Kingston Hospital NHS
NHS Foundation Trust

Quality Account 2012-13

Living our values everyday

CARING SAFE RESPONSIBLE VALUE EACH OTHER

This Quality Account has been produced in-house by the Communications Department of Kingston Hospital Foundation NHS Trust.

Thank you to members of the Council of Governors, including elected Governors, the Patient Assembly and other patient representatives, representatives of Kingston Healthwatch and Richmond Healthwatch who helped to shape the document.

Thank you also to staff throughout the Trust who contributed to the Quality Account.

The full Quality Account and a summary version will be published on the Hospital's website available from 30 June.

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Introduction from the Chief Executive

I am delighted to introduce the fourth Quality Account for Kingston Hospital NHS Foundation Trust. Improving the experience and outcomes for our patients remains the top priority for the Hospital and our vision puts patients at the centre of all that we do. We know that patient experience is critical to both patients and their families and goes well beyond the health outcomes of care.

We know that our staff are highly committed to caring for patients with compassion and empathy, and they identify strongly with the idea that they should care for patients in a way they would want a member of their family to be treated. Regardless of increasing activity, the constant drive for efficiency and the increasing use of technology in healthcare, our staff are focussed on being caring and compassionate in all their dealings with patients, their families and carers.

Here at Kingston we provide a full range of diagnostic and treatment services to the people living in South West London and North Surrey who use our Hospital. Kingston is a popular local hospital and we continue to develop our services to meet the needs of our local population. Last year we agreed three priorities for 2012-13 with our stakeholders:

- Recognise when a patient's condition is deteriorating and take swift clinical action.
- Ensure we maintain consistently high standards of care out of hours, such as evenings and weekends when there are fewer staff on duty.
- Improve communication with our patients.

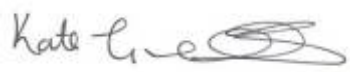
This Quality Account provides information about how we have delivered against these priorities and how we will continue to focus on these areas in the future.

This year's Quality Account also provides us with the opportunity to demonstrate our commitment to continuously reviewing, measuring and improving the services we offer. We have aimed to provide an honest account of our performance, sharing our successes but also the details of where improvements are still required.

Our priorities for the coming year reflect national drivers to improve care for older people, to reduce harm to patients and to ensure not only that the basics of care are provided, but that our minimum standard is to be the best on every occasion. Our priorities have been developed with the help of the patients and their representatives we serve along with the staff at the hospital, they are summarised below:

Patient Safety	- Reduce the number of clostridium difficile infections (C diff) - Reduce the number of patient falls
Clinical Effectiveness	- Improve staff engagement (involvement) *As research shows that the better "engaged" staff are, the better the quality of care they provide*
Patient Experience	- Improve waiting times for patients

We recognise the value of involving our local community in decisions about our services and priorities for improvement and always listen to the feedback we receive when things have gone well and when we could have done better. This feedback has played a key role in setting our priorities for 2013/14. The Quality Account presents a balanced picture of the Trust's performance over the period covered and to the best of my knowledge the information reported in the Quality Account is reliable and accurate.



Kate Grimes

Chief Executive

What is a Quality Account?

All providers of NHS services in England have a statutory duty to produce an annual report to the public about the quality of services they deliver. This is called the Quality Account. Quality Accounts aim to increase public accountability and drive quality improvement within NHS organisations. They do this by getting organisations to review their performance over the previous year, identify areas for improvement, and publish that information, along with a commitment to you about how those improvements will be made and monitored over the next year.

Kingston Hospital focuses on three areas that help us to deliver high quality services:

- Patient safety
- How well the care provided works (clinical effectiveness)
- How patients experience the care they receive (patient experience)

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

Scope and structure of the Quality Account

This report summarises how well we did against the quality priorities and goals we set ourselves for 2012/13 and if we have not achieved what we set out to do, we have explained why and what we are going to do to make improvements. It also sets out the priorities we have agreed for 2013/14 and how we intend to achieve them and track progress throughout the year.

One of the most important parts of reviewing quality and setting quality priorities is to seek the views of our patients, staff and key stakeholders (such as the Clinical Commissioning Groups, Council of Governors, Healthwatch Groups). The Quality Account includes statements of assurance relating to the quality of services and describes how we review them, including information and data quality. It also includes a description of audits we have undertaken, our research work, how our staff contribute to quality and comments from our external stakeholders.

If you or someone you know needs help understanding this report, or would like the information in another format, such as large print, easy read, audio or Braille, or in another language, please contact our Communications Department. If you have any feedback or suggestions on how we might improve our Quality Account, please do let us know either by emailing: enquiries@kingstonhospital.nhs.uk or in writing to our Patient Advice Liaison Service (PALS) at: Kingston Hospital NHS Foundation Trust, Galsworthy Road, Kingston upon Thames, Surrey, KT2 7QB.

Language and Terminology

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

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

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

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

Elective admission: *A patient admitted for a planned procedure or operation.*

Non-Elective admission: *A patient admitted as an emergency.*

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

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

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

Methicillin Resistant Staphylococcus Aureus (MRSA): *It is a bacterium from the Staphylococcus aureus family. MRSA bacteria are resistant to some of the antibiotics that are commonly used to treat infection, including methicillin (a type of penicillin originally created to treat Staphylococcus aureus (SA) infections).*

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

Vital Signs: *The assessment, measurement and monitoring of vital signs are important basic skills for all clinical staff. The vital signs we look for include temperature, heart/pulse rate, respiratory rate and effort,*

blood pressure, pain assessment and level of consciousness. Important information gained by assessing and measuring these vital signs can be indicators of health and ill health.

Completed observations: *We record patients' vital signs on observation charts. Not all patients will require every part of the observation chart to be completed. Clinical judgement should be used to dictate the type and frequency of patient observation required. How many vital signs are recorded is helpful to assess how complete the record is.*

Cardiac Arrest: *cardiac arrest happens when your heart stops pumping blood around the body. The most common cause of a cardiac arrest is a life threatening abnormal heart rhythm called ventricular fibrillation (VF). Ventricular fibrillation occurs when the electrical activity of the heart becomes so chaotic that the heart stops pumping and quivers or 'fibrillates' instead. This is a cardiac arrest. It can sometimes be corrected by giving an electric shock through the chest wall, using a device called a defibrillator.*

Peri-arrest Period: *The recognised period, either just before or just after a full cardiac arrest, when the patient's condition is very unstable and care must be taken to prevent progression or regression into a full cardiac arrest.*

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

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

Acute Assessment Unit (AAU*): An acute assessment unit (AAU) is a short-stay department. The AAU acts as a gateway between a patient's general practitioner, the emergency department, and the wards of the hospital. An AAU is usually made up of several bays and has a small number of side-rooms and treatment rooms. They are fully equipped with emergency medical treatment facilities including defibrillators and resuscitation equipment.*

CQUIN: *A CQUIN (Commissioning for Quality and Innovation) is payment framework that enables commissioners to reward excellence, by linking a proportion of the hospital's income to the achievement of local quality improvement goals. Since the first year of the CQUIN framework (2009/10), many CQUIN schemes have been developed and agreed.*

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

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

National Patient Safety Agency (NPSA): *Patient safety is an aim to reduce risks to patients receiving NHS care and improve safety. The NPSA is an arm's length body of the Department of Health and through its divisions cover the UK health service. The NPSA leads and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.*

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

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

Use of Statistics:

This particular area is a challenge for the production of the Quality Account as there are many differing views on the best way to present and compare. Some of the comments received this year:

"There is too much comparison with other hospitals"

"The use of statistics highlighting either change over time or for benchmarking purposes with similar organisations lacks consistency and might suggest a selective use of these numbers."

"By only comparing nationally and not drilling down to the local level you do not address why there was a rise in November 2012, which fell the following month. The lack of local data in this area may be perceived as being selective in your reporting of this area particularly as other areas of the report contain data and tables (mainly) at the local level."

"Patients and the public would like to see a comparison with last year's facts and figures"

"We are also pleased to see how KHFT performs when compared nationally e.g. Hospital Mortality indicators"

Our ambition is to provide an open and transparent Quality Account which presents data which is informative and allows the reader to get an overview of how they might perceive the quality of care at the Hospital.

We know that we don't always get it right – and we don't get it right for every patient every time.

Where there is local data (to allow comparison to other local Trusts) we have used that – where there is data available which compares the Trust to the national (or regional) position we have used this too.

The collection processes for data does not always remain the same from year to year and therefore it is not always possible to compare our performance over time.

We will continue to improve the presentation of data as we aim to strike a balance of the differing perspectives on how data is presented. We are happy to respond to requests for more data.

Looking Back at 2012 – 13

After an extensive consultation process last year, we set ourselves three priorities for 2012/13.

Our first priority was to focus on our most ill patients, those needing the highest levels of treatment and attention. We wanted to make sure that early signs of deterioration were recognised and acted upon. To support this we planned to improve communication within and between teams when a patient's condition is causing concern, and to make sure that staff responded appropriately.

Our second priority was 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 was how we communicate 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 a Foundation Trust, 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.

Domain	Priority	Outcome
Patient Safety	Recognise when a patient's condition is deteriorating and take swift clinical action	Achieved
Clinical Effectiveness	Reduction in variations in care out of hours.	Achieved
Patient Experience	Improving communication with our patients	Achieved

We will continue to focus on these areas in the coming year as well as our new priorities. Over the coming pages we will describe how we have delivered against the priorities you chose last year.

Priority 1 - Patient Safety: Recognise when a patient's condition is deteriorating and take swift clinical action.

Why did we choose this? In hospital we take measurements from all our patients to help us understand if their condition is improving or getting worse. We measure pulse, blood pressure, temperature, pain level and breathing rates at least twice a day and record the measurements on a vital signs chart. We made ensuring that these charts are properly completed and that we act effectively when measurements are deteriorating our patient safety priority because swift action can affect how well our patients get better or prevent them from harm.

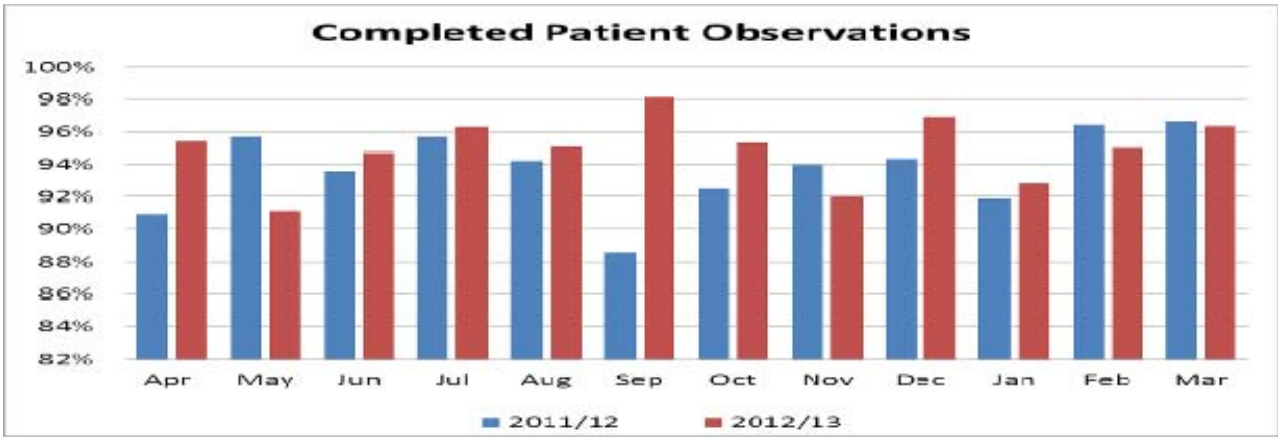
What we said we were going to do? "*During the year, we will look at those patients who are admitted to the Intensive Care Unit, as well as those patients who have cardiac arrests in the Hospital, to see how well we document information and manage their care. This information will identify any improvements that need to be taken. At the end of the year we expect to be able show that the number of incidents where observations were not acted upon, have reduced."*

How did we do?

We attempt to resuscitate all patients who are not expected to die whose hearts suddenly stop beating (cardiac arrest). Nationally the chance of surviving a cardiac arrest is 13.7%. This year at Kingston Hospital 16.7% of patients who had a cardiac arrest in the hospital survived and were able to be discharged. We are proud of the fact that the outcome for our patients is better than the national average.

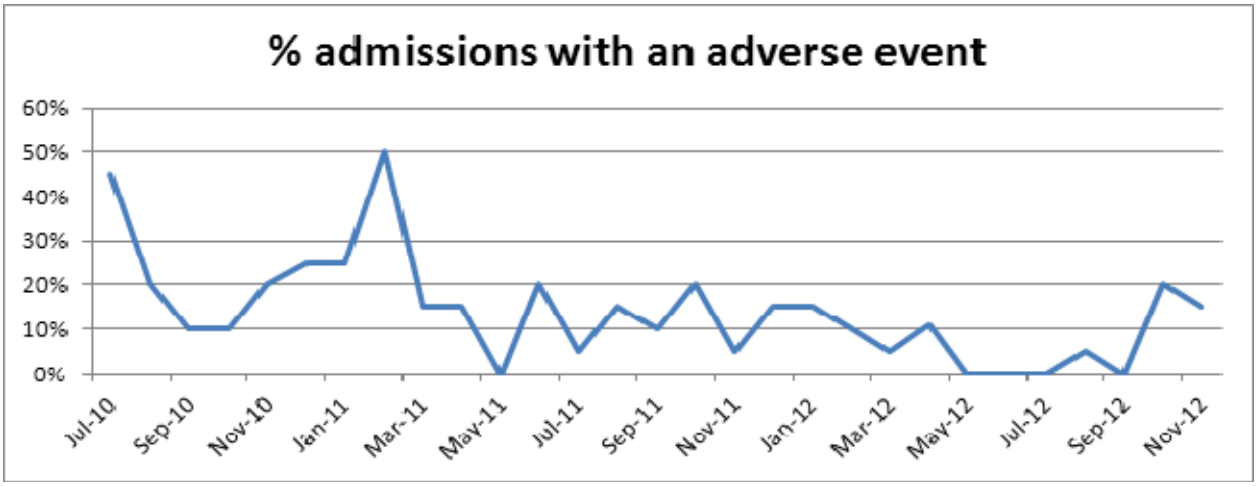
Ideally we want to recognise that patients are deteriorating before a cardiac arrest occurs, but at times patients do become seriously unwell very quickly. We have focused on picking up earlier signs of deterioration by ensuring that good observation charts are kept and that the correct action when patients are becoming unwell is taken. The aim is for all patients to be seen by the appropriate doctor(s) at an early stage and to get the right care to prevent further deterioration and aid the patient's improvement.

Within the last year we have seen an improvement in completion of the observation charts and a decrease in the number of patients who were not seen for early medical intervention. As part of our measurement process, every month we audit how well nurses have completed the patients' clinical observation charts. Many patients have their observations measured and recorded more than twice a day and seriously ill patients need some of the observations measured every few minutes. Compared to last year, we have improved the level of completed observations from 93.5% to 95%, with eight of the 11 months showing improvement for the comparable period last year. The table below shows our completed sets of patient observations:

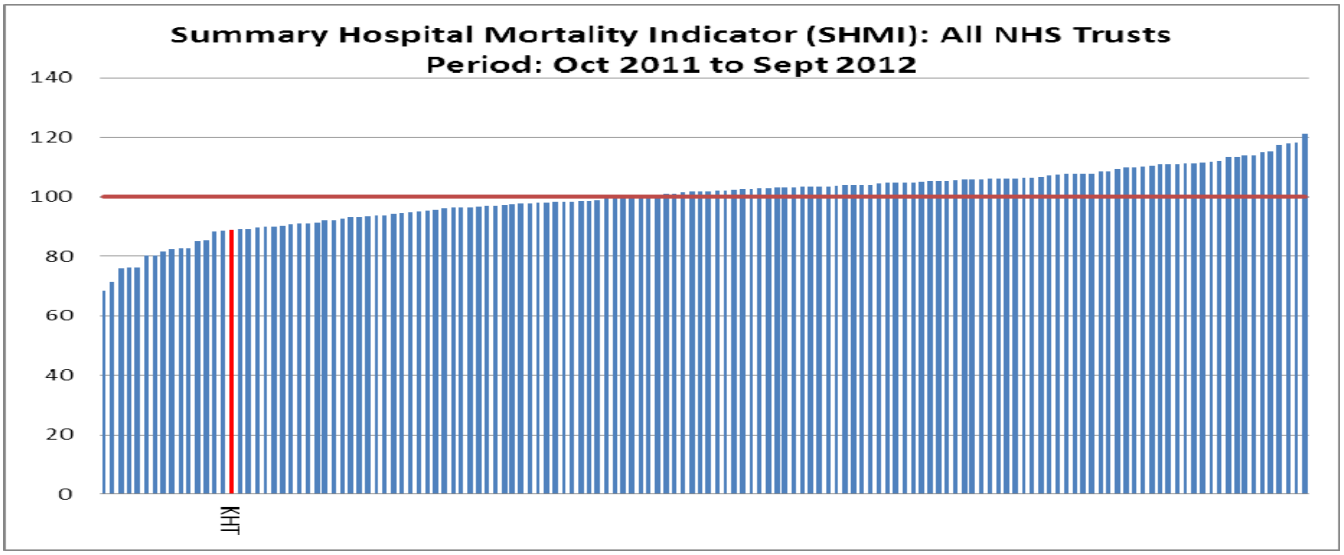


Incident reporting

We encourage all our staff to report incidents when they have concerns about patient care but we also look at a random selection of patient notes every month to see if there are any adverse events that had not been reported. This is part of an international audit called the Global Trigger Tool. This year we have seen the number of incidents related to not reporting abnormal vital signs reduce.



All hospitals in the UK collect information about death rates in their organisations. To try and compare the outcomes of patients in one hospital to another there are statistical methods to look at factors about the patients which influence outcome. One of these methods is the Standardised Hospital Mortality Indicator (SHMI) which is published on the NHS Choices website. SHMI is the new hospital-level indicator which uses standard and transparent methodology for reporting mortality at hospital Trust level across the NHS in England. The SHMI indicator gives an indication of whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline (England).The chart below shows how we are doing on this measure. The vertical red line in the chart (marked “K”) shows the level for Kingston Hospital. The red horizontal line shows the baseline (100) – below this line is “lower than expected” and above this line is “higher than expected”. Being on the left side of the chart is good.



Our results for the year are well below the expected death rate nationally. This shows that we have maintained a consistent performance against hospitals nationally and that our patients are less likely to die as a result of their clinical condition.

Priority 2 - Clinical Effectiveness: Reduction in variations in care out of hours

Why did we choose this? Our patients expect to receive high quality care, whatever time of day or night they are admitted to Hospital or need treatment. Making sure that we are able to do this is difficult at night and at the weekends because hospitals are not run in the same way as during the week. We have a "Hospital at Night" team which co-ordinates shift handover at the beginning and end of each day and although this team is in place, there is still more to do. For example, we need to ensure that we have the right number of staff, with the right mix of skills and experience in place in the Hospital at night time and weekends.

What we said we were going to do? ***"****We will continue to introduce changes that will see consultant led patient care in emergency situations and during an extended working day. The work we have done so far has helped with clinical review of inpatient care and planning for patients to go home (discharge).*

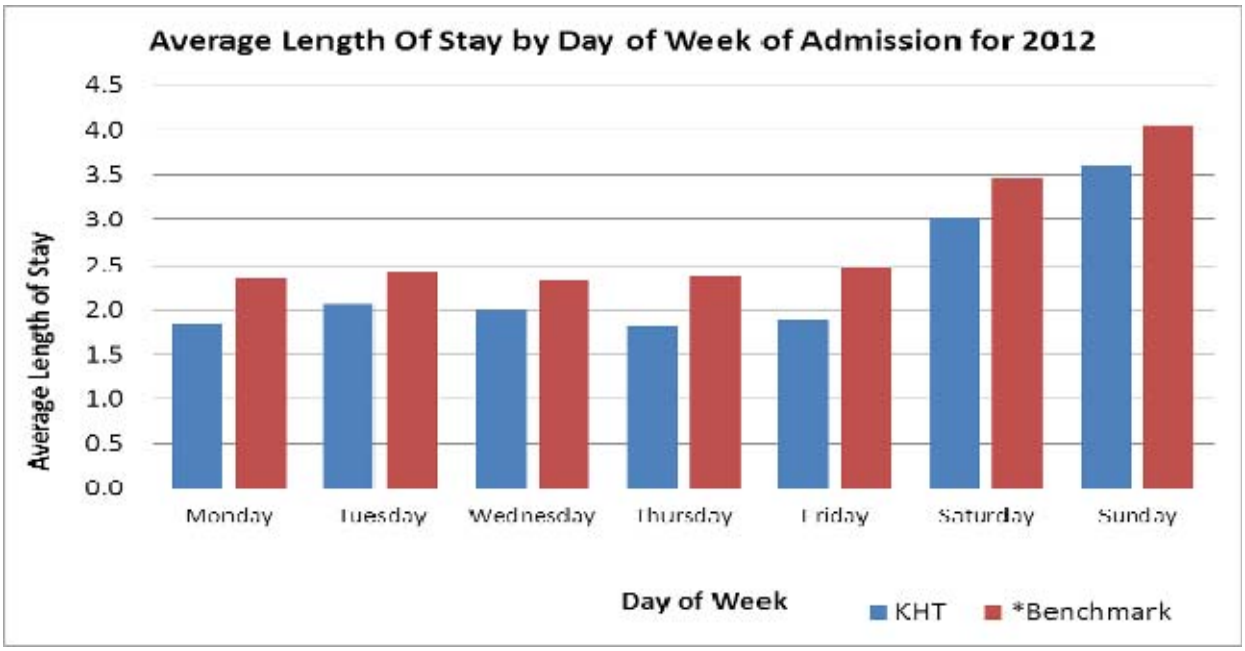
During the year, we will collect and look at data on the patients who were cared for out of hours, including the end results (outcomes) for these patients, compared to those who are admitted or discharged during weekdays.

At the end of the year we expect to show that the care for patients round the clock is consistent and that there have been reductions in the differences in the end results (outcomes) for these patients."

How did we do? We reviewed the mortality rates, lengths of stay and emergency readmission rates for patients comparing the week day and weekends. We compared patient care at weekends and weekdays to ensure that our previous good performance continued.

We changed how 'handover' (communication of patient details/diagnosis/clinical tasks required) is carried out and we now use a more standardised approach.

The table below shows our average length of stay by day of week admitted (also compared to benchmark):

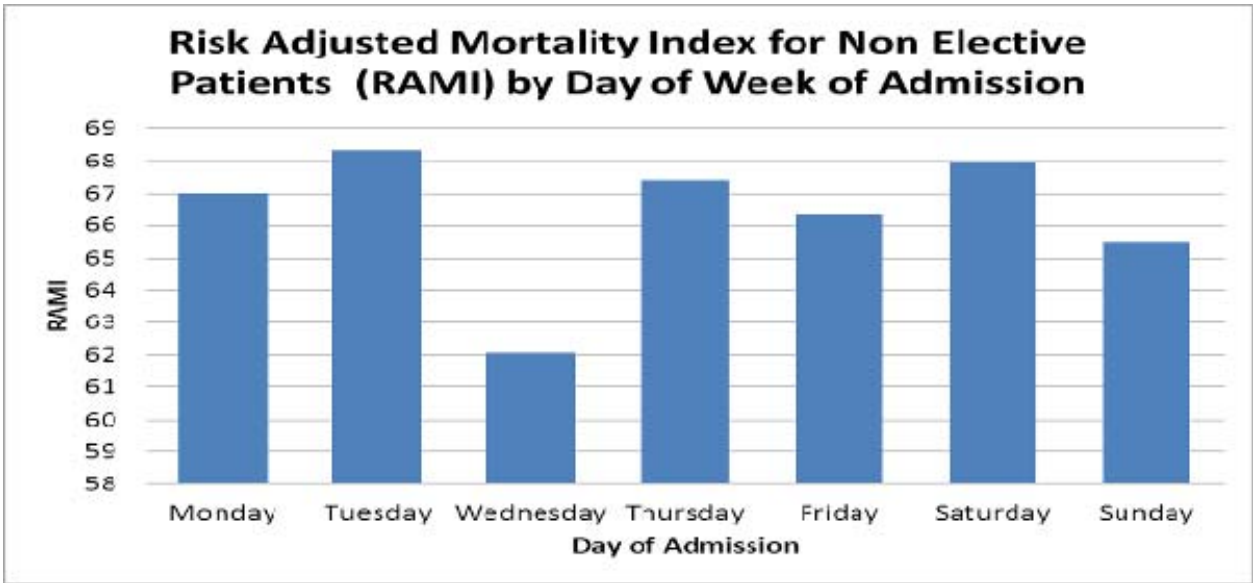


*The Benchmark is the average at our 4 most local Trusts, Epsom & St Hellier, West Middlesex, Croydon and St Georges

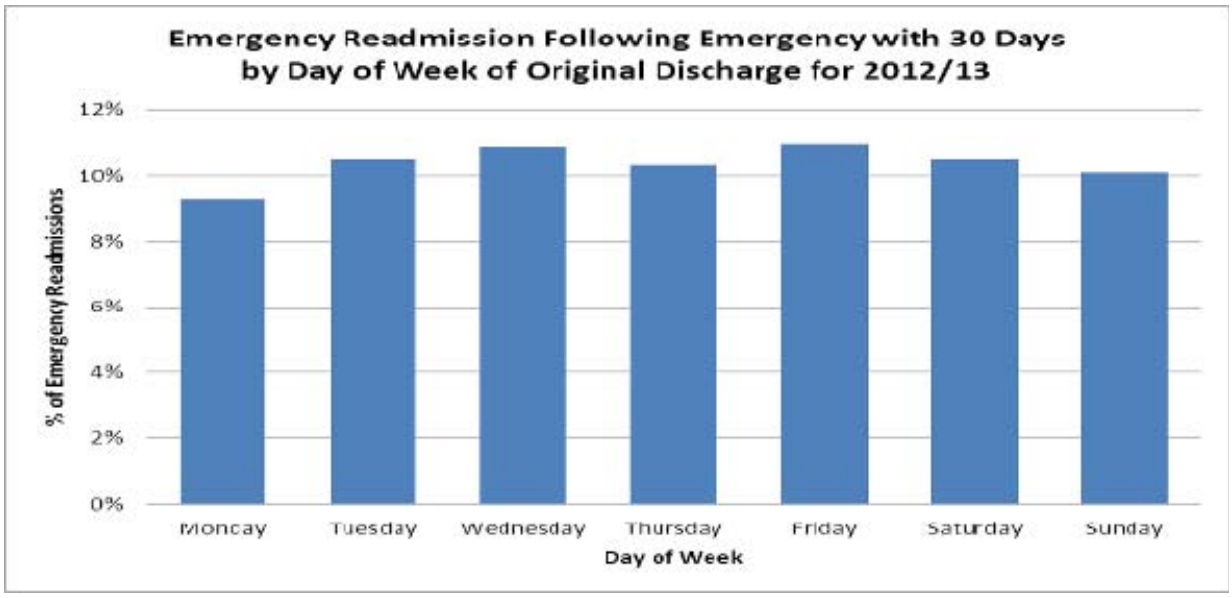
This shows that over the year patients stay in hospital for fewer days than our neighbouring Trusts and that there is a similar level of variation between week days and weekends.

Using another method of assessing standardised mortality rates, Risk Adjusted Mortality Index for Non Elective Patients (RAMI), we can compare if our patients are more likely to have an adverse outcome if they are admitted at the weekend than on week days. We have used this mortality indicator as SHMI data is not available by day of admission.

The table below shows our Risk Adjusted Mortality Index for Non Elective (Emergency) Patients (RAMI) by Day of Week of Admission:



This illustrates that there is very little difference in the outcome for our patients whatever day of the week they are admitted (Wednesday's are lower due to the different rates of elective admissions across the week). There are differences in the number and types of operations performed across the week (not every day has the same number of patients/ procedures).



We also looked at the emergency readmission rates following an episode of inpatient care (admitted as an emergency) within 30 days of discharge and have found that there is very little difference across the whole week.

Priority 3 - Patient Experience: Improving communication with our patients

Why did we choose this? Our main partners are our patients, their carers, relatives and friends. Alongside them, we often work with social care organisations to support patients' wellbeing.

Involving patients and carers in discussions about medication, and ensuring that decisions about their treatment are shared, can improve both the management of their condition and also improve their experience of being in Hospital. The results of national patient surveys for both our inpatients and outpatients have not shown improvement in these areas over recent years. There have been reductions in the absolute number of complaints about attitude and communication, but we know we need to do better.

Specific areas where patients tell us that improvements need to be made include:

- involvement in decisions about treatment and going home (discharge);
- knowing who to contact if they are worried;
- understanding the purpose and side effects of medicines; and,
- being told if there are likely to be any delays to their appointments or their care.

What we said we were going to do? ***"****We will ask patients what they think using lots of methods, including the 'friends and family' test. Any issues identified will be used to develop a series of actions and to identify the ways we can improve our performance.*

At the end of the year, we would expect to show that patients feel that communication has improved in outpatient and inpatient areas"

How did we do? As part of the national inpatient survey there are five questions which ask about different elements of patient experience in Hospital and the latest results show that we have improved in four of the five questions that you said were really important to you.

The specific areas that we wanted to focus upon are described in the table below. We can see that in four of the 5 questions, we have improved by more than 1 point (our objective) in the scores below.

No	Question	2011	2012	Achieved
Q32	Were you involved as much as you wanted to be in decisions about your care and treatment?	68.4	73.6	
Q34	Did you find someone on the hospital staff to talk to about your worries and fears?	52.1	52.6	
Q36	Were you given enough privacy when discussing your condition or treatment?	77.8	84.4	
Q56	Did a member of staff tell you about medication side effects to watch for when you went home?	48.7	52.2	
Q62	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	74.3	86.5	

These results mean that we achieved our CQUIN target around improving patient experience. The one area where we did not achieve a major improvement (talking about your worries or fears) will form part of our patient experience action plan. We have fed this back to staff and we will continue to work on ward level improvements in this area with the senior nurses.

This survey helps identify areas where we need to change so that every patient can be confident they will be treated with dignity, compassion and care. The findings of the Francis report into the care at Mid Staffordshire NHS Trust raised really serious challenges for the NHS. We must act quickly and effectively to make a difference by ensuring everything we do places the patient at the heart of the NHS. Over the last few years the results of our inpatients surveys have not been what we would wish to report but the

2012 survey results show not only have we improved in well over 50% of the areas patients are questioned about but we have also got the best results in SW London and are one of the five best performing Trusts in London. Being amongst the top teams in London is a great achievement; however we know we have more work to do to improve communication with patients. We are committed to continuing to improve in the coming year.

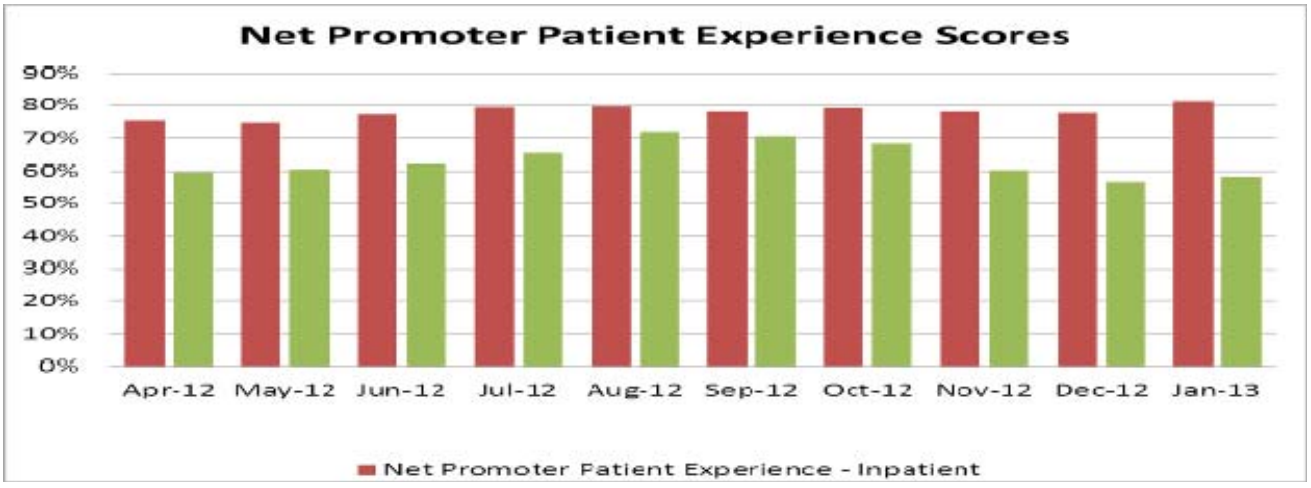
Our patients put us in the top 20% in the country for being treated with respect and dignity, providing single sex accommodation and bathrooms, providing clear printed information and advice e.g. medication before leaving hospital and providing information about who to contact if they were worried about their condition or treatment once they have left hospital. We also scored highly for specialists having the necessary information about a patient's condition or illness, patients being involved in decisions about their care and treatment, nurses providing good responses to questions when asked important questions, providing clear explanations about an operation/procedure as well as highlighting the risks and benefits to the patient and answering questions before an operation/procedure in a way that the patient could understand. For the first time in a number of years, there were no areas where the Trust scored in the bottom 20% of hospitals.

Last year the Trust implemented the Net Promoter Score (NPS) patient feedback process which includes a question about 'How likely they are to recommend the hospital". The responses to the 'likely to recommend' question are divided into three groups:

- Promoters (rating of 9-10)
- Passives (7-8)
- Detractors (0-6)

The percentage of detractor responses is then subtracted from the percentage of promoters to give a Net Promoter Score.

Cards are offered to patients to complete prior to leaving Accident and Emergency, the Outpatients Department, or prior to discharge from a ward. Patients can take the cards home and return them by post. The card is addressed but patients are required to supply a stamp (approximately 2% of cards are returned by post each month). Cards are also offered to inpatients to complete during their admission to flag up issues at an early stage. The NPS survey is completely anonymous, with no linkage to patient information, and the cards are freely distributed to patients, who can also help themselves to the cards that are openly available in clinical settings. Approximately 5 completed cards each month are signed by patients with their contact details written on the card. Wards and departments develop action plans based on feedback from the NPS reports. The table below shows our Net Promoter Score for the Trust:



Over the year we have seen our overall Net Promoter Score (NPS) rate improving, but this has not been achieved in the Outpatients Department. The 2011 Care Quality Commission Outpatient Survey, reported to the Trust Board in April 2012, also indicated that our patients' satisfaction with our service had not improved since the previous survey report of 2009. Key areas of concern included the provision of information around waiting times, the advice and information given regarding prescribed drugs and a similar concern with diagnostic testing. The time spent with doctors was also rated lower than expected and led to patients feeling that the main reason for their attendance had not been addressed. In response to the issues raised by the survey, the Trust set up an Outpatient Improvement Group that has been charged with the delivery of the Outpatient Improvement Action Plan. We will also approve this area as a Quality Account priority for the coming year.

Friends and Family Test:

In February 2013 the Net Promoter Patient Experience Indicator was replaced with the Friends and Family Test (FFT) Score. The FFT is being implemented across the NHS, in response to recommendations by the Nursing Care Quality Forum. The Trust submitted data regarding FFT to the Department of Health for the first time in March 2013.

The Department of Health will publish data on FFT and we will be able to benchmark our scores with other Trusts. The FFT is a simple, comparable test. The FFT score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent. Please be aware that the FFT Score is a different scale to that of NET promoter Score and therefore comparison with the previous months NET promoter needs to factor in this methodology change.

We are implementing a system to collect this information using electronic tablets devices (similar to an iPad ®) which will make it easier for patients to give real time feedback and also reduce the administration time in reviewing results. Each patient will be asked to complete a short questionnaire using the tablet device (or their relatives can fill in for them if they prefer) before they go home. We will publish these results on our website and on each ward.

Accident and Emergency:

To improve the quality of the service that we deliver in A&E, it is important to understand what our patients think about their care and treatment. One way of doing this is by asking them about their experiences. The fourth national survey of A&E patients involved 147 acute and specialist NHS Trusts and they included patients aged 16 years or older who were not hospital inpatients at the time of the survey and who attended A&E in January, February or March 2012. A postal questionnaire was sent to 850 patients and 303 responded to the survey, giving a response rate of 37%.

The CQC benchmarks Trusts nationally and this enables us to measure our performance against other Trusts. The survey consists of 8 sections and each section is made up of several questions. Although the survey highlighted some positive aspects of patient experience, Kingston hospital performed worse than most other Trusts nationally for questions relating to reception and waiting, and leaving the A&E department. We were about the same as most other Trusts for questions related to travelling by ambulance, tests and overall views and experience, doctors and nurses, care and treatment, and hospital environment and facilities.

The A&E Department held a workshop with patients, staff and other relevant stakeholders in October 2012 to review these results and jointly decide on priorities for an action plan to address areas of concern. The action plan has a number of elements but is focusing particularly on patient privacy, communication and pain management. Delivery of the action plan is being monitored via the Patient Experience Committee.

Other Quality Achievements in the Past Year

Whilst focussing on the priority areas identified in the Quality Account, the Trust also routinely monitors performance against a much broader range of measures. In the course of selecting our priorities each year, we focus on areas where there is improvement required, but in this section we want to highlight some of our areas of high performance.

MRSA Infections (Methicillin-resistant Staphylococcus Aureus)

Each year, several hundred people in the UK die from MRSA, although fortunately numbers are falling. The Government, the NHS and Kingston Hospital have been focussing on reducing the levels of infections acquired in hospital.

Good hand washing is a tried and tested way of protecting the most vulnerable patients from the most dangerous strains. Hand-washing by staff between examining patients is a must, and all staff and visitors entering wards and potentially coming into contact with contaminated surfaces and transferring infection must adopt similar hygiene measures. All additional staff (maintenance, cleaning, administrative) are also in the same position and must follow the standard hygiene protocols.

Many MRSA infections occur in hospitals and healthcare facilities, with a higher incidence rate in nursing homes or long-term care facilities.

We are pleased to report that there have been zero hospital acquired MRSA cases since May 2012.

Eliminating Mixed Sex Accommodation

We are pleased to confirm that we are compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice.

We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospital will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area and were ranked in the Top 20% of hospitals in the 2012 inpatient survey.

Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in our Intensive Care Unit)

If our care falls short of the required standard, we will report it and take action to prevent reoccurrence. We have also developed an audit mechanism to make sure that our processes and our staff continue to comply with eliminating mixed sex accommodation.

We are pleased to report that there have been zero mixed sex accommodation breaches since May 2011.

Hospital Acquired Pressure Ulcers

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.

For the second year running we have reduced the rate of patients experiencing stage two pressure ulcers by more than 40% (95 down to 56 events).

Malnutrition Universal Screening Tool (MUST) Assessments

Malnutrition Universal Screening Tool (MUST) is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition or obese. It also includes management guidelines which can be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers. Thorough clinical audits on nutrition take place twice a 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. Whilst this is very positive, the most recent audit has shown that we do not score so well when it comes to documenting and implementing special measures for at-risk patients. We have started a programme of raising awareness and patient notes are now being checked monthly to ensure this performance is measured and we start to improve. We are working on plans to further increase support for patients at mealtimes.

At Kingston Hospital 90% of patients are assessed using the MUST assessment process – we will continue to focus on this to increase this further.

Two Hourly Ward Rounds

In January 2011 the Prime Minister called for changes in the way nurses deliver care. Following a number of critical reports, concern had been expressed about the need to ensure essential aspects of nursing care are consistently delivered. One of the Prime Minister's recommendations was for NHS hospitals to implement hourly nursing rounds, to check on patients and ensure their fundamental care needs are met – an approach related to 'intentional rounding' in the United States. Many Trusts have now introduced their local approach. Two hourly ward rounds or "Intentional Rounding" has a high profile within the Trust. In November 2012 the Trust ran a workshop with staff to review their current practice and the processes. Multidisciplinary groups worked together to consider how they might further develop the initiative in the future. The workshop highlighted to staff the importance of intentional rounding in assuring safe care and improving patient experience. The Leadership Programme for Ward Sister/ Charge Nurse, which started in March 2013, requires every Ward Sister/Charge Nurse to develop an innovation relating to the Chief Nurse's Vision - Compassion in Practice (2012). It is anticipated that intentional rounding will be a focus of some of this work.

Post Discharge Follow Up

In response to the Adult Inpatient Survey 2011, when the discharge process was identified as problematic, a Discharge Improvement project was launched. Part of the work involved a post- discharge telephone follow-up call by the ward sister. Patients felt supported by this and the results have highlighted several areas that we are now working to improve. This includes the importance of ensuring patients are discharged with the discharge information booklet, to provide written information to refer to, should they forget important information. Other recommendations which are currently being developed include a strategy to improve pain management on discharge, by raising awareness and providing education prior to patients leaving hospital. Alongside this a longer term project is to develop a system that improves the process of follow up appointments and investigations, so that patients are discharged knowing when their follow up appointments are scheduled.

Releasing Time to Care (RTtC)

Releasing Time to Care (RTtC) aims to increase the proportion of time nurses spend delivering direct patient care, thereby improving patient experience and increasing job satisfaction. The programme focuses on simple ideas, such as altering patient handover time, reorganising storage facilities and

making better use of data. Over the past year we have implemented several initiatives and changed the way we do things as a direct result of this programme. Together these changes have increased the amount of time nurses spend delivering direct care to patients from 22% to 48%. This doesn't mean that nurses are not doing clinical work the rest of the time – they will be checking records, arranging tests and treatment, co-ordinating care with other staff such as therapists and medical staff. A snapshot of some of these changes is outlined below:

- ***Patient Status at a Glance***

  This is a magnetic board situated behind every bed space. The board displays signage, which acts as an instant visual communication system or "aide-memoire" for all staff. The signs we are using were designed by Trust staff and professionally manufactured. The project to design the signage created a culture where professional groups who may not have interacted regularly, began to understand and appreciate each other's roles and contribution to patient care. This helps reduce the time it takes for staff to handover important information about patients to each other.

  A dietician remarked "working as a team to design symbols that are meaningful to us all has been really useful. The end product is much better than had we worked on our own".

- ***Nursing Documentation Folders***

  Ward teams identified the need to develop a systematic storage system for nursing documentation that also included information for the patient. The nursing staff analysed the way they documented patient assessment, patient care and progress. A bespoke storage system was designed that met the needs of staff and patients alike. It was agreed that the new system would provide patients with easily accessible information explaining their care. As a result there is a nursing documentation folder situated at the end of each patient's bed. This means that nurses spend less time looking for records and recording results/ treatment notes.

Dementia Champions

In April 2013 we launched our Dementia Champions initiative to help raise awareness of the needs of our patients with dementia. To support this we have launched the "Forget me Not" scheme, which helps to easily identify our patients with dementia by placing a flower symbol (as shown below) on both patient summary boards and above patients' beds. We have given identity badges to staff who sign up to our pledges for dementia patients – examples of what we want all Dementia Champions to do every day include:

1. I always ask each patient how he or she is feeling, and respond in a reassuring and kind manner
2. I make an extra effort to talk with the patient's family and carers, without waiting for them to come to me
3. I make the effort to ensure that personal information, such as the '8 important things about me' (or the 'This is Me' document) is completed accurately for each patient so that he/she receives individualised care
4. I role-model good practice and behaviour when I look after patients with dementia
5. If I observe practice which is less than desirable, I will 'speak up' and/or do something to try and improve it, for example: demonstrating good practice by role modelling, taking the time to explain and interpret behaviour, offer help, and/or discuss it with other members of the hospital Dementia and Delirium (DaD) Team.

Clearly, we want this for all patients but we want to make a special effort for our patients with dementia.

Kingston Hospital Priorities for 2013/14

The new Quality Account for the coming year sets out our priorities for quality improvement during 2013/14. We consulted with local people, local community groups, staff and our partner organisations to reduce our 'long list' of six to the three priorities to be taken forward. The six potential priorities were:

Domain: Patient Safety – prevent harm

– Reduce the incidence of pressure ulcers	(Key Performance Indicator)
– Reduce the number of patient safety incident falls	(Key Performance Indicator)
– Reduce the number of clostridium *difficile* infections	(Key Performance Indicator)

Domain: Effectiveness – Improve outcomes

– Improve staff engagement (involvement)	(Workforce KPI)

Domain: Patient Experience – listen and respond to patient feedback

– Reduce complaint response times	(Key Performance Indicator)
– Improve waiting times	(Friends and Family Test)

The Trust shared the proposed priorities with the following groups for feedback:

Nursing and Midwifery Advisory Committee	9th January 2013
Senior managers Team Brief	11th January 2013
Shadow Council of Governors	15th January 2013
Clinical Quality Review Group Agenda	16th January 2013
Kingston Hospital Monthly team brief document	18th January 2013
Quality Scrutiny Improvement Group Agenda	28th January 2013

In February 2013, an online survey was conducted and over 3,500 Kingston Hospital Members were contacted to express a preference for the priorities for the coming year (patient safety and patient experience). 94 responses were received and these were broken down as follows:

Domain	Priority	Outcome
Patient Safety	Reduce the number of clostridium difficile infections (C diff)	48.9% (46/94)
Clinical Effectiveness	Improve staff engagement (involvement)	100% 94/94)
Patient Experience	Improve waiting times	76.6% (72/94)

Whilst the response rate is similar to last year, it remains at quite a low level and in the coming year we will explore ways of getting higher levels of feedback from the local population.

The Director of Nursing and Patient Experience presented an update on the development of the Quality Account to the Quality Assurance Group on 20th February 2013. He outlined the process so far, which included engagement with the Shadow Council of Governors, Clinical Quality review Group and Quality

Scrutiny Improvement Group (which includes LiNKS/ Healthwatch Chairs), Governors and Patient Assembly.

The second draft of the Quality Account was presented to the April 2013 Quality Scrutiny and Improvement Group (QSIG) and the next meeting of the Council of Governors (shadow) for comment.

The Director of Nursing and Patient Experience noted that the current proposals for the Trust Priorities were:

- Patient Safety – Reducing the number of clostridium difficile infections
- Patient Effectiveness - Improving staff engagement
- Patient Experience – Improving waiting times

The QAC suggested that "reducing the number of falls" be added as a fourth priority. The Quality Account will therefore have **four** priorities rather than the original **three** planned.

Domain	Priority	Outcome
Patient Safety	Reduce the number of patient falls	Add

It was also reported that many members of the public did not find the term "Improve Staff Engagement" helpful and this priority was amended to replace "engagement" with "involvement".

Giving stakeholders the opportunity to work with the Trust to choose the quality priorities should ensure that the priorities are pertinent and meet their needs. Over the coming pages we will describe why we think this priority is important, what we aim to achieve, what we have done so far and what we plan to do in the coming year.

As part of our collaboration with the people we serve, we have distributed the draft Quality Account again at the end of April for final comments and suggestions. See P42 – 51.

Domain: **Patient Safety**
Priority One: **Reduce the number of patient falls**

Quality Goal	Measure	Actual Performance (March 2013)	KHT Data Available	Benchmarked/ Comparison
Prevent Harm	Number of Patient Falls per 1000 bed days	5.6 year to date Annual Target <=4.8	Yes	Yes

Reduction of the number of Patient Falls by December 2013

Aim: Our aim for 2013/14 is to reduce the number of patient falls to below 4.8 per 1,000 bed days by December 2013.

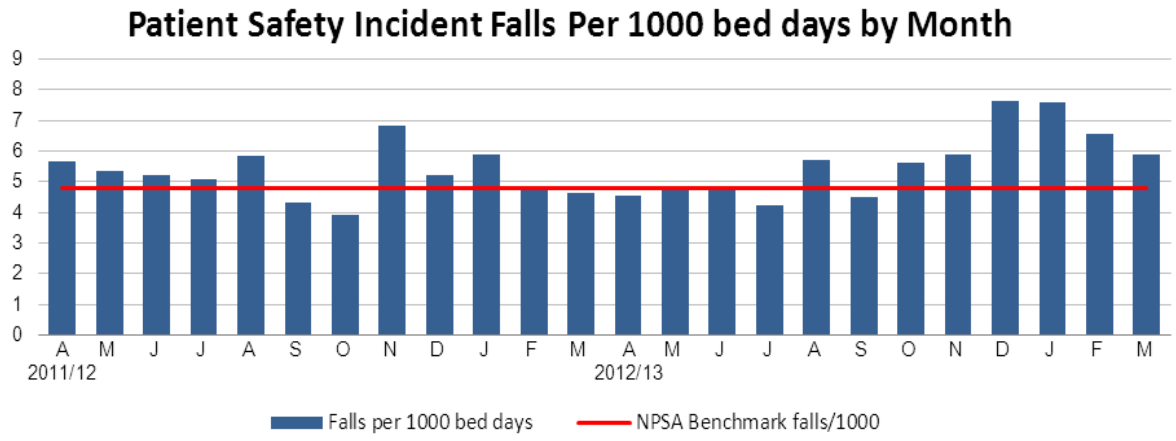
Measurement is the only way to know whether a change represents an improvement, although there are challenges in using reported falls as an outcome measure. The rate of harmful falls per thousand occupied bed days is the recommended outcome measure.

Benchmarking your own reporting rates: *As NHS organisations vary in size and activity, calculating the reported falls per 1,000 bed days is the best way to benchmark with the reported rates from other NHS organisations. Remember that reported rates of falls will be affected by reporting requirements and practice. Actual rates of falls will be affected by differences in local populations served by hospitals, and differences between services and treatments provided by hospitals. Hospitals with higher than average reported rates of falls may have better reporting, or care for more vulnerable patients.*

Why is this important?

Patient falls are among the most common incidents reported in hospitals and are a leading cause of death in people aged 65 years or older. Of those who fall, as many as half may suffer moderate to severe injuries that reduce mobility and independence, and increase the risk of premature death.

Following several incidents of serious harm from falls last year, and an increase in our overall level of falls during the winter months of 2012/13, the Trust has decided to make this a patient safety improvement priority again for this year. The table below shows our rate of falls over the last two years:



What have we done so far?

Improvement strategies have been based around robust risk assessment and deploying individual strategies for patients at risk including the use of low beds, regular nursing rounds of high risk patients

and supervision in a specific ward area with dedicated staffing. Staff training and raising awareness has supported our initiatives.

Following a deeper analysis of falls presented to the Quality Assurance Committee (QAC) in February 2013, the Falls Task Finish Group and Trust Falls Group have been merged into one, and terms of reference updated to reflect this. The Trust Falls Group will be chaired by the Director of Nursing or the Medical Director.

What will we be doing in the coming year?

The Trust Falls Group met on 18th March 2013 and further actions have been agreed. These include additional contact with Trusts known to be performing well in reducing falls to elicit any further areas for focus; updating the patient information on falls avoidance; and review of link to continence management initiatives. We will ensure risk assessments are completed on all patients and take steps to identify causes and actions. We will include falls awareness as part of mandatory training and ensure that oversight processes are more explicit (involving Ward Sister/ Matron earlier), with an increase of the focus on timeliness of care provided.

Identified Issue	Actions
Improve incident reporting analysis	• Utilise implementation of new incident reporting system to improve interrogation of specific falls data – including location, time of fall
Regular Benchmarking of performance	• Review falls Safety Thermometer data to ward level
Falls rates (specific wards)	• Focus additional training to ward areas identified with highest falls rates • Purchase additional falls alarm devices for AAU • Review ward sizes as part of review of medical wards

How will we track progress?

Using our existing Trust wide reporting tools, we will monitor the rate of patient falls and the type of harm (if any) which occurred.

A data collection tool will also be used in 2013/14, known as the Patient Safety Thermometer. Data will be collected on four key areas of potential harm: Venous Thromboembolism (VTE), Falls, urinary catheters and associated infections and Pressure Ulcers Grade 2, 3 and 4. The rationale for collecting on all four areas is to ensure that improvements in one area of care do not have a detrimental effect on another.

We will be able to compare our performance to our peers and monitor the impact of changes made across the Trust.

How will progress be reported?

Monthly performance will be reported through the Trust Executive Committee and the Patient Safety Committee.

Performance will be reported to the public and the Trust Board through the Clinical Quality Report.

Domain: **Patient Safety**

Priority Two: **Reduce the number of Clostridium difficile infections**

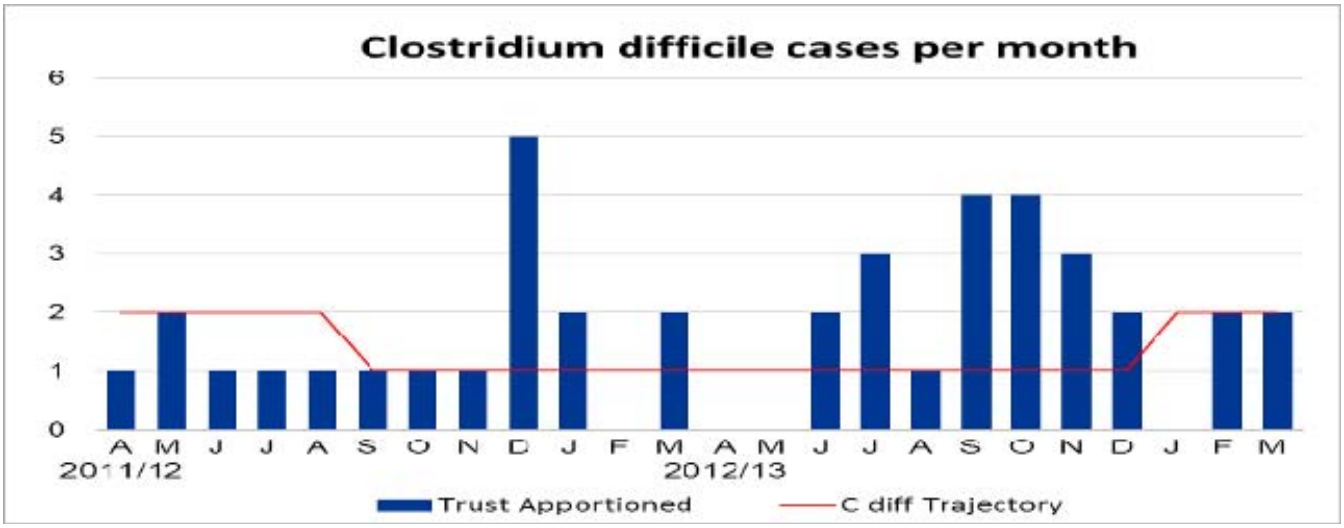
Quality Goal	Measure	Actual Performance (March 2013)	KHT Data Available	Benchmarked/ Comparison
Prevent Harm	Clostridium difficile Infections – Post 72 hours (Hospital Acquired)	23 year to date Annual Target <=15 17.8 cases per 100,000 bed days	Yes	Yes

Reduction of the number of Clostridium difficile infections by December 2013

Aim: Our aim for 2013/14 is to reduce the number of patients acquiring a Clostridium difficile Infection whilst in our care and that this is kept below the threshold of 15 cases per annum.

Why is this important?

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. In 2012/13 the number of cases of C diff at Kingston was higher than the 15 cases per annum set by the local commissioners. The feedback from staff and public surveys made this their highest priority (of the patient safety priorities proposed) and the Trust has decided to make an additional patient safety improvement priority for this year. The table below shows our rate of C diff over the last two years:



The trajectory in the graph is the required level of incidence to ensure the annual limit was achieved (it was exceed last year). The Trust apportioned element indicates the episodes of C diff which occurred in hospital (i.e. after admission).

What have we done so far?

The Trust commissioned a peer review in November 2012 by external consultants who had led the Department of Health programme established to achieve sustainable reductions in MRSA and CDI across the NHS.

The review team found many examples of good practice in the care they observed our teams providing but also suggested some areas where we could do better. Delivering the action plan that the Trust devised after the review will help to ensure that we achieve the reductions planned for the coming year.

What will we be doing in the coming year?

As part of our overarching action plan, we will be focussing on prudent antibiotic prescribing and stewardship. We need to strengthen our practices around isolation procedures (making sure we do this in a timely way) and ensuring that cleaning standards are up to the mark.

If and when cases do occur, we will conduct robust root cause analysis and develop our learning and actions to ensure that we continue to reduce the incidence of C diff.

Identified Issue	Actions
Prudent prescribing and antibiotic stewardship	• Establish an antibiotic management group with focus on treatment, policy and audit programmes • Review the current Trust antibiotic policy
Improve isolation procedures	• Monitor compliance with isolation on suspicion of C.diff diarrhoea within 2 hours and timely sampling of stool samples for patients on admission
Strengthen and improve Cleaning	• Complete implementation of cleaning standards • Review latest National Cleaning Specification published

How will we track progress?

We will continue to monitor and seek to reduce these infections and review our data monthly. Additional audits have been prepared to provide more assurance about our day to day performance and these will be reviewed regularly. We will monitor our progress in delivering our action plan at the monthly meeting which is led by the Director of Nursing and patient Experience.

How will progress be reported?

Monthly performance will be reported through the Trust Executive Committee and the Infection Control Committee.

Performance will be reported to the public and the Trust Board through the Clinical Quality Report.

Monthly data will be submitted to the Health Protection Agency

Domain: **Effectiveness – Improve outcomes**
Priority Three: **Improve staff engagement (involvement)**

Aim: To improve staff 'engagement' (involvement) to be in the 'Top 20% of Trusts' as measured in the NHS staff survey 2013

Why is this important?

Staff 'engagement' is a measure of staff satisfaction, involvement and motivation at work. Research shows that there is a clear link between satisfied and engaged staff and the quality of patient care they deliver. Not only does the evidence tell us that highly engaged and empowered staff generate better outcomes for patients but that there are further that benefits such as: **improved quality of services, reduced patient mortality, improved staff health and well-being, lower levels of sickness absence and greater financial efficiencies.**

What have we done so far?

In 2011 we developed a set of four core values – "Caring, Safe, Responsible and Valuing each other" - which have been agreed with staff and patients, to underpin everything we do at the Trust. We have described the behaviours that reflect these values in everyday practice so that our approach is consistent across the Trust and patients and our staff know what to expect. We have been working to embed these values through appraisal, training and development and improved people management (how staff are managed and teams developed).

As a result the Trust has seen improvements in staff satisfaction in the 2012 NHS staff survey. The survey also measures an engagement score (an overall indicator of staff satisfaction and engagement ranging between 1 and 5) which has improved from 3.61 in 2011 to 3.74 in 2012. This moved the Trust from being 'worse than average' to 'above average' performance when compared to other Trusts (with an average 3.69). We now want engagement to improve further so that our score is on the 'top 20% of Trusts' in 2013.

What will we be doing in the coming year?

1. Ensuring all our staff have clear objectives, an appraisal and a personal development plan reflecting the Trust's objectives and values.
2. As part of the appraisal process, we will be implementing a system that measures every manager and supervisors' people management skills and enables improvement where necessary. Providing management and leadership training to support improved people management.
3. Clarifying the role of team working in delivering safe, effective high quality care – identifying the membership of teams and the importance of providing mechanisms and times for them to meet to reflect on performance and improvement.

How will we track progress?

We will monitor appraisal rates every month and undertake regular checks on the quality of appraisal documentation (including the quality of the content) and that all managers and supervisors have had feedback on their people management. We will use the staff engagement score in the NHS staff survey, including whether staff would recommend the Trust as a place to work and be treated, and the areas relating to communication. We will look for evidence of the impact of having engaged staff in improvements in the questions in the national inpatient survey where we scored below the national average. Finally we will measure that training and developments support is provided to all staff.

How will progress be reported?

Internal appraisal rates, the staff survey action plan and progress on translating the Trust's values into everyday behaviours will be reported through the Trust Executive Committee and the Workforce Committee.

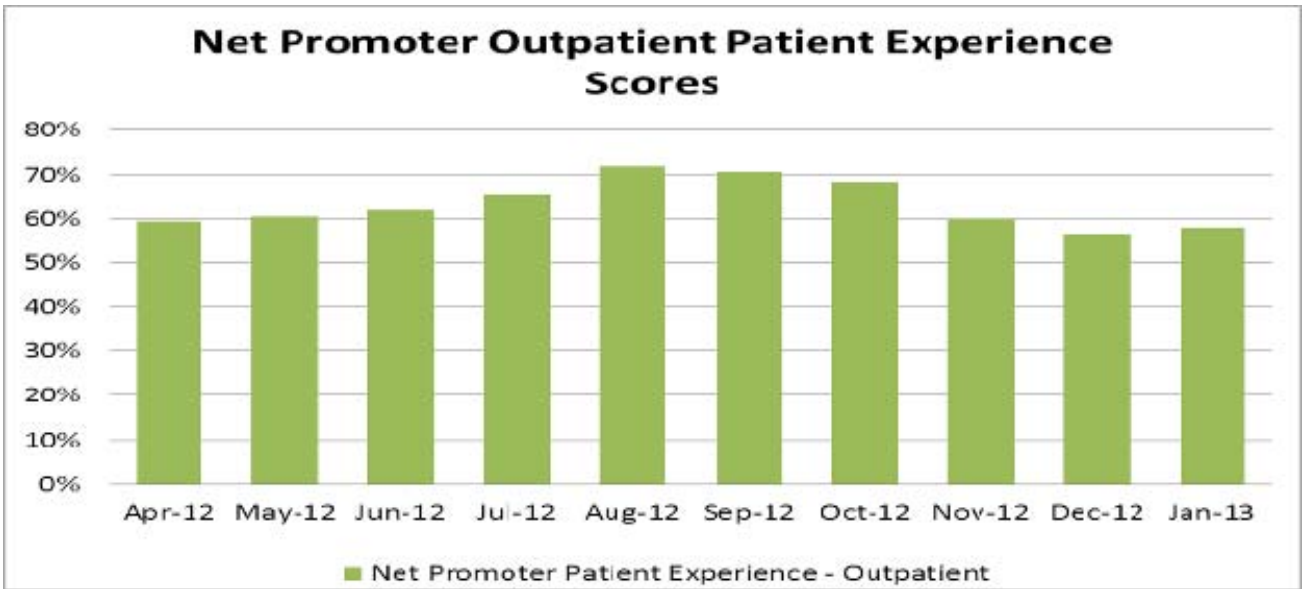
Performance will be reported to the public and the Trust Board through the Trust's Quarterly Workforce report.

Domain: **Patient Experience – Listen and respond to patient feedback**
Priority Four: **Improve Waiting Times (Outpatient Department)**

Aim: To improve the waiting times for patients in the Outpatient Department (waiting to be seen/ waiting for results of tests)

Why is this important?

How long you wait for something is often felt by patients to be a marker of the quality of service they receive. As a Trust we perform well in delivering the performance targets for waiting times in Accident and Emergency and 18 weeks referral to treatment. However, feedback from our patients through the national outpatient survey and through our own net promoter scores tells us that the experience of waiting is not as good as it could or should be. The table below shows our scores from the NPS for Outpatients.



The Net Promoter Scores for Main Outpatients continue to have low numbers of responses. We don't have comparative data to other organisations based on this approach, but we know that our Outpatient National Survey shows this too. An awareness campaign for staff and patients was conducted with a poor uptake. Negative comments from patients all refer to waiting times and the anti-coagulation clinic continues to score poorly.

What have we done so far?

We already have a wide ranging action plan of activities to improve patient experience. The Outpatients Improvement Group has met on six occasions. The meeting is chaired by the Divisional Manager, Ambulatory Care and is supported by the productivity team and Patient Experience Improvement Manager. The nursing staff within Outpatients also held a workshop to identify rapid ways of improving patient experience.

In September 12, a cohort of KHT staff received training from the NHS Institute in Managing Change. Attendees at this programme are required to deliver improvement projects and topics within the programme include anti-coagulant clinic services, main outpatients and cancer services. It is anticipated that all will contribute to further improvements in the outpatient experience. Improve and control direct access to main outpatients to ensure patients take the shortest route to their appointment and that the access is disabled patient friendly

A program of re-design of main reception to minimise queuing and maximise the role of self-service kiosks is underway using a design group that includes staff who both work in and use outpatients along with patient representatives. Relocation of phlebotomy to an alternate area to allow development of a patient waiting hub with IT for queue management is central to the plan. This will both improve the environment and prevent patients from waiting within corridors outside consultation rooms, thus improving privacy and dignity.

The outpatient's survey has been repeated using the same format and whilst it is pleasing that 18 of the 51 questions showed a significant improvement being kept informed of waiting times remains a major concern to patients indicating why we continue to consider this an important initiative.

What will we be doing in the coming year?

We will implement the action plan that the Improvement team have been developing.

We will also implement the Friends and Family Test (ahead of the national timetable) and review the results of patient feedback – with a specific focus on experience of waiting times. We will use this feedback to shape our actions in the coming year.

We will finalise our re-design plans and progress to planning stage. This work will be based upon the outputs from a number of staff and patient members of the Improvement team.

Identified Issue	Actions
Design of Outpatients	• Improve signage, • Address kiosk accessibility & ease of use • Improve parking
Listening & informing patients	• Implement information screens within outpatient areas including latest information on wait times • Implement Friends & Family Test (from current NPS) in OPD areas to obtain real time feedback
Reduce waits	• Relocate phlebotomy service to alleviate bottle necks

How will we track progress?

We will report and publish our monthly FFT score on our website and on the Patient Choices website. We will publish the feedback from our FFT responses on the patient information boards in all the areas where the FFT is implemented.

How will progress be reported?

At the Patient Experience Committee and monthly at the Trust Board.

Review of Services

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

During 2012-13 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
- HIV
- Neonatal Care
- Obstetrics
- Ophthalmology
- Oral and Dental Services
- Orthopaedics
- Paediatrics
- Pain Management
- Parent Craft
- Patient Transport
- Physiotherapy outpatient
- Respiratory Medicine
- Rheumatology
- Surgical Appliances
- Urology

The income generated by these health services represents 91% of the total income for the Trust 2012/ 13 under all contracts, agreements and arrangements held by the Trust for the provision of, or sub-contracting of, NHS services.

Participation in Clinical Audits

Clinical audit is designed to improve patient outcomes across a wide range of conditions. Its purpose is to engage all healthcare professionals in a systematic evaluation of their practice against standards, identify actions to improve the quality of care and deliver better outcomes for patients. National confidential enquiries also assist in maintaining and improving standards by reviewing patient care nationally and issuing recommendations to enable local hospitals to drive up standards and enhance patient safety.

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

<table>
<tr><th colspan="2">Clinical audit providing assurance</th></tr>
<tr><td>National audit – Cardiac Arrest
Kingston Hospital now contributes annually to the National Cardiac Arrest Audit. The 2012 report shows good results in the way that we deliver care. None of our results fall outside of the expected range and no specific action is therefore required.</td><td>Local clinical audit – Nutrition
Clinical audits carried out this year have assured the Trust that nutritional assessments of in-patients are accurate and patients requiring special nutritional care measures have these in place. We will continue to focus on improvements in this area</td></tr>
<tr><th colspan="2">Clinical audit driving improvement</th></tr>
<tr><td>National audit – Pneumonia
Kingston Hospital has participated in the two national audits examining the treatment of adults and children with pneumonia. Our results showed that we needed to make some improvements around the way that we administer antibiotics. To enhance the care of adult patients, we have introduced a pneumonia ‘bundle’, which assists staff to deliver standardised care and treatment, whilst the Paediatric team have developed new local guidelines to ensure consistency of care.</td><td>Local clinical audit – C. difficile infection
Kingston Hospital is committed to reducing hospital acquired infection. One component of this is preventing C. difficile infection by ensuring the good management of the use of antibiotics. A series of clinical audits has been performed to ensure the appropriateness of prescribing, in particular to confirm that the correct antibiotics are given for the proper duration.</td></tr>
</table>

During 2012/13, 34 national clinical audits and 4 national confidential enquiry programmes covered NHS services that Kingston Hospital NHS Trust provides. During that period Kingston Hospital NHS Trust participated in 31 (91 per cent) of national clinical audit and 100 per cent of national confidential enquiry programmes of the national clinical audits and national confidential enquiry programmes which it was eligible to participate in, a similar percentage to last year. The reasons for non-participation in three national audits were as follows:

National clinical audit title	Reason for non-participation
Adult Diabetes	Work pressures within the Diabetes team. Kingston Hospital aims to start participating in this national audit during 2013/14.
ICNARC (Intensive Care National	Kingston Hospital previously had a computer system called ‘Ward Watcher’ for recording intensive care patient data.

Audit and Research Centre)	This has been replaced with the ICNARC system and participation commenced on 1st April 2013.
Parkinson's Disease	Kingston Hospital participated in the 2011 Parkinson's Disease national audit and continues to implement the improvements that were required. Consequently, it has been confirmed that we do not need to audit until next year in order to allow the improvements to take effect.

The national clinical audits and national confidential enquiries that Kingston Hospital NHS Trust was eligible to participate in during 2012/13, and for which the data collection was completed during 2012/13, are listed in Appendix A, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of 26 national clinical audits, applicable to Kingston Hospital, were published during 2012/13 and of these 21 were reviewed during 2012/13. The actions we intend to take to improve the quality of healthcare are included in Appendix B

The reports of 205 local clinical audits were reviewed by Kingston Hospital NHS Trust in 2012/13. Examples of actions that we intend to take, as a result of these, are listed in Appendix C with the whole list available in our Clinical Audit and Effectiveness Annual Report.

Clinical audit results are discussed at clinical meetings in local departments and at wider meetings such as the Trust's annual Clinical Audit Seminar. The results of both national and local clinical audits are used to drive local quality improvement. More detailed information about the actions we have taken from clinical audit will be available in our Clinical Audit and Effectiveness Annual Report, via the Medical Director's Department from July 2013.

Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 59.

The Trust was involved in conducting 39 clinical research studies during 2012/13.

There were 77 clinical staff participating in research approved by a research ethics committee at the Trust during 2012/13. These staff participated in research covering 17 specialities.

Use of the CQUIN Payment Framework

A proportion of income for Kingston Hospital NHS Foundation Trust in 2011/12 was conditional on meeting quality improvement and innovation goals. These are objectives agreed between the Trust and its commissioners, Primary Care Trusts, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The key aim of CQUIN is to support a shift towards a vision where quality is the organising principle. The framework therefore helps ensure that quality is always part of discussions between commissioners and hospitals everywhere.

In January 2013, the Trust agreed to continue to deliver the good performance against the CQUIN goals to the year end. As evidence of our good working relationships with commissioners, this agreement included a 91% achievement of the contract value (overall achievement was 93%).

Theme	Aim	Performance
VTE	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 Increase screening levels.	**100%**
Patient experience	The indicator incorporates questions which are known to be important to patients and where past data indicates significant room for improvement across England. Improve upon previous scores.	**95%**
Dementia	Dementia is a significant challenge for the NHS-25% of beds are occupied by people with dementia, their length of stay is longer than people without dementia and there is often a sense they 'in the wrong place'. Improve screening and treatment.	**100%**
Safety Thermometer	Participation in data collection using the NHS Safety Thermometer is an important preparatory step for NHS-funded provider organisations in reducing harm. Submit monthly data returns.	**100%**
Integration	Improve in hospital care and discharge arrangements working in partnership with community and primary care.	**92%**
End of Life care	Sustain and improve levels of identification of patients in the last year of life. Increase the use of the coordinate my care (CMC) record. Achieve a high level of training to enable clinicians to identify patients in the last year of life.	**100%**
Cancer Staging	Increase the percentage of new cancer patients with stage of tumour accurately recorded.	**100%**
Health Promotion	Screening for smoking, obesity, physical activity and alcohol consumption. Training of staff in Health Promotion Advice and raising the issue. **(Amber - could do better in this area)**	**79%**

Further detail on the agreed CQUIN goals for 2012/13 (and their achievement) and for the goals in 2013/14 can be obtained by contacting the Director of Finance at the Trust.

Statements from the Care Quality Commission - Care Quality Commission (CQC) Inspections

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

We are registered with the CQC - every hospital has to be. This means that we are doing everything we should to keep patients safe and to provide good care. The CQC carries out regular checks to make sure that hospitals are meeting important government standards. Over the past year (2012/ 13), there was one review into the care we provide. We also received the final report into a visit from March 2012. This is how we did.

Inspection of Termination of Pregnancy Regulations:

In March 2012, we had an unannounced visit from the CQC to investigate if we were compliant with Termination of Pregnancy regulations. The inspector reviewed a sample of patient notes and spoke to staff about the Trust's processes. The Trust was found to be fully compliant with the standards required and the final version of their report was received in April 2012.

Full Unannounced Inspection:

An unannounced inspection was carried out in October 2012, during which the CQC assessed the Trust's compliance with eight of the Essential Standards of Quality and Safety. The Trust was compliant with all the standards that the government says patients have the right to expect which were inspected.

After speaking with patients, staff and stakeholders and observing the running of the hospital for two days, the team of inspectors agreed that Kingston Hospital NHS Foundation Trust met all essential standards reviewed including:

- Treating people with respect and involving them in their care
- Providing care, treatment and support that meets people's needs
- Providing safe and coordinated care when patients move between different services
- Caring for people safely and protecting them from harm
- Providing care in a clean environment, protected from the risk of infection
- Staffing
- Risk management systems to assure the health, welfare and safety of patients
- Record keeping

This shows that we are continuously working to provide patients with high quality services and that patients treated at our Hospital receive safe and the right care that meets their needs.

Registration:

The Trust is registered with the CQC with no conditions attached to the registration and there has been no enforcement action during the reporting period.

The Quality Account is prepared each year by the Deputy Director of Nursing and overseen by the Quality Assurance Committee. This group is chaired by a Non – Executive and attended by the Chief Executive. Any guidance issued by the Secretary of State related to the Health Act (2009) is reviewed in the 6

months leading up to the publication of the Quality Account. Such guidance would be appropriately incorporated into the Quality Account prior to finalisation.

Data Quality

The Trust has a five year Data Quality Strategy, of which 2012/13 was the third year. The strategy has a three themed approach to improving data quality in the Trust:

- People
- Reporting
- Systems

There have been a number of actions implemented during 2012/13 which have had significant successes in addressing data quality issues at the Trust.

Data quality (DQ) issues can stem from many different reasons. However, underpinning all of the DQ risks are issues that can be considered as “completeness and accuracy” – e.g. missing encounters or discharges – is all of the data captured and is it captured properly?

The Trust’s Data Quality KPI dashboard report which is presented on a quarterly basis to the Trust Board has been designed specifically to answer this question, putting a particular focus on the volume/size of the problem as well as indicating the potential financial impact. There are Completeness and Accuracy pages showing the progress being achieved across the Trust with regard to lessening the volume of DQ errors in Outpatients, Inpatients and A&E respectively and including an estimate of the potential financial impact of this activity to the Trust – this is only an estimate and is based on average tariffs, but acts as a guide to the importance of fixing the error.

The dashboard report also considers data quality of patient pathway recording and the number of corrections that are required (validating the data does not necessarily mean that the data are wrong and need correcting) and also the accuracy and timeliness of clinical coding, including results from internal clinical coding audits.

Progress against Strategy - 2012/13

During 2012/13 there have been a number of key actions undertaken toward improving data quality. The positive impact of some of these actions – particularly the system hardening and the self-service reporting of 18 weeks - is demonstrated in the KPI Dashboard.

<u>Board Awareness</u>

In July 2012 a session of the Board Development Forum was dedicated to Data Quality. This considered how the different clinical systems in the Trust (CRS, Radiology and Pathology) interact and the risks (Financial and Operational) associated with poor data quality in each system. The Board were able to see what processes and checks are in place for each system to ensure that data is reliable, robust and accurate.

Following the Development Forum session, the Director of Finance as the Trust’s Senior Information Risk Owner (SIRO) has presented quarterly updates to the Board on progress against Key Performance Indicators (KPIs). The dashboard has grown to cover more areas as the KPIs that best reflect data quality have been better understood. This will continue to be grown in 2013/14.

Data Quality Group

A Data Quality group has been established and met on a number of occasions in 2012. The group is chaired by the Trust SIRO and is accountable to the Information Governance Committee. It includes representation from Divisions and Services, the Head of Information, the Data and Information Standards (DIS) Manager and the Information Governance Manager.
The DQ Strategy for 2012/13 included identification and training of DQ Champions. This has proved not to be practical due to other roles and priorities. However, through the DQ group, the 18 week training and the work to automate the PTL reports (see below), there has been a shift in the organisational culture toward ownership of data quality.

18 Week Training

In Q3 the Chief Operating Officer, Patient Access Manager and DIS Manager rolled out a programme 18 Week Training workshops for Clinical and Administrative staff through all services in the Trust. This focused on accurate recording of a patient's Referral to Treatment (RTT) status on CRS and had a clear impact on improving the data quality.

Online Reports

In February 2013 the Information Services Team launched the Trust Patient Tracking List (PTL) reports on DISCO – the online reporting tool. This has enabled Service Managers direct access to the PTLs in almost real-time – any updates made on the CRS system appear in the PTL on the next day. Validation comments can be added to the PTL and are stored directly in the data warehouse so are available for everyone to see. This has reduced the amount of double validation that was required in the past (by both the DIS Team and Service Managers) and ensured that comments are not lost in emails or spread sheets as everything is available in one place. It has also enabled the Information Team to count the number of patients that are validated by the Service, and not just those validated by Data & Information Standards.

System Hardening

In August 2012, the Trust implemented a system change in A&E which meant that Clinicians in A&E could no longer close a record if they had not fully populated the treatment codes.

Further system hardening will be introduced as part of the Clinicals Phase 1 upgrade to CRS in the summer of 2013. This will include changes to A&E (so that a patient will no longer be admitted from A&E without a spell being created) and improved RTT recording.

Deep Dive Reviews

Two deep dive reviews have been undertaken toward the end of 2012/13 looking at HR Sickness data and Hand Hygiene data. These were carried out as pilot reviews to assess whether the methodology would identify any data quality issues and provide sufficient assurance with regard to the data quality of these indicators. The two areas were selected for review by Non-Executive Directors.

The reviews took the format of detailed interviews with key staff, following a set template of open questions that covered the provenance of the data, what analysis is carried out, how and where the data are presented and finally how the data and data quality compare to other Trusts. The results have shown

that the template allows detailed exploration of the data quality issues; it is easy to use and not burdensome on the interviewer or interviewee.

Data Quality – NHS Number and General Medical Practice Code Validity

The Trust submitted records during 2012/ 13 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The following table shows the percentages of data that have valid NHS number and General Medical Practice code:

DQ Indicator		KHT 2012/ 13 (to M11 – Feb)	KHT 2011/ 12	National 2013/ 13 (to M11 – Feb)
Admitted Patient Care	% with Valid NHS number	99.2%	98.9%	99.1%
	% with General Medical Practice Code	100.0%	100.0%	99.9%
Out Patient Care	% with Valid NHS number	99.3%	99.1%	99.3%
	% with General Medical Practice Code	100.0%	100.0%	99.9%
Accident & Emergency Care	% with Valid NHS number	97.1%	96.4%	94.9%
	% with General Medical Practice Code	100.0%	100.0%	99.7%
Maternity - Births	% with Valid NHS number	99.9%		99.6%
	% with General Medical Practice Code	100.0%		99.3%
Maternity – Deliveries	% with Valid NHS number	99.8%		99.4%
	% with General Medical Practice Code	100.0%		100.0%

Clinical Coding

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

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.

The Trust has a high level of accuracy in clinical coding. The 2011/12 National PBR assurance programme “Right data, right payment” published in August 2012 identified Kingston as one of only four trusts nationally, and the only Trust in London, that have consistently been in the best performing category each year since the Audit Commission started the programme in 2007/08. (51 Trusts of the 164 audited have been in this category just once since 2007/08 and 64 Trusts have never been in that category).

In the 2012/13 Payment by Results assurance programme, the Audit Commission looked at inpatient care in the specialty of General Medicine and also recording of A&E attendances. The report is not yet

available (it was expected in May 2013, and will be included in the final version of the Quality Account if received before 30th June 2013).

During 2012/13 the Trust has undertaken four Information Governance Clinical Coding audits. The statutory requirement is to audit 200 episodes each year – we have audited 800 episodes. The findings have shown that:

- The Trust meets the IG Toolkit requirement Level 3 (95% of primary procedures and diagnoses codes are accurate and 90% of secondary procedures and diagnoses codes are accurate)
- There has been a significant improvement in the clinical information recorded in patient notes.

Information Governance Toolkit Attainment Levels

The Trust's Information Governance IG Toolkit Assessment Report overall score for 2012-13 was 82% (2011-12 was 82%; Green-Satisfactory) and was graded Green – Satisfactory across all Six Assurances**.**

The 2012-13 result is from version 10 of the Toolkit. As in previous years the evidence has been rolled over from previous versions to which we have added any new or revised policies and in-year evidence to support monitoring and compliance.

The Requirements have changed only slightly between versions. There are currently 45 requirements for Acute Trusts.

The results by Assurance Level were as follows:

Assurance	2011/12 (V9)	2012/13 (V10)	Level 0	Level 1	Level 2	Level 3
Information Governance Management	86%	86%	0/5	0/5	2/5	3/5
Confidentiality and Data Protection Assurance	81%	81%	0/9	0/9	5/9	4/9
Information Security Assurance	73%	73%	0/15	0/15	12/15	3/15
Clinical Information Assurance	80%	86%	0/5	0/5	2/5	3/5
Secondary Use Assurance	100%	100%	0/8	0/8	0/8	8/8
Corporate Information Assurance	77%	77%	0/3	0/3	2/3	1/3
OVERALL TOTAL	**82%**	**82%**	**0/45**	**0/45**	**23/45**	**22/45**

This year there was a KPMG Internal Audit of 17 out of 45 Requirements of v10 Toolkit which gave a Green (Adequate) score.

National Data from the Health and Social Care Information Centre

This is a new requirement for the 2013/ 14 Quality Account. The tables below represent Kingston Hospital's performance across a range of indicators (as published on the Information Centre Website www.hscic.gov.uk). Many of these are also reported monthly at the public Trust Board meeting as part of the Clinical Quality Report. The data shown is correct as of 11th May 2013 and the Trust will update these tables in the final publication of the Quality Account (by 30th June 2013) if there are any changes at the Information Centre website. As this is the first year of the data being presented in this manner, we will review the responses and comments made during the creation of next year's Quality Account in order to improve the presentation and format of this section.

Indicator	Trust	National	Minimum	Maximum	Comment
Summary Hospital-level Mortality Indicator (SHMI)	88.72	100	68.5	121.1	We are below national average. Lower number is better
Latest Data Published	Oct 11 to Sept 12				

Indicator	Trust	National	Minimum	Maximum	Comment
Percentage of deaths with palliative care coded	9.7%	18.9%	0.2%	43.3%	We are below national average.
Latest Data Published	Oct 11 to Sept 12				

Indicator	Trust	National	Minimum	Maximum	Comment
Age <16 readmissions within 28 days	12.0%	11.4%	6.31%*	14.09%*	We are above national average Lower % is better *For acute Trusts where data available
Latest Data Published	Data for 2010/11 standardised to persons 2006/07				

N.B. Data only available split under or over 16 years

Indicator	Trust	National	Minimum	Maximum	Comment
Age 16+ readmissions within 28 days	8.4%	10.2%	5.85%*	14.62%*	We are below national average. Lower % is better *For acute Trusts where data available
Latest Data Published	Data for 2010/11 standardised to persons 2006/08				

N.B. Data only available split under or over 16 years

Indicator	Trust	National	Minimum	Maximum	Comment
Trusts responsiveness to the personal needs of its patients	64.2	67.4	56.9	85.0	We are just below national average. Higher performance is better
Latest Data Published	2011/12				

Indicator	Trust	National	Minimum	Maximum	Comment
Staff who would recommend Trust as a provider to friends and family	63	62	33	89	We are just above national average. Higher performance is better
Latest Data Published	Staff Survey 2011				

Indicator	Trust	National	Minimum	Maximum	Comment
% of patients admitted that were risk assessed for VTE	91.0%	94.1%	84.6%	100%	We are below national average. Higher performance is better
Latest Data Published	Q3 2012/13				

Indicator	Trust	National	Minimum	Maximum	Comment
Rate per 100,000 bed days for C.diff reported within the Trust for patients >2 years old	*11.5	21.8	0.0	51.6	We are below national average. lower number is better
Latest Data Published	2011/12 2012/13 data is currently not available from the Health and Social Care Information Centre**.** The Trusts 2012/13 data is however provided on page 23.				

*Note: Infection Control data incorrect as an additional case was added which had not been included, figure reported here is corrected

Indicator		Trust	National	Minimum	Maximum	Comment
Number and % of patient safety incidents	Number	1047.0 [1393]		1047.0	4552.0	National and max and min is for medium acute trusts only. Below medium acute Trust average. Higher incident reporting is better.
	rate per 100 admissions	3.1	6.8	3.1	14.4	
Number and % of patient safety incidents that result in severe harm or death	Number	7.0		0.0	95.0	National and max and min is for medium acute trusts only. Below medium acute Trust average. Lower % is better.
	%	0.7% [0.7%]	0.8%	0%	3.6%	
Latest Data Published		Apr 12 to Sep 12. *see additional note at end of page 40.				

Indicator		Trust	National	Minimum	Maximum	Comment
Patient Reported Outcome Measures (PROMS) **Groin Hernia**	**Participation rates for the first questionnaire**	45%	55%	0%	651%	We are below national average. Higher % is better
	Participation rates for the second questionnaire	46%	45%	0%	86%	We are in line with national average.
	Health Gain (EQ-5D)	30%	50%	0%	100%	We are below national average. Higher % is better
	Health Gain (EQ-VAS)	39%	39%	13%	88%	We are in line with national average
Latest Data Published		Apr 12 to Dec 13				

Indicator		Trust	National	Minimum	Maximum	Comment
Patient Reported Outcome Measures (PROMS) **Varicose Vein surgery**	**Participation rates for the first questionnaire**	106.9%	39%	0%	280%	We are above national average. Higher % is better
	Participation rates for the second questionnaire	36%	40%	0%	90%	We are below national average. Higher % is better
	Health Gain (EQ-5D)	89%	52%	11%	89%	We are above national average. Higher % is better
	Health Gain (EQ-VAS)	67%	41%	14%	75%	We are above national average. Higher % is better
	Health Gain Aberdeen Score	89%	83%	50%	100%	We are above national average. Higher % is better
Latest Data Published		Apr 12 to Dec 13				

* The data disclosed in the Quality Account report is consistent with that data published by the Reporting and Learning System (NRLS) database for the period April to September 2012.

However, when compared to our underlying records for the same period, both the number and percentage of patient safety incidents that result in severe harm or death were understated. The corrected figures are in brackets [ ] in the table.

The NRLS have only taken into account 1,047 patient safety incidents against the 1,393 the Trust reported to them, this equates to a 25% shortfall. The Trust has had discussions with the NRLS to understand how this situation occurred and to ensure it does nor re-occur. However, even if the cause can be identified, the NRLS will not be running their report for this period again.

External Audit

In November 2012, Deloitte produced an NHS Briefing on Quality Accounts to assist Foundation Trusts in preparing the Quality accounts for 2012/13. The intention was to highlight areas for improving the readability of the documents and suggestions for improving quality of data that supports Quality Accounts. The table below summarises how the Trust has heeded the advice regarding layout style and format:

Length of Quality Account (average number of pages is 57)	✓
Greater focus on priorities and performance	✓
Inclusion of an introduction	✓
Inclusion of a glossary	✓
Priorities and Domains of Quality should be between 3 and 5	✓
Demonstrate improvement in the previous year	✓
Use graphs and diagrams liberally	✓
Engage with stakeholders in producing the Quality Account	✓

Monthly reporting to the Trust Executive Team and Management Committee on each of the priorities selected will give routine assurance.

Stakeholder Feedback

Where we have received direct comments back from patient representatives (outside of the formal response from stakeholders) we have endeavoured to include these in the final version of the Quality Account.

Kingston Hospital NHS Trust – Commissioner Feedback

The commissioners have reviewed the Trust's Quality Accounts report for 2012 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 this is evident from their performance across the majority of the agreed standards.

Commissioners are confident of further improvement in 2013/14 and look forward to the working with the Trust to improve patient pathways between hospital and community care.

	2012/13	**2013/14**
18 Week Waiting Times Patients to wait no longer than 18 weeks from referral to treatment	Admitted-target >90% Overall the trust was compliant across all but one specialty, this was due to problems in Q1 which were addressed and compliance was achieved in subsequent quarters. For non-admitted patients the trust was compliant in all but three specialties year to date. However, problems within these specialties have been addressed and compliance for all specialties was achieved in quarter 4.	To continue the good work on meeting the national standard for the number of patients waiting no longer than 18 weeks
Emergency Access (A&E 4 hour target) 95% of all patients attending accident and emergency should be treated, admitted or discharged within a maximum of 4 hours	96.44 % of patients were treated, admitted or discharged within 4hrs.	Maintain above 95%
Cancer Waiting Times Targets 2 week rule (the maximum wait for an urgent referral) 1 month to treatment from confirmed diagnosis 2 months to treatment (wait from urgent referral)	The Trust met all the cancer standards bar one on seeing referrals for breast cancer within two weeks.	Maintain good performance on all targets
CQUIN Achievement	The Trust has continued to achieve good performance against CQUIN targets 2011/12 92% 2012/13 93%	To maintain a good performance against CQUIN targets

	2012/13	2013/14
Eliminating Mixed Sex Accommodation	The Trust had no episodes of mixed sex accommodation breaches in 2012/13.	To maintain a good performance
Healthcare Acquired Infections no more than 1 case of MRSA	Achieved.	To maintain a good performance
Healthcare Acquired Infections no more than 15 cases of Clostridium Difficile	There were 23 cases reported.	To achieve the target for 2013/14
Maternity Services A caesarean section target of <=28%	Achieved.	To maintain a good performance in in 2013/14
Never Events	There were 2 never events in 2012/13.	There are No Never Events in 2013/14
Serious Incidents (SI) Timely reporting and learning from errors	The Trust SI review process aims to reduce as far as possible the potential for the same error to recur.	To maintain this
CQC / External Audit Results		
National Survey of Adult Inpatients	The results of the National NHS patient Survey of adult inpatients 2012 showed significant improvement in the patient experience related questions within the national inpatient survey.	Further improvement in experience of inpatients
National Survey of A&E	The results of the National Survey of A&E revealed areas for improvement in patient experience.	Improvements in A&E patient experience

Response:

The Trust is grateful for the feedback received from our Commissioners and looks forward to working closely with the Clinical Commissioning Groups in the coming year to deliver seamless care between the community and the hospital to our patients.

Additional changes made based on feedback:

1. Confirmed we will focus on last year's priorities in the coming year, P7.

2. Amended the CQUIN performance chart to specify achievements for each CQUIN target, P31.

A number of other questions were raised as part of the feedback received, and these have been provided through the Clinical Quality Review Group meeting (a meeting between commissioning GP leaders and hospital clinical leaders), held every month at the Trust.

Healthwatch Kingston feedback on the Kingston Hospital Quality Account 2012-13

Healthwatch Kingston was pleased to receive the Quality Accounts report from Kingston Hospital and wishes to congratulate the hospital on achieving most of its outcomes.

HealthWatch Kingston has continued to work with Kingston Hospital NHS Trust over the past year and its members have provided feedback on a range of issues, as well as identified areas for improvement. Members have represented Healthwatch Kingston on the Patient Information Readers Panel, the Clinical Ethics Forum, the Patients Experience Committee (PEC), the Nutrition Steering Group, and the Patient-Led Assessments of the Care Environment (PLACE) inspections (formerly the Patient Environment Action Team (PEAT)). It has also been involved with the Patient and Public Involvement workshop.

In previous years, Healthwatch Kingston (as Kingston's LINk and then Healthwatch Kingston Pathfinder) commented on the wordiness of the Quality Account and jargon being used. We were therefore very pleased to see that much effort has been made to make the document understandable for lay people with a list of different terms explained.

The way the hospital engages with its patients also seems to have improved, although we were concerned that the patient satisfaction with the Outpatients Service had not improved. We have taken note of the measures that are being put in place and hope to see improvement in next year's report.

Looking ahead to 2013-14, it is reassuring to note that Kingston Hospital recognises that there are areas that need to be improved and that suggestions have been made on how to do this. We would particularly want to see regular updates on how this is being achieved, particularly around some of the patient safety outcomes (falls and Clostridium difficile infections).

Another issue we would like to see addressed is for the report to show independent feedback from patients to make sure a truly honest and fair account is given about services and the experiences patients have. Whilst internal feedback is essential in assuring that any issues can be addressed by staff quickly and successfully and trends can be spotted, and we would very much encourage Kingston Hospital to work with organisations such as Healthwatch Kingston and neighbouring Healthwatches. This will give patients and independent voice and confidence their concerns are being heard.

We very much look forward to continue working with Kingston Hospital, and how it intends to develop now it has Foundation Trust status.

Response and Changes made as a result of the feedback above

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

Comments from Kingston Health Overview Panel, Royal Borough of Kingston upon Thames

1. Overall we are very encouraged to see the progress made on a number of important objectives and other key indicators described in the Quality Account especially around the care of cardiac patients, and continuing reductions for MRSA and pressure sores. We are also pleased to see how KHFT performs when compared nationally e.g. Hospital Mortality indicators, and the evidence that day of week of admission has little effect on patients at Kingston Hospital in terms of clinical outcomes.

2. We are particularly pleased to see evidence of enthusiasm, drive and determination to continually improve patient care both in terms of clinical, nursing and managerial aspects and also what is important from the viewpoint of patients themselves. There is strong and professional leadership and we congratulate the Trust on achieving Foundation Trust Status. We recognise the advantages that this brings, especially in attracting staff.

3. Although not directly referred to in the Quality Account, during our discussion with the Deputy Director of Nursing we learned that a significant proportion of pressure sores are present already on admission and we wonder whether it would be possible for the Trust to initiate steps to advise local nursing and residential homes on preventative care and suitable equipment, perhaps in conjunction with the Royal Borough of Kingston, Your Health Care and the Kingston Clinical Commissioning Group (KCCG).

4. Another area we discussed was the progress the Trust has made with the introduction of electronic patient records and prescribing. We suggest that this could be a further area for joint work in relation to expanding the electronic patient record interface between the Trust and GP surgeries. We would recommend that this too is progressed with the KCCG.

Falls

5. It is possible that the spikes in the number of falls in the winter months reflect the increased admission rates at this time of year of older people with medical conditions who are more likely to suffer from a degree of disorientation due to illness. Perhaps an additional emphasis on care around falls prevention could be introduced as part of the winter planning process and commissioners encouraged to fund evidence based falls prevention programmes.

6. We welcome the introduction of low (adjustable) beds and other precautionary equipment such as alarms and soft mats close to beds.

Communication with Patients

7. We note the comment that in the section about Communication in Outpatients “time spent with doctors was (also) rated lower than expected and led to patients feeling that the main reason for their attendance had not been addressed”. We recognised that it can be difficult balancing technological demands of recording information with personal interaction with patients. We wonder whether perhaps there could be a small training need about overt listening skills/body language so that patients pick up that professionals are listening and responding to their concerns?

Malnutrition Universal Screening Tool (MUST)

8. We welcome the on-going local audit of nutrition and the progress with MUST and are pleased to see that 90% of patients are assessed using the tool. We note however that further progress is still to be made with implementing special measures for at-risk patients. Nutritional intake is a key part of good recovery and we recognise that help with feeding can be a very time consuming part of patient care particularly for patients experiencing swallowing difficulties (which can be due to a range of conditions including advancing dementia). During our discussions with the Deputy Director of Nursing we learned about some of the initiatives being planned and put in place to address this area and we would welcome an update to the Health Overview Panel during 2013/14 on how feeding is supported.

Audits

9. We welcome the participation in the **national audit on pneumonia** as pneumonia can be significant for many patients and is a cause of death for some.

10. We are concerned to see that it was not possible to participate in the **national adult diabetes audit** and we would recommend that urgent steps are taken to identify funding/staff time to progress this as Diabetes will be an increasing concern in coming years (associated with increasing levels of obesity plus changing population profiles) and care and prevention strategies need to be targeted and strengthened to help avoid preventable illness and death as well as healthcare costs which will otherwise arise.

Patient feedback

11. One of the Health Overview Panel purposes is to represent the views of local people which Councillors are well placed to pick up as local Ward representatives. Councillors do often receive information from residents who are patients of local health providers. This information is often regarded by the health service as “anecdotal” and perhaps not given the same level of value and attention as that derived from more direct patient experience surveys. We would suggest that more regard is given to feedback passed on by Councillors.

12. One area which has come to our attention is the question of **patient confidentiality in A&E** where perhaps there are not the same levels of care around observing auditory privacy i.e. enabling patients not to be overheard when discussing what can be very personal and private details about their conditions. We would recommend that all patients are offered the opportunity to go somewhere more private for these discussions wherever possible.

13. We are also aware that there can be difficulties in ensuring carers are kept fully informed about relatives’ conditions and best care. We appreciate that patient confidentiality can be a difficult issue but it is important that a patient’s best interests are kept in view when it comes to involving carers and **sharing information** which is relevant to their care at home and their future progress.

General

14. “Quality Accounts are annual reports to the public from providers of NHS healthcare

about the quality of services they deliver", Source DH Guidance. Whilst recognising the statutory requirements of the Quality Account, we would suggest that consideration is given to simplifying the format, structure and language to ensure it is aimed at a level which is more accessible and helpful to the public.

Marian Morrison
Democratic Support Officer
Royal Borough of Kingston upon Thames
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Response

The Trust is grateful for the feedback received from Kingston Health Overview Panel and looks forward to working closely with them in the coming year to improve the services we provide to the people of Kingston.

Additional changes made based on feedback:

1. The Trust has begun discussions with the Clinical Commissioning Group about how we can improve joint working to reduce the rate of pressure ulcer incidence for patients coming into hospital

2. We have made good progress in introducing electronic records and a significant programme of work will be launched in 2013 (including electronic prescribing).

3. A comprehensive falls programme of work is underway and the helpful suggestion will be taken forward through this group.

4. Communication training/ skills will be reviewed to assess if inclusion of areas such as body language could be helpful.

5. The Chief executive is leading an initiative to improve the support for patients at meal times and the Trust would be happy to present an update later in the year.

6. The diabetes audit will form part of the audit work for 2013/14.

7. Specific issues were raised regarding privacy in A&E and this will be responded to as part of a formal complaint process.

We will continue to strive to make the Quality Account more accessible to the general public whilst meeting our statutory responsibilities regarding format and content.

We acknowledge an improvement in the presentation of the Quality Account this year. The English used is accessible and clear and we welcome the inclusion of the section explaining terminology.

We are pleased to see some improvements made to care at Kingston Hospital, in particular the good mortality rating [SHIM - Summary Hospital Mortality Indicator) for the hospital.

It is really important that year on year improvement is demonstrated in these reports for all areas of the Hospital. This would help identify any weaknesses or deterioration in services and give residents growing confidence in the hospitals ability to strive for first class care in all areas rather than just meeting Government targets.

The report presents totals in several areas without providing sufficient detail to give the reader a sense of the seriousness of the incidents concerned which is misleading in some cases. The severity of the incidents, particularly where significant harm or, as was the case during 2012-2013, death has occurred as a result of falls or infections, must be made clear to users of services. We suggest and need more open and transparent reporting of incidents. Such reporting would demonstrate that the Kingston Hospital is open to accepting areas of poor performance where they exist and provide an opportunity for the Hospital to commit to making improvements.

Residents would benefit from knowing why no or minimal improvements were made in some areas. For example, whilst we welcome the inclusion of falls and infections as priorities for the coming year, patients should be told why the hospital has difficulty in managing their fall & infection rates over the past year.

There is no analysis of the Accident & Emergency department which has been under particular scrutiny this year with reports from both the Picker Institute and Richmond LINk identifying many shortcomings. A workshop was held by the Picker institute in September 2011 to examine the findings of this report with the Hospital. It is disappointing that Kingston Hospital has missed the opportunity for candidly reporting the results of this in this Quality Account and committed to making improvements.

Healthwatch Richmond has inherited a particular interest from Richmond LINk in A&E, the care of the elderly and care of disabled patients whilst undergoing treatment. We look forward to continuing the work Richmond LINk began with Kingston Hospital in these and other areas.

This year, the focus of the hospital has been on obtaining Foundation Trust status. We look forward to the coming year where your stated values for Patient Care and Quality are the priority. We welcome the opportunity this provides for Kingston Hospital to work with Healthwatch Richmond to build a more collaborative approach to patient involvement, and that the Hospital is able to use to use this to demonstrate how involvement has led to improvements in their priorities for the coming year.

Healthwatch Richmond

Response and Changes made as a result of the feedback above

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

to the people we serve.

Incidents which result in serious harm or death are reported and reviewed in line with the structures, definitions and processes laid down for any NHS Trust. Given the very small number of incidents (and therefore the potential for an individual patient to be identified) these are reported in a format which protects the interests of the individual patient. Our performance in this important area is both published (nationally) and included in the Quality Account. Notwithstanding this, we view any episode of care with a serious harm event as a very important matter and learning from these events are shared internally and regionally through the existing reporting structures.

The quality account shows many examples of good and improving performance. We wish to see that performance in falls and infection control improve further and hence their inclusion as priorities for the coming year.

An additional entry has been included regarding A&E patient experience. P15.

Richmond upon Thames' Health, Housing and Adult Services Overview and Scrutiny Committee response to Kingston Quality Account.

Following on from the meeting held on Tuesday 7th May 2013, to discuss Kingston Hospital NHS Trust's (Kingston) Quality Account, we welcome the opportunity to provide additional input, as the London Borough of Richmond upon Thames (hereinafter 'LBRuT') is determined to champion the interests of its residents by playing a full and positive role in ensuring that the people living and working in the LBRuT have access to the best possible healthcare and enjoy the best possible health.

Whilst we appreciate that the version provided is a draft and the final version is yet to be approved we have a number of points we wish to raise and a number of suggestions we wish to proffer.

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

- We approve of the "Language and Terminology" section at the front of the document and the more detailed glossary at the back. This takes into account the fact the public are not always aware of the terminology used and thereby increases the Quality Account's (QA) accessibility.
- We also endorse your report structure, in particular setting the context for the new priorities by reviewing your priorities for the previous year, why they were chosen, what you set out to do and what has been accomplished before moving on to the priorities for 2013/14. We are also pleased to see a consistent level of detail and evidence to inform the new priorities vis-a-vis last year's priorities in terms of setting out the specific aim, what and how it will be achieved and how this will be measured. The report is detailed, evidenced and provides both explanation and context. We were happy to see that feedback has been taken on board and in addition to the areas identified as a priority you will also be looking to address other issues such as 'Falls'. We therefore, endorse the main and additional priorities for the upcoming year.
- We were delighted and applaud the use of a forget-me-not to alert members of staff that a patient suffers from dementia. This shows a great deal of respect for the person and their dignity.

However: -

- Under Priority 1 for 2012/ 13 (page 9-10) under the section titled 'incident reporting',

you mention and have graphs of the 'percentage of admissions with adverse events' and 'the standardised hospital mortality rate'. We recognise and understand it is important to place Kingston's performance in a national context. Whilst we congratulate you for your results being well below the national expected average. We would have liked / like to see how these numbers break-down at the local level which would in turn give a clear picture of which areas need focus. By only comparing nationally and not drilling down to the local level you do not address why there was a rise in November 2012, which fell the following month. The lack of local data in this area may be perceived as being selective in your reporting of this area particularly as other areas of the report contain data and tables (mainly) at the local level.

- With regards to the national inpatient survey as referenced on page 13 of the draft report we are aware, by your own recognition that the target you set of 1 objective point is very low. In our view, this target is not acceptable particularly in relation to questions 34 and 56 as these are some of the basic tenets - which serve to ensure good quality patient experience, improved levels of satisfaction and better outcomes for patients - that should be met. We urge and hope that a more realistic target has been set for this year and henceforth.

Suggestion:

The following suggestion is external to this QA in as much as this concerns operational implementation. It can and should be utilised as part of the evidence base for future QAs. It related to Question 56 of the patient survey:

Q56	Did a member of staff tell you about medication side effects to watch for when you went home?	48.7 (2011)	52.2 (2012)

- The creation of a booklet / print out / easy to understand guide for patients explaining their medication which they take with them on discharge: This would include, for example a picture of each pill; its name; the required dose; when and how frequently it should be taken; side-effects and any commonplace contra-indications (for example, grapefruit and medication such as Irbesartan). Many patients are confused about what they should take and when. For those that are, this would enable them have gain a better awareness, understanding and control of their medication, help ensure greater compliance which could lead to reduced admission rates due to incorrectly administered medication in an out-of-hospital setting and a reduction in the number of patients presenting to hospital or GP surgeries because they were unaware of the side-effect and their potential implications.

  There are a number of hospitals and trusts which already do this. In order to ensure best / good practice in this area we suggest you look further afield than other hospitals in your trust / locality. Foundation trusts and hospitals in other parts of the country may have effective and / or innovative ways which suit your requirements better.

Conclusion:

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

improvements will be made and monitored over the next year.

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

London Borough of Richmond upon Thames Health, Housing and Adult Services Overview and Scrutiny

Response and Changes made as a result of the feedback above

The Trust is grateful for the feedback received from London Borough of Richmond upon Thames Health, Housing and Adult Services Overview and Scrutiny and looks forward to working closely with them in the coming year to improve the services we provide to the people we serve.

- A new section (Use of Statistics) has been included, P7.
- We will continue to take action to improve overall patient experience, with a particular focus on outpatient areas in the coming year.

We welcome the suggestion for improvements to our patient information regarding medications and will review our current provision and seek to learn from other organisations to improve where possible.

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).

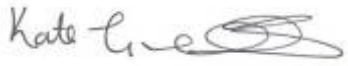
In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- 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
Chairman



Kate Grimes
Chief Executive

26th June 2013

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF KINGSTON HOSPITAL NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are 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 2013 ("the Quality Account") and certain performance indicators contained therein as part of our 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, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the following indicators:

- Percentage of patient safety incidents that resulted in severe harm or death; and
- Rate of clostridium difficile infections

We refer to these two indicators collectively as "the indicators".

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 Regulations).

In preparing the Quality Account, the 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 are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2012/13 issued by the Audit Commission on 25 March 2013 ("the Guidance"); and

- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2012 to June 2013;
- papers relating to the Quality Account reported to the Board over the period April 2012 to June 2013;
- feedback from the Commissioners dated 4 June 2013;
- feedback from Local Healthwatch dated 7 June 2013;
- the trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated June 2012;
- the latest national patient survey dated 16 April 2013;
- the latest national staff survey dated 27 March 2013;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2013;
- the annual governance statement dated 6 June 2013;
- Care Quality Commission quality and risk profiles dated 31 March 2013; and
- the results of the Payment by Results coding review dated May 2013.

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

This report, including the conclusion, 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. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Kingston Hospital NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;

- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Senior Statutory Auditor, for and on behalf of

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

Appendix A: National Clinical Audits

National Clinical Audit	Participated	Number of cases submitted
Peri and Neonatal		
Neonatal intensive and special care (NNAP)	Yes	426/426 100%
Children		
Fever in children	Yes	50/50 100%
Paediatric pneumonia	Yes	46 cases submitted (minimum of 5 required) 920%
Paediatric asthma	Yes	23 cases submitted (minimum of 5 required) 460%
Childhood epilepsy	Yes	39/39 100%
Diabetes	Yes	Case numbers available Mid June 2013
Acute Care		
Emergency use of oxygen	Yes	12 cases submitted (minimum of one required) 1200%
Adult community acquired pneumonia	Yes	60/ 5 1200%
Renal Colic	Yes	50/50 100%
Non-invasive ventilation	Yes	18 cases submitted (minimum of 5 required) 360%
Cardiac Arrest	Yes	101/147 69%
Adult Critical Care (ICNARC)	No	Due to start participating from April 2013
Potential Donor audit	Yes	64 – percentage not applicable
Long Term Conditions		
Diabetes	No	Due to start participating from April 2013
Chronic pain (National pain audit)	Yes	236 questionnaires submitted 100%
Ulcerative colitis & Crohn's disease (Inflammatory bowel disease)	Yes	Still collecting and submitting data – deadline 31.12.13
Parkinson's disease	No	Kingston Hospital was given permission to participate in this national audit next year instead of 2012/13 so that the action plan from the previous audit could be implemented.
Adult Asthma	Yes	16 cases submitted (minimum of 5 required) 320%
Dementia National Audit	Yes	40/40 100%
Bronchiectasis	Yes	19 cases submitted (minimum of 5 required) 380%
Elective Procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	30/30 100%
Coronary angioplasty (Cardiac Interventions)	Yes	Organisational survey submitted, no patient cases required
PROMS – Hernia and varicose veins only	Yes	Data for Quarter 1 2012/13 – 74/112 patients completed questionnaires (66%)
Cardiovascular disease		
Acute myocardial infarction &	Yes	203/ 466 44%

other ACS (MINAP)		
Heart Failure	Yes	167/ 347 48%
Acute stroke SINAP)and SSNAP	Yes	SINAP – Kingston Hospital not eligible as insufficient number of direct admissions of patients with stroke. This has been superseded by SSNAP from January 2013 67/67 100%
Cardiac arrhythmia	Yes	156/156 100%
Cancer		
Lung cancer (NLCA)	Yes	117/159 74%
Bowel cancer (NBOCAP)	Yes	121/134 90%
Oesophago- gastric cancer (AUGIS)	Yes	37/37 100%
Trauma		
Hip fracture		332/360 92%
Severe trauma (TARN)	Yes	20/60 33%
Fracture Neck of Femur	Yes	50/50 100%
Blood transfusion		
National Comparative Audit of Blood Transfusion audit- Medical Use of Blood- Part 1	Yes	42/42 100%
National Comparative Audit of Blood Transfusion audit Sample Collection and Labelling	Yes	12/12 100%

Appendix A: National Confidential Enquiries

Programme type	Participated	Number of cases submitted
Child Health Programme: National Study of Epilepsy	Yes	None appropriate for submission during study period. Organisational questionnaire submitted.
Medical and Surgical: Alcoholic Liver Disease	Yes	Data submitted on 9 cases. Detailed information sent on 3/3 cases (100%) Organisational questionnaire submitted.
Hospital treatment following a subarachnoid haemorrhage	Yes	Data submitted on 11 cases. Detailed information sent on 1/1 case (100%). Organisational questionnaire submitted.
Maternal, Infant and Perinatal: MBRRACE-UK	Yes	All perinatal deaths - 22 (100%)
Mental Health	Not applicable	
Other: National Review of Asthma Deaths	Yes	4/4 (100%)

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

National audit reports published in 2012/13	Date Report Issued	Report discussed during 2012/13	Actions Identified
Children			
Paediatric pneumonia	Oct 2012	Yes	This audit resulted in the development of local guidelines based on British Thoracic Society best practice guidance.
National Neonatal Audit Programme	Jul 2012	Yes	The data in this report has been discussed. However, data accuracy is being explored prior to an action plan being identified.
Paediatric asthma	Apr 2012	Yes	The Paediatric team have reviewed patient management regarding the use of nebulisers and treatment escalation. They have also improved the discharge process to ensure that all patients receive a leaflet, a check of their nebuliser technique and to ensure that patients are fully aware of their follow up management plan before leaving hospital.
Paediatric fever	Feb 2013	Yes	This national audit was carried out on patients who attended the children's section of the Accident and Emergency Department. Actions identified include ensuring that staff are fully aware of the importance of documentation of the Glasgow Coma Scale (GCS) and a review of pain scoring in children.
Childhood epilepsy (Epilepsy 12)	Sep 2012	Yes	This national clinical audit was set up as a result of concern over the quality of care for children and young people with epilepsy. Review of Kingston Hospital's results has led to service improvement discussions around nurse specialist staffing and a plan for improved clinic provision. A teaching session on interpreting electro-encephalographs (EEGs) has also been held.
Diabetes	Sep 2012	No	Kingston Hospital is due to start participating in this national audit during 2013/14.
Acute Care			
Adult Community acquired pneumonia	Jun 2012	Yes	As a result of this national audit, the Respiratory team have designed a pneumonia 'bundle'. This is an admission pathway which is designed to ensure that patients, who are admitted with community acquired

			pneumonia, receive consistent treatment.
Non-invasive ventilation	Jun 2012	Yes	Non-invasive ventilation refers to the administration of breathing support without the use of an invasive artificial airway. It is used in the management of patients with acute and chronic respiratory diseases. This national audit resulted in the Respiratory team producing a non-invasive ventilation prescription chart.
Severe sepsis and septic shock	May 2012	Yes	As a result of this national audit, the A&E Department are revising their clinical documentation to include a section on systemic inflammatory response syndrome (SIR).
Cardiac arrest	Jul 2012	Yes	This national audit showed that Kingston Hospital's results are generally in line with national expectations and therefore no actions are required at this time.
Long term Conditions			
Heavy menstrual bleeding	Jul 2012	Yes	The report issued in July 2012 was an interim report, which contained no patient level information or recommendations; these are due in Summer 2013. Therefore, no actions have been taken at this stage.
Parkinson's disease	Jun 2012	Yes	This national audit has led to discussions regarding the level of specialist nursing support for patients with Parkinson's disease.
Chronic pain	Dec 2012	Yes	Following review of the results of this national clinical audit, the Pain Clinic service is considering the feasibility of running pain management sessions for the carers/family of patients with chronic pain.
Adult asthma	Feb 2013	No	This national audit report is due to be discussed by the Respiratory team in May 2013.
Elective Procedures			
Coronary angioplasty (Cardiac interventions)	Jan 2013	No	This national audit only requires Kingston Hospital to complete an organisational form and we receive no recommendations to action.
Cardiovascular diseases			
Myocardial infarction national audit project (MINAP)	Nov 2012	Yes	The national audit results for April 2011-March 2012 were discussed by the Cardiology team. Recommendations include the importance of national data collection and individual trust participation in the MINAP clinical audit. This national audit

			now has a new Consultant Cardiologist lead at Kingston Hospital and data input has increased substantially in the past year.
Heart failure	Nov 2012	Yes	The Heart Failure national audit resulted in some reorganisation in the Cardiology Department to ensure that nurse specialists work with patients with heart failure.
Heart Rhythm Management	Jan 2013	No	The Heart Rhythm Management National Audit is actually a register of cardiac rhythm devices, for example cardiac pacemakers. If a concern with a particular device was raised, the register would be used to contact hospitals who use such devices. No recommendations are generally contained in the annual reports.
Stroke SSNAP (organisational audit)	Nov 2012	Yes	The recommendations of the stroke organisational audit include access to clinical psychological provision for patients. Kingston Hospital is in the process of recruiting a psychologist to provide care to patients who have suffered a stroke. Other actions include improving information on social services and other benefits at stroke follow-up clinics and investigating the establishment of links with local stroke groups.
Renal Diseases			
Renal Colic	Feb 2013	Yes	This national audit raised the important factor of ensuring documentation of pain scores in patients presenting with renal colic in the A&E Department and this will be highlighted to medical staff.
Cancer			
Bowel Cancer 2012 report	Dec 2012	Yes	During the past year, the Colorectal Team have established a process to review the data to be submitted to this national audit on a quarterly basis so that remedial action can be taken if necessary. The results in this report showed that Kingston Hospital was generally in line with or above the national average with regard to care/treatment. The main action taken following this report was to ensure that all patients were given the opportunity to see the Nurse Specialist.
Lung Cancer	Dec 2012	No	The report is awaiting presentation.
Oesophago-gastric cancer	Jul 2012	Yes	As a result of the recommendations contained in this national audit report, an internal clinical audit of nutritional

			assessment in patients with oesophago-gastric cancer is being undertaken to provide detailed local information and to ensure adherence to clinical standards.
Trauma			
Hip Fracture	Sep 2012	Yes	Kingston Hospital's results were generally very good, showing that 99% had a preoperative assessment by an Consultant Orthogeriatrician (national 43%) and that 97% of patients were discharged on bone protection medication (national 69%). However, our results showed a problem with admitting patients to an orthopaedic ward in a timely manner. This is thought to have been a data processing issue and we have therefore concentrated on ensuring this data is robust for the future.
National Joint Registry	Sep 2012	Yes	No actions are required since this is a registry, which monitors the performance of joint replacement implants. The registry would be used to contact hospitals if issues or concerns arose with implants. The yearly report does not contain recommendations for action.
Fractured neck of femur	Feb 2013	Yes	The actions highlighted by this national audit concern education for doctors regarding the importance of documenting analgesics that may have been given to the patient prior to their admission and reinforcing the protocol for requesting x-rays.

Appendix C: Local Audit Examples

Local Clinical Audit examples	Actions identified
Acute Medicine and A&E	
Epilepsy in pregnant women	A local clinical audit which investigated the quality of care given to pregnant women diagnosed with epilepsy has led to a number of improvements being made in care planning. These include a specific care pathway for pregnant women with epilepsy, from the pre-conception stage to the postnatal period and a birth plan which specifically details pain relief and appropriate care for women who may be at risk of epilepsy during their delivery.
Ambulatory Care	
Survey of patients attending the Out-Patient Department	Following the publication of the 2011 National Out-Patient Survey, Kingston Hospital developed a comprehensive action plan to make improvements to the patient experience. In November 2012, following completion of some of the action plan work, a local survey was undertaken to gauge patient reaction. Patients reported an improvement in many areas including being able to find the Out-Patient Department easily, being provided with information regarding test results and medication, doctors understanding patient history and explaining reasons for treatment, staff introducing themselves and an overall feeling of being treated with respect and dignity. The current action plan includes comprehensive plans to improve clinic waiting times and provide patients with information following their consultation to ensure questions are fully answered.
Surgery and Critical Care	
Urgent patient referrals to the Maxillo-Facial Department	This local clinical audit reviewed whether patients were being referred into urgent clinic slots according to guidelines issued by the National Institute for Health and Care Excellence (NICE). The actions identified by the audit included ensuring that all clinicians were fully aware of the NICE guideline criteria, including referring dentists and GPs.
Women and Child Health	
Audit of Child Protection Documentation	This audit assessed adherence to documentation standards of child protection in line with the Laming report. The actions resulting from this audit included adding the name of the child's chaperone to the hospital records, updating staff training regarding procedural issues and including examples of child protection medical examinations in teaching sessions for doctors.