# Quality Accounts 2017/18

KING EDWARD VII's HOSPITAL

*Version 1.0*

# Contents

# Chief Executive's Statement

**2017-18 was a year of challenges, reflection and opportunity for the hospital. The Care Quality Commission inspection in early 2017, with subsequent report published in August 2017, provided feedback on where the hospital was strong, such as its care of, and responsiveness to, patients, for which we are very proud. However, it also identified areas for development especially within clinical and corporate governance, which we have taken as opportunity to improve.**

The hospital has responded and in the seven months post report we have made swift and decisive changes to ensure we can continue to provide the best quality of care within a strengthened governance framework. We have employed a Director of Governance and Medical Director, both with substantial governance knowledge and experience to help guide the hospital in its improvement journey. The Board of Trustees and I are fully assured that we have already come a considerable way in a short time and we view the events of the last twelve months as a platform to deliver the highest standard of patient care and service for the hospitals next evolution.

As we look to the future, quality governance and dynamic healthcare leadership will bolster the continued excellent quality of care that is central to every patient journey. The strong values of this unique hospital underpin all the quality work to which we remain committed.

The hospitals charity has benefitted from very generous donations following a successful fundraising campaign for the Veterans Health Centre. The quality of the work undertaken by the specialist Pain Management team is outstanding and we are very proud to be able to offer such an innovative and transformative programme to our veterans. Other fundraising has enabled significant projects in other areas of the hospital over the next two years that will not only increase our capacity but enable new patient pathways and service provision.

Lindsey Condron
Chief Executive

# Vision, Values and Strategy

## Hospital Vision

To be the leading private hospital in the UK and to support an increased number of veterans through our charitable work.

## Mission Statement

To consistently deliver the highest standards of personalised patient care, in a safe and kind environment, through our exceptional and empowered teams. We will do this whilst continuing to deliver our charitable work within the veteran community.

## Our Values

**1. Professionalism** - Do your job well and to the best of your ability and training.

**2. Quality** - To provide excellent care in order to achieve 100% customer satisfaction.

**3. Respect -** To respect one another's views and maintain a culture of openness, honesty and fairness.

**4. Safety** - To ensure that safety is the number one priority at all times.

**5. Teamwork -** Team unity and good communication is essential to achieve PQRS

## Quality Strategic Objectives

- Be recognised by the CQC as providing Good or Outstanding care across all areas of service delivery, and as Outstanding across all domains and services by 2021.
- Continue to strengthen our culture of quality and safety built on transparency and openness, through continual learning and improvement and investing in staff development.
- To develop benchmarked, comprehensive, comparable and reliable measures of care, services and quality experience that will achieve excellence in healthcare outcomes.
- Ensure that the Hospital is recognised for driving innovation and exploiting new technology to deliver accessible world class health care whilst remaining aligned to our core values.

# Executive Team

**Lindsey Condron**
Chief Executive

**Professor Justin Vale**
Medical Director

**Caroline Cassels**
Matron

**Tim Brawn**
Director of Fundraising and Veterans' Health

**Dr Jenny Davidson**
Director of Governance

**Ian Deans**
Finance Director

# Quality Achievements in 2017/2018

This section outlines some of the main quality achievements from the year.

# 1. Governance framework, systems and team

**A governance review was undertaken in the winter of 2017, led by the new Director of Governance. A new Committee framework was put in place to ensure a 'ward to board' flow of information and assurance, enabling the whole organisation to have effective communication about governance data, risks and best practice.**

A new Governance team was formed including the new roles of Patient Safety and Risk lead, Audit and Compliance Lead, Consultant Credentialing Co-ordinator and Governance Officer. This highly experienced and knowledgeable team provide a service to the staff, consultants and patients to ensure the care and provision of services is best practice, monitored, measured and evaluated on a continual basis. The team have introduced Quality Improvement methodology and a comprehensive programme of staff engagement with governance.

The systems for Risk Management, Complaints management, Clinical Audit and Policy and Guideline management have all been reviewed and updated in alignment with best practice and national standards.

We have seen significant improvements in governance during this year that reflects the hospital embracing modern effective governance systems, processes and culture. Being open and transparent is at the core of all our care and services, which can be seen in our increased reporting, shared learning, monitoring of performance, responding to errors, issues and complaints and commitment to continual improvement.

# 2. Learning from incidents and complaints

**In December 2017 the new governance committee framework was introduced which included ward to board level meeting structure to review, discuss and share learning and actions in relation to incidents, complaints and legal issues. This learning culture is across the organisation and ensures a broad knowledge of the risks and successes within the hospital.**

The learning and actions from incidents and complaints are also shared via a monthly staff newsletter introduced in December 2017. In addition a consultant newsletter is shared quarterly to keep our consultant colleagues updated and informed.

Early 2018 we introduced a process whereby staff who report incidents receive feedback and assurance of action having been taken where required on the incident; a positive feedback loop to assure staff that things improve as a result of reporting issues and concerns. We also introduced 'hotboards' in departments that display examples of where actions and improvements have been made as a result of patient feedback.

# 3. Caring for patients with additional needs

**In late 2017 a committee was set up to review how easy it is for patients with additional needs such as dementia, learning difficulties, visual disability, hearing disability and hidden disabilities to access our services. The committee meets every two months and has promoted the introduction of the butterfly scheme for patients with dementia and memory loss.**

We are working in partnership with the relevant local and national organizations such as Action on Hearing Loss to ensure that the service we provide is both appropriate and beneficial. For example, 'Action on Hearing Loss' carried out a hospital wide audit, motivating us to install hearing loops in all patient facing areas, purchasing devices for amplifying TV sound and providing staff training.

We appreciate that the assistance provided should be specific to the requirements of the individual and we developed a process with our referrers and front line staff to ensure we now gather the information we need so that staff are best prepared to assist. We have purchased patient information leaflets in different formats such as easy read and bigger print thus allowing all patients to be able to access information and make an informed choice about treatments.

# 4. Clinical Nurse Specialists

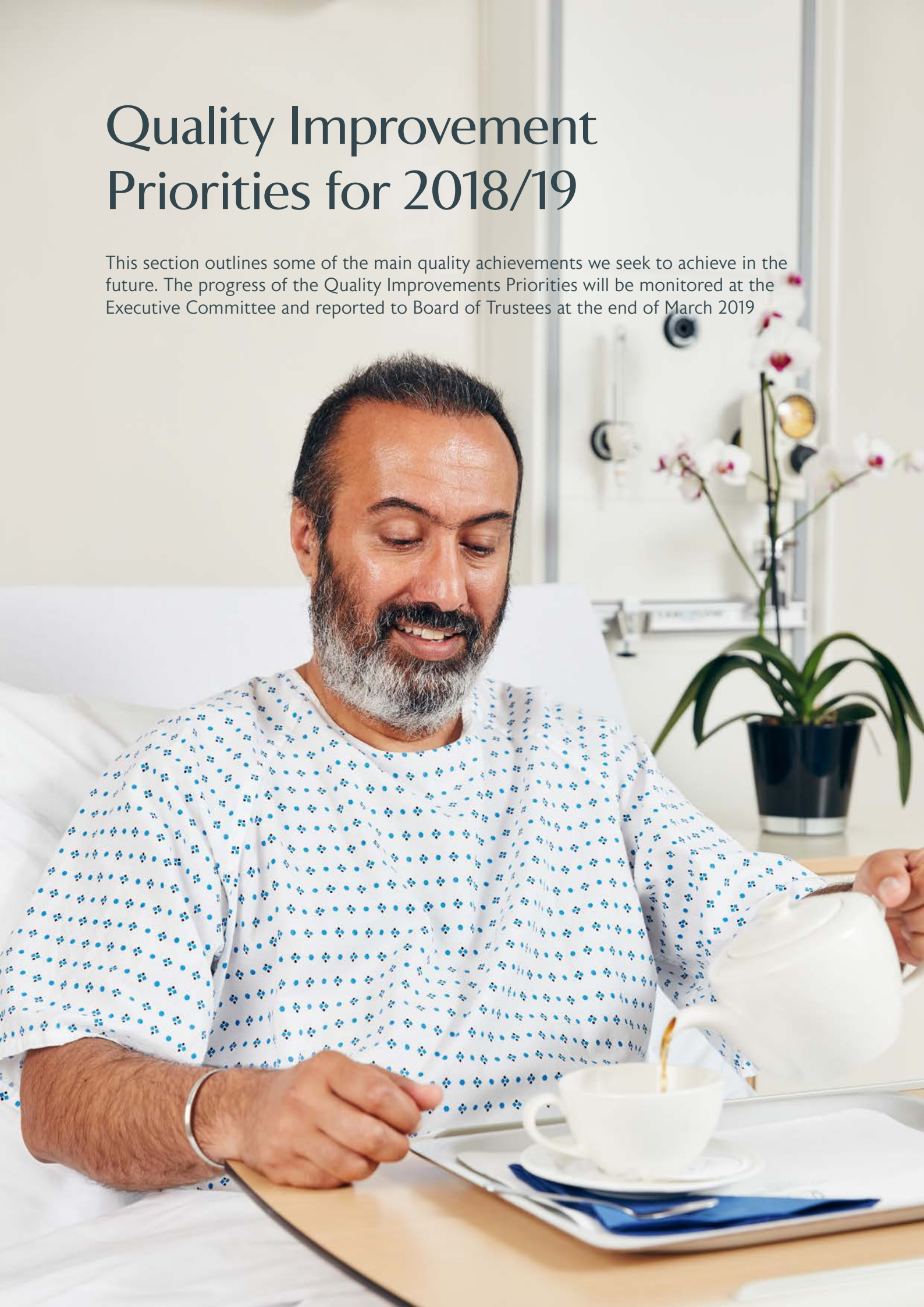
**In the final quarter of 2017 the Hospital identified a need for Clinical Nurse Specialists (CNS) to support consultants' practice, enhance the patient journey, build on our Centres of Excellence, and establish and co-ordinate the Multi-Disciplinary Team (MDT) meetings within the Hospital.**

The CNS is an expert practitioner able to independently lead and organise complex care across multiple disciplines. Patients benefit from the dedicated approach of the CNS throughout the duration of their treatment. The CNS is a key person in facilitating and maintaining the shared governance environment and this new role makes the CNS a valuable resource in helping the Hospital achieve its goals.

Specialist areas recruited for in 2017-18 are those involving cancer and complex patient journeys particularly, Colorectal, Gynaecology, Breast and Orthopaedics.

# Quality Improvement Priorities for 2018/19

This section outlines some of the main quality achievements we seek to achieve in the future. The progress of the Quality Improvements Priorities will be monitored at the Executive Committee and reported to Board of Trustees at the end of March 2019



# 1. Falls prevention and reduction

**We aim to reduce the rate of falls in the year from 3.09 per 1,000 occupied bed days to 2.32 per 1,000 occupied bed days (a reduction of 25%)**

Whilst our falls rate is low compared to national levels we want to make all and every effort to reduce the risk of any patient falling in our hospital. We plan to continue our Quality Improvement Falls Prevention program which was commenced in January 2018 and is led by a dedicated Falls Lead. Using a referenced improvement methodology the program will collect and analyse data to identify themes and trends and implement measurable cycles of improvement.

The responsible executive for this improvement priority is Caroline Cassels, Matron

# 2. Involving patients in care and services review and development

**We aim to involve patients in care and services in a more meaningful and influential way.**

We have always established loyal relationships with our patients and in this way have a continual dialogue and feedback. However, we feel it is time to formalise this with the introduction of a patient forum, increasing the number of patient representatives on hospital committees and using patient feedback to focus and drive improvements. We will also be reviewing and improving the collection of Patient Reported Outcome Measures (PROMs) through engagement of groups of patients in a co-production forum.

The measure of the success of this improvement priority will be an established patient forum, patient representatives on at least 3 hospital committees and evidence of patient feedback and evaluations measures informing improvement across the hospital.

The responsible executive for this improvement priority is Tim Brawn, Director of Fundraising

# 3. Dementia care

**We aim to introduce the 'Butterfly Scheme' across the hospital, improving staff knowledge, the environment, resources and care pathways for those patients with dementia.**

Feedback from the CQC inspection identified that this was an area for improvement. After review it was decided to engage and introduce the 'Butterfly Scheme' to assist the hospital in organisational change in this area. This programme includes training for all staff, care pathways and environment review and updating. It is expected the scheme will be fully implemented by March 2019.

The responsible executive for this improvement priority is Justin Vale, Medical Director

# 4. "Sign up to Safety" Campaign

**We are joining the NHS England's "Sign up to safety" campaign where we will commit on five key areas of patient safety. This campaign will include all staff who work in the hospital and our consultant users.**

We will develop pledges within the five key areas of the campaign and will introduce opportunities for learning around key concepts of error, human factors, system failures, just culture, safety huddles and improvement cycles. This will ensure there is a system-wide approach to patient safety using evidence based methodology. Our aim is that 50% of staff will have completed the first stage of the programme throughout the year and expect an associated positive trend in the patient safety culture survey results in 2019.

The responsible executive for this improvement priority is Jenny Davidson, Director of Governance.

# 5. Outcomes

**We will be improving our scope and breadth of quality and performance outcome measures in 2019.**

To meet the requirements of being open and transparent we will be working to improve our ability to extract and use meaningful data on which to inform and assure ourselves, our consultants and our patients.

This priority will rely on developing our IT capability and staff and consultants engagement. We aim to be able to provide broader and more specific outcome measures, trends and themes by March 2019.

The responsible executive for this improvement priority is Ian Deans, Finance Director

# Safe

**King Edward VII's Hospital is committed to providing the best and safest care possible for our patients.Reporting incidents helps us learn and improve care and services as well as focus on where more resources such as training is required. We instil a culture of continual learning and improvement and uphold the values of open and transparency.**

# Incidents

The Hospital's reporting system recorded the following number of reported incidents. We are pleased to see an increase in the number of reported incidents by 34% as an indicator of effective staff engagement in developing a safe culture.

The biggest area where we have reported incidents is in key performance indicators; these were previously collected in paper format so the collection via our reporting system allows for more efficient and effective analysis of key quality data.

Staff training and support on incident reporting has increased reporting in a number of areas, notably data documentation errors and equipment failure or issues. We see increased reporting as a positive indicator of a safe culture where staff are open about issues and incidents, they are reviewed to see where learning can be identified and changes made to continually improve.

It is also positive that staff are reporting near misses as valuable opportunities to learn how errors were prevented so this can be shared.

Where we have more serious events or incidents or incidence these are investigated and reviewed to national standards, insuring systemic issues are identified and addressed. We are committed to being open and honest, and fulfil our professional and statutory Duty of Candour requirements.

We are committed to work with patients and families when unexpected events occur so we always provide a point of contact during investigations. Any event provides us with an opportunity to make changes, improve systems and reduce the risk of re-occurrence.

# Patient falls

When a patient has a fall it can have serious implications causing distress, pain, injury, reduced confidence and even mortality. Acute illness, particularly in frail older people or those recovering from serious injury or surgery, increases the risk of a fall in hospital. Patients are vulnerable to delirium, dehydration and deconditioning, all of which affect balance and mobility, especially in unfamiliar surroundings.

In 2017 the hospital undertook an in depth review of patient falls and took action to reduce the number of falls. In January 2018 we appointed a Falls Project Lead with aims to reduce inpatient falls, improve patient safety and promote positive change. This remains a priority for the year 2018-19

# Falls project progress January to March 2018

| Planned Action 2017/2018 | Summary Update 2017/2018 |
|---|---|
| **Introduce 'Call Don't Fall' signs to every patient's room.** | We have placed 'Call Don't Fall' signs in each patient's bedroom to encourage patients to call for help prior to getting up |
| **Raise awareness of falls and safety among staff** | We have added a systematic template to our falls incident reporting systems to promote thorough investigations into falls incidents and enhance learning opportunities (Measure – template / evidence of actions taken following incident investigations).<br><br>We have formed a 'Falls Team' which consists of ward based nursing staff and employees from the physiotherapy, pharmacy and medical departments. This group meets on a monthly basis. They act as a point of contact regarding falls in their clinical area, along with completing audits and providing experience and clinical knowledge to guide the project |
| **Raise awareness of falls prevention and moving and handling equipment and its location** | We have completed a manual handling and falls equipment inventory and location list which has been distributed to all staff. Equipment has been relocated to one central storage cupboard for everyday ease of access.<br><br>We have purchased and provided training in the use of an inflatable lifting system to enhance safety when moving a fallen patient from the floor. |
| **Reintroduce falls prevention and management training at clinical updates** | We now deliver falls safety training at clinical updates. All clinical staff attend annually and the session promotes awareness about why patients fall and particularly why they have a greater risk of falling while in hospital. We consider ways in which we can reduce the risk of patients falling whilst they are in our care. |

# Pressure ulcer and tissue viability

Pressure ulcers can have a significant impact on a patient's quality of life, as well as causing anxiety and hindering recovery. Several national guidance documents, including the National Institute for Health and Care Excellence (NICE) quality standards describe pressure ulcers as a high-priority area for quality improvement, with evidence based guidence designed to support the measurement of improvement.

King Edward VII's hospital took action to embed these recommendations and to identify ways to reduce the number of avoidable acquired pressure ulcers at the hospital by introducing a tissue viability service in 2017 led by an external nurse consultant to lead

on the prevention and reduction of the incidence and, consequently, harm caused by pressure ulcers.

A new tissue viability education strategy tailored to the needs of the hospital was introduced aimed at all clinical registered and unregistered staff. This covers basic aspects of wound management, pressure ulcer prevention and management and topical negative pressure wound therapy (TNPWT).

The aim of the tissue viability strategy is to empower staff and give them the competencies, tools and confidence to carry out their duties and practice in accordance with the current best evidence available.

The tissue viability nurse has so far developed:

- Guidelines for referral to the tissue viability services – to aid staff making correct and prompt referrals of complex cases for specialist advice.

- An online referral form – this links with the Guidelines for referral to the tissue viability services document and is a straightforward form that is downloaded from the intranet and submitted via email to the tissue viability nurse/group.

- A reviewed suite of policies related to tissue viability, including wound care policy and procedures and pressure ulcer prevention and management policy and procedures.

- Linked to the above, a new wound assessment and documentation chart has been devised as well as a reviewed Waterlow Scoring Sheet and a Pressure Areas Management Plan (PAMP), which will include the SSKIN care bundle (Surface, Skin Inspection, Keep Moving, Incontinence, Nutrition and Hydration) and a Referral Form for Ongoing Wound Care.

- Reviewed the Pressure Ulcer prevention and management data collection tool used for audit and quality improvement.

A patient information leaflet is available for patients giving them guidance on how to prevent the development of pressure ulcers.

All pressure ulcers either acquired at the hospital or inherited on admission are reported on the hospitals incident reporting software, Datix, and investigated accordingly in order to take learning points and implement corrective measures where necessary.

The aim for the next 12 months is to have a minimum of 50% of staff attending the training sessions and to reduce the overall number of avoidable acquired pressure ulcer incidents, with the caveat that the numbers reported may increase due to more accurate reporting.

# Infection control

King Edward VII's Hospital is committed to ensuring the promotion of high standards of infection control to maintain patient safety. We are very proud of our very low infection

rates and have a dedicated, experienced and highly knowledgeable team to lead and support the hospital, staff and patients in preventing infection.

The Infection Prevention and Control Team ensure a safe environment for all patients and staff by working together to reduce healthcare acquired infections. The hospital promotes robust monitoring systems and best practice in hand hygiene, mandatory reporting, surveillance, cleaning and auditing to minimise the risk of infection to patients.

We participate in the national mandatory surveillance reporting required by Public Health England. Continuous monitoring and surveillance of Surgical Sites Infections (SSI) is carried out with added staff and patient education to improve patient outcomes.

## Infection control meetings and auditing

Bi-annual environmental audits are carried out in all patient centred areas of the hospital by the Microbiologist and IPCN to ensure consistency in practices and patient safety needs are met. The Infection Control Committee meets quarterly and minutes are circulated to all staff via the Link Nurses or Heads of Departments. The IPC meeting also feeds into the Integrated Governance Committee. Hand hygiene Audits, peripheral line insertion/care audits, urinary catheter insertion/care audits and antibiotic audits are carried out quarterly or bi-annually so as to identify areas for improvement.

## Safeguarding

The Matron is the Safeguarding Lead for the hospital for adults and children, although the hospital does not admit or see any patient under the age of 18. In the period being reported there have been no reportable safeguarding concerns.

There is a safeguarding policy in place and associated mandatory training. The hospital is also in the process of organising Level 4 safeguarding training for key personnel.

All safeguarding issues are reported and discussed at monthly Senior Clinical Team meeting.

To ensure staff are fully trained we provide mandatory training at all levels in line with best practice standards.

# Caring

# End of life care

Although numbers requiring end of life care are small, the hospital has put in place individualised care plans for all palliative care patients. The implementations of these individualised plans of care are supported by two palliative care consultants. The hospital has put in place a palliative care lead nurse who has undertaken training in palliative and end of life care.

A full study day on End of life care for the nursing team is being provided by the Royal Marston hospital annually. We now audit all end of life care events in the hospital. This audit is based on the National Clinical Audit Commission which was designed to ensure the priorities of care for the dying person are met. Since being introduced 6 months ago we have moved to 100% compliance.

# Patient experience

Measuring the patients' experiences of their care and treatment whilst at King Edward VII hospital highlights areas where the hospital is successful and where we need to work harder to deliver the improvements that matter to patients. We gather feedback by providing our patients with a survey (paper or online) which asks them about their Hospital experience. We review this patient feedback, as well as complaints and comments, at the Patient Experience Committee monthly. This gives us a direct insight into what is working well, and not so well, in the way we deliver care.

Regular feedback allows us to study patterns and trends and to see how common certain experiences are for patients. We can highlight if a problem is occurring more or less frequently over time, and if our interventions are working. The Committee makes recommendations to the Executive Committee in order to drive organisation wide quality improvement priorities.  For example the hospital purchased duvets for patient's beds to use instead of blankets as we had received a number of negative patient comments about the blankets.

Heads of Department share the Patient Satisfaction Results with staff at monthly departmental meetings as well as providing copies of positive comments to the individual staff mentioned – a real morale boost.

Our annual report is published in January and it showed we had 1003 responses, with a sharp increase in the number of responses from 18% in Jan 2017 to 47% in December 2017 following the introduction of the online survey. We now average about 30-35% response for inpatients per month.

Outpatient response rate remained low in 2017 at less than 10%. Although the figures contained in the report are likely to be representative of patient opinion, it is not possible to calculate a level of accuracy on this sample size. Our main focus going forward is to improve the response rate in outpatients.

# Positive trends

Numerous positive comments regarding the staff and the wonderful care they provide.

| Key questions: | Annual report 2017. Inpatient | Annual report 2017. Outpatient |
|---|---|---|
| **How likely are you to recommend our hospital to friends and family if they need similar care or treatment? Extremely likely/likely** | 98% | 99% |
| **Please give your overall opinion of the quality of your care. Excellent// very good.** | 97% | 97% |

# Plaudits

The Hospital began to record the numerous plaudits received in the form of cards and letters from patients, in January 2018. The average number is 15 per month with some lovely comments showing us that the patients truly appreciate the care they receive.

**"All the kindness and support given has helped me make a good and speedy recovery"**

**"We are so grateful to all of you over T's journey to recovery which we owe to all of you wonderful people"**

# Effective

# Patient reported outcome measures (PROMS)

Patient reported outcome measures (PROMs) assess the quality of care delivered to patients from the patient's perspective. PROMs calculate the health gains after surgical treatment using pre and post-operative surveys. PROMs measure a patient's health status or health-related quality of life at a single point in time and are collected through short, self-completed questionnaires. This health status information is collected from patients through PROMs questionnaires before and after a procedure and it provides an indication of the outcomes or quality of care delivered to patients.

King Edward VII's Hospital values PROMs as a vital way of understanding the importance of integrating patients' perspectives in how we define effectiveness in healthcare and will be including this in future work involving patients

In 2017, we collected PROMs for the following procedures: hip, knee, cataract, hernia, transurethral resection of the prostate (TURP) and septoplasty. PROMs data is sent to the Private Healthcare Information Network (PHIN) who publish the data on their website. We have identified areas for improvement when encouraging patients to engage in this feedback and are reviewing our pathways to see where requests or reminders for completion of PROMS questionnaires can be improved.

# National Clinical audit

Clinical audit involves improving the quality of patient care by looking at current practice and modifying it where necessary.

KEVII participated in the following national audits:

- Intensive Care National Audit & Research Centre (ICNARC) Case Mix Programme
- National Joint Registry (NJR) treatment outcomes for hip and knee replacements
- National Patient Related Outcome Measures (PROMs) programme
- Public Health England (PHE) Surgical Site Infection Surveillance Service

| | **No. of cases submitted 2017-2018** |
|---|---|
| **National Joint Registry** | 364 |

# PLACE audit

The Patient-led Assessment of Care Environment (PLACE) audit is not mandatory for King Edward VII's Hospital as we do not see any NHS patients however, we value the participation from former patients and the feedback we receive in order to help improve the overall environment and service of the hospital. The assessments involve patients and staff considering how the environment supports cleanliness, privacy and dignity for the patient in addition to evaluation of the food and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or staff job performance.

Following the publication of the PLACE audit results we develop/create an action plan to ensure that the necessary improvements are carried out and the full audit cycle completed.

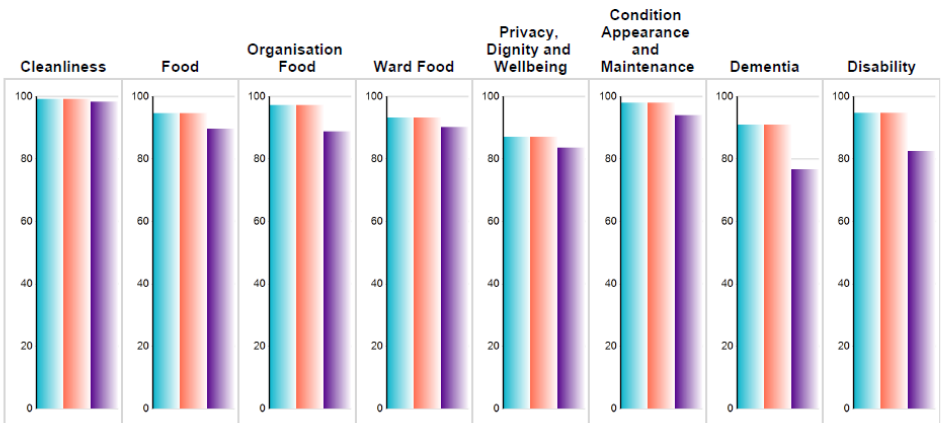
King Edward VII's Hospital scored above the national average in all areas. Areas for improvement could be identified through the 'Privacy, Dignity & Wellbeing' section. The hospital is planning a refurbishment of the main reception and imaging waiting areas in 2018 which will improve this aspect. Two of the points on the action plan were:

- Endoscopy department was not restricted
- Cleaning checklist was not visible in the CCU visitor room toilet.

The Endoscopy department has since been refurbished and access control has been put in place to ensure security and privacy to patients.

Cleaning checklist was created and housekeeping and CCU staff made aware of the list location and arrangements for cleaning.

**KING EDWARD VII'S HOSPITAL SISTER AGNES- Collection: 2017**




| | Cleanliness | Food | Organisation Food | Ward Food | Privacy, Dignity and Wellbeing | Condition Appearance and Maintenance | Dementia | Disability |
|---|---|---|---|---|---|---|---|---|
| Achieved Score (Actual) | 1317.0000 | 320.0249 | 113.3737 | 206.6512 | 108.0000 | 702.0000 | 358.8571 | 305.6134 |
| Available Score (Actual) | 1328.0000 | 338.1846 | 116.5880 | 221.5966 | 124.0000 | 716.0000 | 394.8571 | 322.3697 |
| Site Score | 99.17% | 94.63% | 97.24% | 93.26% | 87.10% | 98.04% | 90.88% | 94.80% |
| Organisation Average | 99.17% | 94.63% | 97.24% | 93.26% | 87.10% | 98.04% | 90.88% | 94.80% |
| National Average | 98.38% | 89.68% | 88.80% | 90.19% | 83.68% | 94.02% | 76.71% | 82.56% |

# Clinical audit

KEVII has a comprehensive annual audit programme in place and ensures all departments (clinical & non-clinical) carry out the required audits on a regular basis. The audit schedule ensures that there is sufficient knowledge of overall hospital audits carried out throughout the year.

Additional audits have been identified and added to the present year's audit programme. Audit results and findings were reviewed at the Audit and Standards Committee, overseen by the Integrated Governance Committee. These committee ensure any actions identified are completed and necessary measures put in place.

# Examples of where improvements have been made as a result of audits

## Nursing Documentation

Documentation is a crucial aspect of nursing care, both to facilitate continuity of care and to form a record of care provided. The documentation audit was commenced to monitor the quality of nursing documentation and to demonstrate compliance with the clinical record keeping policy and NMC policy. Following a review of the results areas of improvement were identified including specific training on completing the Waterlow Score.

## WHO Safe Surgery Checklist

The WHO Safe Surgery Checklist identifies three phases of an operation – "sign in" before the induction of anaesthesia, "time out" before the incision of the skin and "sign out" before the patient leaves the operating room. This audit is focused on ensuring that the checklist is correctly completed to reduce potential risk to the patient.

## Controlled drugs

The CD audit is based against the NICE Guideline "Controlled drugs: safe use and management (NG46)". The guideline covers the systems and processes for using and managing controlled drugs safely. It aims to improve working practices to comply with legislation and to reduce the risks associated with controlled drugs. The audit was carried out quarterly, each time achieving high compliance with an average of 99%. Learning from the audit focused on documentation in the controlled drug log book, staff were reminded the importance of including all details including date and time of administration and any drug wastage.

# Venous thromboembolism (VTE)

KEVII's Hospital is committed to the prevention of VTE by correctly risk assessing and initiating VTE prophylaxis to prevent largely preventable deaths. This audit assesses all patients on admission to identify those who are at increased risk of VTE (Venous Thromboembolism) or DVT (Deep Vein Thrombosis).

The audit is measuring compliance with the NICE guidelines and aims to help healthcare professionals identify people at increased risk of VTE. The audit aims to monitor the use and management of interventions used to reduce the risk of VTE. We have reviewed the audit and created an action plan to be able to put steps in place to ensure risks are lowered and high standards are continually met.

# Mortality

The hospital continually monitors mortality rates and reviews all deaths as per the requirements of the Care Quality Commission. Since January 2018 there has been an established Mortality Review Group led by the Medical Director that oversees all mortalities in the hospital. This group focusses on learning from deaths and ensure required reviews are undertaken at the standards expected. We have also introduced the Structured Judgement Review process in line with the NHS.

We audit the care we provide during the period of end of life to ensure we have the best and most effective care in place for each patient and their families.

In the coming year we will continue to strengthen the end of life and mortality review processes including improving documentation of 'difficult conversations' and timely consideration of resuscitation/ceiling of care decisions.

# Research

The hospital encourages and supports clinical research as an investment in the future of healthcare and to offer the opportunity for patients to be part of research projects. Below are the active research projects which are reviewed and overseen by the Ethics Committee under direction of the Medical Director.

1. Plantaris Release for Non-Insertional Achilles Tendonoplasty. Mr James Calder, Consultant Orthopaedic Surgeon

2. Intensive Care Unit App. Dr John Goldstone, Intensive Care Clinical Lead

3. H1 All Ceramic Hip Resurfacing Arthroplasty. Professor Justin Cobb

4. Phantom Limb Pain: Service Evaluation. Miss Olivia Pounds, Research Assistant

5. Veterans Pain Management Programme. Dr Jannie van der Merwe Consultant

# Key performance indicators

We collect and review data on a number of key areas including Unplanned Return to Theatre cases, Readmission cases within 28 days of surgery, cases of Unexpected Admission to Critical Care Unit, Surgical Site Infection and Mortalities. This data allows the hospital to identify themes and trends and investigate cases to identify any learning and improvement, and the data is also submitted to PHIN as required by healthcare regulations.

To further improve how we can use this data in a more meaningful way in the coming year we will be looking to collect data differently, triangulate this data set with other data sets and attempt to benchmark with similar hospitals to ensure our rates are within acceptable limits.

# Information governance leaflets

The Information Governance toolkit was submitted to NHS Digital in March 2018 and the hospital passed all level 2 (required standard) and some elements at level 3. This was a substantial piece of work that demonstrates the hospital's commitment to protecting data and meeting best practice standards.

Following on from this work the hospital updated its policies, procedures and privacy notice to be in line with the new General Data Protection Regulations.

The hospital has a Data Protection Officer and a Caldicott Guardian

# Responsive

**The hospital is known for being accommodating and responsive to patient's individual needs. We ask for feedback and make changes and improvements as a result.**

**Here are some examples from the year of 'You said, we did'**

| You said | We did |
|---|---|
| **The rooms felt cold** | The estates team went to each room to ensure that the heating was working correctly and to adjust settings where necessary. Hotel services were reminded to include temperature in the admission room checks |
| **Some staff knocked on the door but didn't wait to enter room** | All staff were reminded to wait for response before entering a patient room. |
| **We were not aware we could ask for chaperones** | Chaperone signs were designed and shown in all patient areas. |
| **The Wi-Fi signal was very erratic and poor** | The hospital is investing significant money to improve our Wi-Fi service |
| **The patient bells are very noisy and disturbing** | The Hospital will be installing a new bleep system this year with the ability to change the settings. Once the IT system is in place we can switch the bells to not audible to the patients and the call goes direct to a nurses' pager |
| **We don't know when staff finish their shift and feel lost when new staff start.** | We have included shift change times to our patient information booklet. We reiterated to staff the importance of communication with the patient so that they know what to expect. Staff have been reminded to see their patient at the beginning of each shift to introduce themselves. |
| **The Breast clinic should not be in both buildings** | The Breast Clinic was moved and is now all on one floor. |
| **We couldn't read the patient information – the print was so small** | Large, big print and screen reader versions are now available |
| **I couldn't get a real coffee** | Coffee machines have been ordered for patient areas |

# Complaints

The hospital is very proactive in meeting patients' needs and dealing with issues and concerns raised in a timely and effective manner. The hospital welcomes feedback of all types as a valuable way to knowing about issues and identifying areas for improvement. In January 2018 the complaints process was further strengthened by the introduction of a new complaints leaflet and all formal complaints being logged into a central reporting system to allow reports, trends and themes to be identified.

There were 7 formal complaints received in 2017/18, 6 were upheld and 1 was not upheld. All complaints were resolved at stage 1 except 1 which went to stage 2 and is ongoing in the current year. There were no themes identified in the complaints and where a

complaint was upheld the learning and improvements identified were actioned.

Complaint summary and responses, including learning, is shared via the Governance newsletter to staff and at governance meetings.

## Cinical coding

As part of Monmouth Partners contract with the hospital, they perform quality assurance checks on the completed clinical coding against national standards. The quality assurance cycle aims to assure that the quality of the clinical coding is in line with Information Governance Toolkit level two.

In the February 2018 audit the summary report concluded the coding well exceeded the required level of accuracy i.e. IG tool kit level two in all areas.

# Well led

# Staff survey

In November 2017, a pulse staff survey was conducted across the Hospital and its purpose was to gauge the overall level of staff engagement. Highlights from the results showed that staff are proud to work for King Edward VII's Hospital, that they feel they are given useful feedback about their performance by their manager and that their manager listens to their work-related concerns.

The survey also identified areas for opportunity and commitment to improve on said areas was facilitated by departmental engagement action plans. We are focused on increasing engagement through communication and are doing so by ensuring important messages and business updates are shared from top down through different mediums such as team meetings, staff newsletters and 1:1 conversations with team members.

# Leadership programme and staff development

In 2017 the Hospital commenced leadership management training for employees in managerial or supervisory positions. This was run by an external training provider and eight sessions were held in this period. Feedback received from attendees showed that employees found the sessions to be extremely interactive and beneficial in developing their own leadership skills and behaviour in managing people and change. This training programme will be introduced again into the next period.

# Innovation and development

The Sensium™ Wireless Monitoring System was introduced in 2017 as an exciting cutting edge innovation. It is used by health care professionals for routine surveillance of patient physiological parameters in a healthcare setting with data transmitted wirelessly to a central location. Alerts are set on an individual patient basis to inform healthcare professionals when vital sign readings are measured outside of preset limits.

The surgical group of patients includes patients who undergo orthopedic surgery, colorectal surgery and breast surgery. By patching this group of patients, the Sensium patch will help with early identification of post-surgical complications such as sepsis, opioid induced respiratory depression and surgical AF.

This system has enabled our ability to monitor in real time the patient's condition, whether medication is working and gives extra reassurance to patients that they are being closely monitored. Patients who are transferred from CCU to the wards are also using the Sensium patch adding additional reassurance to the patient and nurse of continuous monitoring during the step down period.

## The joint advisory group (JAG) on gastrointestinal endoscopy

This scheme sets acceptable standards for endoscopy units, quality assures endoscopy training and quality assures endoscopy services. The hospital commenced an endoscopy service in 2017 and is now working toward this accreditation as its commitment to high quality endoscopy services.

## Consultant credentialling

Since the latter part of 2017 there have been improvements in the credentialing process and an increase in the amount of compliant consultants. A new full time Consultant Credentialing Coordinator has been employed to request, monitor and update compliance documentation as well as improve the quality of the consultant data stored. There will also be a new Customer Relationship Management System (CRM) introduced in the summer of 2018 which has been purpose built to help maintain a more accurate record of required compliance documentation. This system will be developed over the year to improve the way we credential and store information as well as being able to report on consultant numbers and activity.

## National Institute Clinical Excellence (NICE) guidelines

In February 2018 the hospital embarked on a comprehensive review and update of all clinical policies and procedures to demonstrate how we meet and adhere to national standards of NICE guidance. This work is invaluable to be able to more clearly evidence the best practice standards that our staff deliver on a daily basis. This work is monitored via the governance meetings.

## CQC inspection, regulation and action plan

The Care Quality Commission inspected the hospital in February 2017 and published their report in August 2017. The hospital welcomed the feedback and was please the caring, effectiveness and responsiveness was considered to be 'good'. We also saw this as an opportunity to grow and improve particularly in relation to the 'well-led' domain and 'safe' domain which overall gave us a 'requires improvement' outcome. We have been swift to address the issues pointed out as requiring improvement by the regulators and have made substantial changes in governance and leadership in particular that have benefitted staff, consultants and most importantly, the patients.

Below is a summary of the actions taken on our improvement journey:

- Established a substantive Governance Team led by the new Director of Governance and including Patient Safety and Risk Lead, Audit and Compliance Lead and Consultant Credentialing Co-ordinator.

- Restructured our committee framework to establish a 'ward to board' governance structure
- Updated the Risk Register to enable it to be a meaningful management of risk process
- Introduced new ways of sharing learning and improvements from incidents and complaints including a newsletter and all staff forum
- Ensured our open incidents are reviewed, investigated and closed in a timely way
- Significantly improved our consultant credentialing system with a new CRM being implemented in the summer of 2018
- Reviewed and updated the clinical audit program
- Purchased an additional airway trolley as per requirements
- Introduced training and revised care pathway for patients at the end of their lives
- Introduced a new learning disabilities link nurse with training for staff and revised policy
- Developed a strategy for CCU
- Introduced a nurse rotation to NHS ICU to enable skills to be shared and updated
- Changed processes in outpatients to ensure consultants share their consultation summary records with the hospital

In November 2017 the hospital invited an external company to provide a gap analysis targeting a review of the areas identified in the CQC report as requiring improvement. The gap analysis identified that there had been considerable progress in updating process and implementing robust systems within the hospital to enable the organisation to ensure more emphasis is being placed on governance and leadership.

The action plan has been overseen by the Executive Committee and Board of Trustees.

The hospital intends to complete the action plan based on the outcome of the CQC inspection report in summer 2018, then work on a system of continual improvement in line with the 5 CQC domains.

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