KING EDWARD VII's HOSPITAL

Quality Accounts 2018/19

Introduction

King Edward VII's Hospital is an independent private Hospital that provides acute care and supports veterans through its charitable work. King Edward VII's Hospital is governed by Royal Charter and regulated by both the Care Quality Commission (CQC) and Charity Commission.

The Hospital was established in 1899 by Sister Agnes Keyser to treat sick and wounded officers returning from the Second Boer War. His Majesty King Edward VII became the Hospital's first Patron, and in 1930 was incorporated by Royal Charter to operate as an acute Hospital. In 1962, the Hospital became a registered charity (number: 208944).

The Hospital has 56 in-patient beds, a four bed Critical Care Unit that can provide care for level 1, 2, and 3 patients, three operating theatres, an endoscopy suite, 18 outpatient consultation rooms, an ophthalmic diagnostic suite, imaging department including MRI and CT, a dedicated breast care service, physiotherapy and hydrotherapy, an in-house pharmacy and a Centre for Veterans' Health.

VISION, VALUES AND STRATEGY

Our strategy and business plan outline our objectives in order to provide the best possible care and provide the highest quality services for our patient groups and regulated activities.

We are an expanding Hospital with growth and development in many areas including significant building projects and commercial growth. Charity remains at the heart of the Hospital and the significant fundraising has enabled the established services for veterans' health to be further expanded, with objectives to increase this work in the coming year.

We recognise that in great healthcare services have to continually review change to better meet the needs of the patient; our services are being realigned to enable clearer patient pathways, expanding existing services and retain and attract the best consultants to work with us. This will further enhance the already well established personalised patient care we provide for our patients today.

Underpinning all development and provision is the commitment to good governance, the safest care and a culture of continual improvement. Our objective is to ensure that whilst services develop, quality and patient safety remain central to every decision with effective scrutiny, measurement and accountability.

The Hospital vision is:

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

Our mission statement is:

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

Our Values are:

Professionalism	**Do your job well and to the best of your ability and training.**
Quality	**To provide excellent care in order to achieve 100% customer satisfaction.**
Respect	**To respect one another's views and maintain a culture of openness, honesty and fairness.**
Safety	**To ensure that safety is the number one priority at all times.**
Teamwork	**Team unity and good communication is essential to achieve Professionalism, Quality, Respect, Safety.**

QUALITY STRATEGIC OBJECTIVES

- Be recognised by the CQC as providing Outstanding care across all domains and services by the next inspection.
- Become renowned for providing outstanding patient centered care in musculoskeletal, women's health, men's health and later life care, underpinned by leading clinical services and wellness and wellbeing initiatives.
- 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 continue 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.

CEO statement

This year has been a period of significant growth and change for the Hospital which has brought challenges and opportunities. Our CQC regulatory inspection in December 2018 provided a focus for the whole organisation to review, reflect and improve in a structured and sustained way. The report, published in March 2019, rated the hospital to be 'Good' demonstrating the progress made in all areas of the Hospital and I am very proud of the teams for being so responsive and committed to demonstrating the high quality and safe care provided here.

The Hospital provides an excellent patient experience with attention to detail that sets us apart from other providers. Our values provide a strong foundation for our success and this has enabled not only a safe and quality organisation but an innovative and commercially mature one, where we attract the best consultants and support cutting edge medical developments to our patient's advantage. We have continued with our substantial projects to support the development of our care and services, with the Kantor Medical Centre Outpatient and Diagnostics facility due to open in 2020 and the re-development of our main Hospital reception that warmly welcomes our patients and visitors.

Our work at the Hospital includes our charity, based in the Centre For Veterans' Health whose Pain Management Programme for veterans was noted as outstanding practice by the CQC. This Programme has helped over 170 veterans during the last 3 years and makes a profound impact on their daily lives. Within the main Hospital our Breast Service Team were also noted as providing an outstanding service, demonstrating the truly patient centred, compassionate and highest quality care patients need at a crucial time in their lives.

A predominately new executive team has brought a fresh leadership approach, enabling a balance of tradition and forward thinking as we move into the next year. This year's Quality Accounts provide evidence of our great care and achievements as well as demonstrating we are an adaptable, responsive and modern healthcare organisation.

Lindsey Condron

Lindsey Condron
Chief Executive

Executive team

Ms. Lindsey Condron
Chief Executive Officer

Professor Justin Vale
Medical Director

Dr. Jenny Davidson
Director of Governance

Ms. Tonya Kloppers
Director of Nursing/ Matron

Ms. Kate Farrow
Director of Operations

Mr. Mike Lord
Commercial Director

Mr. Tim Brawn
Director of Fundraising and Veterans' Health

Mr. Rod Morgan
Interim Finance Director

Ms. Becky Hine
HR and Learning & Development Director

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Quality Achievements in 2018/19

This year the Hospital has implemented robust quality improvement methodology and employed an experienced Quality Lead to continually drive improvements to care and services. We are committed to being an open and listening organisation that places quality and safety at the heart of what we do, always striving for better and wanting the very best for all of our patients.

The Quality Improvement priorities developed in March 2018 have been very successfully achieved, with good progress in all areas and most of this work continues into the current year.

1. Falls prevention and reduction

In March 2018, we aimed 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%) within a year. Whilst our falls rate has always been low compared to national levels[1] we wanted to make every effort to reduce the risk of any patient falling in our Hospital. We implemented our Quality Improvement Falls Prevention program in January 2018, led by a dedicated Falls Lead. Using a referenced improvement methodology, the programme collected and analysed data to identify themes and trends and implement measurable cycles of improvement.

The programme included enhanced investigation into all falls and near misses to identify key elements, a bespoke falls training course for all clinical staff, a falls safety awareness week improvements to the falls risk assessment process and bed rail assessment form, a review and updating of falls equipment, the development of a falls prevention leaflet for patients, implementing ‘call don’t fall’ signs in patients rooms and the introduction of falls safety crosses in ward areas and a falls safety newsletter for staff.

With this program we reduced the falls rate to **1.74 per 1000** occupied bed days which is a **40% reduction** (March 2019 data), successfully achieving this priority.

[1] Nationally there is an Acute Hospital Patient Falls rate of 6.1 per 1000 occupied bed days (NHSI, 2017)

2. Involving patients in care and services review and development

In March 2018, we aimed to involve patients in care and services in a more meaningful and influential way. The Hospital had always established loyal relationships with our patients and in this way have a continual dialogue and feedback. However, we planned 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 also planned to review and improve the collection of Patient Reported Outcome Measures[2] (PROMs).

In 2018 we set up a Patient Focus Group which meets quarterly to provide insight and feedback from the perspective of patients and their carers; contributing to the development of services, plans and policies that affect these service users. This group is co-chaired by a patient and currently has nine members and is well attended. The group has participated in lively discussion with staff around different topics including the introduction of new menu items, information leaflets, outpatient services and digital pre-operative assessment to name a few. Members of the group also sit on the Integrated Governance Committee, Acute Pain Committee, Patient Experience Committee, Property and Projects Committee and a Discharge working group.

In 2018 we gathered feedback about the patient experience of their care by providing our patients with a survey (paper or online) and the Doctify[3] app which asks them about their Hospital experience. This patient feedback, as well as complaints and comments, is reviewed every month at the Patient Experience Committee and actions are taken to respond and improve where required. Summary patient feedback themes and trends are also reported quarterly to the Board of Trustees Meeting.

In 2019 we reviewed the process for collection of Patient Reported Outcome Measures (PROMs) and have implemented an electronic option for patients to report and expanded the number of procedures where we ask for this type of feedback from patients.

These measures have **significantly improved patients engagement**, with valuable involvement of patients in many areas of the Hospital development, successfully achieving this priority. The work with PROMS continues in 2019/20.

[2] Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to patients from the patient perspective. 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 before and after a procedure and provides an indication of the outcomes or quality of care delivered to patients.

[3] https://www.doctify.co.uk Doctify enables patients to search, book and review medical specialists online

3. Dementia care

In March 2018, we aimed to introduce the 'Butterfly Scheme' across the Hospital, improving staff knowledge, the environment, resources and care pathways for those patients with dementia. This programme includes training for all staff, care pathways and environment review and updating. The Butterfly Scheme allows people whose memory is permanently affected by dementia to discreetly make this known to Hospital staff and provides a simple, practical care approach for meeting their needs. The patients receive more effective and appropriate care, reducing their stress levels and increasing their safety and well-being. By year end, all staff in the Hospital have received certified training in dementia care and will continue to do so through induction.

The Hospital put in place butterfly magnets and stickers to allow staff to identify those with memory loss allowing us to provide individualised care. We produced an information leaflet for patients and carers as well as the '*This is me*' booklet which allows carers to inform clinical, catering and housekeeping staff about the day to day individual needs of the person living with dementia.

A Care Pathway for patients with memory loss was developed and implemented in May 2018.The pathway commences at pre-operative assessment and follows the patient though their journey sign posting the necessary steps to optimism the patients' care.

An environmental audit was carried out in September 2018 and following this the Hospital made some changes to support people living with dementia while they are in Hospital. This included dementia clocks in waiting areas and patient rooms, improved signage including icons, a photographic menu and red crockery. In April 2019 ,we became the first private Hospital to sign the Dementia Friendly Hospital Charter through the National Dementia Action Alliance. The Charter sets standards of care that are expected to improve the experience of people living with dementia and their carers when they visit Hospital. The Hospital has held a number of events to raise awareness of people living with dementia, including Dementia Awareness Week, educational posters, social media links and talks for staff.

These measures have **significantly improved the care we provide** to people living with dementia/ memory loss when they are admitted to Hospital, ensuring that care is aligned with the preferences and needs of people living with dementia.

4. Sign up to Safety programme

In March 2018, we planned to introduce a Patient Safety programme for all staff who work in the Hospital and our consultant users. The programme was designed introduce concepts of error, human factors, system failures, just culture, safety huddles and improvement cycles to ensure there is a system-wide approach to patient safety using evidence based methodology. We aimed to have half of our staff having completed the first stage of the programme by March 2019, with an associated positive trend in the patient safety culture survey results following introduction of the programme.

In the summer 2018, we signed up to the NHS led Sign Up To Safety Campaign[4] and, led by the Patient Safety and Risk Lead, we launched a number of initiatives pledging that we will:

a. Put safety first
b. Continually learn
c. Be honest
d. Be collaborative
e. Be supportive

We undertook a baseline staff Patient Safety Culture Survey to identify areas of strength and where we could do better. In addition we launched a staff and consultant governance leaflet which included a section on 'everyone's role in patient safety'. This outlined how we were empowering team leaders to investigate and take ownership of incidents and safety in their own areas, share learning from incidents through a monthly newsletter and all for clinical staff attended an update on patient safety and a safe, learning culture. A new consultant communication briefing was introduced which includes shared learning and updates on safety issues. Quality Improvement methodology was introduced, facilitated by the Quality Lead to ensure continual improvement occurs in all areas of the Hospital. We also recruited a staff member to be our 'Freedom to Speak up' Guardian[5] in November 2018.

In 2019, we have launched human factors training for all staff and in the summer 2019 we will repeat the Patient Safety culture survey to assess the impact of the campaign.

This initiative has created **better understanding and awareness** of patient safety and all clinical staff have attended the update training session, fully meeting this priority.

[4] https://www.signuptosafety.org.uk Sign up to Safety is a national patient safety campaign announced by the Secretary of State for Health. It launched on 24 June 2014, with the aspiration to bring organisations together behind a common purpose; to create the conditions for making care safer.

[5] https://www.cqc.org.uk/national-guardians-office/content/national-guardians-office

5. Patient Outcomes

In March 2018, we planned to improve our scope and breadth of outcomes measures in 2019. To meet the requirements of being open and transparent, we planned to extract and use meaningful data on which to inform and assure ourselves, our consultants and our patients. We aimed to be able to provide broader and more specific outcome measures, trends and themes by March 2019.

In 2018 we engaged CRAB c-ci Clinical Informatics[6] who undertook a clinically risk-adjusted analysis of our data. Using a reputable methodology CRAB compared the observed mortality/ morbidity with that predicted from exponential mathematical models derived from POSSUM variable. In addition CRAB is the only system to routinely examine all aspects of complications which are identified from HES codes relationships and complex HES and process of episodes of care algorithms.

The headline findings from this review are very positive and reassuring:

1. Risk adjusted mortality for King Edward VII's Hospital overall was well below expected for patient case mix complexity at O/E rate of 0.27, which is excellent. Furthermore, no surgical speciality with significant inpatient volumes had an O/E ratio for mortality above 1.
2. Risk adjusted observed complications ratio for the Hospital overall was low at 2.5% and had an overall complication O/E of 1.00 (i.e. as expected for case mix complexity of patients treated)
3. Low readmission rates across all specialties suggest that ward based care was better than national averages

In 2019 will continue to work with CRAB on regular data analysis of our outcomes enabling us to identify trends, outlying performance where applicable and any areas of practice that merit further review. It also adds to our ongoing assurance of the highest quality and safety standards achieved in this organisation.

This review has provided **assurance of the quality of our care and treatment** in terms of patient outcomes, fully meeting this priority.

[6] http://www.c-ci.co.uk Copeland's Risk Adjusted Barometer (CRAB)

Quality Improvement Priorities for 2019/20

1. Pain Management of Post-Operative patients

This coming year we aim to improve the management of acute post-operative pain for patients. With most of our patients having surgical procedures it is essential that pain management is effective to aid recovery and ensure a good patient experience. Our patient survey has identified that this is an area we can improve with deficits noted in patient education, assessment and management. Through the multidisciplinary Pain Management Group that was established in 2018, data will be identified and analysed including pain scores, patient feedback, and pain related medicines management to ensure we have optimal pain management in place.

We will measure improvements in this area through patient feedback via our satisfaction survey, and regular auditing of pain scores and analgesia prescribing.

This priority will be monitored through the Pain Management Group and will be led by the Medical Director

2. Patient information

Ensuring patients have sufficient up to date and appropriate information on which to base their decisions, understand their patient journey and be signposted on to other information is vital. Last year there was an identified trend in patient feedback and complaints identifying that we can provide better and more information in some areas of the Hospital.

Developments will include a review of patient information within the Hospital and the information provided by consultants, the implementation of a pre-assessment tool including access to patient information, increasing follow up calls post discharge and the development of clearer information about costs of care and treatments

We will measure improvements in this area through a complete patient information review, reduction in the number of complaints relating to this area, improvements in patient feedback, successful implementation of a pre-assessment tool with pre-operative patient information.

This priority will be monitored through the Patient Experience Committee and will be led by The Director of Governance

3. Learning disability awareness

Building on the excellent work led by our Learning Disability link nurse in 2018, we will be focusing on actions and improvements to deliver the outcomes that people with learning disabilities, autism and their families expect and deserve. Developments will be concentrate on the NHS improvement standards, which include: respecting and protecting rights, inclusion and engagement, workforce capability and capacity. Our proposal will include staff training sessions, establishing Learning Disability champions, Learning Disability resources, accessible information, environmental audit and launching awareness days.

We will measure improvements through patient feedback, family and carer feedback, the PLACE[7] audit and staff knowledge assessments.

This priority will be monitored through the Patients' with Additional Support Needs Group (PASN) and will led by the Director of Nursing

4. Staff Wellbeing and Mental Health

Growing a safe and positive culture relies on a happy and healthy workforce and a strong team approach to care. Through supporting our staff and encouraging them to pay attention to how they talk to each other and patients, the excellence in care that surrounds them every day and the importance of kindness, respect and humility are all key ingredients. This priority will focus on a number of proactive projects to ensure staff wellbeing including:

- A re-launch of the Employee Assistance Programme by the end of August 2019
- Completion of the annual Employee Opinion Survey by the end of September 2019
- Recruitment of a Lead Freedom to Speak Up Guardian
- Continued encouragement of staff to talk to each other about concerns they have for their well-being, ensure posters promoting this are displayed clearly in all staff areas
- Review a possible App service accessible for all employees to register their well-being and have access to tools to support areas of concern.

We will measure the success of this priority through the staff survey, staff sickness rates and through information facilitated by the Lead Freedom to Speak up Guardian, yet to be identified.

This priority will be monitored through the sickness absence tracking and EAP report activity[8]

[7] http://www.c-ci.co.uk Copeland's Risk Adjusted Barometer (CRAB)

[8] Although anonymous; the reports can identify areas as to why staff call the help-line and then a more targeted approach to communication on available resources can be implemented and will be led by The Director of Human Resources

5. Nutrition improvement

Good nutrition helps patients prepare for and recover from surgery, and it also helps keep our staff well and fit for work. We have chosen this priority as we have an outstanding catering team led by a highly experienced chef, keen to improve and respond to individual patient needs. We also work with a number of senior dieticians that have different areas of expertise e.g sports nutrition, allergies or malnutrition in the elderly to ensure the best outcomes for different groups.

We will review our patient assessments, patient education and menus providing fresh innovative options and information whilst taking into consideration the guidance provided by the Malnutrition Task Force and the Small Appetite Campaign. We will evaluate the support we provide for patients and carers around eating and drinking at the end of life, and the standards of the IDDSI[9]. Staff and patients have commented that they would like a greater choice of vegetarian and vegan options for health, religious or ethical reasons and we will have selected nutrition as one of our priorities for the year ahead.

This priority will be monitored through the Operations Meeting and will be led by The Director of Operations

[9] International Dysphagia Diet Standardisation Initiative.

Our regulation and the Care Quality Commission

We are regulated by the Care Quality Commission (CQC), the independent regulator of health and social care in England. The aim of the CQC is to make sure health and social care services provide people with safe, effective, responsive and caring services which are well led.

The CQC monitor, inspect and regulate our Hospital to make sure we meet the standards of quality and safety. Our last inspection was in December 2018 and they rated the Hospital as 'Good', a credible reflection of the substantial improvements to governance, assurance and leadership that was implemented in the previous 12 months. Notably, the Veterans Heath Pain Management programme and the Breast Care Service were both considered an outstanding practice by the CQC inspectors.

The full report can be downloaded from the CQC website; https://www.cqc.org.uk/location/1-114202635

Our last inspection was in December 2018 and they rated the Hospital as 'Good', a credible reflection of the substantial improvements to governance, assurance and leadership that was implemented in the previous 12 months.

The highlights from the report were:

The following services were noted as being outstanding by the regulators; The Centre for Veterans' Health, which provides a tailored Pain Management Programme for veterans and The Breast unit which was described as being "designed and organised around patients' individual needs, taking emotional effects into consideration and valuing patients' time. It was well managed and staff were enthusiastic and compassionate.

"Overall the Hospital had improved the systems in place for reporting, investigating and learning from incidents.

The Hospital used current evidence-based guidance and quality standards to plan the delivery of care and treatment to patients. There were effective processes and systems in place to ensure guidelines and policies were updated and reflected national guidance and improvement in practice.

Staff treated patients and their families with compassion and care to meet their holistic needs.

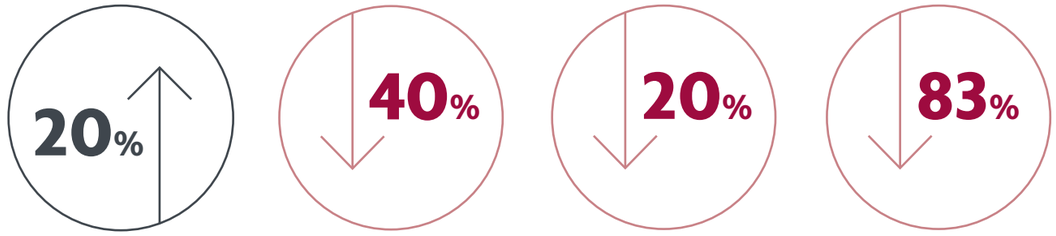
The Hospital planned, developed and provided services in a way that met and supported the needs of the population that accessed the service, including those with complex or additional needs.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Managers had implemented systems to strengthen governance, performance and risk management arrangements across the Hospital since the last inspection.

Managers across the services promoted a positive culture that supported and valued staff. The majority of staff felt listened to and well supported by managers and colleagues and were confident to raise any concerns they had."

Safe



Staff have been very engaged in reporting more incidents[10] so we can have a better understanding of the issues and ensure we can learn and improve in a meaningful way. We have been pleased to continue to see an increase in the number of reported incidents, by 20% in the last 12 months, as an indicator of a safe culture. The Governance Team have promoted a 'Just Culture' message, with focus on learning through error within an open and transparent process.

Clinical Incidents

Following extensive quality improvement work by the Falls Lead, there was a significant 40% reduction in patient falls improving our already low patient falls rate. Medication incidents have decreased by 20% and our in house Pharmacy team have been responsive to patient needs by producing information leaflets on medication side effects and a guideline on Insomnia management for patients that led to a reduction in the prescription of night sedation.

Health and Safety/Staff incidents

Staff have been encouraged to report any injuries they sustain at work which has enabled the organisation to have a better understanding of the volume and type of injuries sustained and take preventative actions. There were two RIDDOR incidents reported to the Health and Safety Executive in 2018/19. We now have an in-house physiotherapist who looks at manual handling incidents and takes lessons learned to the mandatory training sessions.

Trends from incidents and complaints are reflected in our departmental and organisational risk registers where controls and actions are implemented and monitored from ward to board. Learning from incidents and complaints is shared in regular governance meetings and newsletters throughout the hospital.

[10] Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare (NHS Improvement, 2019)

The hospital also captures, reviews and submits Key Performance Indicators (KPI) required by Private Healthcare Information Network (PHIN). The number of Key Performance Indicators (KPI)[11] reported for the period covering 2018 to 2019 has remained the same in overall volume. All KPIs are reviewed by a KPI group chaired by the Medical Director. The Clinical Nurse Specialists are involved in reviewing cases, and are also carrying out post discharge follow up phone calls so that any post op issues are captured promptly.

There have been six expected in hospital deaths during this period; all of these cases are discussed at the Mortality Review Group, chaired by the Medical Director, and there is a process in place for a Structured Judgement[12] Review to be undertaken where required.

Pressure Ulcers

There has been a reduction in the number of reported pressure ulcer acquired at KEVII in 2018/19 compared to the same period in 2017/18. Our highly experienced Tissue Viability Nurse has established and developed high standards of evidenced based clinical patient centred service in the last two years.

Staff are aware that a Safeguarding Decision tool must be completed for patients admitted with any pressure ulcers of concern. The 'STOP the pressure' campaign was launched with the Tissue Viability Nurse to increase healthcare professional awareness about the damaging impact of pressure ulcers and a new risk assessment was put in place. Regular audits show excellent compliance with care standards which is confirmed with the significant reduction in Hospital acquired pressure ulcers.

Infection control

King Edward VII's Hospital is committed to ensuring the promotion of high standards of infection control policies and procedures to maintain patient safety. 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 practices 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.

[11] KPI were previously set by the CQC for regular submission and include: mortality serious injury, return to theatre, unplanned transfer, readmissions, infection control surveillance.

[12] Structured Judgement Review is a method developed by the Royal College of Physicians commissioned by the Health Quality Improvement Partnership (HQIP) to introduce a standardised methodology for reviewing case records of adult patients who die in Hospital.

Healthcare Acquired Infections

The number of infections remain reassuring low at the hospital. Continuous monitoring and surveillance of Surgical Sites Infections (SSI) is carried out with added patient education to improve patient outcomes and ensure patient safety. Bi-annual environmental audits are carried out in all patient centred areas of the Hospital by the Microbiologist and Infection Prevention and Control Nurse to ensure consistency in practices and patient safety needs are met. The Infection Prevention and Control (IPC) Committee meets quarterly and minutes are circulated to all staff via the Link Nurses or Heads of Departments. The IPC Committee meeting also provides an assurance report to the Integrated Governance Committee, a sub-Board committee. Hand hygiene Audits, peripheral line insertion/care audits, urinary catheter insertion/ care audits and antibiotic audits are carried out quarterly or bi-annual so as to identify areas for improvement. Overall the audits show good compliance with standards and there are high assurance levels with the monitoring and measures we undertake.

Safeguarding

This means protecting a person's right to live in safety, free from abuse and neglect. One of the most important principles of safeguarding is that it is everyone's responsibility and the Hospital follows the guidance of the Royal College of Nursing (RCN) intercollegiate document to ensure all staff in the Hospital has appropriate training. This intercollegiate document has been designed to guide professionals and the teams they work with to identify the competencies they need in order to support individuals to receive personalised and culturally sensitive safeguarding. All our staff receive safeguarding training appropriate to their role.

The Director of Nursing/ Matron is the Safeguarding Lead for the Hospital for adults and children. Posters displayed in all areas of the Hospital inform staff and patient how to report safeguarding concerns and there is a safeguarding policy for both adults and children.

In the period being reported there has been one reportable safeguarding concerns and this was escalated appropriately. All safeguarding issues are reported and discussed at a monthly Clinical Services meeting.

Effective

National 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
- Patient Led Assessment of the Care Environment (PLACE)
- National Audits and National Confidential Enquiries[13] (NCEPOD)
- Public Health England (PHE) Surgical Site Infection Surveillance Service
- Public Health England (PHE) Alert Organism

We continue to contribute to the NJR database. THE NJR audit aims to highlight the number of revision surgeries and mortalities related to the initial surgery. The data published is reviewed at our Audit & Standards Committee and our aims for the following year to improve the quality of healthcare provided are to continue to participate in the registry and monitor the performance of joint replacement implants and the effectiveness of different types of surgery, improving clinical standards; benefiting patients and clinicians.

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.

Our PROMs data is sent to the Private Healthcare Information Network (PHIN) who publish the data on their website. In order to ensure that we are able to achieve a high level of engagement from patients and consultants the hospital undertook an extensive review of the whole PROMs process this year. We have reviewed the PROMs provider and made specific updates with the quality reports to enable us to be able to use the data to highlight our strengths and any weakness to help us improve our service. In addition, we have added a number of QPROMs to our current list which will help in reviewing outcomes from the cosmetic procedures carried out.

PLACE Audit

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

Following the publication of the PLACE audit results, we develop an action plan to enable us to address any issues identified and to continue to provide continuous improvement in our patient environment. At this point the full audit cycle is completed.

[13] Note; due to low numbers and set entry requirements we were not eligible to participate in the current NCEPOD enquiries this year.

King Edward VII's Hospital scored above the national average in all areas of the audit for the second year running, which was very positive. An area highlighted as requiring improvement was the appearance of the main reception and waiting areas.

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The refurbishment work to upgrade the main reception and ground floor hallways was completed in March 2019 and has significantly improved the look and feel of the Hospital and the patient experience as they enter the Hospital. Part of the refurbishment included installing a hydraulic ramp to ease accessibility for patients requiring wheelchair access.

Another aspect identified as requiring improvement was the lack of clear signage for the Outpatients Department at Emmanuel Kaye House. This has been addressed by the purchase of new signage to help patients orientate themselves around the Hospital buildings.

The annual waste management audit was carried out in October 2018 by an external company, and new measures were put in place to ensure compliance with current legislation; to date the Hospital has achieved a high 92% compliance and we continue to work on increasing standards.

Clinical Audit

King Edward VII's Hospital has a comprehensive annual audit programme in place and ensures all departments (clinical and non-clinical) carry out the required audits on a regular basis. The hosptial recognises that clinical audit is a key element for developing and maintaining high quality patient centred services. The audit schedule ensures that there is sufficient knowledge of overall Hospital audits carried out throughout the year. For the year 2018/19 a total of 89 local audits were registered.

The hosptial recognises that clinical audit is a key element for developing and maintaining high quality patient centred services.

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 (if required) to ensure that we provide safer and more effective care.

We recognise that there are two areas of improvements for our audits – these are to increase overall awareness of audits throughout departments and to improve on the quality of the actions 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 National Medical Council (NMC) Good Record Keeping Guidelines. We found the use of unapproved abbreviations needed addressing so now include this in our annual clinical update training; we have reviewed and updated the documentation policy and displayed the list of approved abbreviations at our nursing stations. We also identified that the signature list was not always being completed; the Hospital is planning on moving towards electronic patient record system which will remove this issue. Overall compliance for the year was 89%, a good improvement from the previous year (80%).

Bare Below the Elbows

In January 2018 an audit of compliance with showing 83%, we introduced a monthly audit to check staff and consultants throughout the Hospital. Having rolled out a cultural change programme to empower staff to challenge any non-compliance, increased signage to highlight the need for bare below the elbows and changed the porters and ward clerks uniform to short sleeves we achieved 100% compliance for six consecutive months.

Accreditation and assurance schemes

IRMER (Ionising Radiation Medical Exposure Regulations)
IR(ME)R 2017 Compliance is reviewed annually by the Radiation Protection Adviser (RPA)/Medical Physics Expert (MPE), who reports his findings to the Radiology Manager and Hospital Director. We follow best practice guidelines and carry out investigations of incidents and carried out regular clinical audit to ensure ongoing compliance with IRMER requirements and to continually improve the experience of the patient.

HFEA (Human Fertilisation and Embryology Authority)
The HFEA is the UK's independent regulator of fertility treatment. Our Poundbury Suite is a satellite site of The Lister Fertility Clinic which is accredited by the HFEA.

JAG (Joint Advisory Group)
The JAG accreditation scheme is a patient-centred and workforce-focused scheme based on the principle of independent assessment against recognised standards. The scheme was developed for all endoscopy services and providers across the UK in the NHS and independent sector.

We are the only private Endometriosis Centre in London to be accredited by the British Society for Gynaecological Endoscopy (BSGE).

The Hospital embarked on JAG accreditation in 2018. The fourth, six monthly Global Rating Scale (GRS) submissions was completed at the end of April 2019. We can apply for the Accreditation Audit visit from JAG which can occur 6 months after the submission (October 2019 onwards). The majority of the actions arising from the previous GRS submission have now been completed and there is an ongoing live action plan in place.

BSGE Endometriosis Centre

Gynaecology services at King Edward VII's Hospital are part of the King Edward VII's Women's Health Centre of Excellence. We are the only private Endometriosis Centre in London to be accredited by the British Society for Gynaecological Endoscopy (BSGE). In order to achieve this accreditation our gynaecologists work in appropriate clinical teams, audit their outcomes and have sufficient workload to maintain their surgical skills. Our team of highly skilled clinicians understand patient needs and treat every aspect of the condition. They operate in state-of-the-art operating facilities to enable the highest level of care.

The Hospital's leading authority on the condition, Mr Alfred Cutner, led the NICE guidelines on treating endometriosis in 2017. Mr Cutner is also the Chair of our Medical Advisory Committee and the Clinical Lead for Women's Services at the Hospital.

Mortality

In addition to the Clinical outcome audit that was undertaken by CRAB ci-ci in Autumn 2019 referenced on page 9, the hospital reviews all in hospital deaths in line with national standards. The Mortality Review group, chaired by the Medical Director, also directs Structured Judgement reviews to be undertaken of cases where required. This is also in line with best practice.

Risk adjusted mortality for King Edward VII's Hospital overall is well below other comparable hospitals with similar patient groups and procedures being undertaken. Our patients excellent survival rates are a testament to the quality of care, consultants and overall service provided.

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. Our Critical Care Unit Fellows who provide senior medical staff presence at all times on the Critical Care Unit are active researchers and contribute to the educational and learning culture of the organisation. In the coming year the Hospital intends to encourage and support more research activity and will implement a revised Research Committee to facilitate this function.

Below are the active research projects which are overseen by the Medical Director.

- **H1 All Ceramic Hip Resurfacing Arthroplasty** *Professor Justin Cobb*
- **Phantom Limb Pain: Service Evaluation** *Miss Olivia Pounds, Research Assistant*
- **Veterans Pain Management Programme** *Dr Jannie van der Merwe Consultant Clinical & Health*

Data security & protection toolkit

The Data Security and Protection Toolkit (https://www.dsptoolkit.nhs.uk) is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.

All organisations that have access to patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

The Hospital fully participates and submitted our annul data on 29th March 2019. The complete set of 40 Mandatory Standards (consisting of 100 assertions) were "Met", meaning we are fully compliant with good data protection and governance.

Caring

End of Life care

One of the ways we demonstrate our commitment to personalised care this is through the quality of the palliative care we provide to patients and their loved ones. Palliative care at KEVII is led by our consultants in palliative medicine, with support provided by our palliative care lead nurse. The team works closely with other services in our Hospital, including our occupational therapist, pain service, clinical nurse specialists: as well as community-based services, to ensure that the most appropriate care is delivered seamlessly. Our priority is to adhere to and exceed national recommendations and guidance, to ensure that we provide quality care to our patients. We updated our end of life care plan in May 2018, and it has been used in the care of patients who have died with us. This plan helps us to guide the care patients receive in the last stage of their life, with comprehensive symptom assessment and management.

> Our priority is to adhere to and exceed national recommendations and guidance, to ensure that we provide quality care to our patients.

Patient experience

At KEVII we are committed to providing the highest standard of personal patient care in a safe and supportive environment. Patient experience enables our patients to direct us through feedback, involvement and engagement to providing care that is not only clinically outstanding but provides a holistic approach to patient wellbeing. We will build on our existing success and make our services people centred by involving patients in many more of our improvements and redesign projects. Engaging with our patients, including diverse and vulnerable groups highlights areas where the Hospital is successful and where we need to work harder to deliver the improvements that matter to patients.

> Patient experience enables our patients to direct us through feedback, involvement and engagement to providing care that is not only clinically outstanding but provides a holistic approach to patient wellbeing.

The 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 for direct feedback. In 2019, The Director of Nursing launched a monthly Appreciation Award to recognise the special contribution that our clinical staff make towards excellent patient care, exemplifying the Hospital Values and making a real difference to our patients. The comments and commendations are received monthly for inpatients, and quarterly for outpatients. The Patient Experience Committee review all the commendations from our patients and the award goes to the clinical staff member who has made the most impact to patients that month.

Our annual report published in January showed a total of 1260 responses, a response rate of 31% from those asked.

	Inpatient	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.	**96%**	**99%**

Clinical Nurse Specialists (CNS)

We have grown our clinical nurse specialists over the last 18 months to establish our current team:

- Orthopaedic CNS
- Colorectal CNS
- Breast care CNS
- Gynaecology CNS
- Urology CNS

Our Clinical Nurse Specialists are expert practitioners who lead and organise complex care across many specialities working with the nursing and consultant team to support patients and set up protocols, pathways, multi-disciplinary meetings, clinics and multi-disciplinary ward rounds. The CNS team provide holistic care, advice and support to the patients and their families; helping the patients to achieve a successful recovery and rehabilitation. Each CNS sees the patient from pre-assessment to discharge home and follows up with a post discharge telephone call to be a reassuring point of contact for patients throughout their care pathway. The feedback from our patients is that they find the service excellent and they feel reassured to have this additional personal clinical and emotional support.

Their impact on our wards through their individualised care of patients and development of our staff has been very positive. The CNS team have provided a role model for nursing career progression and have developed bespoke multi-disciplinary training for our staff in their specialist areas. The training improves staff skills and knowledge which enriches care for the patient; and furthers role satisfaction and staff retention for our clinical teams.

> The CNS team provide holistic care, advice and support to the patients and their families; helping the patients to achieve a successful recovery and rehabilitation.

The clinical governance activity undertaken by our CNSs includes audit, measuring outcomes and quality improvement projects. As leading change agents they utilise the outcome of these activities to focus their efforts to effectively enhance the patient journey.

Plaudits

In 2018 we have collated the positive feedback we receive in a variety of ways; directly from patients, via cards from patients and patient feedback forms.

Patients with additional support needs

We have a dedicated Learning Disability link nurse who visits all patients with additional needs to obtain comments and feedback. This has led to improvements to better meet individual's needs such as installing full length mirrors in the bathroom, an accessible toilet on ground floor, portable mirrors for patients to use in bed and encouraging patients to make use of double appointment slots.

Portable hearing loops were purchased for all patient areas and training given to staff to ensure that those with a hearing impairment can communicate effectively.

An interpreter able to provide BSL was commissioned in order to assist those that use sign language to communicate. All our printed procedure specific leaflets are available in Gaint print and Scrren reader version to allow those with visual impairment to read them.

Responsive

Complaints

In January 2018 we reviewed and updated the complaints management process in line with national guidance and using our DATIX reporting system to log all complaints incidents. This has allowed better central oversight and review of the complaints received, triangulating it with other governance data and identifying themes and trends.

Lessons from complaints are shared with staff in a monthly governance newsletter and in local meetings to ensure upheld issues are actively managed and improvements are made.

The main themes from the year's upheld complaints relate to invoicing delays / unexpected costs and low level nursing care concerns. In the reporting period we had two stage 2 complaints and no stage 3 complaints.

The Hospital undertook the Independent Sector Complaints Adjudication Service[14] self-assessment framework process in 2018 and met all but three of the elements fully. Those not met fully were partially complaint and an action plan has been implemented to address these.

Clinical coding

Clinical coding is the process whereby information from the Hospital case notes for each patient is expressed as codes. This includes the operation/treatment, diagnosis, complications and comorbidities. Procedures are coded using the latest version of the Office of Population, Censuses and Surveys Classification of Surgical Operations and Procedures book. Coding allows for data to be submitted reviewed as a whole including activity and outcomes for patients. The Hospital is obliged to submit coded data to the Private Healthcare Information Network[15] (PHIN) and the accuracy of this submitted data is vital to ensure it reflects the activity and work at the Hospital.

> The clinical coding audit, undertaken April 2019, reviewing the previous 12 months coding activity, produced a fantastic result, with the Hospital attaining the highest level possible, 'Advisory Level'.

[14] https://iscas.cedr.com The Independent Sector Complaints Adjudication Service (ISCAS) is the independent adjudicator of complaints for the private healthcare sector. Clients and patients can refer a complaint about an independent healthcare providers (IHP) if they are dissatisfied having already referred a complaint directly to the IHP.

[15] https://www.phin.org.uk The Private Healthcare Information Network (PHIN) is the independent, government-mandated source of information about private healthcare, working to empower patients to make better-informed choices of care provider.

The clinical coding audit was undertaken April 2019 and reviewed the previous 12 months coding activity. The audit produced a fantastic result, with the Hospital attaining the highest level possible, 'Advisory Level' (previously Level 3 in Information Governance audits).

% coded correctly				Overall level of accuracy
Primary Diagnoses	Secondary Diagnoses	Primary Procedures	Secondary Procedures	
99%	97.25%	96.84%	98.43%	97.90% (Advisory level)

You said, we did

The Hospital is committed to listening and being responsive to feedback from patients, carers and staff. Here are some examples of what we have changed in response to feedback:

You said	We did
You would like provision of formal catering later in the evening	**Catering assistants shifts altered for later finish**
You would like face cloths provided	**Face cloths now provided to all patients**
You would like more vegetarian food choices	**Introduction of full vegetarian menu with broad choice of high quality vegetarian dishes**
You would like more gluten free options	**We now make our own gluten free granola and provide gluten free options for all the menus**
You wanted smoother pre-assessment processes	**We introduced a new pre-assessment system called Lifebox that allows a complete and simple pre-assessment process**
You wanted broader reading material in the waiting areas	**We reviewed and updated the reading material provided**
You wanted there to be prompter responses to call bells during handover times	**The morning handover process was reviewed and altered to ensure call bells can be responded to promptly**

Well led

Staff survey

The 2018 staff survey produced very encouraging results when compared to previous surveys. In all but the two survey questions there was a positive % increase in how staff are feeling within the Hospital. Particular improvement was seen in staff views on senior management communication and visibility and being recognised and given useful feedback by managers. Action plans for each department were drawn up and implemented. A survey, scheduled for September 2019, will identify if these actions have resulted in improved staff engagement and further identify other areas where specific focus could be helpful as well as ensuring positive responses are maintained.

Particular improvement was seen in staff views on senior management communication and visibility and being recognised and given useful feedback by managers.

Leadership programme and staff development

The employment of an experienced Education and Training Manager in early 2019 allowed for a re-focus on staff development. The Leadership programme for senior managers continues to be an excellent development opportunity and has been well evaluated.

Review of staff courses will be undertaken in the coming year and a strategy developed to address key development requirements for both clinical and non-clinical employees. An annual staff survey planned for autumn 2019 and a review of appraisals and requests data will allow an informed approach to organisational development programmes to support staff at all levels within the Hospital.

Quality Improvement

In 2018, we introduced a Quality Improvement (QI) framework with a recognised methodology to support continual quality improvement in the organisation. In 2018 there were a number of QI projects that have focussed on service and care quality developments, with measurable outcomes. Examples of these QI projects are:

- Patient Falls prevention
- Safer Nurse shift Handover (ward)
- Improving the Surgical Patient Pathway
- Giving Nurses time to nurse – improving efficiency around catering and refreshment provision
- Efficient TTO process and delivery
- Discharge Summary efficiency and accuracy.

In 2018, the Hospital employed a Quality Lead who oversees, supports and trains staff in Quality Improvement methods.

Consultant Credentialing

In 2018, we launched our new Customer Relationship Management (CRM) system for consultant credentialing. This new software allows us to have a smoother process for on boarding and regular review of consultants to ensure they have the required documents, information on scope of practice, registrations and training. This system will allow us to become paperless in this area of governance by the end of 2019.

We are committed to keeping patients safe, consultant colleagues supported and with good clinical governance in place for to assure patients, regulators and the board.

Our consultant credentialing compliance is excellent with a member of the governance team dedicated managing the system and process. In 2018-19 the Medical Director undertook a complete review of all consultant scope of practice and assured no issues of working out of scope were identified. We are committed to keeping patients safe, consultant colleagues supported and with good clinical governance in place for to assure patients, regulators and the board.

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 through the governance meetings.

Board of Trustees statement

Our vision is to be the leading private Hospital in the UK and to support an increased number of veterans through our charitable work. As a Hospital, we seek to ensure we provide safe and caring services for our patients in an effective and efficient manner. As a charity we strive to provide the very best support and care for our veterans through our Pain Management Programme, Pain Clinic, military grants and discounts. We are able to invest all surplus funds into our charitable work and hospital facilities and services; the beautiful new entrance to the Hospital demonstrates our most recent commitment to this.

Our rating as 'Good' by the Care Quality Commission following their inspection in December 2018, was testament to the commitment of our staff across all areas of the Hospital. The way our teams across the Hospital pulled together during the inspection was admirable and inspiring, from both our clinical and non-clinical areas. Every member of staff was enthusiastic in demonstrating what a unique place our Hospital is, and I am proud of the contribution that our staff made to the visit and of our 'Good' result.

The Board of Trustees has overall responsibility for King Edward VII's Hospital and the services it provides. As Chairman, and on behalf of the Board of Trustees, I confirm that this report aligns with the internal and external sources of information including Board minutes, Committee reports and Governance reports to the Board for the period April 2018 to March 2019, CQC inspection report (February 2019), The CRAB ci-ci report (December 2018), patient feedback collated by HWA, the staff survey from 2018 and the organisation's Risk Register and Dashboard. The Board also confirms that this Quality Account is a reliable and accurate reflection of the quality performance of the Hospital and that there are robust internal controls over the collection and reporting of the organisation's quality data.

Sir Richard Sykes
Chair of the Board of Trustees

KING EDWARD VII's
HOSPITAL

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