2011-12: >7%

#### Number of Post Operative PE or DVT
- 2010-11: 3
- 2011-12: 2

#### % of patients with MUST assessment*
- 2010-11: >70% to <85%
- 2011-12: 96.9%

#### Number of Mixed Sex accommodation breaches
- 2010-11: <=20%
- 2011-12: <=20%

#### Number of complaints
- 2010-11: 469
- 2011-12: 52

#### Average Number of Preoperative bed days for patients with fractured neck of femur
- 2010-11: 1.5 - 2
- 2011-12: 1.5 - 2

#### A&E - Service Experience
- 2010-11: >=80%
- 2011-12: <=80%

#### PET Tracker Utilisation
- 2010-11: % Complaints responded to within 25 working days
- 2011-12: 51.9%

#### PET Tracker Question: Do Staff Respect your privacy and dignity?
- 2010-11: % of complaints referred to ombudsman
- 2011-12: 47.3%

#### PET Tracker Question: Do you feel that nurses include you with discussions about your care
- 2010-11: Data from Dr Foster and not available
- 2011-12: 25.7%

#### Pet Tracker Question: Do you feel that nurses include you with discussions about your care
- 2010-11: Data from Dr Foster and not available
- 2011-12: 94.7%

#### Patient Experience
- 2010-11: >=80%
- 2011-12: <70%

#### Key
- Data Not Applicable, i.e. no relevant patients
- Data always reported in arrears
- Data from Dr Foster and not available
- Provisional Data
- To be confirmed: Data not yet available
- TBC
- Provisional Data
- Italic:

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LIVING OUR VALUES EVERYDAY

QUALITY ACCOUNT 2011-12

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PART 3: Looking back at 2011-12

Core Quality Indicators

The National Quality Board, which has steered the policy underpinning Quality Accounts since their introduction, has recently considered how to foster readers’ understanding of comparative performance whilst maintaining local ownership.

They have recommended the introduction of mandatory reporting against a small, core set of quality indicators. Ministers have accepted this advice and are likely to introduce this new requirement by amending the Quality Accounts regulations for the 2012-13 reporting period.

In accordance with best practice the Trust has decided to incorporate reporting against the proposed core set of indicators in its current Quality Account.

We have used the following symbols to indicate how well we have done in 2011-12:

- Met the target
- Good progress but more to do
- We did not meet the target

NHS OUTCOMES FRAMEWORK DOMAIN 1: Preventing people from dying prematurely

Indicator: Summary Hospital-level Mortality Indicator (SHMI)

SHMI is a hospital-level indicator which measures whether mortality associated with hospitalisation was in line with expectations.

The SHMI value is the ratio of observed deaths in a trust over a period of time divided by the expected number given the characteristics of patients treated by the trust (where 1.0 represents the national average). Depending on the SHMI value, trusts are banded between 1 and 3 to indicate whether their SHMI is low (3), average (2) or high (1) compared to other trusts.

SHMI is not an absolute measure of quality. However, it is a useful indicator for supporting trusts to ensure they properly understand their mortality rates across each and every service line they provide.

SHMI was only introduced as a national measure in 2011-12. Historically trusts have monitored the Hospital Standardised Mortality Ratio (HSMR). The main differences between the two measures are that:

- HSMRs reflect only deaths in hospital care where as SHMI also includes deaths occurring outside of hospital care within 30 days of discharge;
- The HSMR focuses on 56 diagnosis groups (about 80% of in hospital deaths) where as SHMI includes all diagnosis groups (100% of deaths); and,
- The HSMR makes allowances for palliative care where as the SHMI does not take palliative care into account.
How did we do?

In 2010-11 the Trust performed better than would be expected for all measures of mortality.

This means less people die in the Trust’s care, or within a month of discharge from the Trust, than the profile of patients would predict.

Looking at the HSMR measure, the Trust has continued to perform well over the period April 2011 to December 2011. The ratio of the actual number of deaths to the expected number of deaths, (where 100 is the expected number) is below what would be expected for the Trust:

The latest SHMI available is for April 2011 to December 2011 and shows a value of 55.

This data comes from CHKS Ltd. Previously, the Trust used Dr Foster and was able to show SHMI compared to HSMR. As the Trust no longer has the Dr Foster tool it is not possible to update the HSMR figure for the same time period.
PART 3: Looking back at 2011-12

NHS OUTCOMES FRAMEWORK DOMAIN 3: Helping people to recover from episodes of ill health or following injury

Indicator: Emergency readmissions to hospital within 28 days of discharge

The Trust reduced emergency post elective readmissions (within 30 days of discharge) from 2.2% in April 2011 to 1.8% in March 2012.

The Trust also reduced emergency post emergency readmissions (within 30 days of discharge) from 10.6% in April 2011 to 9.9% in March 2012.

Emergency post elective readmissions have reduced from 2.2% of all elective admissions in April 2011 (33 patients out of 1,500 patients admitted) to 1.8% of all elective admissions in March 2012 (38 patients out of 2,064 patients).

Emergency post emergency readmissions have reduced from 10.6% of all emergency admissions in April 2011 (153 patients out of 1443 patients admitted) to 9.9% of all emergency admissions in March 2012 (159 patients out of 1599 patients admitted).

Readmission rates are a good measure of how well a treatment or procedure went. If it went well (good outcome) then this reduces the risk of having to return to hospital for further treatment.

The Accident & Emergency Department at the Trust has an excellent track record of managing admissions and has one of the lowest conversion rates in the country. The reductions in readmission rates have helped to maintain that record and the Trust will be looking to sustain and, hopefully, build on the improvements in readmission rates in future years. This will include an increasing focus on the time of discharge for patients.
NHS OUTCOMES FRAMEWORK DOMAIN 4: Ensuring that people have a positive experience of care

Indicator: Responsiveness to inpatients’ personal needs

Patient experience is a key measure of the quality of care. The NHS should continually strive to be more responsive to the needs of those using its services, including needs for privacy, information, and involvement in decisions.

This score is based on the average of answers to five questions in the Care Quality Commission national inpatient survey:

- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

How did we do?
In 2010 the Trust obtained an average survey score of 64.5 for these questions. However, in 2011 this decreased to an average score of 64.2.

Indicator: Percentage of staff who would recommend the provider to friends or family needing care

How members of staff rate the care that their employing trust provides can be a meaningful indication of the quality of care and a helpful measure of improvement over time.

The NHS staff survey includes the following statement: “if a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust” and asks staff whether they strongly agree, agree, neither agree nor disagree, disagree or strongly disagree.

How did we do?
In the 2011 survey, the Trust scored 3.53, an improvement on the score of 3.45 achieved in the 2010 survey.

The national average for the 2011 survey was a score of 3.5, so the Trust is slightly better than the national average. The assigned rating was Green: Average.
NHS OUTCOMES FRAMEWORK DOMAIN 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Indicator: Percentage of admitted patients risk-assessed for venous thromboembolism (VTE)

VTE (deep vein thrombosis and pulmonary embolism) can cause death and long-term morbidity, but many cases of VTE acquired in healthcare settings are preventable through effective risk assessment and prophylaxis.

Meeting the 95% risk assessment target set in 2010-11 was selected as one of our Quality Account priorities for 2011-12 (Priority 3 above).

How did we do?
We achieved our CQUIN target of at least 90% of patients receiving a VTE assessment upon admission to the hospital; however, we did not achieve the stretch target of 95% that we set as a Quality Account priority last year.

In March 2012 91.9% of patients (4,556 patients) received a VTE assessment upon admission.

The Trust has made a concerted effort to ensure that all patients who are admitted to hospital have a VTE assessment. All assessments are recorded on the Care Record Service.

Indicator: Rate of Clostridium Difficile

Clostridium difficile (C Diff) can cause symptoms including mild to severe diarrhoea and sometimes severe inflammation of the bowel. Hospital-associated clostridium difficile is preventable.

How did we do?
For 2011-12, the Trust was given a target of no more than 17 hospital acquired cases and reported 18 cases.

For 2012-13, the target has been set at no more than 15 hospital acquired cases.
PART 3: Looking back at 2011-12

Quality Account 2011-12

Indicator: Rate of patient safety incidents and percentages resulting in severe harm or death

An open reporting and learning culture is important to enable the NHS to identify trends in incidents and implement preventative action. The expectation is that the number of incidents reported should rise as a sign of a strong safety culture, whilst the number of incidents resulting in severe harm or death should reduce.

How did we do?
The latest Organisation Patient Safety Incident Report, published by the National Patient Safety Agency, shows that from 1 April 2011 to 30 September 2011 the Trust reported 3.0 incidents per 100 admissions compared to the median of 6.3 incidents (2010-11: 4.3 reported incidents per 100 admissions compared to the median of 5.7 incidents). The Trust is reviewing its incident reporting processes to ensure all incidents are recorded and reported appropriately on the national database.

Nationally, 68% of incidents are reported as no harm, and just less than 1% as severe harm or death. The Trust reported 40.2% (403 incidents) as no harm and 0.3% (3 incidents) as severe harm or death.

Despite exceeding the target set for 2011-12 Trust performance is still consistently below both all London Trust and all Trusts in England.
Who We Involved in Setting the Priorities for 2012-13

To develop and select the 2012-13 priorities, a multi-faceted approach was adopted to engaging with our stakeholders to get their views.

This included four stages:

**Stage One**
An editorial board was set up to work on this year’s Quality Account. The board was chaired by the Director of Nursing & Patient Experience and included the Deputy Director of Nursing, representatives from communications, patient experience, membership, business intelligence, and the Head of Financial Services.

The board developed an overall work plan and identified the key phases in generating the Quality Account. A key component was to generate ideas for this year’s priorities and the board initially compiled a “long list” of priorities based on the national operating framework, local feedback from complaints, best clinical practise developments, Trust priorities, and Health Authority projects.

**Stage Two**
This list of priorities was discussed with the LINk chairs and Trust Executive Management Team in January 2012.

The Nursing and Midwifery Advisory Committee was also asked to comment.

**Stage Three**
The focus within each of the quality domains was debated and used to inform and shape priorities for 2012-13. From the responses received and suggestions put forward, the editorial board met and the original long list of over 35 suggestions was pared down to a more digestible short list of seven themes in the three domains of quality:

<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety</td>
<td>Recognising when a patient’s condition is deteriorating and taking swift clinical action</td>
</tr>
<tr>
<td></td>
<td>Ensuring the Trust implements the NHS Safety Thermometer</td>
</tr>
<tr>
<td></td>
<td>Continuing to improve our infection control systems and performance</td>
</tr>
<tr>
<td>Clinical Effectiveness</td>
<td>Reduction in variations in care out of hours</td>
</tr>
<tr>
<td></td>
<td>Continuing to build on improvements to assess and manage patients’ pain relief</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Improving communication</td>
</tr>
<tr>
<td></td>
<td>Implementing the recommendations of the Commission for Dignity in Care</td>
</tr>
</tbody>
</table>

**Stage Four**
We sought a much wider audience to refine and select the topics which patients and staff felt were of the greatest importance to them. To involve our community in the development of our priorities and review our last year’s performance we:

- Met with HealthWatch Kingston Pathfinder and Richmond upon Thames LINk on a regular basis;
- Met with Foundation Trust members and the patient assembly on two occasions in
January and February 2012, including a focus group of 7 Trust members and representatives from Kingston HealthWatch and Richmond LINk; and,

- Undertook an online survey which included:
  - Asking 1,200 members and staff (through the CEO weekly email) to review and prioritise their preferences;
  - Publishing the survey on the homepage of our website and “Spotlight” on the Trust’s intranet; and,
  - Specific invitations to the HealthWatch and LINk chair and members to participate in the survey;

- Attended Royal Borough of Kingston upon Thames Overview & Scrutiny Committee; and,
- Inviting the Clinical Quality Review Group to comment on the themes.

Survey Results

Over 200 responses were received through the various feedback routes (including 10 postal, 109 internet and 22 via focus groups). This identified that four areas were favoured by respondents more than others.

As we are already performing well in the area of infection control, the three highest priorities were:

<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>Theme</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety</td>
<td>Recognising when a patient’s condition is deteriorating and taking swift clinical action</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Effectiveness</td>
<td>Reduction in variations in care out of hours</td>
<td>2</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Improving communication with our patients</td>
<td>3</td>
</tr>
</tbody>
</table>

Preferences were calculated from overall selection scores (total number of votes by ranking) based on the total responses received. More than 70% of the responses received were from patients and the public:

There was a strong correlation between what patients/public voters perceived as important with those expressed by staff.
The Trust provided copies of the draft Quality Account to HealthWatch Kingston Pathfinder and Richmond upon Thames LINk on 30 April 2012, and Kingston Health Overview Panel and South West London Acute Commissioning Unit on 10 May 2012. During May 2012, face to face briefings were provided for the chairs of the Overview and Scrutiny Committees of Richmond and Kingston.

Comments made about the Trust’s draft Quality Account have been incorporated into this final version.

Statements received from our partners on the final Quality Account are included in Part 4 of this document.
PART 4: Statements from our Partners
HealthWatch Kingston Pathfinder

During 2011-12 HealthWatch Kingston Pathfinder has continued to work on developing its role as a supportive ‘critical friend’ to Kingston Hospital, identifying where there is scope for improvement and acknowledging the progress made. Its members have been actively involved with the Clinical Ethics Forum, the Nutrition Steering Group and associated benchmarking exercises, the Patients Experience Committee (PEC), the Patient Information Readers Panel and Patient Environment Action Team (PEAT) inspections, in addition to sending a representative to public events and attending regular meetings with the Director of Nursing & Patient Experience.

The Quality Account, however, is a complex document that can be difficult for patients and public to read and understand. This may be because it is set to a prescribed template; if this is so, it would be worth spending time considering the terminology and presentation used, especially of statistical data. Such complex information is currently difficult for lay people to interpret meaningfully and accurately and a short Executive Summary would be very useful.

We are pleased to note that more senior staff are now available at weekends. It is unclear from the wording of this document how issues which were raised as problematic in the 2010-11 Quality Account have continued to be monitored through 2011-12 to maintain and/or improve standards. We note that a number of targets have not been fully met and trust these will continue to be monitored. To ensure that this occurs it may be useful to have a standing item on the PEC agenda to receive reports about Quality Account targets on a regular basis and the progress being made towards them. We look forward to seeing such ongoing attention being reflected in the 2012-13 Quality Account.

At the recent Picker workshop one of the presenters made the comment that Kingston Hospital was ranked as Average, along with the majority of other NHS Trusts. The question was raised: “Would any organisation want to have as their strapline ‘Aiming to be Average’?” The answer was that Kingston Hospital NHS Trust has the stated ambition to work internally and externally to be much better than average. Kingston HealthWatch Pathfinder looks forward to being involved with the development of the 2012-13 Quality Account at the earliest opportunity and will work in partnership with Kingston Hospital NHS Trust to help them to aim even higher.

Sandra Berry
Chair

Helen Hutson
Lead, Hospital Services Working Group

31 May 2012
Trust Response

The Trust is grateful for the input from the Pathfinder.

The Pathfinder has been invited to attend the Quality Assurance Committee, which, together with the Patient Experience Committee, will continue to monitor priorities from the previous Quality Account to ensure progress has been made.

An easy read version of the Quality Account has been produced and is available on the Trust website.
Richmond upon Thames LINk

Reading this year’s Quality Account from Kingston Hospital NHS Trust provides a challenge to patients and public alike; whilst we appreciate the Trust wishes to make this as comprehensive as possible the result is a report that, in our opinion, is confusing and lacks the clarity to enable residents to make an informed opinion of the effectiveness of care and services at Kingston Hospital.

Richmond LINk has been developing its involvement with Kingston Hospital, as a major provider of hospital care for our borough’s residents, over this past year. We are participating in Patient Environment Action Team (PEAT) inspections and the Patient Experience Committee (PEC) and we have seen a significant improvement to the approach and outcomes.

Regarding the outcomes of the nine objectives in the Quality Account priorities for 2010-11 whilst we welcome the achievement of the targets for five of these – it is disappointing to see that four did not meet their target. These are of particular concern to us.

Regarding patient falls, it is good to see a reduction in the overall number of falls but we were most alarmed to see through the Richmond upon Thames LINk monthly reports that there had been an increase in the number of patients who had experienced severe harm which in five cases resulted in death.

The readmission rates within 30 days for both elective and emergency admissions are unclear and need attention.

It is vital that all areas continue to be monitored and plans put in place where appropriate to ensure standards do not slip and that further improvement can be recognised even if it is not a Quality Account priority for the year.

We note the priorities for the forthcoming year. We will work with the Trust to identify some tangible targets for these as without them it will be difficult to measure any improvement. We suggest that priorities for future years always have measurable targets.

Overall, this Quality Account does not give confidence in the openness of the culture underpinning the organisation. A more outward approach that faces weaknesses and a determination to be much better than national average would be encouraged and supported by Richmond upon Thames LINk and we will work with the Trust to achieve some clarity about how data and outcomes are reported.

Bonnie Green Maureen Chatterley
Chair Lead, Hospital Group

31 May 2012
Trust Response
The Trust is grateful for the input from the LINk.

The LINk has been invited to attend the Quality Assurance Committee, which, together with the Patient Experience Committee, will continue to monitor priorities from the previous Quality Account to ensure progress has been made.

An easy read version of the Quality Account has been produced and is available on the Trust website.

The Trust is disappointed in the perception of the LINk regarding their confidence in the openness of the culture at the Hospital. The Quality account has been amended to reflect the LINk’s comments regarding harm to patients caused by falls.

The Trust will continue to explore opportunities to work more closely to address their concerns.
PART 4: Statements from our Partners

Kingston Health Overview Panel

The Panel made the following comments.

Priority 1
Basic observations are fundamental to patient care and these are often undertaken by Health Care Assistants. The Panel suggests that training in recording observations and acting on them is implemented, maintained and monitored for effectiveness.

Progress will be measured by auditing admissions to Intensive Care among other indicators. However patients may experience a subtle deterioration because of a failure to monitor their progress, which does not result in a major deterioration but which prolongs their stay in hospital and causes increased distress. The Panel suggests that indicators of deterioration at ward level also be monitored for appropriate action.

Priority 2
While commending the Trust's excellent record in maintaining good care at weekends, the Panel suggests that this is perhaps not as much of a key priority as an area that has been identified as in need of improvement.

Health Care Assistant training in the handover process was also identified as a need for improvement.

Priority 3
Aiming to improve the perception of patients is good, but aiming to improve the reality could be better! ‘Continuous Learning’ requires continuous education, with protection of the training budget and good-quality learning opportunities offered to all staff, particularly including front-line administrative staff.

The 2011-12 Patient Experience Priority listed the ways in which patients were consulted about their experiences. Although there were a number of different methods the Panel were concerned that there was no mention of particular ways of communicating with patients who have particular needs. For instance, those with sensory impairments, learning difficulties, memory loss, mental health problems, etc. may be at significant disadvantage. These groups have all been identified by research as needing specific care and their needs may be overlooked if there is not targeted consultation.

The Panel noted the reduction in incidence of Pressure Ulcers but is concerned about the number of ulcers described as grades 2, 3 and 4 and wishes to see further reductions in the coming year.

The Panel noted that the problems in the Eye Hospital had been identified and an Action Plan implemented. There is still a significant level of concern locally and the patient experience in this area continues to give rise to anxiety. The Panel suggests that these issues are addressed urgently. The Panel is also concerned that the recent national reports of increasing delay in cataract treatment is not reflected locally, particularly as this area has been reviewed previously.

The Panel noted that the exercise to monitor patients’ records had been undertaken in order to ensure the accuracy of waiting lists. The panel suggests that this continues to be monitored. The Panel also noted the difficulty of contacting the Hospital in order to cancel or change an appointment, which may also contribute to the inaccuracy of information.
The Panel congratulates the Trust for its good performance overall and its commitment to improvement.

Margaret Thompson (Chair)
31 May 2012

Trust Response
The Trust is grateful for the input from the Panel.
The following changes have been incorporated into the Quality Account:

Priority 1:
• Training and recording observations; and,
• Monitoring deterioration at ward level have been included in this section.

Priority 2:
• Monitoring of Healthcare Assistant training.

Priority 3:
• Increased focus on patients with particular needs.

The Trust notes the feedback on the Royal Eye Unit and 18 week performance, and has included sections in Part 3 of this Account.
A sub-committee of the London Borough of Richmond’s Health, Housing and Adult Services Overview and Scrutiny Committee was established for purposes of reviewing Quality Accounts and it has now had the opportunity to meet and review those of Kingston Hospital. The sub-committee thanks the Trust for the opportunity to do so and their attendance was valued. The Sub-committee was happy that the account was accurate and was pleased with the identified direction of travel. The sub-committee however has no direct comments on the Quality Account at this time.

**Trust Response**

The Trust is grateful for the input from the Panel.
South West London Acute Commissioning Unit

The commissioners have reviewed the Trust’s Quality Account report for 2011 and the following is a summary of performance against national standards (listed below).

The Trust has worked hard to improve the quality of care it provides to our patients and the improvement in the 2011-12 CQUIN performance and the good performance on Healthcare Acquired Infections serves to demonstrate this.

The Trust had problems with the 18 week target at the beginning of the year and worked hard to improve their position; the impact of this hard work being reflected in good performance from quarter two to the end of the year. Commissioners are confident of further improvements in 2012-13 in the areas that have not met the agreed standards in 2011-12.

<table>
<thead>
<tr>
<th></th>
<th>2011-12</th>
<th>2012-13</th>
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</thead>
<tbody>
<tr>
<td><strong>18 Week Waiting Times</strong></td>
<td>For admitted patients the target was not met for the first 3 months of the year but was achieved in the remaining 9 months of the year.</td>
<td>To continue the good work on meeting the national standard for the number of patients waiting no longer than 18 weeks.</td>
</tr>
<tr>
<td></td>
<td>For non-admitted patients the target was not met for the first 5 months of the year but was achieved in the remaining 7 months of the year.</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Access (A&amp;E 4 hour target)</strong></td>
<td>97.06% of patients were treated, admitted or discharged within 4hrs.</td>
<td>Maintain above 95%</td>
</tr>
<tr>
<td><strong>Cancer Waiting Times Targets</strong></td>
<td>The Trust met all cancer targets.</td>
<td>Maintain good performance on all targets.</td>
</tr>
<tr>
<td>2 week rule (the maximum wait for an urgent referral).</td>
<td>1 month to treatment from confirmed diagnosis.</td>
<td></td>
</tr>
<tr>
<td>1 month to treatment from confirmed diagnosis.</td>
<td>2 months to treatment (wait from urgent referral).</td>
<td></td>
</tr>
<tr>
<td><strong>CQUIN Achievement</strong></td>
<td>A significant improvement was achieved.</td>
<td>To maintain a good performance against CQUIN targets.</td>
</tr>
<tr>
<td></td>
<td>2010-11 82%</td>
<td></td>
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<tr>
<td></td>
<td>2011-12 90%</td>
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</tbody>
</table>
## PART 4: Statements from our Partners

<table>
<thead>
<tr>
<th>Part</th>
<th>2011-12</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eliminating Mixed Sex Accommodation</strong></td>
<td>The Trust had 5 episodes of mixed sex accommodation breaches in May, and then maintained a good performance with regards to mixed sex accommodation for the rest of the year, with no further breaches.</td>
<td>Trust to take the necessary action to maintain its good performance in relation to mixed sex accommodation in 2012-13.</td>
</tr>
<tr>
<td><strong>Healthcare Acquired Infections</strong></td>
<td>KHT had 2 cases of MRSA in 2011-12</td>
<td>To maintain a good performance</td>
</tr>
<tr>
<td>No more than 3 cases of MRSA (bacteraemia) during 2011-12</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Healthcare Acquired Infections</strong></td>
<td>KHT had 18 cases reported during 2011-12</td>
<td>To maintain a good performance</td>
</tr>
<tr>
<td>No more than 17 cases of Clostridium Difficile during 2011-12</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternity Services</strong></td>
<td>KHT had a caesarean section target of &lt;=26%. The year-end achievement was 28.12%.</td>
<td>To achieve Maternity CQUIN milestones in 2012-13</td>
</tr>
<tr>
<td><strong>Never Events</strong></td>
<td>There were 2 never events in 2011-12</td>
<td>No Never Events in 2012-13</td>
</tr>
<tr>
<td><strong>Serious Incidents (SI)</strong></td>
<td>The Trust has improved the SI review processes to reduce as far as possible the potential for the same error to recur.</td>
<td>To maintain a good performance.</td>
</tr>
<tr>
<td>Timely reporting and learning from errors</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CQC / External Audit Results</strong></td>
<td>The results of the 2011 National Inpatient Survey showed no improvement in the index based score on 5 questions within the national inpatient survey.</td>
<td>Improvement in experience of inpatients.</td>
</tr>
<tr>
<td><strong>National Survey of Adult Inpatients</strong></td>
<td>KHT were:</td>
<td>Action plan in place to improve patient experience in outpatients</td>
</tr>
<tr>
<td>Among the best performing 20% of Trusts in 0 questions.</td>
<td>Among the worst performing 20% of Trusts in 29 questions.</td>
<td></td>
</tr>
<tr>
<td><strong>National Outpatient Department Survey</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Trust Response</strong></td>
<td>The Trust is grateful for the comments from its Commissioners, and the recognition of the progress made in 2011-12.</td>
<td></td>
</tr>
</tbody>
</table>
Statement of Directors’ Responsibilities in respect of the Quality Account

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust’s performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and,
- The Quality Account has been prepared in accordance with Department of Health guidance.

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

By order of the Board

Ian Reynolds                              Kate Grimes
Chairman                                 Chief Executive
27 June 2012                              27 June 2012
I am required by the Audit Commission to perform an independent assurance engagement in respect of Kingston Hospital NHS Trust's Quality Account for the year ended 31 March 2012 ("the Quality Account") as part of my work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and the National Health Service (Quality Account) Amendment Regulations 2011 ("the Regulations"). I am required to consider whether the Quality Account includes the matters to be reported on as set out in the Regulations.

Respective Responsibilities of Directors and Auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011)).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- The Quality Accounts presents a balanced picture of the Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and,
- The Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a Statement of Directors' Responsibilities within the Quality Account.

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the Quality Account is not consistent with the requirements set out in the Regulations.

I read the Quality Account and conclude whether it is consistent with the requirements of the Regulation and to consider the implications for my report if I become aware of any inconsistencies.

This report is made solely to the Board of Directors of Kingston Hospital NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.
Assurance work performed
I conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the NHS Quality Accounts Auditor Guidance 2011-12 issued by the Audit Commission on 16 April 2012. My limited assurance procedures included:
• Making enquiries of management; and,
• Comparing the content of the Quality Account to the requirements of the Regulations.

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
The scope of my assurance work did not include consideration of the accuracy of the reported indicators, the content of the Quality Account or the underlying data from which it is derived.

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. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

Conclusion
Based on the results of my procedures, nothing has come to my attention that causes me to believe that the Quality Account for the year ended 31 March 2012 is not consistent with the requirements set out in the Regulations.

Paul Grady
District Auditor
Audit Commission,
1st Floor, Millbank Tower,
Millbank, London, SW1P 4HQ

28 June 2012
### Glossary of Terms

The following glossary gives an explanation of some of the terms used in the Quality Account.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Quality Commission (CQC)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Chronic Obstructive Pulmonary Disease (COPD)</strong></td>
<td>Chronic obstructive pulmonary disease is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease.</td>
</tr>
<tr>
<td><strong>Clinical Quality Indicators (CQUINs)</strong></td>
<td>National quality indicators, agreed with local commissioners, against which the Trust will be measured. They will cover areas of safety, effectiveness and patient experience.</td>
</tr>
<tr>
<td><strong>Clostridium Difficile (C Diff)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Department of Health (DH)</strong></td>
<td>The Department of Health is a government department that exists to improve the health and wellbeing of people in England. It also sets direction for the NHS, for adult social care and public health.</td>
</tr>
<tr>
<td><strong>Deep Vein Thrombosis (DVT)</strong></td>
<td>Deep Vein Thrombosis is the formation of a blood clot in a deep vein most commonly in the leg or pelvis.</td>
</tr>
<tr>
<td><strong>Foundation Trust (FT)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Healthcare Associated Infections (HCAI)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Hospital Standardised Mortality Ratio (HSMR)</strong></td>
<td>This is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.</td>
</tr>
<tr>
<td><strong>Methicillin Resistant Staphylococcus Aureus (MRSA)</strong></td>
<td>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).</td>
</tr>
<tr>
<td><strong>National Institute for Clinical Excellence (NICE)</strong></td>
<td>NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.</td>
</tr>
<tr>
<td><strong>Net Promoter Score</strong></td>
<td>A survey which asks patients two questions. The outcome of the</td>
</tr>
</tbody>
</table>
### Patient Advice and Liaison Service (PALS)

The PALS service provides:

- confidential advice and support to families and their carers;
- confidential assistance in resolving problems and concerns quickly; and,
- explanations of complaints procedures and how to get in touch with someone who can help.

### Patient Experience Tracker (PET)

Patient Experience Trackers are electronic hand-held units used to carry out patient surveys on a visit-by-visit basis. They enable us to obtain patient feedback and get real-time data to help us improve the services we provide. When the acronym PET is used within this document it always refers to Patient Experience Tracker and should not be confused with Positron Emission Tomography which is not used or implied at any time within this Account.

### Payment by Results (PbR)

This is the system by which most acute healthcare is priced and paid for by commissioners (usually Primary Care Trusts).

### Pressure Ulcers

Pressure ulcers (formerly known as ‘bed sores’) are areas of skin that break down when a person stays in one position for too long. A pressure ulcer starts as reddened skin but gets progressively worse, forming a blister, then an open sore, and finally a hole. Pressure ulcers are staged by severity and can progress, from stage one (least severe) to stage four (most severe).

### Primary Care Trusts (PCT)

NHS bodies aligned to local government geographic areas which have responsibility for commissioning healthcare on behalf of local residents.

### Referral to Treatment (RTT)

This is a term used in connection with the 18-week target. By December 2008, all Trusts had to ensure that elective care was delivered within 18 weeks of the initial GP referral. The total time elapsed is the RTT.

### Strategic Health Authority (SHA)

Strategic Health Authorities manage the NHS locally and are a key link between the Department of Health and the NHS. They hold all local NHS organisations (apart from NHS Foundation Trusts) to account for performance.

### Secondary User Service (SUS)

A single source of comprehensive data to enable a range of reporting and analysis. SUS supports the NHS and its partners in the areas of: planning, commissioning, management, research, audit, public health along with a number of national initiatives, such as Payment by Results and the reimbursement mechanism for acute care.

### Venous Thromboembolism (VTE)

VTE is a clot that is transported around the body by the circulation and can be fatal. Identifying patients at risk through assessment enables preventative treatments to be delivered.