Maidstone and Tunbridge Wells NHS Trust

Quality Accounts
2013/14

Introduction

Providing safe, high quality health services and a good overall experience for our patients, staff and the public is at the centre of everything we do at Maidstone and Tunbridge Wells NHS Trust (MTW).

The Health Act 2009 requires all NHS healthcare providers in England to provide an annual report to reflect on standards of care and set priorities for improvement. These are called Quality Accounts.

Our Quality Accounts for 2013/14 highlight the progress we have made against key priorities for the year, to improve services for our patients, and highlight those areas that we will be focusing on as priorities for 2014/2015.

We believe patients have a fundamental right to receive the very best care. This should be provided to them in the most appropriate setting, by teams of highly skilled and expert healthcare professionals who care passionately about the care they provide. We believe we have continued to make strong progress at MTW in providing patients the highest standards of care.

Following the publication of a number of reports following the public enquiry into standards of care at Mid-Staffordshire NHS Foundation Trust, including the Berwick Report into patient safety and the Clwyd/Hart report into complaints handling, we continue to take determined actions to enhance the care within our services. Through the application of clinical governance we have systems in place to monitor standards and address areas of concern. Key aspects of quality delivery fall into the three categories of **Patient Safety**, **Clinical Effectiveness** and **Patient Experience**. Our performance in these three important areas is covered in this document.

There are a number of national targets set each year by the Department of Health and locally, against which we monitor the quality of the services we provide. Through these Quality Accounts we aim to provide you with information on how effective our services are, how they are measured and where we aim to make improvements.

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Part One
Chief Executive's Statement

Welcome to our fifth set of annual Quality Accounts for Maidstone and Tunbridge Wells NHS Trust (MTW).

Our two main hospital sites, Maidstone Hospital and Tunbridge Wells Hospital at Pembury, continued to see and treat hundreds of thousands of people throughout the year. In the last year over 3,000 (2%) more people sought treatment from our emergency care professionals.

Our aim throughout has been to do this with the utmost care and compassion. This has been reflected in our patient feedback, particularly from our Family & Friends surveys, which has been consistently above the national average for both in-patient care and Accident & Emergency Care. We have seen improvements in all areas of our National In-Patient Survey too, scoring higher than previous years in 13 areas. The five key areas that formed part of our local quality and innovation measures in the past have all seen good levels of improvement.

We have continued to actively recruit to our MTW public membership scheme, with over 8,000 people now enrolled and actively giving us feedback on our services. We have also increased our use of social media including Facebook and Twitter. This enables us to receive feedback from a wider group of service users, and to provide immediate feedback to their concerns or acknowledge their praise.

We continue to work closely with our Clinical Commissioning Groups to ensure that the services we provide in our hospitals closely reflect the care needs of our local communities.

Whilst we provided high quality care to the majority of our patients throughout the year, there were some areas where we did not always do this consistently.

Infection prevention overall has seen some significant improvements with our lowest ever rate of clostridium difficile. At the same time we had three cases of MRSA bacteraemia last year. While this is a very small number of cases, when compared to the many thousands of patients we see, our drive is to have zero avoidable hospital-acquired MRSA infections.

While the majority of our patients were seen in a timely way, we did not do as well as planned with the provision of care for our stroke patients within a dedicated stroke unit.

Falls were also a challenge for us throughout the year. While we have seen some improvements in the overall rate of falls towards the end of the year, we can do even better.

Falls prevention and stroke are included in our key priorities for this year along with other equally important areas of focus.

As well as the feedback mentioned above, to identify our key priorities for this year we have also analysed trends in our complaints, worked collaboratively with our many stakeholders and taken account of national reports.

As a result, our priorities for 2014/15 are:

Patient Safety

- Reducing the number of avoidable harms with a focus on:
    - Hospital acquired infections, in particular MRSA, C Difficile,
    - Falls
    - Hospital acquired pressure ulcers
    - Review and enhance the emergency care provision for children in our Accident & Emergency Department

Clinical Effectiveness

- To Reduce the length of stay for patients
- To provide an integrated approach to care with our community colleagues with a specific focus on:
    - Dementia
    - Discharge Planning
- Enhance Stroke Care pathway

Patient Experience

- To improve our ward environments, with particular focus on day rooms and communal areas between wards at Tunbridge Wells Hospital.
- To improve management and actions in response to complaints to ensure each is used as an opportunity from which we can learn
- To improve the quality of written information, particularly in relation to patient information leaflets and letters to General Practitioners.
- To ensure all patients (in-patients, out-patients and maternity) are offered the opportunity to feedback to the Trust using the Friends & Family Test.

We will continue to support our highly skilled staff to help achieve the improvements we have set ourselves, as part of our ongoing commitment to provide safe, high quality care. We will closely monitor the clinical priorities in our Quality Accounts throughout the coming year and make our progress publicly available.

The information contained within this report represents an accurate reflection of our organisation's performance in 2013/14 and has been agreed by the MTW Trust Board.

Thank you for taking the time to read our Quality Accounts. If you have any comments or suggestions for our Trust, you can contact us in the following ways:

Write to us at: The Patient Experience Committee, Care of Room 128, Service Centre, Maidstone Hospital, Hermitage Lane, Kent, ME16 9QQ.

Follow us on Twitter: www.twitter.com/mtwnhs
Join us on Facebook: www.facebook.com/mymtwhealthcare

Become a member of our Trust: www.mtw.nhs.uk/mymtw

Glenn Douglas
Chief Executive

Part Two
Quality improvement initiatives

How has MTW prioritised its quality improvement initiatives for 2014/15?

Priorities for Improvement

Section 2 of a Trust's Quality Account focuses on a) priorities for improvement in the year ahead and b) statements of assurance relating to the quality of the Trust's services.

To prioritise the areas for improvement this year we have again consulted with patients, the public and our staff to identify areas where improvement is needed and where we can have the most impact.

During the last year we focused on the following priorities:

Patient Safety

- Reducing the number of avoidable healthcare associated infections
- Prevention of blood clots or venous thromboembolism (VTE)
- Reduce the number of patient falls
- Reduce the number of hospital acquired pressure ulcers

Clinical Effectiveness

- Continue to improve the care we provide for patients who are suffering from dementia
- Improve the management of discharge planning
- Reduce the overall length of stay

Patient Experience

- Improve the management and quality of responses to complaints we receive and ensure each is used as an opportunity from which we can learn.
- To improve our discharge planning for patients
- To improve the quality of written information.

In part 3 we reflect on the progress that has been made against these targets.

To identify the priorities for this year we have again looked at progress against those we identified last year, trends in the complaints we have received, national reports, such as the Francis Report, Clwyd Hart Report and Care Quality Commission reports following our inspections and areas highlighted by local and national surveys of our patients.

As a result of this we have identified the following priorities for this year:

Patient Safety

- Reducing the number of avoidable harms with a focus on:
    - Hospital acquired infections, in particular MRSA, C Difficile,
    - Falls
    - Hospital acquired pressure ulcers
    - Review and enhance the emergency care provision for children in our Accident & Emergency Department

Clinical Effectiveness

- To provide an integrated approach to care with our community colleagues with a specific focus on:
    - Dementia
    - Discharge Planning
- Enhance Stroke Care pathway

Patient Experience

- To improve our ward environments, with particular focus on day rooms and communal areas between wards at Tunbridge Wells Hospital.
- To improve management and actions in response to complaints to ensure each is used as an opportunity from which we can learn
- To improve the quality of written information, particularly in relation to patient information leaflets and letters to General Practitioners.
- Friends and Family Test

We monitor our progress against these targets via our governance committee structure that reports to the Trust Board. In addition our organisation meets bi-monthly with our local healthcare commissioners to report on the progress we are making towards meeting all the quality standards that are set.

Our Quality and Safety Committee receives reports on progress against the key priorities. This committee then provides assurance on progress to the Trust Board. The Patient Experience Committee is also regularly updated regarding progress.

During 2013/14 we developed a new Quality Strategy which was published in February 2014 following consultation with key stakeholders including staff, Patient Experience Committee, West Kent Clinical Commissioning Group and the NHS Trust Development Authority.

Patient Safety

Reducing the number of avoidable harms with a focus on:

- Hospital acquired infections, in particular MRSA, C Difficile,
- Falls
- Hospital acquired pressure ulcers
- Review and enhance the emergency care provision for children in our Accident & Emergency Department

Infection Prevention and Control

We have again included the reduction of infection rates for C. difficile and MRSA as a key priority for this year. This is an ongoing focus for us to ensure we meet the challenging targets that are set each year on a Trust by Trust basis.

Aim/Goal
To reduce our C. difficile cases to less than 40 for the year and to sustain or decrease our low rate of MRSA bacteraemia, maintaining our zero tolerance of avoidable infection.

Description of Issue and rationale for prioritising
Our rates of C. difficile infection have continued to fall, having had 35 cases against a limit of 42 for the year. The limit for 2014/15 has been set at 40 for the year, however we believe that if the improvements made over the last year can be sustained we will continue to see further significant decreases in the number of C.difficile cases attributed to our care.

Our MRSA bacteraemia rate has plateaued in the last year with three cases in 2013/14.
As a Trust we have a zero tolerance approach to healthcare associated infection (HCAI) and aim to have no avoidable HCAI.

Identified areas for improvement and progress during 2013/14
The following actions were taken to support the reduction in HCAI

- Revising the C. difficile action plan including learning from root causes identified as contributing to the infection and trend analysis
- Revising the root cause analysis (RCA) process to ensure further consistency of approach
- Launch a “focus on…” series to make improvements to reduce the risks of chest infection and urinary tract infection, implementing the work of the HCAI task and finish group
- As a result of the HCAI group a ‘BRUSH’* campaign was launched focusing on good oral hygiene as contributor to the reduction in hospital acquired chest infection.
- Peer review from a high performing organisation
- Review and benchmarking of antibiotic prescribing and guidance
- Working across the health economy to have a whole system approach to the reduction of C. difficile.
- We have strengthened our working relationships with the CCG, this included the joint development and facilitation of a C. difficile prevention day to include General Practitioners and the wider multi-disciplinary community team.

Initiatives for further action for 2014/15

- Continued focus on robust antibiotic stewardship
- Rigorous monitoring of deep cleaning programme
- Sustain relationships and joint working with community colleagues to ensure good progress is maintained for appropriate antibiotic prescribing and management.

Executive Lead: Chief Nurse
Board Sponsor: Director of Infection Prevention and Control
Implementation Lead: Lead Nurse for Infection Prevention and Control
Monitoring: via the Infection Prevention and Control Committee to Quality and Safety Committee.

*’BRUSH is a strap line related to ‘brushing your teeth’ it has no other professional or technical meaning.

Reducing the number of Patient Falls

We have included the target of reducing the number of patient falls again this year with our focus on reducing the number of avoidable harms for patients during their hospital stay.

Aim/goal
We aim to reduce the rate of falls in the year from 7.2 per 1,000 occupied bed days to 6.8 per 1,000 occupied bed days.

Rationale:
Slips, trips and falls can:

- Result in loss of confidence and self-esteem
- Result in cuts, bruises, broken bones or other injuries
- Lead to a longer stay in hospital

Progress and Actions taken in 2013/14

- Appointment of a Falls Prevention Practitioner
- Reviewed and amended the Falls Risk Assessment
- Enhanced awareness and training initiatives including workshops for falls risk and prevention at weekly nursing Key Performance Indicator meetings.
- Falls review group in place and sustained
- Blue Identification (ID) Bands and patient safety board identifier in place
- Sustained availability of mobility aides and anti-slip footwear
- Variable height/depth chairs in place
- Overall rate of falls decreasing – Rate of 7.1 per 1,000 occupied bed days at March 2014.

New initiatives for 2014/15

- Review of Bed Rails assessment
- Review and implementation of revised checking process for selection and condition of alarm mats
- Consideration of a ‘review sticker’ to demonstrate medications review has been undertaken
- Review of Serious Incident investigation and closure process

Board Sponsor: Chief Nurse
Implementation Lead: Associate Director of Nursing (Planned Care Services)
Monitoring: via Standards Committee to Quality and Safety Committee

Reducing the number of Hospital Acquired Pressure Ulcers

Aim
Our priority for the coming year is to sustain the reduction in the number of hospital acquired pressure ulcers in line with the current national agenda of zero tolerance to pressure damage as set out by the National Patient Safety Agency. We are aiming to reduce the incidence of category 2 pressure ulcers by 15% and to achieve zero incidence of hospital acquired category 3 and 4 pressure ulcers.

Rationale
Pressure ulcers impact on a patient's quality of life impacting as they can on future health and mobility. The acquisition of a pressure ulcer can also extend the length of time someone has to spend in hospital which again can be detrimental to the patient as well as challenging for the hospital when bed pressures are acute.

Progress and actions taken in 2013/14
During 2013/14 the trust has developed a more robust way of collating the number of hospital acquired pressure ulcers of all grades and with the introduction of a Trust-wide action plan there has been a reduction in the number of grade 3 and 4 pressure ulcers.

- All grade 2 pressure ulcers are now subject to a full root cause analysis (previously only carried out for grade 3 & 4) and an action plan developed
- Introduction and review of "skin bundles"[1] a more holistic approach to ensuring all patients receive the appropriate care to prevent pressure damage
- The introduction of core care plans with respect to pressure ulcers to ensure consistency of evidence-based care delivery
- Partnership working with community colleagues to reduce the number of patients admitted to hospital with pressure ulcers
- Monthly review of all pressure damage undertaken as part of the national Safety Thermometer data collection process.
- Bi-annual pressure ulcer prevalence audit. We have a consistently low prevalence of hospital acquire pressure damage, being consistently around 3% compared to a national prevalence of between 8% and 10%.

Initiatives for 2014/15

- Enhance and strengthen the work between the Tissue Viability team, the Safeguarding Matron and the Lead Nurse for Dementia Care to develop and implement strategies to manage challenging behaviours in relation to concordance with care, ensuring frontline staff have the skills required to adequately prevent tissue damage in patients with cognitive impairment.
- Review the provision of dynamic[2] mattresses
- Review the efficacy of the current mattress systems (non-dynamic) to ensure they remain the product of choice
- Review the role of the link nurse and the way in which frontline staff gain and maintain pressure damage prevention skills.

Board Sponsor: Chief Nurse
Implementation Lead: Tissue Viability Clinical Nurse Specialist
Monitoring: via Standards Committee to Quality and Safety Committee

[1] Skin bundles refer to a care planning and documentation process where several interventions a 'bundled' together.
[2] Dynamic mattresses are powered air mattresses that automatically alter the pressure of air within the mattress.

Enhance the emergency care provision for children within our Accident & Emergency Care Department:

Aim
All persons under the age of 18 years should receive care from Registered Nurses who are specifically trained in the care of sick children.

Rationale
The Royal College of Paediatrics and Child Health (2012), in partnership with the Royal Colleges of Emergency Medicine, Anaesthetists, General Practitioners and Nursing have set out guidance for the staffing levels and skill set required based on the number of annual attendances.

Progress and actions taken in 2013/14
This is a new area of focus for us. Following discussions with our Clinical Commissioning Group colleagues and feedback from the Care Quality Commission, we are undertaking a review of our paediatric pathways and capacity.

We have in place pathways for the management of sick children, with clear criterion for their care and transfer to a paediatric in-patient facility within the Trust or to a tertiary referral centre as appropriate.

All of our front line Accident & Emergency nurses are trained to the standards set out by the Royal College of Nursing, however we do have limited numbers of Registered Nurse (children) working substantively in the department.

Initiatives for 2014/15

- Undertake a full acuity and dependency review for the Accident & Emergency Department (using RCN Emergency forum 'Baseline Emergency Staffing Tool' (BEST), and triangulate with the Hurst Model and Professional Judgement Model for setting safe staffing levels. Consider linking to the modified Paediatric Acuity and Nursing Dependency Assessment (PANDA) tool being trailed within Paediatrics)*.
- Build on the full review of staffing, in line with the National Quality Board recommendations (work already undertaken in 2013/14)
- Strengthen communication and supervision links between the A&E Department and Children's Services directorate
- Review pathways for sick children, ensure they remain appropriate and are consistently followed.

Board Sponsor: Chief Nurse
Implementation Lead: Matron for Accident & Emergency and Matron for Children's Services
Monitoring: via Standards Committee to Quality and Safety Committee

* Hurst Model, Professional Judgement Tool, BEST and PANDA are recognised tools or methodologies to setting safe staff levels. The Hurst Model is the precursor to the Safe Staffing Tool currently being reviewed by NICE. The NICE report is expected to be published in the summer/autumn of 2014.

Clinical Effectiveness

To provide an integrated approach to care with our community colleagues with a specific focus on:

- Dementia
- Discharge Planning
- Improvements to Stroke Pathway

Improving Dementia Care

Care for patients who have dementia remains a key focus for us at our Patient Experience Committee. Various initiatives have been implemented in the last year and have paved the way for further work to improve the care for our patients with dementia. We are therefore keen to maintain this momentum and, in line with consultation results, to keep this as a key priority. A key focus this year is to continue the work that has been started with partner organisations in the community to help support patients with dementia and their carers with the aim of preventing hospital admissions where possible.

Aim/goal
To identify those patients with dementia with a view to ensuring that an effective care plan is in place to enable them to receive the best care possible throughout their pathway between the acute and community sectors.

CQUIN[3] (local quality and innovation) targets:
To assess at least 90% of patients aged 75 and over admitted as an emergency for more than 72 hours to determine whether they have dementia.
Implementation of a carer's survey and action on feedback
To ensure there is sufficient clinical leadership of dementia within provider organisations and appropriate training of staff.
To ensure carers of people with dementia feel adequately supported.

Progress and actions in 2013/14
The Trust made the following progress against the targets set for last year:

- Dementia CQUIN screening tool is now fully implemented
- Achieved consistently >96% screening and assessment of patients aged 75 and over admitted as an emergency for more the 72 hours.
- Dementia pathways completed and implemented to ensure standardised practices
- Development of guidance on the management of behaviour that challenges due to dementia or delirium.
- Have reduced the prescribing of anti-psychotic drugs for patients with dementia – data collection for this CQUIN is now routinely collected. Anti-psychotic review audit is undertaken quarterly by Enhancing Quality (EQ) facilitator. Completion of pilot of core care plan for patients with cognitive impairment and implementation of this.
- Development of patient/carer information resource leaflet for those admitted with dementia, including carer's survey form.
- Development of dementia buddy scheme in association with Alzheimer's and Dementia Support Services
- Developed and published a Dementia Care Policy
- Developed and published a Dementia Care Strategy

[3] CQUIN – commissioning for quality, innovation and improvement. A means of rewarding a Trust for enhancing and improving the quality of care provided in a specific condition or process.

New Initiatives/goals for 2014/15

- Continue with work commenced last year with the Association for Alzheimer's and Dementia Support Services for the implementation of the dementia buddy scheme.
- Work closely with the Patient Environment Steering Group to ensure best practice guidance for dementia friendly environments are considered and implemented in all future refurbishment and estate development
- Establish a reporting mechanism for the results of the carers' survey to ensure that feedback is disseminated across the Trust and findings are understood and implemented locally.

Board Sponsor – Chief Nurse
Implementation Lead – Lead Nurse for Dementia
Monitoring: via the Dementia Strategy Group to Quality and Safety Committee

Discharge Planning

Work is on-going between the Trust and partnership organisations – social services and local healthcare commissioners - to ensure that those patients who are medically fit can be discharged into the most appropriate care environment for them. In addition there are specific actions that we are taking to ensure patient discharge is planned in an efficient and effective way.

Aim/goal
Ensure all patients have their discharge from hospital planned to ensure there is a seamless transfer home with appropriate support in place and communication with all relevant parties, with particular focus on enhanced electronic discharge notification ensuring all agencies receive electronic notification, as appropriate.

Progress on actions for 2013/14

- Established a high-level meeting between the Trust and partnership organisations to review patients who are medically fit for discharge, but are delayed within the hospital.
- Twice-weekly meetings occur on both sites to review all patients with a length of stay greater than 7 days to ensure appropriate actions are being taken.
- Performance regarding delayed discharges to be reported to Trust Board monthly.
- New discharge lounge built at Maidstone Hospital that is fit for purpose.
- Review of the Discharge Team, now providing 'named' support consistently to a group of wards to enable early identification of 'complex' discharge issues and ensure planning and appropriate engagement occurs early.

Actions for 2014/15

- Development of detailed action plans in partnership with project leads from each organisation aimed at improving the efficiency and effectiveness of services at a whole system level.
- Test new ideas for service integration, for example, Telehealth for patients with respiratory and Chronic Obstructive Pulmonary Disease conditions as part of reducing the presentation of patients with these conditions at A&E
- Development and implementation of Enhanced Electronic Discharge Notification (EEDN) allowing full multi-disciplinary notification of discharge, including community and social care teams.
- Review work plans to enable 7 day working across disciplines and specialities.

Board Sponsor – Chief Operating officer
Implementation Lead – Associate Director of Nursing (Emergency Services)
Monitoring: Operationally to the Trust Management Executive meeting and Quality and Safety Committee

Improvements in Stroke Pathway

Aim:
To ensure 80% of patients with a diagnosis of stroke receive 90% of their care on a dedicated stoke ward.

Rationale:
Outcomes for patients suffering stroke are significantly improved if they receive timely care in a specialised unit. Their on-going care on a stroke unit greatly enhances the likelihood of regaining significant functionality.

Target:
80% of patients suffering stoke to receive 90% of their care in a dedicated stroke unit.
Patients to be admitted to a stoke ward within 4 hours.
Patients to have a CT scan within 12 hours
Patients to be assessed by a stroke consultant physician within 24 hours

Progress during 2013/14
The national target/benchmark for 2013/14 was 80%. The Trust achieved this for quarter 4. However for the full year we achieved 76.9%.

The most recently available data (Stroke National Audit Programme - SNAP) to compare against peers shows the trust performing as:

SNAP indicators – national comparison (July to Sept 2013) as %			
Standard	**Maidstone**	**Tunbridge Wells**	**National Average**
Admitted directly to a stoke unit	25.4	19.2	58.4
CT <12hrs	86.8	80.8	83.8
Assessed by Consultant	55.9	67.9	72.8

Actions for 2014/15

- Stroke Steering Group initiated
- Action Plan developed
- Ring fenced bed on each acute stroke ward
- Escalation criteria to be monitored

Executive lead; Chief Operating Officer
Project Lead: Associate Director of Nursing – Emergency Care.
Monitoring Committee: Operationally to Trust Management Executive Meeting and through to the Quality and Safety Committee

Patient experience

- To improve our ward environments, with particular focus on day rooms and communal areas between wards at Tunbridge Wells Hospital.
- To improve management and actions in response to complaints to ensure each is used as an opportunity from which we can learn.
- To improve the quality of written information, particularly in relation to patient information leaflets and letters to General Practitioners.
- Improve response rates for the Friends and Family Test

Improve our ward environments with particular focus on day rooms

Aim
Following the publication of the Francis report, which put heavy emphasis on patients having access to communal areas, and feedback from Patient-led Assessment of the Care Environment (PLACE), we have decided to focus on both day rooms across the Trust, and the inter-ward spaces at Tunbridge Wells Hospital.

Rationale
The standards contained within the new PLACE inspection regime reflect the recommendations of the Francis Report. The common theme from the PLACE inspections undertaken last year related to the availability of day rooms and/or space for private conversations away from the ward area.

Progress to date:
Space for private conversations is less of an issue at Tunbridge Wells Hospital due to the single room nature of care provision. However, patients at Tunbridge Wells Hospital lack access to 'inviting' communal space. Each ward does have a day room, however, there has been minimal investment in furnishing these spaces.

Feedback from both staff and patients indicate further work is also required on the inter-ward spaces at Tunbridge Wells Hospital, particularly following the initiative on Ward 20 following investment from the Dementia Challenge funds which allowed the space to be furnished to facilitate a lunch club approach for patients on Ward 20.

Wards at Maidstone have variable access to day rooms. The Maidstone Programme Board have given an undertaking that day room space will be considered for each ward as part of the wider Maidstone Hospital ward refurbishment plan.

Actions for 2014/15

- Patient Environment Steering Group (PESG) to ensure ward day rooms are prioritised for investment from PLACE funds
- PESG to liaise closely with members from the Dementia Steering Group to ensure any initiatives supplement and support the work of the Dementia Steering Group
- Set of principles for common areas to be agreed to ensure that they are inviting spaces for all

Executive Lead: Chief Nurse
Project Lead: Deputy Chief Nurse
Monitoring Committee: PESG to the Quality & Safety Committee

Complaints Management

Aim
Our aim this year is to build on the work over the last year to ensure that all complaints are seen as an opportunity to learn from and that we embed the learning. We aim to ensure complainants receive timely responses which have been fully investigated and address all issues raised.

We aim to ensure that our Trust Board are fully appraised of the numbers of complaints per month, the emerging themes and trends, and are sufficiently sighted on these to enable full cross organisational understanding and improvement.

Targets:
75% compliance with stipulated timescales for responding to complaints.
75% of complainants that respond to our survey score us as 4 or 5 (out of 5) for satisfaction with the service.
Rate of new complaints to be < 6.26 per 1,000 episodes (excluding day cases) – National average.

Progress and actions in 2013/2014

- A reduction in the rate of new complaints achieving 5.07 per 1,000 episodes for the year.
- Enhanced reporting in relation to learning from complaints feeding into key governance committees
- Introduced a new system for reviewing and challenging the investigation of serious complaints in conjunction with the patient safety team to ensure robust investigation and learning takes place, raising incident reports and/or Serious Incidents if not previously identified.
- Compliant with the recommendations from the Clwyd-Hart Report
- Patient stories to the Board

Initiatives in 2014/2015

- Implementation of further training re investigation of issues and drafting of complaint responses including using complaints and PALS scenarios in the development of a new Trust-wide customer services/Organisational Development programme
- Continue with the development of more efficient statistical reporting so that actions can be targeted on recurring themes and areas of high incidence in a more timely way
- Report publically the number of complaints received, the number of upheld and actions taken
- Strengthen the links between patient experience/stories and the Board, by offering more patients the opportunity to tell their story, in person, to the board.
- To continue to develop and enhance our practice of early engagement with patients and families

Board Sponsor: Chief Nurse
Implementation Lead: Complaints & PALS Manager
Monitoring: Quality and Safety Committee

Improving the quality of written information

Keeping our patients and the public informed of what is happening within our Trust is essential for our local population so that they know about developments and proposals for the future of health care close to home. In the last year we have developed a newsletter for patients. There has also been a revision to our internet to include social media components and live information in relation to, for example, waiting times in accident and emergency departments.

While these developments evolve we also want to ensure that we improve the quality of information in terms of leaflets about conditions and treatments and also the letters that we send out, particularly to General Practitioners and other continuing care facilities.

Aim:
To enhance the quality of the information that we provide to patients and carers to ensure that it is clear, informative, timely and in a suitable format.

Rationale:
An internal review has identified the need to improve the quality of some of the information that we provide to patients and General Practitioners. Discussion at the Patient Experience Committee also highlighted the unintended consequences of a 'house style' or standardised corporate layout making some key information leaflets difficult to locate.

Progress and actions in 2013/14:

- The 'Patient Information and Leaflet Group' (PILG) work with Directorates to improve their ownership of leaflets and enhance the accuracy and relevance of clinical information
- A review schedule for existing leaflets is now in place.
- Ensure leaflets that are easier to read and understand by patients (the PILG editorial group includes patients, clinicians and Communication officers).
- Ensure a set of core leaflets, relevant to all clinical areas, are readily available to patients and their relatives.
- Development of social media, in particular Facebook and Twitter, including rapid acknowledgement and feedback.
- Real time display of waiting times for our Accident & Emergency Departments on the internet.
- Liaison with CCG to monitor quality of letters to General Practitioners
- Recruiting and communicating with 8,430 public members as part of our bid to become a Foundation Trust.

Actions for 2014/15

- Health Records Manager and Communications Department to improve the quality, readability and consistency of patient letters.
- Patient Information and leaflet Group to consider an alternative approach to highlight information leaflets by subject matter, e.g. colour coded stripe.
- In addition to essential patient and visitor information, the trust will also improve the information provided about changes we are making in relation to feedback from the public via surveys and complaints.

Board Sponsor – Chief Nurse
Implementation Lead – Associate Director of Quality and Governance
Monitoring: via the Patient Experience and Quality & Safety Committees

Improve response rates for Friends & Family Test

Aim:
To significantly improve our response rate for the Friends & Family Test (FFT), whilst maintaining our overall net promoter score:

Target:
To achieve the National CQUIN[4] for Friends & Family
To achieve full implementation of the Friends & Family for Outpatients
To achieve implementation of the Friends & Family test for staff

Progress for 2013/14
The FFT went live at the beginning of 2012/13 with reasonable response rates, however, this was not sustained throughout the year, with particular challenges with achieving a good response rate within Accident & Emergency. Maternity services had a problematic start, as the FFT test has more than one touch point, compared to a single touch point for inpatients.

Whilst return rates have been disappointing the net promoter score (i.e. how well our patients think we are doing) has been consistently above the national average for both inpatients and Accident & Emergency. The net promoter has not deteriorated as the rate increased, providing a degree of confidence in the score.

Initiatives for 2014/15

- Improved internal awareness
- Weekly reporting of returns to departments
- Consideration of alternative means of feedback (e.g. increased use of IT, mobile technologies)
- Implementation of FFT for all outpatients
- Implementation of FFT for staff

Executive Sponsor: Chief Nurse (Director of Workforce for Staff returns)
Project Lead: Deputy Chief Nurse
Monitoring committee: Trust Management Executive

[4] CQUIN – commissioning for quality, innovation and improvement

In this following section we report on statements relating to the quality of NHS services provided as stipulated in the regulations.

The content is common to all providers so that the accounts can be comparable between organisations and provides assurance that MTW's Board has reviewed and engaged in national initiatives which link strongly to quality improvement.

Statements relating to the quality of NHS services provided as required within the regulations

The Trust is registered by the Care Quality Commission to provide the following services:

- Maternity and midwifery services
- Termination of pregnancy
- Family Planning
- Surgical procedures
- Diagnostic and screening services
- Treatment of disease, disorder and or injury

No conditions were applied to the registration.

At the end of June 2013 the provision of Patient Transport services transferred to NSL Care Services – this was as a result of a tendering process by NHS Kent and Medway.

During 2013/14 the Trust provided and/or subcontracted the full range of services for which it is registered. During 2013/2014 the Trust provided and/or sub-contracted 101 NHS services. We have reviewed all the data available on the quality of care in these NHS services. These are reviewed formally with commissioners.

The income generated by the NHS services reviewed in 2013/2014 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2013/2014.

Reviewing Standards

To ensure that we are providing services to the required standards the Trust supported a number of reviews of its services during 2012/13, undertaken by external organisations such as:

- Care Quality Commission – 3 inspections – further details are provided later in the report.
- Care Quality Commission IR(MER) compliance visit
- NHS Trust Development Authority (NTDA)
- Annual Cancer Review
- PLACE (previously PEAT)
- ISO accreditation of Radiotherapy and portering services
- Pharmacy aseptic units regional quality assurance visits
- HSE – microbiology laboratories
- Joint Advisory Group on GI Endoscopy (JAG) both sites
- MHRA – transfusion
- Human Tissue Authority (HTA) – Tunbridge Wells Hospital
- Visits by West Kent Clinical Commissioning Group

Internally we have the following ongoing reviews to assess the quality of service provision:

- Care assurance audits
- Internal PLACE (previously PEAT) reviews
- Hand hygiene audits
- Trust Board member “walkabouts”

The outcomes of these are included within our triangulation process to review clinical areas and identify any where additional support and actions are required to maintain standards. Reports are scrutinised within identified committees within our governance structure and where necessary action plans are developed and monitored.

Clinical Audit

This section of the Quality Account provides information about the Trust's participation in clinical audit. Identified aspects of care are evaluated against specific criteria to ascertain compliance and quality. Where indicated, changes are implemented and further monitoring is used to confirm improvement in healthcare delivery. Participation in national clinical audits, national confidential enquires and local clinical audits is mandated and provides an opportunity to stimulate quality improvement within individual organisations and across the NHS as a whole.

During 2013/14, MTW participated in 100% of relevant confidential enquiries and 100% of all relevant national clinical audits. During the same period, MTW staff successfully completed 182 clinical audits to action plan stage from 421 started and in progress, which led to improvements in patient note keeping, quality of information leaflets on clinical procedures provided to patients, and staff training to update and improve knowledge of processes and procedures (please see details below).

The national clinical audits and national confidential enquiries that Maidstone & Tunbridge Wells NHS Trust participated in during 2013/14 are shown in Table 1 as follows-

National Clinical Audits for inclusion in Quality Accounts 2013	***Participation*** Y, N or NA	***No of cases submitted***	***% cases submitted***	***Comments***
Recruited patients during 2013-14				
Peri and Neonatal				
Neonatal Intensive and Special Care (NNAP)	Y	650	100%	
Perinatal Mortality (MBRRACE-UK)	Y	23	100%	22 still births and 1 Neonatal death
Children				
Paediatric Inflammatory Bowel Disease. (Round 4)	Y	19	100%	
Child Health (CHR-UK)	Y			Data entered by individual clinicians. No Trust figures available.
Epilepsy 12 (Childhood Epilepsy)	Y	40	100%	
Paediatric Asthma	Y	28	100%	
Paediatric Diabetes (NPDA)	Y	896	100%	
Moderate or severe asthma in children (care provided in emergency departments)	Y	81	100%	
Paediatric Intensive Care (PICANet)	N/A			MTW does not provide this service
Acute Care				
National Cardiac Arrest Audit (NCAA)	Y	289	100%	
Adult Critical Care Case Mix Programme (ICNARC) (Round 2)	Y	991	100%	
Sentinel Stroke National Audit Programme (SSNAP)	Y	681	100%	
Emergency Laparotomy Audit (NELA)	Y	43	100%	
Emergency use of Oxygen	Y	24	100%	
Paracetamol overdose (care provided in emergency departments)	Y	100	100%	
Severe Sepsis & Septic shock	Y	100	100%	
National audit of seizures in hospital (NASH)	Y	60	100%	

Long Term Conditions				
National (Adult) Diabetes Audit (NDA)	Y	3542	100%	
National Diabetes Inpatient Audit (NaDIA)	Y	105	100%	
Inflammatory Bowel Disease (IBD)	Y	32	78%	Patients casenotes not available
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Y	74	100%	
Rheumatoid and early inflammatory arthritis	Y	10	100%	
National audit of memory clinics	N/A			MTW does not provide this service
National Audit of Intermediate Care	N/A			
Elective Procedures				
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein	Y	Hip: 121 Knee: 131 Groin: 52 Varicose: N/A	83%	Not all patients returned the questionnaires. Varicose Vein: Insufficient number of questionnaires returned to be able to quantify data.
Coronary angioplasty	Y	324	100%	
Cardiovascular disease				
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Y	347	100%	
Heart failure	Y	438	100%	
Cardiac Rhythm Management (CRM)	Y	638	100%	
Adult Cardiac surgery	N/A			MTW does not provide this service
Congenital heart disease (Paediatric cardiac surgery)	N/A			MTW does not provide this service
Pulmonary Hypertension	N/A			MTW is not a Specialist PH centre.
Vascular surgery (VSGBI database)	N/A			MTW does not provide this service.
Renal Disease				
Renal Registry (UKRR)	N/A			MTW does not provide this service
Cancer				
Lung Cancer (NLCA)	Y	100	100%	
Bowel Cancer (NBOCAP)	Y	331	100%	
Head & Neck Cancer (DAHNO)	Y	33	100%	
Oesophago-gastric cancer (NAOCG)	Y	97	100%	
Care of dying in hospital (NCDAH)	Y	51	100%	
Trauma				
Falls and Fragility Fractures Audit Programme (FFFAP)	Y	40	100%	
National Hip Fracture Database (NHFD) Now part of FFFAP	Y	503	100%	
Severe Trauma (Trauma Audit & Research Network) TARN	Y	332	100%	
National Joint Registry (NJR)	Y	1039	100%	
Psychological conditions				
Prescribing Observatory for Mental Health	N/A			MTW does not provide this service
Schizophrenia	N/A			MTW does not provide this service
Suicide and homicide in mental health (NCISH)	N/A			MTW does not provide this service

Blood transfusion				
(National Comparative Audit of Blood Transfusion) Use of anti-D	Y	61	100%	
National Confidential Enquiries				
Alcohol Related Liver Disease	Y	4	100%	
Subarachnoid Haemorrhage	Y	3	100%	
Tracheostomy Care	Y	27	100%	
Deaths following lower limb amputation	Y	N/A		Organisational data submitted. No clinical cases fitted criteria for inclusion in this national study.

41 national audits were published in 2013/14 with actions taken in 2013/14 to address areas of non or partial compliance. A number of improvements have been made in line with national recommendations, including-

1. **Feverish Children in A&E.** The Paediatric A&E Card has been redesigned to ensure that blood pressure and Glasgow Coma Score are recorded in every instance. A new information leaflet is in the process of being designed to be handed to parents/carers setting with advice on the care of the child following discharge from A&E.
2. **Fractured Neck of Femur in A&E.** Since this audit the reception of ambulance patients in the department has been overhauled. This group of patients are now received and assessed in A&E in two specific bays. Anecdotally this seems that patients are assessed and given analgesia more promptly. The nursing role has been developed to include requesting hip x-rays when clinical findings indicate an x-ray is necessary. This will speed up the assessment process in the A&E department. Training has commenced with nursing staff to ensure that pain scores are recorded regularly and pain re-evaluation is carried out after administration of analgesia.
3. **National Diabetes Audit (NDA)** A new proforma to be used in clinics is being designed. This will ensure better recording of the key clinical areas that need monitoring in the diabetic patient to ensure that any areas of concern are identified and appropriately treated. (Monitoring of Hb1Ac, blood pressure, cholesterol levels, serum creatinine, urine albumin, foot surveillance, BMI and smoking status).
4. **National UK IBD (Irritable Bowel Disease) Biologics.** A new consultant Gastroenterologist with an interest in IBD is in the process of being appointed. This will enable an increased clinic capacity and allow the review of patients at 3 and 12 months after starting biologic therapies.
5. **Dementia Audit (Round 2).** All staff now receive basic awareness training to enable recognition of the signs of dementia. Staff that work with patients with known dementia have a more in depth course involving competency assessment and sign off**.** The trust is now signed up to a Dementia Action Alliance and is deemed to be dementia friendly**.**

Please see Appendix A for full details of progress against each of the reported national audit results <u>2013/14</u>.

The reports of **47** national clinical audits, published in 2012/13 were reviewed by MTW staff, with a number of actions to be in place by 2013/14 to improve patient care. Areas of improvement include-

- Expanding the role of nursing staff - enabling nurses to request diagnostic tests such as chest x-rays and undertake more procedures for patients.

- Improving further the in-house training given to junior doctors, especially in relation to prescribing and common disease management such as asthma.

- Increased communication with patients about their care via new and improved booklets, leaflets, letters and face to face discussions with clinical staff. For example, Pharmacists, Occupational therapist and psychologists are increasingly involved in delivering inpatient health education sessions.

- Improvements in the medical equipment available to treat patients, such as the new inpatient hypoglycaemia boxes on all wards to treat patients who develop hypoglycaemic episodes.

- Working closely with other care providers such as Kent Community Health for additional funding to support post-discharge rehab programmes and to improve access for additional groups of patients.

Please see Appendix B for full details of progress against each of the reported national audit results 2012/13

A number of service improvements have been made as a result of the **152** local clinical audits completed to action plan stage, across all directorates, in 2013/2014. Trust staff identified local areas of concern/interest, reviewed their practice and made recommendations for change. Staff actively use clinical audit as a quality improvement process to improve patient care and outcomes through the systematic review of the care they provide against explicit criteria. Improvements include:

Actions taken following local audits	Trust Actions
Thromboprophylaxis prescribing. General Surgery	The VTE assessment tool has been amended to assist in the correct dosage of thromboprophylaxis for immobilised surgical patients; a new drug chart is now in use to record the prescribing of Anti-Embolism Stockings and VTE education is now included on mandatory induction programmes for junior doctors.
Trauma & Orthopaedics	The Electronic Discharge Notification (EDN) system has been amended to have a pre-entered drug list for patients with fractured neck of femurs. This is to ensure patients receive thromboprophylaxis for the 4 weeks following fracture as this group of patients are at a higher risk of developing DVT's during this first month following fracture.
Obstetrics	A VTE form has been incorporated into the new maternity hand held notes to improve the recording of assessment and documentation within the case notes. The VTE forms will be included in the post natal notes and the discharge notification template has been amended to provide information for the patients showing the duration that they need to take the thromboprophylaxis.
Trauma & Orthopaedics	Recording of information in post operative case notes has shown significant improvements with all elements now being completed. A poster showing the information required was put up by the desk where clinicians complete the post operative forms as a reminder of what needs to be recorded. Serial numbers for prosthesis used are now recorded on the electronic case notes these were previously recorded on the handwritten notes.
Critical Care (ITU and HDU)	Significant improvements in the weaning practices for long term ventilated patients have been shown since the introduction of a new guideline setting out the processes involved. Additional training was provided to clinical staff on who manage these patients.
Specialty Medicine	A diabetes information file has been placed in each clinic room in Outpatients with appropriate patient information leaflets about the newly introduced Insulin Passports. This is to ensure that the necessary information is always available to be handed to the patient attending the diabetic clinic.
Haematology	A proforma has been produced to record actions for IVC insertion, removal and follow up. This is now kept in the patient notes to ensure correct time of removal therefore reducing morbidity/mortality due to the associated risks of in vivo thrombosis associated with permanent filters
Respiratory Medicine	A new aspiration kit has been introduced to the trust which facilitates safe aspiration and drainage of pneumothoraces. Patients now only have one procedure and aspiration is not

	missed. These kits are available in A&E and at selected points within the trust where pneumothorax is likely to require treatment.
Paediatrics	A checklist is to be attached to the notes of children suspected of neglect or abuse to ensure that copies of any correspondence and referral forms are sent to social services and GPs.
Anaesthetics	New anaesthetic charts have been produced with pre-printed analgesia to aide post operative prescribing for pain relief. This is to ensure that patients receive appropriate levels of post operative analgesia and anti-emetics.
Oncology	All non-small cell lung cancer (NSCLC) adenocarcinomas are tested for Epithelial Growth Factor Receptor (EGFR) routinely and the path labs in Kent are now centralised at the Maidstone site. Results are therefore available for the oncology team when the patient comes to clinic
Haematology	A local guideline for prescribing Warfarin for acute inpatients has been written, approved and is available on to the Trust intranet. to help ensure safer, more standardised prescribing
Microbiology	Introduction of stop date stickers to highlight patients with antibiotic duration longer than recommended 5 days. Introduction of information on diagnosis of CA-DSU in antimicrobial guidelines.to avoid unnecessary antibiotic prescribing

NICE Guidelines

Every year the National Institute for Health and Clinical Excellence (NICE) develops a number of guidelines for the NHS to review and implement to enhance practice and the care of patients. As at the end of 2013/14 there have been **871** NICE guidance disseminated to the specialty leads throughout the Trust. Of those, **765** (**87.8%**) have been evaluated. **309** (**40.4%**) of the evaluated guidance are relevant to the Trust.

All **95** relevant NICE Clinical Guidelines have been or are planned to be audited to ascertain Trust compliance. To date, **75** clinical guidelines have completed audits against them.

Of the audits completed against NICE clinical guidelines in the last 12 months, **2** showed the Trust to be fully compliant against the guidance (Pressure Ulcer and post operative analgesia following elective caesarean section). Both have re-audits on the 2014/15 audit programme. **22** audits have shown partial compliance and have actions being implemented to address risks. These guidelines are also to be re-audited to check compliance.

The clinical audit team continue to monitor action plan implementation and must ensure all clinical guidelines are audited once according to commissioner guidance. Progress with reviewing and auditing NICE Clinical Guidelines is progressing well. A large number of audits are showing partial compliance with guidance but all audits have action plans in place to mitigate risks and are on the re-audit programme. Several NICE guidelines will have been audited more than once since publication. The Clinical Audit Team continues to work closely with the Deputy Medical Director to disseminate and ensure the full review of Quality Standards. The process around ensuring compliance and the auditing of quality standards is currently under discussion on a region-wide basis lead by NICE.

Please see Appendix C for full details of progress against each of the NICE clinical guidelines.

Research

Participation in clinical research

Commitment to research as a driver for improving the quality of care and patient experience

During 2013/14, over 1,500 patients were recruited to research trials at MTW. The majority were placed in national portfolio-led trials spanning all trust directorates (please see split below).

There are presently 153 studies open and recruiting, inclusive of randomised clinical trials, observational studies, MTW investigator led and student projects. Participation in clinical research demonstrates Maidstone & Tunbridge Wells NHS Trust commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

72 new clinical research studies were opened across the following directorates during 2013/14 - Oncology, Radiotherapy, Rheumatology, Cardiology, Diabetes, Ophthalmology, Stroke Services, General Surgery, Anaesthetics, Orthopaedics, Gastroenterology, Respiratory, Paediatrics, Gynaecology, Radiology and Neurology. 91 studies are closed to recruitment with patients being followed up until the close of the trials.

Over 300 clinical staff participated in research approved by a research ethics committee during 2013/14. Maidstone and Tunbridge Wells NHS Trust has focused on encouraging non-medical staff to lead innovative research locally and nationally to increase the diversity of research conducted. Clinical staff, with the role of either Principle or Chief Investigator, now includes consultants, senior nursing staff, therapeutic and support service staff.

Since 2008/9, over 200 research papers have been published either solely by research staff at Maidstone and Tunbridge Wells NHS Trust or through collaboration working with staff from other institutions, spanning a wide range of journals, both in the UK and across the world.

The Kent Oncology Centre Clinical Trials Unit (KOCCTU) at Maidstone Hospital continues to expand its portfolio of cancer trials ensuring that all cancer patients have an opportunity to participate in the open trials at MTW. Last year over 300 patients were successfully recruited to a cancer trial.

New bids for research funding submitted during 2013/14 include a funding application to the NIHR look at developing a perioperative isometric-resistance exercise intervention programme for patients undergoing elective abdominal and thoracic surgery for cancer. This joint venture with Christ Church University in Canterbury, Kent has successfully completed the first vigorous round of scrutiny by the funding body. It is hoped funding will be awarded early in 2014 for the study to begin later in the year.

Goals agreed with commissioners

Use of the CQUIN payment framework
This section describes how the Commissioning for Quality and Innovation (CQUIN) payment framework is used locally. The CQUIN framework aims to support a shift within the NHS to ensure that quality is the organising principle for all NHS services. It provides a means by which payments made to providers of NHS services depends on the achievements of locally agreed quality and innovation goals.

In 2013/14 2.5% of the contract value was dependent on achieving the CQUIN targets in line with the CQUIN payment framework.

Further details of the agreed goals for 2013/14 and for the following 12 month period are available electronically at www.mtw.nhs.uk

Within the commissioning payment framework for 2013/14, quality improvement and innovation goals were set as indicated in the table below.

	Target	**Achieved (local data)**
National CQUINS		
Friends & Family Test - % response rate for combined A&E & IP	**20%**	**12.4%**
Friends & Family Test – Increase score for FFT.	**76** (upper quartile)	**69**
Friends & Family Test – Maternity (from October 2013)	**100%**	**100%**
Safety Thermometer % surveyed monthly	**95%**	**95%**
Safety Thermometer % of harm free care	**92%**	**95.4%**
Dementia Screening - % patient admissions >75yrs	**90%**	**98.9%**
Dementia Risk Assessment - % of those screened who had a risk assessment completed <72hrs after admission	**90%**	**99%**
Dementia – referral for specialist diagnosis	**90%**	**100%**
VTE - % of adult inpatients that have a VTE Risk Assessment	**95%**	**95.2%**
Regional CQUINS	**Target (Jan-Dec 2013)***	**Achieved**
Improvement and maintenance of % of patients receiving pathway metrics for key areas:		
Pneumonia with CURB (Apr - Dec 12)*	**59.3%**	**59.24%**
Heart Failure (Jan - Dec 12)	**70.6%**	**75.1%**
Enhanced Recovery: Colorectal – all measures	**45.1%**	**64.5%**
Enhanced Recovery; Gynaecology – all measures	**58.7%**	**88.1%**
Enhanced Recovery; Orthopaedics – all measures	**59.9%**	**90.2%**
Data completeness	**95%**	**98%**
Local CQUINS	**Target**	**Achieved**
Reduction in length of stay	**6.5 days**	**4.9 dyas**
20% reduction in patients admitted in diabetic crisis: % variation 13/14 from 12/13	**20%**	**15.6%**
Provision of 2 sessions consultant education per year in each of the 4 specialities – Diabetic, respiratory, Cardiology, Neurology	**8**	**Achieved**

PROMS – increase in % eligible taking part in Q3 13/14	**68.8%**	**67%**
A&E - % treated within 1 hour of arrival by Q3	**50%**	**50.1%**
A&E Data control: tom improve accuracy of GP and practice coding in A&E dataset	**98.5%****	**98.5%**
Rate of written complaints per 1,000 episodes	**6.26**	**5.07**
Effective Communication – 50% of A&E/Non-elective Discharge notifications to be electronic	**50%**	**59.5%**
Falls: 10% reduction in rate against 2012/13 data	**7.2**	**7.1**
Falls: harm resulting from falls – all Fragility admitted as inpatients to be seen by othogeriatrician or Geriatrician for osteoporosis assessment	**50%**	**90.2%**
Falls: harm resulting from falls – all patients discharged from A&E following fragility fracture referred to CFT for assessment (Q4)	**50%**	**82.6%**
Falls Screening in hospital settings for >75yrs if appropriate (Q4)	**90%**	**96%**
Respiratory: 100% of COPD patients referred to smoking cessation service	**50%**	**23.7%*****
Psychiatric Liaison:		
Evidence of improved ou7tcomes in at least 5 of the 8 indicators	**Improvement**	**Achieving**

* Note differing data collection timeframes

**Target for this measure not agreed with CCG

***Of the COPD patients discharged from April 2013 to march 2014 that were identified by PAS or htte Smoking Cessation Service as Smokers, 23.7% were referred to the Smoking Cessation Service.

You will note that a number of these are linked to the key priorities set for 2013/14

Similarly we have used these outcomes to help inform our decision on what to make key priorities for 2014/15.

Statements from the CQC

The Care Quality Commission carried out three inspections within the trust in 2013/14:
To Maidstone Hospital in March 2013, Tunbridge Wells Hospital in November 2013 (as part of an 'out of hours' review) and Maidstone Hospital in February 2014.

Actions were required following the visit to Tunbridge Wells Hospital in November. These related to;

Paediatric Staffing in Accident & Emergency
Safe storage of medicines.

A full action plan is in place with compliance for the safe storage of medicines across the Trust now compliant.

Paediatric staffing Accident & Emergency is subject to a wider review as detailed earlier in this document.

The report for the February visit to Maidstone hospital was as a result of the concerns relating to upper GI surgery following and invited review by the Royal College of Surgeons.

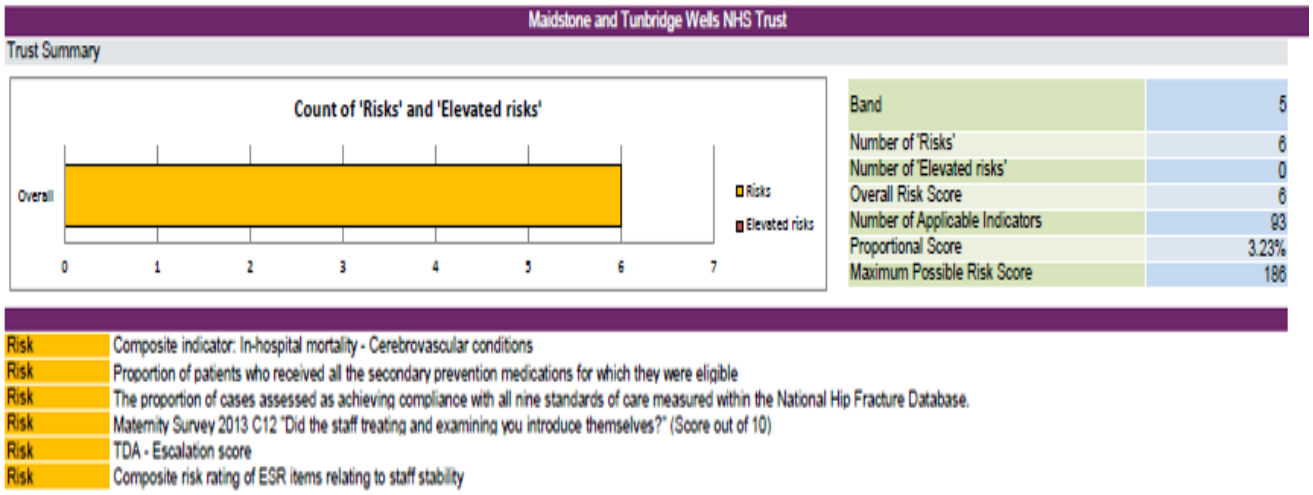
The findings from this report relate to staffing, medical staff job planning and governance.

An action plan to address these concerns was being developed at the time of preparing this Quality Account. However, key issues relating to job planning were already being addressed. Challenges to the frequency of meetings of the Quality & Safety Committee have also been addressed. The Quality & Safety Committee now meets monthly, with a focused topic for 'deep dive' alternate months.

Actions are monitored via the relevant governance committees.

Intelligent Monitoring:
The CQC developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals in 2013. These indicators relate to the five key questions asked of all services – are they safe, effective, caring, responsive and well-led? The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements. Judgements will always be based on the result of an inspection, which will take into account Intelligent Monitoring analysis alongside local information from the public, the trust and other organisations.

Trusts are given a risk rating between 1 and 6, with Band 1 being the highest priority rating (or greatest risk) and 6 being the lowest priority (or lowest risk). The rating is revised every quarter. For the two quarters published to date the Trust had achieved and maintained a banding or score of 5. The most recent available profile is in the table below.



Full reports can be accessed via the CQC website www.cqc.org.uk

Improving data quality at MTW

Maidstone and Tunbridge Wells NHS Trust is committed to providing a service of the highest quality. To achieve this, data that clinical, operational and strategic decisions are based on need to be of the highest quality. Specifically, MTW needs to ensure its data quality so that it can:

- Provide effective and efficient services to its patients, staff and partners.
- Produce accurate and comprehensive management information on which timely, informed decisions are made to inform the future of the Trust.
- Monitor and review its activities and performance
- Produce accurate data to ensure appropriate reimbursement and account for performance as required
- Meet the standards set out for Information Governance and the requirements of the Information Commissioner

During 2013-14 the Trust successfully completed the completeness and validity checks set out as part of the Information Governance Toolkit. This is confirmed by the results from the NHS Information Centre's Secondary Uses Services data quality reports. The Trust has not been subject to an Audit Commission Payment By Results audit in 2013/14.
The Trust has a Data Quality Steering Group that takes action on data quality issues. Areas identified for improvement during 2014-15 are:-

- Continue to expand the use of the NHS Number within in the Trust as the primary identifier.
- Support the procurement of a spine compliant Patient Administration System
- Continue an on-going program of data quality workshops for staff based on targeted areas for improvement.

NHS Number and General Medical Practice Code Validity
Maidstone and Tunbridge Wells NHS Trust submitted records during 2013-2014 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:
Which included the patient's valid NHS number was:

98.7% for admitted patient care;
99.2% for outpatient care; and
92.7% for accident and emergency care.
Which included the patient's valid General Medical Practice Code was:
99.8% for admitted patient care;
99.8% for outpatient care; and
99.5% for accident and emergency care.

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Information Governance Toolkit attainment levels
The Trust achieved an 82% satisfactory score against the Information Governance Toolkit Version 11, and achieved 22 of the 45 requirements at level 3. The remaining requirements were achieved at level 2 as required by the Operating Framework for England for 2011/12.
The Trust has a robust Information Governance Management Framework that has been in place throughout the year and significant improvements continue to be made in many areas. An action plan has been developed to address the areas of weakness identified and progress against the action plan is monitored by the Information Governance Committee which is chaired by the Trust

Senior Information Risk Owner. The Trust Board is kept fully appraised of Information Governance issues affecting the organisation.
The trust has an action plan in progress to continue to improve its compliance with the IG standards.

Clinical Coding
Maidstone and Tunbridge Wells NHS Trust employ a team of appropriately qualified staff to code clinical data. This coding it independently audited to ensure that the coding reflects the patient's diagnosis and treatment. Audit results for 2013-14 were as follows:-

Primary Diagnosis	93.19%
Secondary Diagnosis	99.14%
Primary Procedure	96.83%
Secondary Procedure	97.64%

Errors may occur when a clinical coder translates the written information provided by a clinician regarding a patient's diagnosis and treatment into standard codes. These codes are nationally and internationally recognised and are used by healthcare professionals and researchers to check on the outcomes of a patient's diagnosis and treatment and compare it to other patients and organisations in other parts of the country and abroad.

An action plan has been developed to address staff training issues identified as a result of the audit.

Part Three
Review of Quality Performance

With this section we have reviewed our performance against key priorities that we set for last year and also other areas of quality performance.

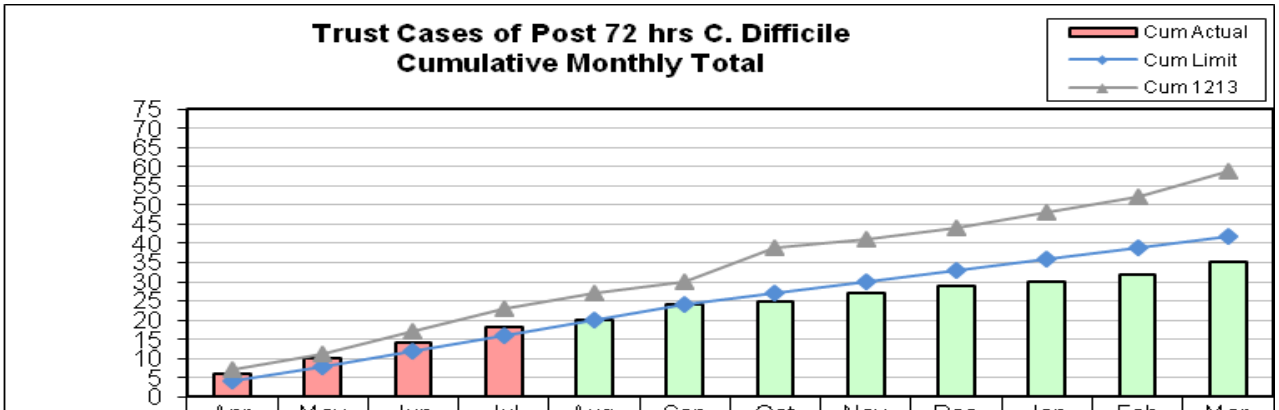
In relation to some of the key priorities that have been included again for 2013/14 some information has already been included in Part Two.

PATIENT SAFETY
Reducing the number of avoidable healthcare associated infections
See key priorities for 2014/15

Our rates of C. difficile infection have continued to fall, having had 35 cases against a limit of 42 for the year. This represents a 39% reduction with zero cross infection.

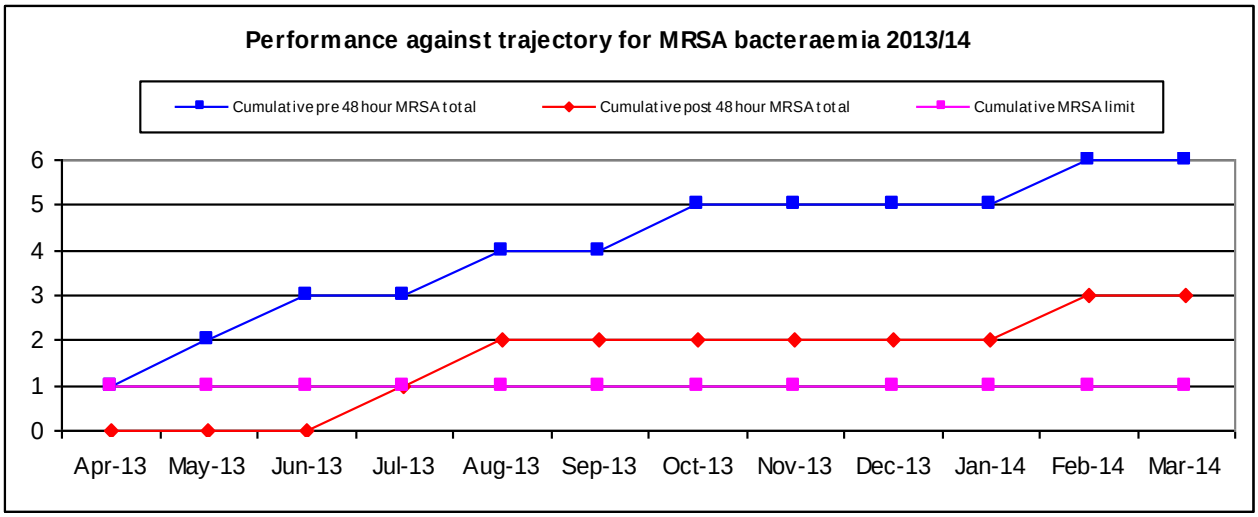
Our MRSA bacteraemia rate has plateaued in the last year with three cases in 2013/14.

Infection Control – C.Difficile Cases – The Trust exceeded this standard with with 35 cases against a limit of 42 for the year.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cum Actual	6	10	14	18	20	24	25	27	29	30	32	35
Cum Limit	4	8	12	16	20	24	27	30	33	36	39	42
Cum 1213	7	11	17	23	27	30	39	41	44	48	52	59

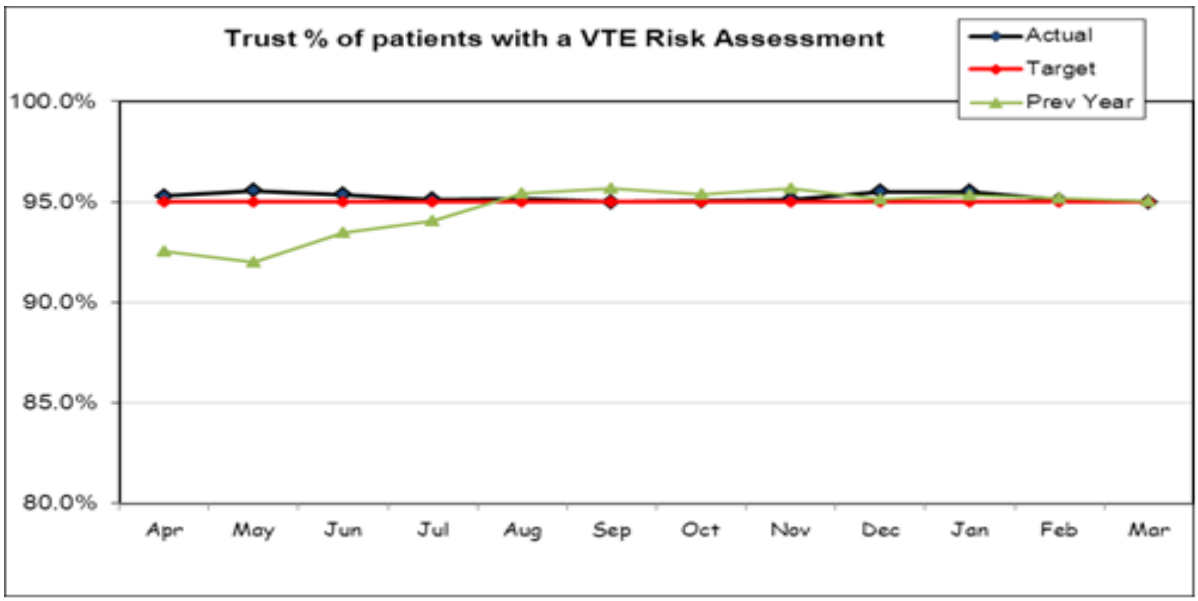
Infection Control – MRSA Cases – The Trust did not achieve this standard, with 3 cases of post 48hr MRSA bacteraemia throughout the year against a Trust standard of zero avoidable.



The Trust has an action plan in place aligned to published evidence on the prevention of health care associated infections (HCAI) and seeing improvements in MRSA screening and, where appropriate, early implementation of decolonisation treatment.

Prevention of blood clots or venous thromboembolism (VTE)

% Patients VTE Risk Assessment – The Trust ensured that 95% of patients were given a VTE Risk Assessment in 2013-14.

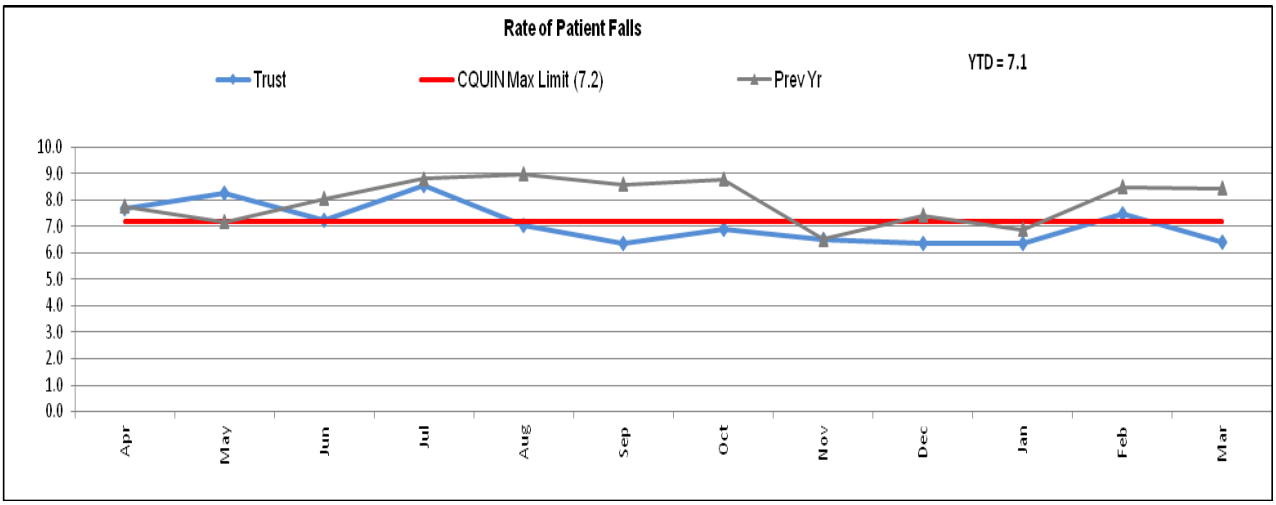


MTW has been compliant with the national CQUIN goal for VTE that 95% of patients had been risk assessed and managed accordingly.

Reducing the number of patient falls

See key priorities for 2014/15.

10% reduction in falls rate against 2012/13 (8.0) – The Trust has achieved a 13% improvement with a year end rate of 7.1



The trust has implemented a number of actions to help reduce the number of falls. There is a "Falls Group" which reviews falls and ways to minimise the risk for patients. There is a specific panel looking at the root causes as a result of which we have a trust-wide action plan.

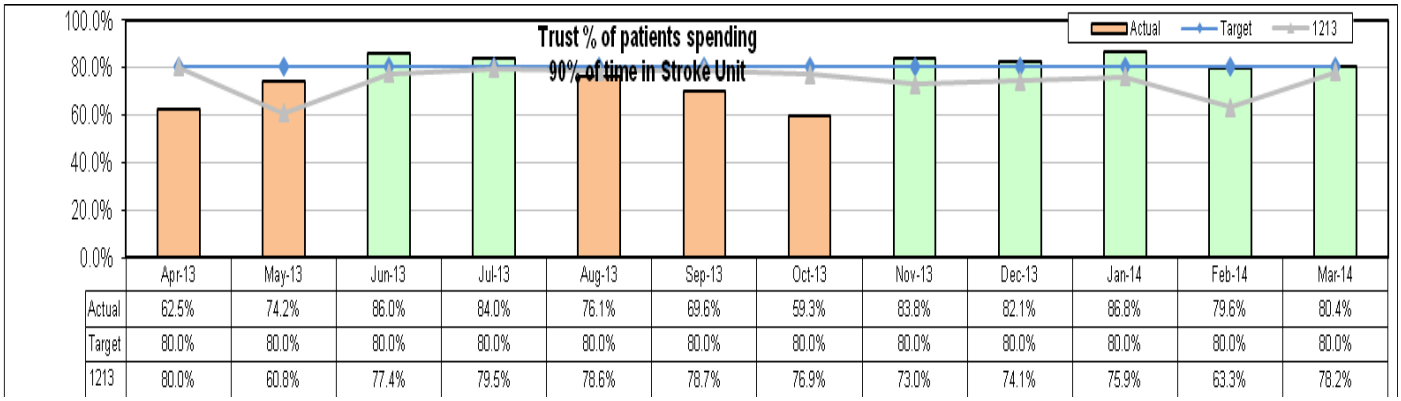
We have seen an overall decrease in the rate of falls measured by 'per occupied bed day'.
Our base line rate for improvement at the start of the year was a rate of 8.0 per 1,000 occupied bed days. Over the course of the year this rate has decreased to 7.2 per 1,000 occupied bed days with represents a 13% improvement.

There have been a total of 1585 falls over the last year compared to 1827 in the previous year. Of these, 59 resulted in moderate to severe harm compared to 69 for the previous year.

Whilst represents significant improvements, it does remain a cause for concern and is, therefore, a key priority for improvement in the coming year.

CLINICAL EFFECTIVENESS
Continue our focus on improving care for patients who have had a stroke

80% of patients spending 90% of time on in Stroke Unit - The Trust did not achieve this for year.



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Actual	62.5%	74.2%	86.0%	84.0%	76.1%	69.6%	59.3%	83.8%	82.1%	86.8%	79.6%	80.4%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
1213	80.0%	60.8%	77.4%	79.5%	78.6%	78.7%	76.9%	73.0%	74.1%	75.9%	63.3%	78.2%

Overall the Trust did not meet this standard consistently throughout the year. Work is in train to address the patient flow challenges and to consider who the boundaries of a 'stroke unit' can be effectively safely extended.

Continue to improve the care we provide for patients who are suffering from dementia

See Key priorities for 2014/15

The Trust made considerable improvements within 2013/14 to ensure patients suffering from dementia receive the appropriate care.

The Trust has a Lead Nurse for Dementia Care in post. Key achievements include the development and publication of a dementia care policy, a dementia care strategy, development of care guides and care plans to inform the care of dementia patients across all in-patient settings, liaison with community groups and carers groups, establishment of a 'buddy scheme' is well underway in partnership with the Alzheimer's and Dementia Support Services Charity. Links have also been made with a number of local Dementia Cafes.

The Lead Nurse has worked closely with the Estates and Facilities teams as well a clinical teams to ensure the needs of dementia patients and others with cognitive impairments are considered when ward refurbishments or service redesign initiatives are being planned.

The key criterion within the national dementia CQUIN has been met.

Improving the management of discharge planning

See key priorities for 2014/15

The trust has taken a number of initiatives to improve discharge planning for our patients. This has included closer working with partner organisations in the community to ensure that patients receive appropriate care in the community following discharge. To enhance this multidisciplinary approach there has also been further training for staff in relation to the required information sharing to facilitate the required care.
There is a county-wide strategic level group to support the multiagency working.

Internally, the discharge planning team capacity and capability has been reviewed. Following this, further investment was made following a pilot of ward based discharge co-ordinators. The team now have key staff who are aligned to specific wards and who attend the ward 'board rounds' and liaise with clinical staff, community teams, patients and their families.

We have also been improving the electronic discharge notifications to General Practitioners so that they receive information about the care that has been received by their patients within 24 hours of the discharge. We continue to work on enhancing the information and the timeliness of sending it out.

We have outlined a number of further actions to be taken in 2014/15 to further improve the process for patients which have been outlined in the key priorities.

PATIENT EXPERIENCE

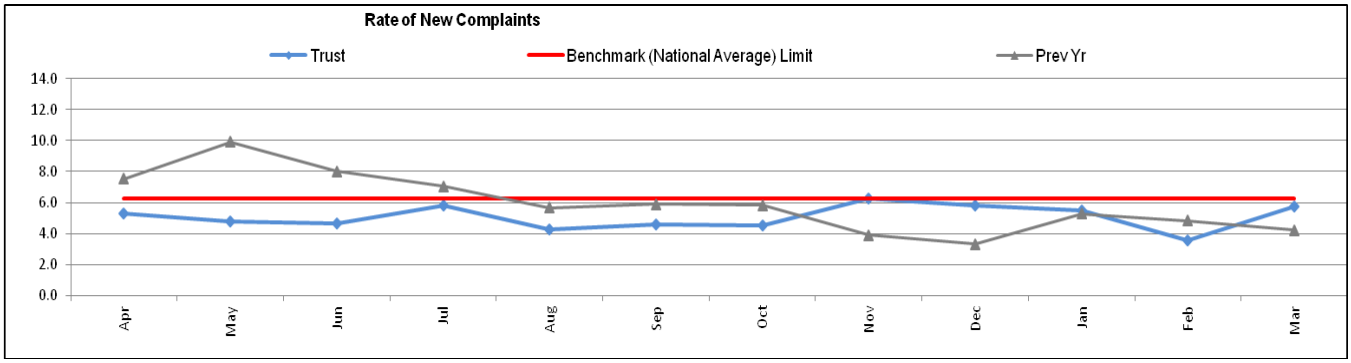
Complaints management

See key priorities for 2014/15

Improving the management and quality of responses to complaints we receive and ensure each is used as an opportunity from which we can learn.

The complaints handling process was revised last year, and liaison with directorates over this last year has seen a positive impact on the overall number of complaints in terms of numbers responded to within agreed time frames, number of re-opened complaints and a reduction in the overall number of new complaints received.

New complaints are monitored by rate per 1,000 episodes. The national benchmark is a rate of 6.26. Over the course of the year we had 573 new complaints equating to a rate of 5.07.



Complaints themes are monitored regularly via the Quality & Safety Committee and a detailed report is provided to the Trust Board on a quarterly basis.

Further work is to be undertaken to review the complaints process satisfaction survey to ensure we are doing all we can to make the process as transparent and straight forward as possible, ensuring that all the recommendations from the Clwyd Hart report are fully incorporated and effective.

Patient Surveys

With respect to the key priority in relation to patient surveys the following actions have been taken:

- Two surveys relating to enhancing quality measures for patients undergoing hip and knee surgery and those being treated for heart failure have been introduced.
- The Trust internet page is now able to be accessed by patients to record their opinions in line with the national “friends and family” initiative.
- The Trust has also introduced the national friends and family question across all inpatient wards and A&E departments. This is reported to the trust Board for scrutiny alongside other survey results.
- Surveys for Outpatients due be completed in May 2014
- Surveys for Accident & Emergency due to commence in 2014

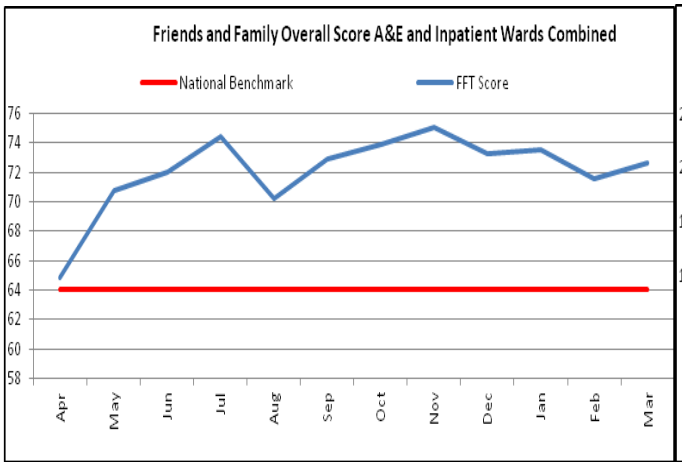
As stated in last year’s account we also aimed to improve the experience of patients across the organisation through focusing on key areas highlighted as requiring attention in the national inpatient survey. Below are the questions we focused on and this years results are compared with those of the previous year where possible. Improvements were made in all areas.

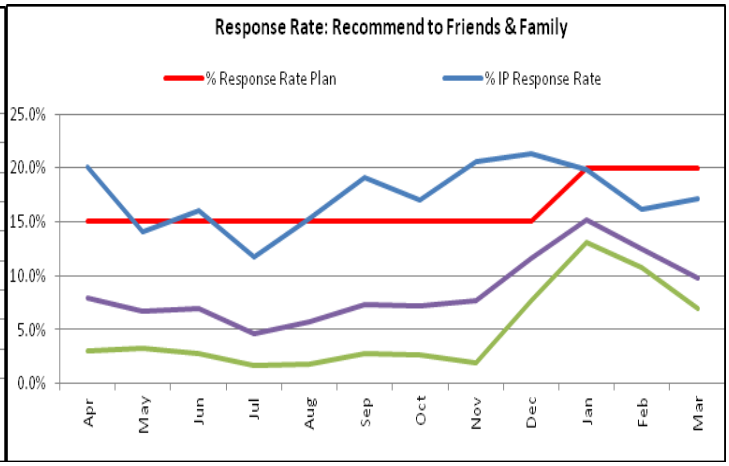
National Inpatient Survey 2013

Focus questions from National Inpatient Survey		National Inpatient Survey	
		2012	2013
1	Were you involved as much as you wanted to be in decisions about your care and treatment?	88.9%	91.2
2	Did you find someone on the hospital staff to talk to about your worries and fears?	44.3%	45.5
3	Were you given enough privacy when discussing your condition or treatment	97.7%	97.4
4	Did a member of staff tell you about medication side-effects to watch for when you went home?	36.5%	43.7
5	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	65.3%	73.6

We continue to survey our inpatients using electronic questionnaires and these are reported monthly to the trust board.

The Trust has failed to meet the desired response rate for Friends & Family, however, the Trust is performing consistently on the overall net promoter score, being consistently above the national benchmark.





Learning from Serious Incidents / Never Events
To minimise any risks to our patients we have a robust reporting system for incidents. These are reported centrally to a national system that looks at incidents and trends to enable us to share learning from these on a national basis.

All incidents that are classified as serious are reported to an executive led review panel to ensure we have identified the root cause of the incident and appropriate action is being taken to prevent a similar situation arising again.

A number of actions have been taken to minimise risks over the last year. These include:

- Revised processes within maternity and gynaecological theatres for the identification of post-operative packs
- Change in standard theatre pack. The pack no longer contains a pack or tampon as a routine thus reducing the likelihood of a pack being inserted without the team's knowledge.
- Implementation of 'pack ID bands' for patients who have a surgical pack insitu
- Review of training and potential removal of radiological investigation requesting rights if the same practitioner requests inappropriate investigations (or provides incorrect patient details resulting in an inappropriate investigation) twice.
- Review of systems and processes for the reporting of radiological investigations to ensure timely reporting to requesting clinician, including daily review of potential backlog and outsourcing if and where appropriate.

The number of Serious Incidents for the year has decreased with a total of 129 compared to 141 in the previous year.

Never Events: these are a nationally agreed list serious incidents.
The Trust has had one "never event" reported this year. This related to a specimen slide labelling error within the pathology laboratory. A full root cause analysis investigation was undertaken and changes to practice instigated as a result.

Berwick Review: A Promise to Learn – a commitment to act: improving the safety of patients in England.

The Trust fully supports the recommendations contained within this report, and actively seeks to engage with staff at all levels as part of the investigation to ensure that all opportunities for learning are maximised.

The Trust engages with patients during the course of these investigations to ensure open and transparent dialogue takes place. Where any complaint or concern is raised this is cross referenced to any incident and outcome shared with the patient.

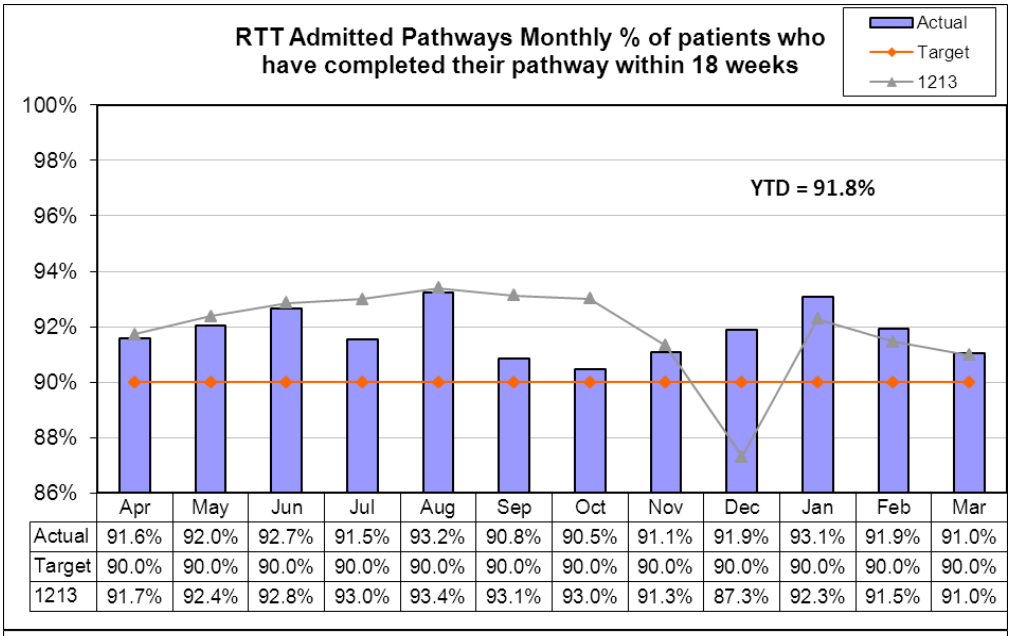
The Trust monitors trends of incidents both within a particular service and across the range of services it provides to ensure lessons learnt in one area are understood in another.

The Trust is performing well overall and noted elsewhere within this account, the Trust is achieving in excess of 92% in the Safety Thermometer score – a tool designed to identify key safety issues and monitor progress of improvements.

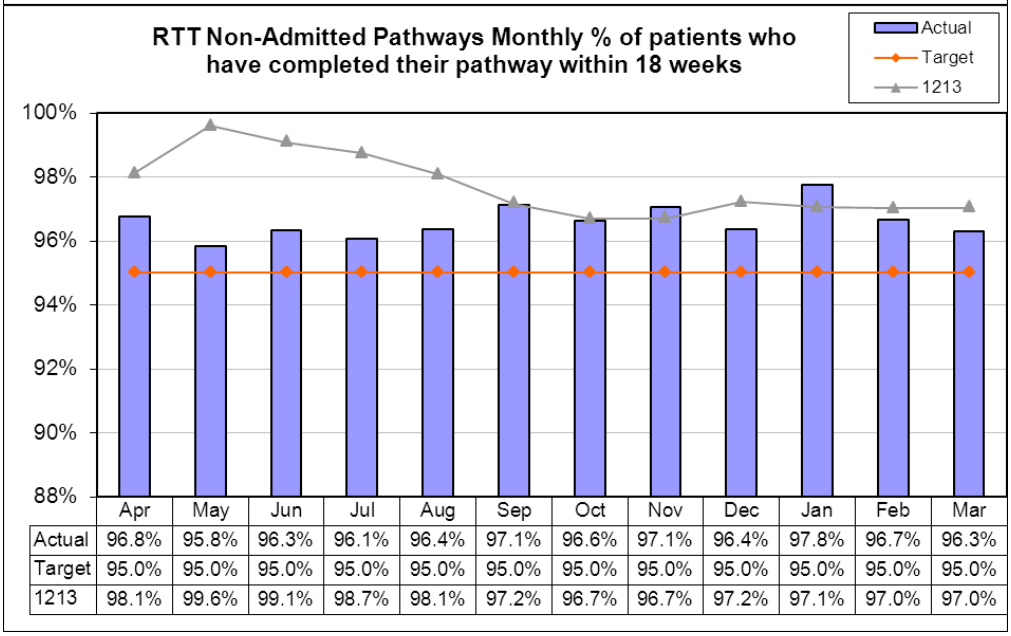
Other Quality Monitoring and Improvement Measures

Maidstone and Tunbridge Wells NHS Trust met the majority of national waiting time standards in 2013-14. These are designed to ensure patients are seen appropriately according to their clinical need.
The Trust's overall performance is measured against 70 local and national standards on a monthly basis. These results are shared with commissioners of local health services and are discussed by the Trust Board at its public meetings.
A summary of the Trust's overall performance in all local and national standards for 2013/14 will be available to view on the Trust's website in May 2013 – www.mtw.nhs.uk a summary of the Trust's overall performance for the 11 months up to February 2014 is available on the website now.

18 weeks standard – The Trust achieved this standard, ensuring at least 90% of admitted patients were treated in hospital following GP referral in 18 weeks. The Trust also ensured 95% of non-admitted patients were seen within the same period.

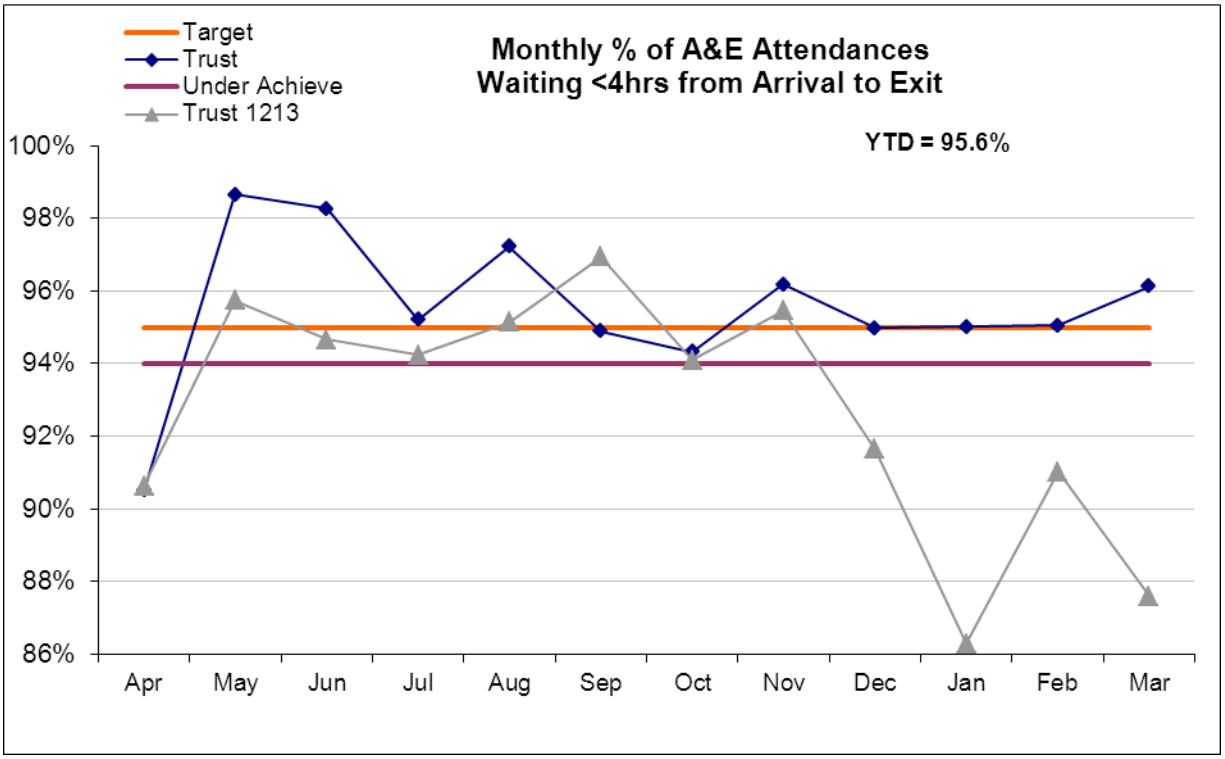


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	91.6%	92.0%	92.7%	91.5%	93.2%	90.8%	90.5%	91.1%	91.9%	93.1%	91.9%	91.0%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
1213	91.7%	92.4%	92.8%	93.0%	93.4%	93.1%	93.0%	91.3%	87.3%	92.3%	91.5%	91.0%

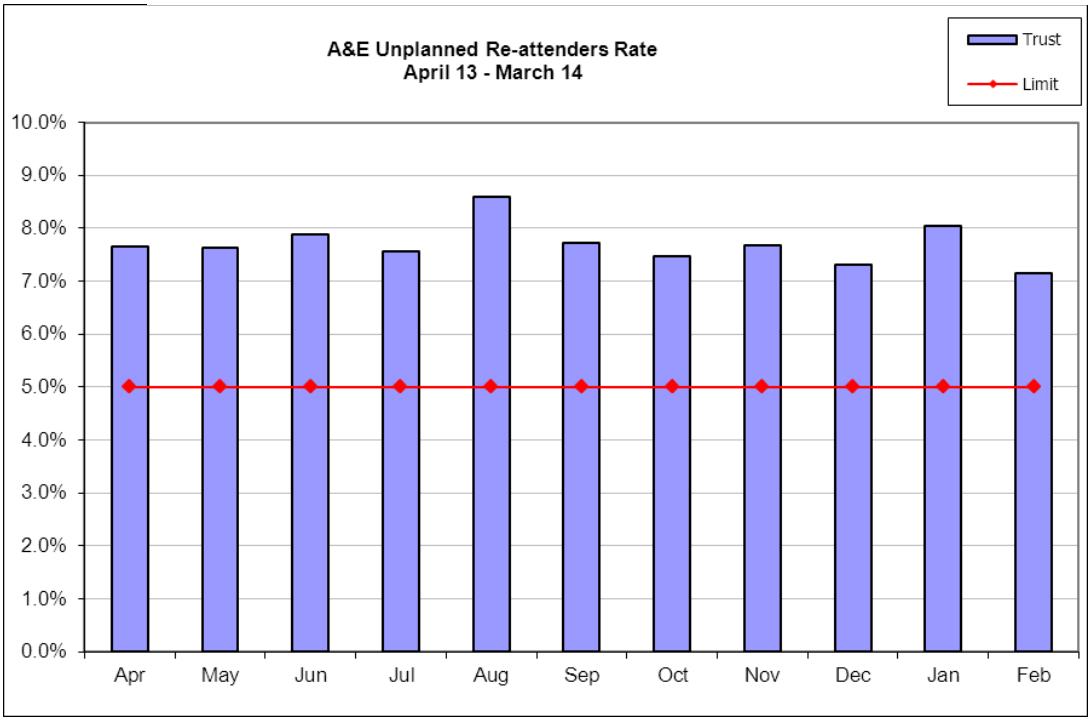


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	96.8%	95.8%	96.3%	96.1%	96.4%	97.1%	96.6%	97.1%	96.4%	97.8%	96.7%	96.3%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
1213	98.1%	99.6%	99.1%	98.7%	98.1%	97.2%	96.7%	96.7%	97.2%	97.1%	97.0%	97.0%

Emergency 4 hour access – The Trust achieved this standard of 95% of patients being seen, treated, admitted or discharged within 4 hours of arrival in its A&E departments in 2013-14. Overall performance was 95.6%.

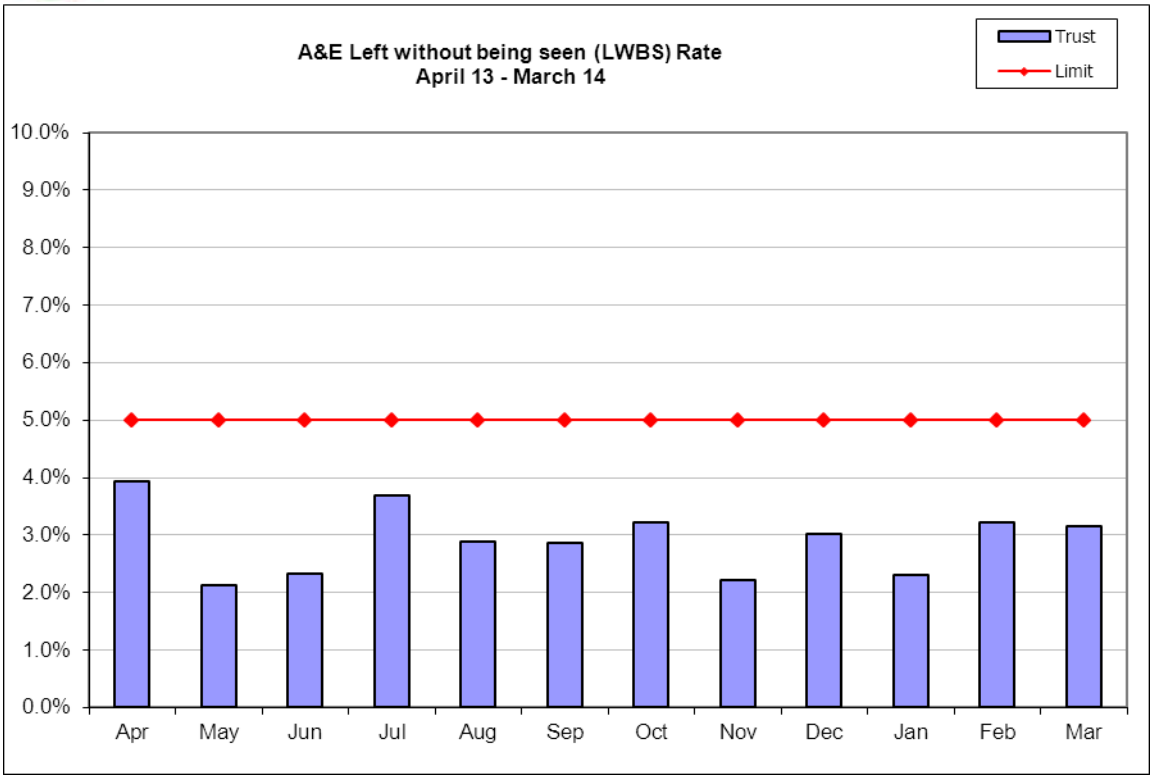


A&E Unplanned Re-attendance Rate – The Trust did not achieve this standard of less than 5% unplanned re-attendance rate.

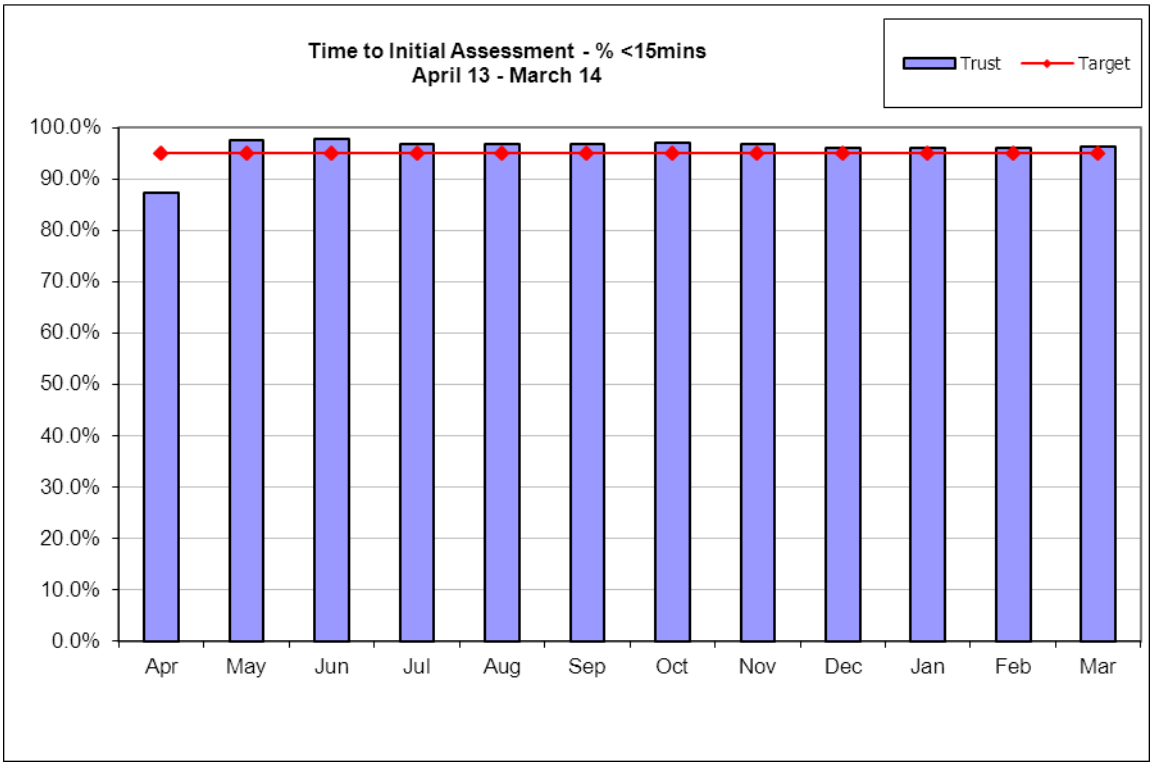


The Trust has in place a number of initiatives in partnership with community colleagues for non-elective admission avoidance following trauma, stroke and repiratory conditions. The Trust has an Urgent Medical Amublatory Unit at Maidstone to enable follow up review of patients initially seen and discharged from the Accident & Emergency Department.

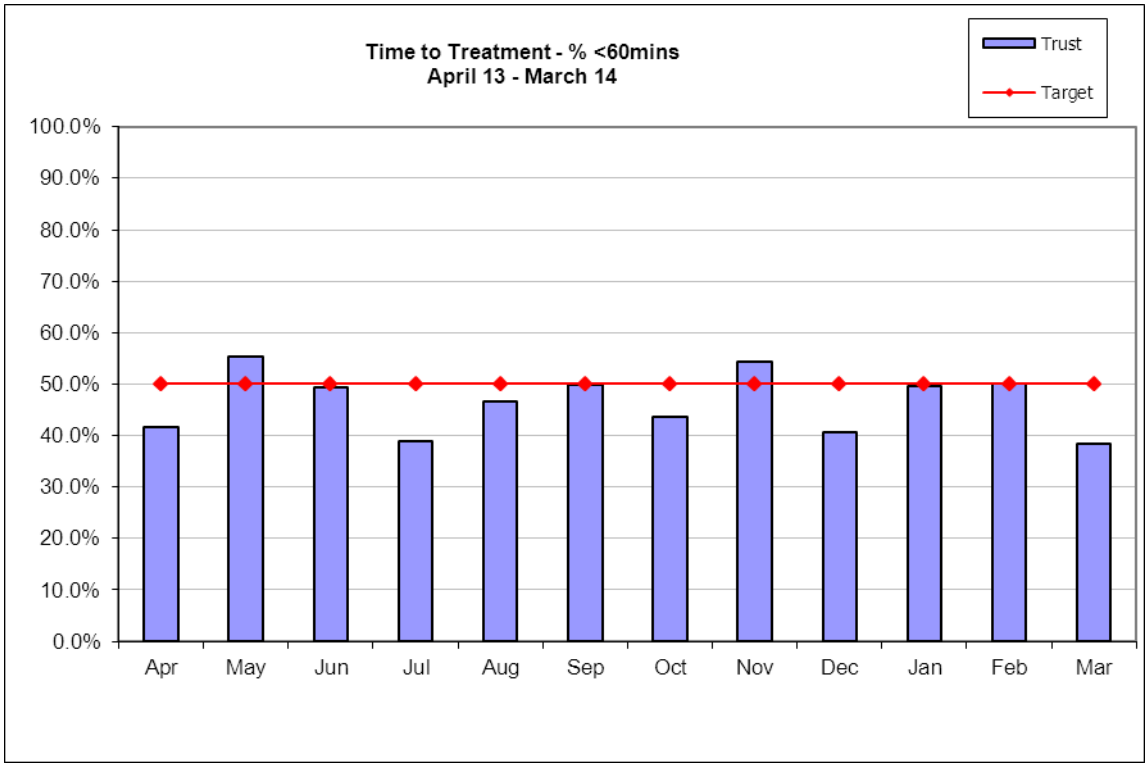
A&E Left without being Seen Rate – The Trust achieved this standard, of less than 5% of patients leaving its A&E Departments without being seen.



A&E Time to Initial Assessment <15 minutes – The Trust achieved this standard of 95% of patients arriving in its A&E Departments being assessed within 15 minutes of arrival.

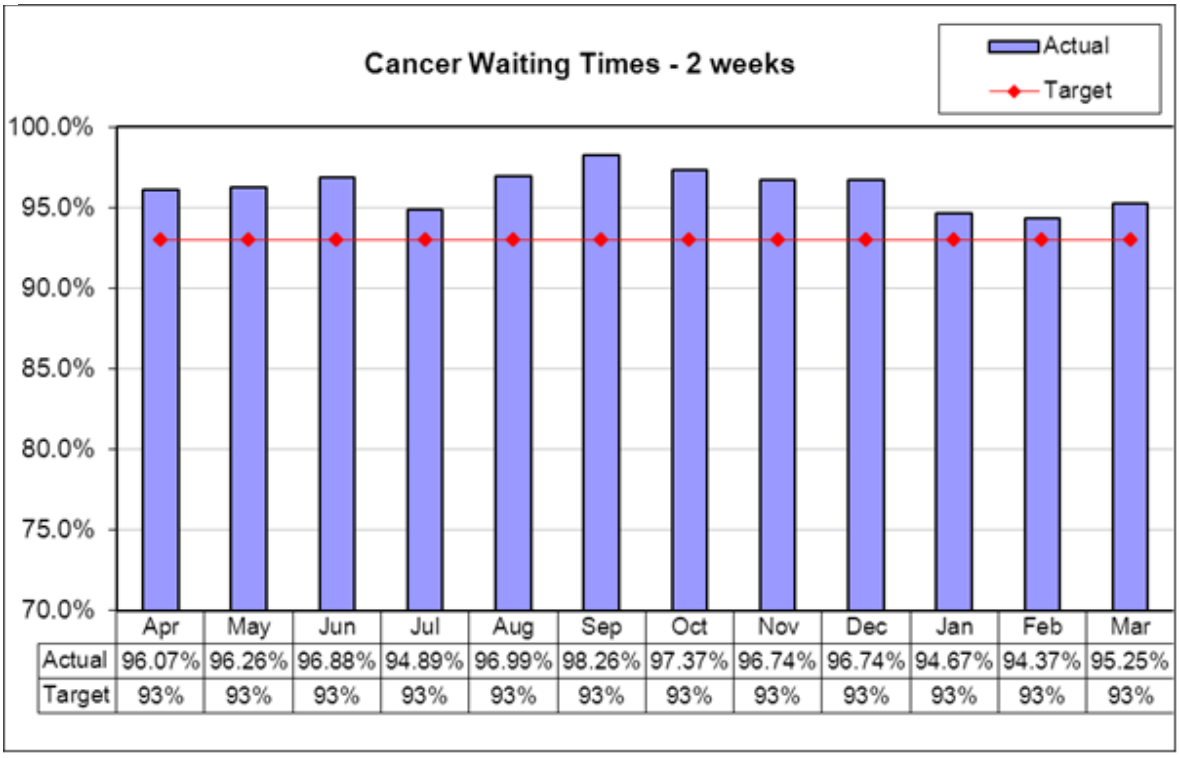


A&E Time to Treatment <60 minutes – The Trust did not achieve this standard of 50% of patients arriving in its A&E Departments being treated within 60 minutes of arrival.



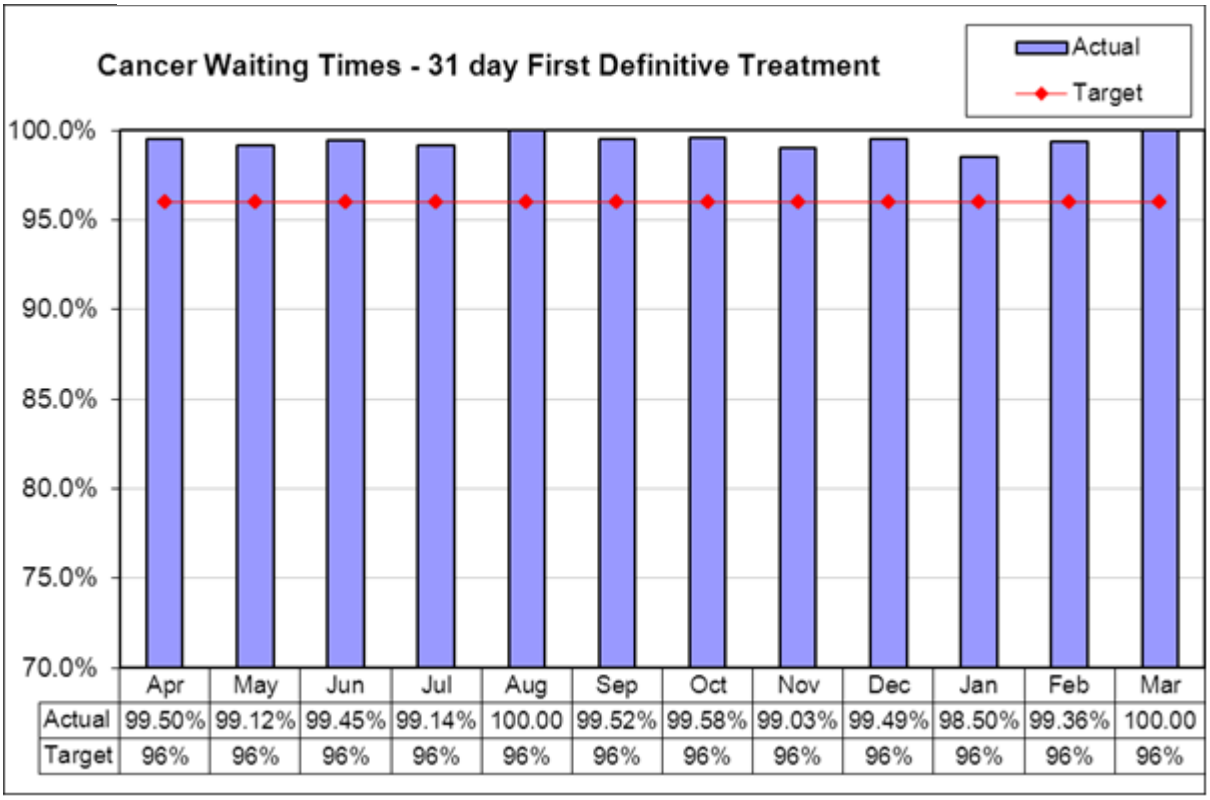
The Trust has an Accident & Emergency Improvement plan in place with the key focus on performance at the Tunbridge Wells Hospital site.

Cancer Waiting Time Targets - 2 weeks from referral – The Trust has achieved this standard ensuring that 93% of patients with suspected cancer were seen within two weeks.



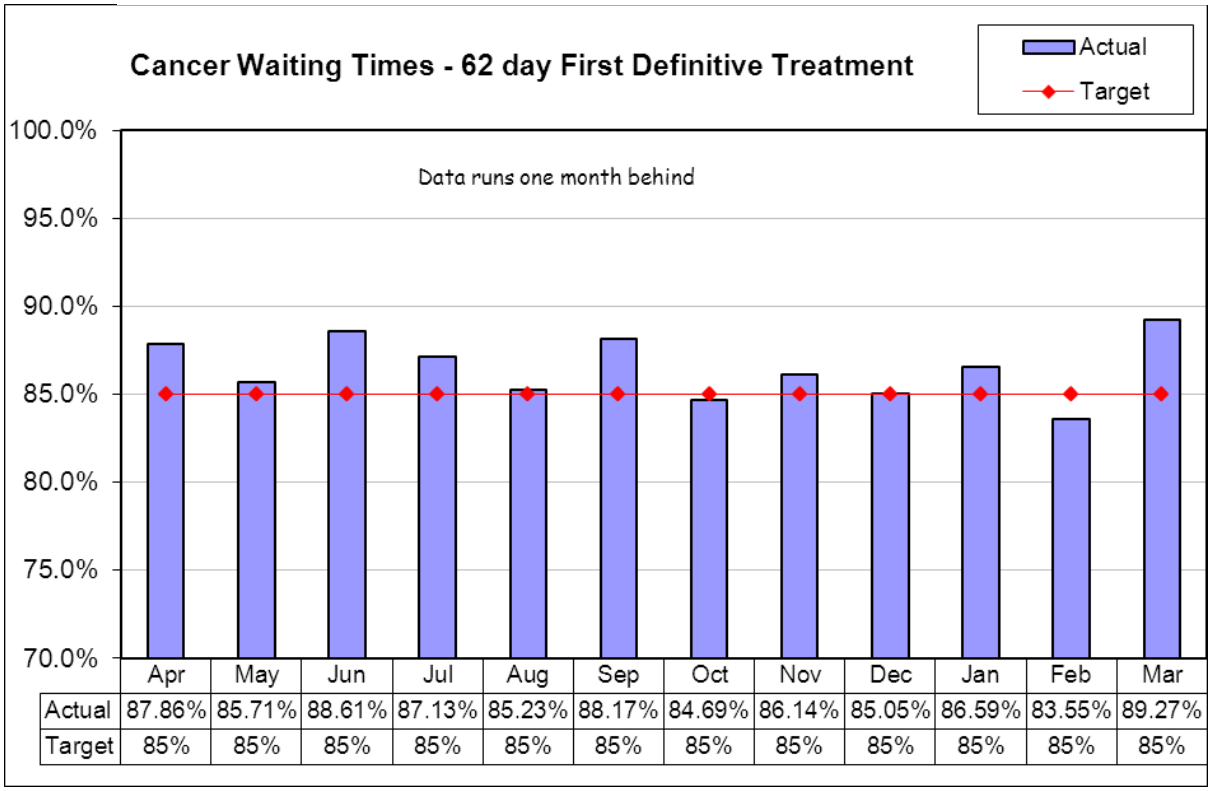
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	96.07%	96.26%	96.88%	94.89%	96.99%	98.26%	97.37%	96.74%	96.74%	94.67%	94.37%	95.25%
Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

Cancer Waiting Time Targets – 31 Day First Definitive Treatment – The Trust has achieved this standard ensuring that 96% of patients who needed to start their treatment within 31 days did so.



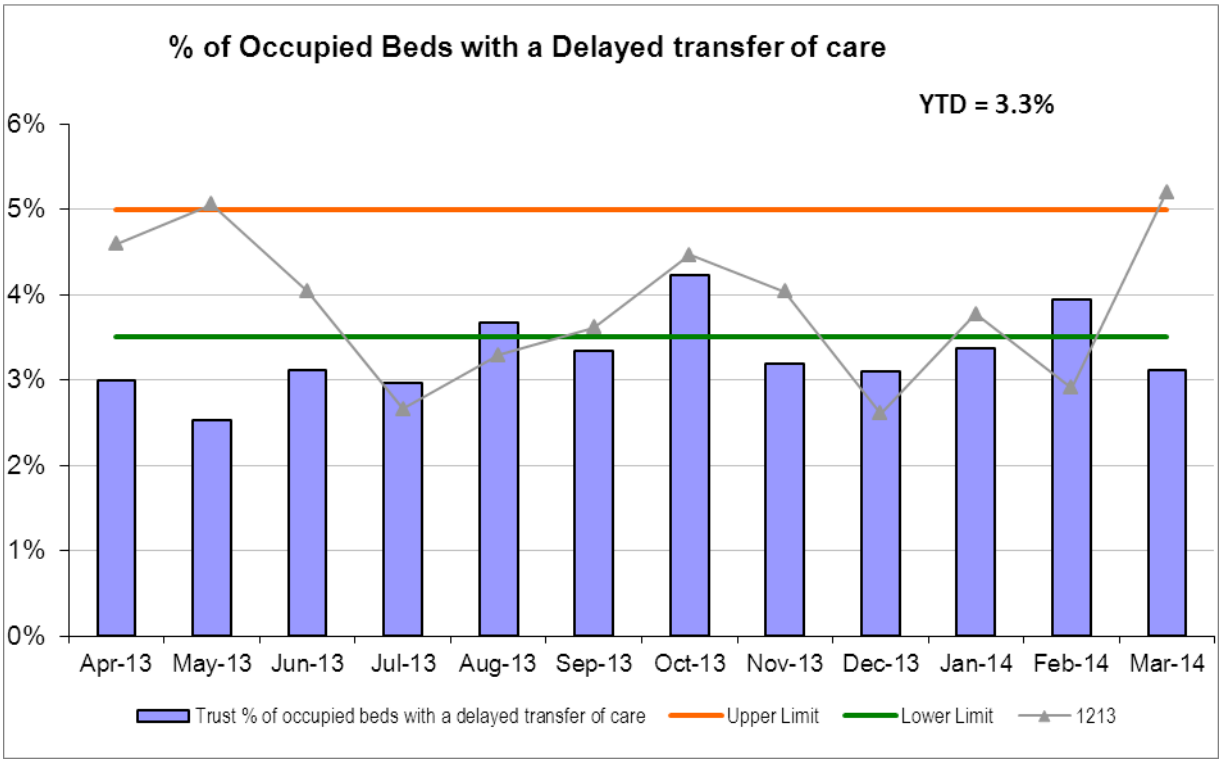
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	99.50%	99.12%	99.45%	99.14%	100.00	99.52%	99.58%	99.03%	99.49%	98.50%	99.36%	100.00
Target	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

Cancer Waiting Time Targets – 62 day First Definitive Treatment – The Trust has achieved this standard ensuring that 85% of patients who needed to start their first definitive treatment within 62 days did so.

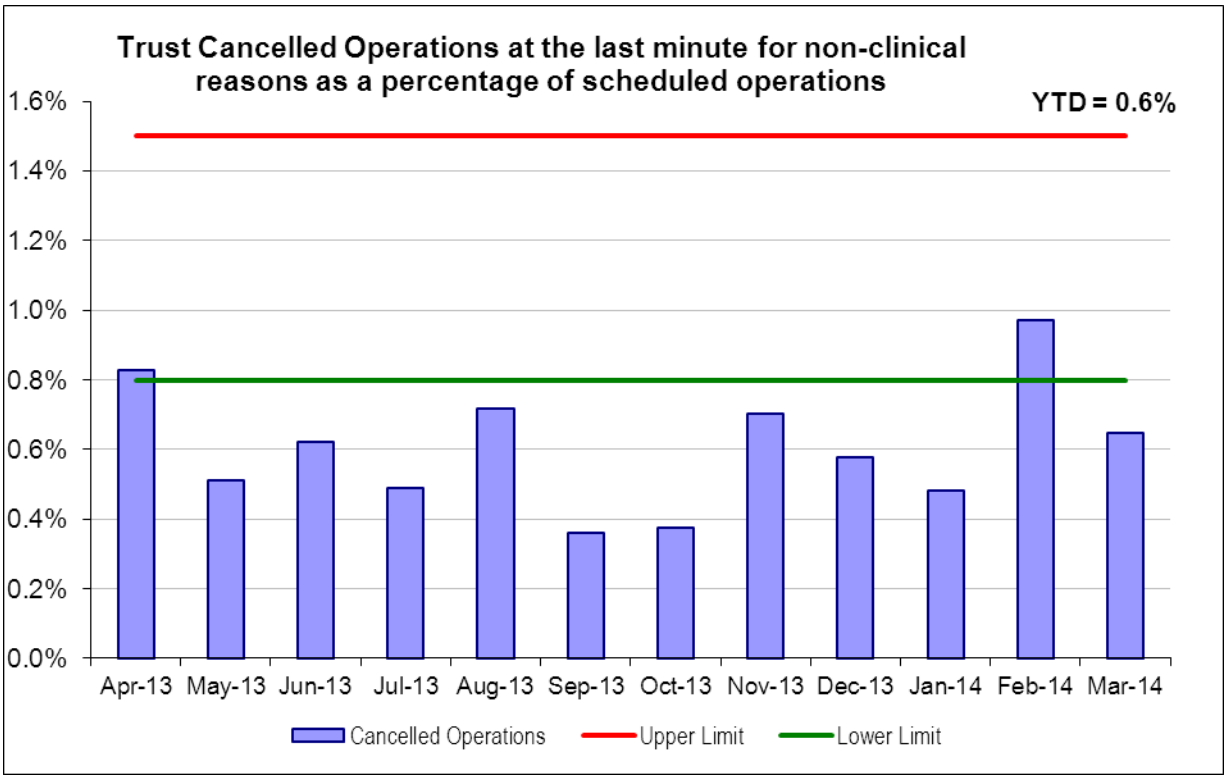


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	87.86%	85.71%	88.61%	87.13%	85.23%	88.17%	84.69%	86.14%	85.05%	86.59%	83.55%	89.27%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Delayed transfers of care – The Trust achieved this standard of Delayed transfers of care remaining below the national limit of 3.5% for the year at 3.3%.



Cancelled operations – The Trust achieved the cancelled operations national standard of 0.8% for the fifth year running.



Maidstone and Tunbridge Wells NHS Trust met the majority of national waiting time standards in 2013-14. These are designed to ensure patients are seen appropriately according to their clinical need.

National Indicators

There are a variety of national indicators highlighted within the Outcomes Framework that each Trust is required to report on.

Maidstone and Tunbridge Wells NHS Trust considers that this data is as described for the following reasons:-

The Trust has achieved level 2 for the Information Governance Toolkit. As part of this process audits of clinical coding and non-clinical coding have been undertaken as well as completing the "completeness and validity checks".

In addition three key indicators are selected and audited each year as part of the Board's assurance processes. This is over and above the indicators audited as part of the audit of these quality accounts.

The NHS Outcomes framework has 5 domains:

1. Preventing people from dying prematurely
2. Enhancing the quality of life for people with long-term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm

Domain	**Prescribed data requirements** **The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to —**	**2012/2013 local and national data**	**2013/2014**	**2012/2013 National average**
1 & 2	(a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. *The palliative care indicator is a contextual indicator.	98.2 Oct 11 – Sept 12 *(Better)*	100.31 Oct 12 – Sept 13 (Worse)	National average is 100
3				
	i) groin hernia surgery	0.102	0.082	0.087
	ii) varicose vein surgery	N/A	N/A	0.225
	iii) hip replacement surgery	0.407	0.433	0.416
	iv) knee replacement surgery	0.318	0.280	0.302
	during the reporting period *(See below for explanation of reporting data)*	(Apr 10 to Mar 11)	(Apr 11 to Mar 12)	(Apr 11 to Mar 12)
3	the percentage of patients aged— i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.***1**	**Trust** 10.9% **Elective** 5.7% **Non-Elective** 12.8%	**Trust** 10.4% **Elective** 5.8% **Non-Elective** 11.3%	**Elective:** 6.81% **Non-Elective** 14.10% (Q1 13/14 position)
4	The trust's responsiveness to the personal needs of its patients during the reporting period. (Based on the five key questions in the inpatient survey relating to CQUINS)	66.4		

Domain	Prescribed data requirements **The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to —**	2012/2013 local and national data	2013/2014	2012/2013 National average
4	the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	71	69	
5	the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	94.5%**2**	95.2%	93.7 (Dec 2012)
5	the rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	25.8 ***3**	15.7	15.5
5	The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. *(See below for explanation of reporting data)*	1.4%***4** 0.97% (Q1and Q2 published data)	2.0% 1.2%	

*1 Local and national data is based on 30 day re-admission.
*2 Trust was required to meet 90% target for April-July 2012 and 95% from August 2012 onwards. Q4 not yet published.
*3 Figure based on local data as national data not published at time of report. National denominator figure derived from HES data, local denominator derived from KH03 return.
*4 Local % based on incident occurrence date during 2012/13. National % based on incident closure date during 2012/13.

Explanation re PROMS:
A patient reported outcome measure (PROM) looks at the impact of a procedure on a patient's lifestyle. This is separate to any surveys which look at the experience a patient has during their stay in hospital – highlighted above. This may be positive or negative. Depending on the type of surgery the patient is asked about specific activities before and six months after the procedure. The results are analysed to provide a numerical value indicating whether or not there has been an improvement.

From the four surgical procedures for which PROMs data is captured, the findings were:

Groin Hernia – 44 returns of which 25 reported an improvement on lifestyle following the operation[5].
Hip Replacement – 171 returns of which 150 reported an improvement in lifestyle[1].
Knee Replacement – 195 returns of which 150 reported an improvement in lifestyle[1].
Varicose Vein – insufficient number of questionnaires returned to be able to quantify the data[1].

The clinical director for T&O has begun to drill into the patient identifiable data to ascertain where improvements can be made.

[5] EQ-5D Index HSCIC April 2012 to March 2013, provisional data (published 08 May 2014) returned records = modelled records.

Explanation re incidents
The proportion of patient safety incidents which resulted in severe harm or death for 2013/14 was 2.0% (1.4% 2012/13). This is calculated by dividing the number of serious and catastrophic incidents reported by Maidstone and Tunbridge Wells NHS by the total number of patient safety incidents 5743 (5417 for 2012/13)

How performance compares with the national average for this indicator where the data is available and meaningful:
The latest report from the National Reporting and Learning System (NRLS), which was published in March 2014 and covers the period of 01/04/13 to 30/09/13, provided a reporting rate of 6.04 compared to 5.8 the same time last year. The rate of incidents reported is per 100 admissions. This places the Trust within the middle 50% of reporters.

Improving performance
Maidstone and Tunbridge Wells NHS Trust is taking the following actions to improve performance, and so the quality of its services. Monitoring and actions to further improve include the following:

Mortality data – we continue to review this bi-monthly at the Trust's Standards Committee which is chaired by the medical director. A trust-wide morality review group will meet alternate months to review mortality by speciality.

We have a rolling programme of audits to ensure three key indicators are reviewed every year in relation to C difficile, 18 week referral to treatment and A&E four-hour waits.

With respect to the number of severe harm and death incidents – we continue to monitor all such incidents via an executive-led panel. This reviewed the root causes of incidents to ensure that actions can be put in place to mitigate the risk of recurrence of similar events. The learning is disseminated across the Trust through directorate and corporate governance committees.

Along with the key priorities for the year these indicators are scrutinised by the relevant governance committees and the Quality & Safety Committee.

Additional areas of significant improvement during 2013/14

Safety Thermometer – The Safety Thermometer is a national reporting system that requires trusts to undertake a point prevalence audit of all inpatients at 'a point in time' each month. This is normally done on the third Wednesday of each month.
The Safety Thermometer reviews four key harms that are deemed to be indicators of a safe organisation. These harms are pressure ulcers, falls with harm, catheter associated urinary tract infection and new VTE.
The national benchmark is 92% harm free care. The Trust has been consistently achieving in excess of this throughout the year. The Trust included Safety Thermometer in its annual audit programme to validate the process of the data collection and validation. The audit provided the Trust with significant assurance that processes for data collection and validation were appropriate and accurate.

Enhanced Recovery: The Trust is exceeding all targets in Enhanced Recovery for Elective Colorectal, Gynaecology and Orthopaedic pathways. Colorectal surgery improvements include giving specific information to patients regarding the operation and administering Carbohydrate drinks preoperatively. Gynaecology improvements include ensuring the correct/timely antibiotics are given and clear discharge instructions and provided. Orthopaedic improvements include information related to the operation and managing to mobilise within 24 hours of their operation.

Elective LOS: LOS has remained at a similar level at 2.8 days (3.3 previous year) and is now at the lower control limit. This has shown a downward trend throughout the year and is now lower than the national median of 3.7 days. General Surgery and Gynaecology are showing a downward trend.

Non-Elective LOS: LOS increased slightly in March across both sites to 7.1 days (7.2 March last year). The National Median is 6.1 days. Full year remained at 6.8 days (7.0 previous year). Medical specialties and T&O had both shown a decreasing trend but have increased over the last quarter and are now above the long term average for March. Gynaecology and General Surgery continue to show a decreasing trend.

Part 4
Appendices A, B and C

Appendix A

41 National reports were published in 2013/14 with action to be taken in 2013/14

National Annual reports published March 2013 - April 2014	Report Received	
Peri and Neonatal		
Neonatal Intensive and Special Care (NNAP) 2012	Yes	Report received August 2013. All babies with a gestational age of <32 weeks or 1501g at birth undergoing 1st retinopathy or prematurity (ROP) screening are recognised in admission book by sticker system Babies then entered straight away into ROP book on correct date for examination
Children		
National Paediatric Asthma Audit 2012	Yes	Report received April 2013. Medical records are completed & have written evidence of our plans for the child Existing asthma leaflets, and salbutamol weaning regimes to be combined with a check list
National Patient level Insulin pump audit	Yes	Report received March 2014 and with Specialities for action plan development
Paediatric Pneumonia 2012	Yes	Report received, June 2013. Action plan being finalised
Child Health (CHR-UK)	Yes	Report received September 2013 and with Specialties for action plan development.
A&E Medicine		
CEM Feverish Children in A&E	Yes	Report received April 2013. Redesign the Paediatric A&E card to ensure recording of blood pressure and GCS (Glasgow Comma Score). New information leaflet being designed to give parents advice about what to do after their feverish child is discharged from A&E.
CEM Renal Colic in A&E	Yes	Report received April 2013. Directive to be disseminated to all A&E staff to ensure pain scores are recorded regularly and reassessed after analgesia is given.
CEM #NOF in A&E	Yes	Report received April 2013. Development of nursing role to include hip x-ray requests when clinical findings indicate an x-ray is necessary. Directive to be disseminated to all A&E staff to ensure pain scores are recorded regularly and reassessed after analgesia is given.
Seizure Management (NASH2) 2013	Yes	Report received January 2014 and with Specialties for action plan development.
CEM Consultant Sign-Off in Emergency Departments	Yes	Report received June 2013. Directive to be disseminated to all A&E staff to ensure patients attending A&E are seen / discussed with a senior doctor prior to their discharge.

National Potential Donor Audit Round 2	Yes	Report received August 2013. With Specialty for action plan development.
Adult community acquired pneumonia	Yes	National comparative data received July 2013 and with Specialty for action plan development.
Emergency use of Oxygen	Yes	Report received December 2013. Directive to be disseminated to all junior doctors to ensure that oxygen therapy is recorded on the prescription chart and target range is set.
Non-invasive ventilation – adults 2013	Yes	National comparative data received July 2013 and with Specialty for action plan development.
Long Term Conditions		
National Adult Diabetes Audit 2012	Yes	Report received April 2013. New clinic proforma being designed to ensure better recording of the 8 care processes (monitoring of HbA1c level, blood pressure, cholesterol, serum creatinine, urine albumin, foot surveillance, BMI and smoking status).
National Dementia Round 2	Yes	Report received June 2013. Training programme with competencies now available for all clinical and non-clinical staff working with patients with dementia. Trust now signed up to Dementia Action Alliance as dementia friendly. All staff now receive basic awareness of dementia training on induction days.
Adult Diabetes Inpatient Audit (NADIA)	Yes	Report received October 2013 and with Specialty for action plan development.
National Parkinson's Disease 2012/13	Yes	Report received October 2013 and with Specialties for action plan development.
National BSR Gout Audit 2013	Yes	Report due January 2014 not received until April 2014
Elective Procedures		
Adult Critical Care Case Mix Programme (ICNARC) (Round 2)		Report received June 2013 with specialty for action plan development.
Cardiovascular Disease		
National Cardiac Interventions (eg angioplasty)	Yes	Report received August 2013 and with Specialty for action plan development.
National UK IBD Biologics 2012	Yes	Report received August 2013. Appointment of a new Consultant Gastroenterologist with and interest in IBD to be able to increase clinic capacity for review of patients at 3 and 12 months after starting biologic agent.
National Cardiac Rehabilitation Audit	Yes	Report received September 2013 and with Specialty for action plan development.
MINAP 2012/13	Yes	Report received October 2013 and with Specialty for action plan development.
Cardiac Arrhythmia 2012	Yes	Report received October 2013 and with Specialty for action plan development.
Heart Failure Audit	Yes	Report received December 2013 and with Specialty for action plan development.
Cancer		

Bowel Cancer (National Bowel Cancer audit Programme)(NBOCAP) 2013	Yes	Report received July 2013 and with Specialty for action plan development.
Head & Neck Cancer (DAHNO) (8th report)	Yes	Report received July 2013 and with Specialty for action plan development.
Lung Cancer (National Lung Cancer Audit) 2013	Yes	Report received January 2014. High level of compliance. Our Low Median Survival will be reviewed more formally
Oesophago-gastric cancer (NOGCA) 2013	Yes	Report received June 2013 and with Specialty for action plan development.
Trauma		
Severe Trauma (Trauma Audit & Research Network) TARN 2013	Yes	Report received April 2013. With specialty for action plan development
National Joint Registry: Hip and knee replacements 2013	Yes	Report received September 2013. With specialty for Action plan development.
Hip Fracture (National Hip Fracture Database) (NHFD) 2013	Yes	Report received September 201.3 With specialty for Action plan development.
Heavy Menstrual Bleeding Audit	Yes	National report received September 2013. With Specialty for action plan development.
Sexual Health		
BHIVA 2012 – People with HIV not in care and survey of clinic policy and practice regarding retention in care.	Yes	Report received July 2013 and with Specialty for action plan development.
BASH/BHIVA 2013. Survey of partner notification for HIV patients	Yes	BASHH Power Point presentation and statement received April 2014 and with Specialty for action plan development.
Patient Surveys		
National Cancer Experience Survey 2012-13	Yes	Report published August 2013 Report received and disseminated. With Specialties for action plan development
National Inpatient Survey	Yes	Report published April 2013 Report received and disseminated. With Specialties for action plan development
National Maternity Survey 2013	Yes	Report published December 2013. Report received and disseminated. With Specialties for action plan development.
National Chemotherapy Patient Experience Survey 2012	Yes	Report published February 2014. Report received and disseminated. With Specialties for action plan development.
Confidential Enquiries		
Alcohol Related Liver Disease	Yes	Received July 2013. Recommendations reviewed by Consultant Team. High level of compliance with recommendations. New Consultant appointed with lead for Alcohol Care. New Trust guideline to be written on Managing Acute Alcohol Withdrawal, a protocol is available on the trust website accessible by all trust employees. Blood cultures can now be taken as part of the initial investigations in line with recommendations. Liaise with Mental Health and Community Services and the Drug and alcohol Liaison services to find out what services are available in the community in order to prevent acute re-admissions. Antibiotics to be prescribed for patients who present with alcohol related liver disease who present with gastrointestinal bleeding.

Subarachnoid Haemorrhage	Yes	Received November 2013. Report received and disseminated with specialties for review.

Appendix B

The reports of 46 national clinical audits were reviewed by the provider in 2012/2013 and Maidstone and Tunbridge Wells NHS Trust intends to take the following actions to improve the quality of healthcare provided:

National Annual reports published March 2012 - April 2013	Report Received	
Peri and Neonatal		
Neonatal Intensive and Special Care (NNAP)	Y	All mothers, who deliver between 24 & 34+6 weeks gestation, given any dose of antenatal steroids. SHOs to get mothers notes to ascertain details of steroid dates & times.
Children		
Paediatric Diabetes (PNDA)	Y	Report received February 2013. Action plan being developed.
Childhood Epilepsy (Epilepsy 12)	Y	12 lead ECG to be done for all children with convulsive seizures. A business case has been written and submitted for an Epilepsy Specialist Nurse.
Paediatric Pneumonia	Y	A Senior review of antibiotic route on every ward round with increased use of the oral route. More judicious allocation of IV antibiotic therapy in Community Acquired Pneumonia to be developed.
A&E Medicine		
CEM Severe sepsis & septic shock	Y	Department handbook updated to contain standards on urinary catheterisation and output measurements. New training for nurses to improve documentation of observations.
CEM Pain Management in Children	Y	Paediatric A&E documentation updated to with a paediatric appropriate pain score chart. Education of nursing staff in the use of the new chart.
Audit of Consultant Sign off in Emergency Departments 2011	Y	Directive disseminated to all A&E staff and Jnr. Doctors training sessions to ensure patients attending A&E are seen / discussed with senior doctor prior to their discharge.
Adult community acquired pneumonia	Y	Chest X-rays to be prioritised by Radiology. Pilot scheme is in place to allow nurses to request chest x-rays. Doctors to receive training on compliance with CURB65 scoring and appropriate use of antibiotics. Patients with a high predicted mortality to be discussed with the critical care team.
Emergency use of Oxygen	Y	Continued education of junior doctors on the prescribing of oxygen especially for patients with pneumonia. Drug chart updated to include a specific section for oxygen prescribing.
Non-invasive ventilation – adults	Y	Report Received June 2012. Formal education in place for A&E and general medical junior doctors regarding the investigations required for Acute asthma admissions. Respiratory Nurses to liaise with admitting teams to ensure all patients are

		referred to the Respiratory team for review. Patients to be reviewed by middle grade or consultants prior to their discharge to check their Preventer inhaler therapy.
Sentinel Stroke Audit (SINAP)	Y	Increased numbers of staff able to carry out swallow assessment on stroke patients. Continued liaison with East Sussex Social Services and Lewis Clinical Commissioning Group to improve discharge planning of stroke patients
Adult Asthma	Y	More formal education programme for junior doctors in the prescribing of steroids and measuring of PEFR (peak expiratory flow rate) and ABG (arterial blood gases) on admission to hospital.
National Audit of Seizure management in Hospitals (NASH)	Y	Received December 2011. Organisational data received July 2012. Assessment tool and action plan currently being finalised
National BTS Pleural Procedures audit 2011	Y	National report received December 2011. Awaiting completed action plan from Audit lead.
Long Term Conditions		
Chronic Obstructive Pulmonary Disease Discharge Audit 2012	Y	Business case being developed to increase respiratory physiologist hours to allow for increased numbers of spirometry tests.
National Adult Diabetes Audit	Y	Although the trust did not submit data for this national audit due to lack of software (Diabeta3), the report and recommendations were reviewed and assessed. The trusts practice was fully compliant with all the recommendations made.
Adult Diabetes Inpatient Audit (NaDIA)	Y	Guidelines for the management of Inpatient hypoglycaemia have been developed and made readily available. Hypo boxes are now in place on all wards to treat patients who develop hypoglycaemic episodes. Blood ketone testing training to be undertaken with current nursing staff.
National Parkinson's Disease	Y	Appointment of a Parkinson's Disease Nurse Specialist to enable patients to be reviewed at 6 and 12 month intervals
Chronic Pain (National Pain Audit)	Y	(Phase 2+3) Received January 2013. With specialty for action planning.
BTS Bronchiectasis 2012	Y	Received March 2013. With specialty for Action planning.
BTS Bronchiectasis audit 2011	Y	Report reviewed by Specialty. Awaiting completed action plan from Audit lead.
Elective Procedures		
National Joint Registry (Hip, knee and ankle replacements.) NJR	Y	Patients with metal on metal prosthesis now receive annual follow ups.
Cardiovascular Disease		
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Y	Report Received December 2012. Action plan development
National Cardiac Rehabilitation Audit	Y	Liaising with Kent Community Health for additional funding to support post-discharge rehab programmes and to improve access for additional groups of patients. Develop a business plan to fund home-based exercise courses for patients who are unable to attend sports centres. Pharmacists, Occupational therapist and psychologists to be

		involved inpatient health education sessions.
Cardiac Arrhythmia	Y	December 2012. With specialty for Action planning.
Coronary angioplasty	Y	Increased use of radial artery for access as this increases risk of complications in patients requiring angioplasty.
Heart Failure Audit	Y	The report and national recommendations have been reviewed and the Trust is fully compliant and will continue to submit data to this national audit.
Cardiac Arrest (National Cardiac Arrest Audit)	Y	Response times at weekends slightly lower than the national average. Resuscitation team to review the arrest forms for weekend period to identify if there is any correlation between staffing levels, time of arrest and patient outcome. Trust has a high "alive to home discharge" which is higher than the national survival measure.
Cancer		
Bowel Cancer (National Bowel Cancer audit Programme)	Y	Report received November 2012. With specialty for Action planning.
Head & Neck Cancer (DAHNO)	Y	Report received June 2012. With specialty for Action planning.
Lung Cancer (National Lung Cancer Audit)	Y	High level of compliance. Our Low Median Survival will be reviewed more formally
Oesophago-gastric cancer (NAOCG)	Y	Report received December 2012. With specialty for Action planning.
Trauma		
Severe Trauma (Trauma Audit & Research Network) TARN 2012	Y	Report Received October 2012. Reviewed by specialty. Compliant and no actions required. Will continue to subscribe to this national audit.
Hip Fracture (National Hip Fracture Database) (NHFD)	Y	Orthogeriatrician appointed and now in post. Pre-operative assessment is now carried out by Orthogeriatrician. Fast tracking and ring-fencing of beds to allow for admission to appropriate ward within 4 hours. An IR1 form to be completed for each case of pressure ulcer. Patients to have falls assessment carried out prior to discharge. Fracture Neck of Femur specific Electronic Discharge Notification now in place to ensure patients are assessed and appropriate bone protection medication is prescribed.
Heavy Menstrual Bleeding Audit	Y	July 2012. Report disseminated to division. National figures only, not site specific.
Blood transfusion		
'O' Neg blood use "Medical Use of Blood" (National Comparative Audit of Blood Transfusion)	Y	The results in the national report were not hospital or site specific. From the findings the haematology dept were confident that practice at MTW was within the guidance. However, services are being realigned at MTW
Platelet use "Bedside Transfusion" (National Comparative Audit of Blood Transfusion)	Y	Business case to be written by end of 2014 for electronic systems supporting blood transfusion bedside checking to be available
Blood Sampling and Labelling	Y	A project is in place that will require second sample use (electronic issue) otherwise fully compliant
Potential Donor Audit (NHS Blood &	Y	Action taken to link with the critical care unit's Practice

Transplant)		Development Nurses and outreach team to establish, implement and evaluate an education strategy for organ donation within the trust and build relationships with clinical staff.
Sexual Health		
National HIV Patient Outcomes Survey: Provision of psychological care and adherence to support.	Y	National report and recommendations received December 2012 and reviewed by Specialty. Trust compliant with using new data collection system HARS (HIV and AIDS reporting system).
British Association of Sexual Health and HIV national audit "STI Management Standards".	Y	Received January 2013. With specialty for Action planning.
Patient Surveys		
National Emergency Department Survey	Y	Received December 2012. With the specialty for review and action plan development.
National Cancer Patient Experience Survey	Y	Received August 2012. Report has been circulated across the Directorate and Trust. Report findings have been presented to Cancer Board, Senior Management, and Patient Experience Committee. Action Plan is currently being developed and will then go to Board/Directorate Level for approval.
National Radiotherapy Access Survey	Y	Report currently being reviewed by the Directorate. An action plan will then be developed.
National Radiotherapy Patient Experience Survey	Y	The results of the report were shared with the Directorate. A resume was sent to the Chief Executive for inclusion in the trust news letter to disseminate results. An action is currently being developed within the Management team.
National Imaging Access survey	Y	Report not yet published.

Appendix C

Please see the tables below for full details of progress against each of the NICE clinical guidelines.

Acute and Emergency Medicine

No	Audit Title	Completion date / due date	Compliant?	Status / Assurance
56	CG56 Head Injury re-audit	21/10/2013	Partially	A&E Head Injury proforma introduced to highlight appropriate prioritisation of patients. CT requests to be colour coded to highlight urgency No re-audit planned as data now collected for TARN.
109	CG109 Transient loss of consciousness re-audit	20/05/2013	Non-compliant	Training being carried out in A&E to reinforce the need of thorough documentation. Re-audit due July 2014.
109	CG109 Transient Loss of Consciousness re-audit	01/11/2014		Not due to start yet
25	CG25 Violence: short term management in Emergency Departments	01/11/2014		Not due to start yet

Cancer and Haematology

No	Audit Title	Completion date / due date	Compliant?	Status / Assurance
122	NICE CG 122 - Ovarian Cancer Audit	31/10/2013	Partial	Current practice conforms to NICE Guidance for management of stage 1 ovarian cancer.
80	National RCR audit of breast radiotherapy	07/05/2013	Partial	No action required but will carry on monitoring the 31day radiotherapy pathway.
76	Re-audit: CG76 - Medicines Adherence	30/11/2014		Audit not due to start yet
88	Re-Audit of lumbar spine x-rays performed for the investigation of lower back pain	01/10/ 2014		Audit not due to start yet
67	NICE CG67 - Lipid modification	30/06/2014		Audit at the data collection stage
24	NICE CG24 Network Audit of Small Cell Lung Cancer Patients including Patient Pathways & Outcomes	30/09/2013		Chasing for copy of final report/action plan Deputy Medical Director letter sent
131	NICE CG131 - Colorectal cancer	31/01/2014		Audit not started due to planned delay by directorate

Critical Care Outreach

Type	No	Audit Title	Completion date / due date	Compliant?	Status / Assurance
None relevant					

Diagnostics, Therapy and Pharmacy

Type	No	Audit Title	Completion date / due date	Compliant?	Status / Assurance
None relevant					

Paediatrics

No	Audit Title	Completion date / due date	Compliant?	Status / Assurance
16	NICE CG 16 - Management of Paediatric Self Harm	13/06/2012	Non-compliant	Direct access from A&E to paediatric ward if child attends with DSH to be discussed further. DSH checklist to be circulated and included in the A&E handbook. Re audit in May 2015
47	NICE CG 47 - Re-audit of feverish illness in children	20/06/2012	Partial	Paediatric vital signs chart already on trial at Maidstone A&E. Laminated traffic light system in place in paediatric cubicles & rooms in MH and TWH A&E departments.
54	NICE CG 54 - Audit of Urinary tract infection in children: diagnosis, treatment & long term management	13/06/2012	Partial	Imaging guidelines made clearer and awareness of better documentation during teaching sessions.
84	NICE CG84 - Audit of the management of children with diarrhoea & vomiting	12/06/2012	Non-compliant	Re-audit on the 2014/15 programme with proposed completion date of June 2014. At the data collection stage.
98	NICE CG98 - Audit of the management of Neonatal Jaundice	02/07/2013	Partial	Documentation to be improved and raised to all medical and nursing staff. Availability of the transcutaneous bilirubinometer is to be improved. Re-audit has been added to the 2014/15 programme
99	NICE CG 99 - Audit of the management of Constipation in children and young people	03/01/2014	Partial	Poor documentation of details of history taken and examination performed. This introduces risk to the organisation due to the medico-legal implications of poor documentation. Re-audit added to the 2014/15 audit programme.
102	Management of Children & young people with suspected/confirmed Bacterial meningitis and meningococcal septicaemia; Clinical & Organisational Criteria	27/11/2013	Partial	In general, the NICE Guidelines are being followed on our unit. The exception is not giving Amoxicillin to babies under 3 months age; the rationale for this being the rarity of Listeria infection in this unit. To be reviewed in the Clinical Governance.
112	Audit of the efficacy of Sedation in children & young people needing imaging	21/03/2014	Partial	The success rate as identified by the audit was 85%, which is below the ideal target of 100% but considered a satisfactory standard by the auditors. Re-audit has been added to the 2016/17 audit programme.
137	QUALITY ACCOUNT - National Childhood Epilepsy 12 Audit 2011	11/04/2013	Non-compliant	12 lead ECG to be carried out for all children with convulsive seizures and to have appropriate assessments. Business case for epilepsy specialist nurse for the Trust has been written and submitted. Registration complete for Round 2.
15	HQIP National Paediatric Diabetes Audit (NPDA) 2014 (Quality Account)	30/01/2015		Audit not due to start yet
16	NICE CG16 - Re-audit of management of paediatric Deliberate self-harm (DSH)	29/05/2015		Audit not due to start yet
54	NICE CG54 - Re-audit of Urinary Tract Infection in children: diagnosis, treatment & long term management	31/10/2014		Audit not due to start yet
99	NICE CG99 - Re-audit of Diagnosis & Management of Idiopathic Constipation in Secondary Care setting for children & young people	30/05/2015		Audit not due to start yet

Specialist Medicine

No	Audit Title	Completion date / due date	Compliant?	Status / Assurance
121	CG121 Lung Cancer diagnosing & staging only re-audit	03/01/2014	Partially	EBUS service now available. Re-audit due October 2014
117	CG117 Tuberculosis re-audit	31/12/2013	Partially	Not all patients are being nursed in single room which is not always possible at Maidstone but a side room should be made available. No re-audit planned as all patients reviewed at TB Cohort review body.
103	CG103 Delirium	30/07/2013	Non-compliant	Delirium risk assessment to be added to the Medical Clerking Proforma To be re-audited as part of the documentation audit. Dates to be advised.
87	CG87 Type 2 Diabetes	28/02/2014	Partial	Pathway for starting insulin therapy written and Diabeta3 to be used to record all treatment information. More leaflets to be made available in treatment rooms. Re-audit due March 2015
95	CG95 Chest pain of recent onset	31/12/2013	Partial	More clinic slots made available from June 2013. No re-audit planned as key standards met.
134	CG134 anaphylaxis	01/07/2014		Not due to start
136	CG136 Service user experience in adult mental health (in hospital section only)	01/09/2014		Not due to start yet
108	CG108 Chronic Heart Failure	01/08/2012		Not started- measured against EQ and NHFA
48	CG48 Secondary prevention in secondary care for patients following MI re-audit	31/12/2013		Re-audit completed but no paperwork received. Carol chasing every month at Governance
64	CG64 Early management of Unstable Angina & NSTEMI	01/05/2013		Action plan development
64	CG64 prophylaxis against effective endocarditis	01/05/2013		Action plan development
127	CG127 Hypertension	May 2013		Action plan development
126	CG126 Stable angina re-audit	September 2014		Not due to start yet
15	CG15 Type 1 diabetes	01/07/ 2013		Report writing
130	CG130 Hypoglycaemia in acute coronary syndrome	01/06/2014		Not started
119	CG119 Diabetic Foot problems – inpatient care	01/07/2014		Not started
152	CG152 Crohn's disease	01/07/2014		Not started
118	CG118 Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's Disease or adenomas	01/10/2014		Not due to start yet
165	CG165 Hepatitis B (chronic)	31/01/2015		Not due to start yet
86	CG86 early recognition and diagnosis of coeliac disease re-audit	01/10/2014		Not due to start yet
8	CG8 Multiple Sclerosis	01/09/2014		Not due to start yet
137	CG137 Epilepsy in adults	31/07/2014		Started early, in Data collection
96	CG96 Management of Neuropathic pain in the outpatient non-specialist setting re-audit	31/12/2014		Not due to start yet
21	CG21 Lung Cancer diagnosing and staging only re-audit	01/02/2015		Not due to start yet
79	CG79 Management of patients with newly diagnosed rheumatoid arthritis re-audit	31/12/2013		Action plan development
146	CG146 Osteoporosis – fragility fracture	30/11/2014		Not due to start yet

Surgery

No	Audit Title	Completion date / due date	Compliant?	Status / Assurance
29	Pressure Ulcers	20/05/2013	Fully	Re-audit due to start September 2014
13	CG13 post operative analgesia following elective LSCS re-audit	25/11/2013	Fully	Re-audit due to start April 2015
65	CG65 Perioperative hypothermia (inadvertent)	27/11/2013	Non-compliant	Re-audit due for completion in September 2014. Actions are ongoing.
131	CG131 Surveillance following colorectal surgery	19/11/2013	Partial	To develop a new system for colonoscopy follow-up. Re-audit to take place August 2015.
92	CG92 extended thromboprophylaxis in cancer patients undergoing major abdominal surgery re-audit	22/01/2014	Non-compliant	Juniors to be advised of the importance of prescribing AES in discharge summaries. Re-audit due to start December 2014.
92	CG92 Administration of thromboprophylaxis following neck of femur fractures re-audit	01/11/2013	Partial	All #NOF patients received appropriate thromboprophylaxis for 28-35 days following fracture. Re audit May 15.
145	CG145 Spasticity in orthopaedic paediatric surgery	14/02/2014	Non-compliant	Carbon copy of clinic letters to paediatrician responsible for patient or statement in the clinic letters that child does not currently need to be reviewed by a paediatric specialist. Prompt referral to physiotherapy at initial consultation; documenting that patients are / have been under the care of a physiotherapist. Following physiotherapy review, all patients must have a documentation of botox assessment (current or previous) in order to clarify the indications for proceeding to surgery. Re-audit Jan 15.
3	CG3 Use of routine pre-operative tests for elective surgery re-audit	31/03/2013	Quality checking report	
135	CG135 Organ donation staff survey	30/04/2014	Data collection	
92	CG92 extended thromboprophylaxis in cancer patients undergoing major abdominal surgery re-audit	31/05/2015	Not due to start yet	
74	CG74 Surgical Site Infection	01/09/2013	Report writing	
174	Intravenous Fluid therapy in Adults in hospital. An audit of how fluid status is managed in surgical patients at Tunbridge Wells Hospital	30/06/2014	Data analysis	
175	CG175 How accurate is MRI in picking up clinically significant prostate cancer?	30/04/2014	Data collection	
124	CG124 Neck of femur – Are we NICE enough? Re-audit	30/11/2013	Data collection	
145	CG145 Spasticity in orthopaedic paediatric surgery re-audit	01/01/2015	Not due to start yet	
49	CG49 Faecal Incontinence	01/01/2015	Not due to start yet	

Trauma and Orthopaedics

Type	No	Audit Title	Completion date / due date	Compliant?	Status / Assurance
None relevant					

Women's and Sexual Health

No	Audit Title	Completion date / due date	Compliant?	Status / Assurance
13	NICE CG 13 - Caesarean Section (RCOG Greentop 45)	29/06/2011	Partial	CS proforma to be incorporated in Maternity notes. VBAC clinic name changed to encourage more women to attend.
15	NICE CG 15 - QUALITY ACCOUNT - HQIP National Diabetes Audit - Paediatric Units 2010	21/06/2011	Non-compliant	To take part in National Diabetes Audit annually. All data must be collected correctly within the time period measured by the audit. Record BMI & BP routinely for each patient at each visit. Continue to measure albumin and carry out eye & foot exams, which are already done routinely. Monitor creatinine & cholesterol levels. Paula Carr eye screening unit to send us all results of screening.
40	NICE CG40 - Audit of outcomes & procedures for TVT & TVTO procedures (Urinary incontinence)	25/06/2013	Partial	The need for proper documentation of possible complications during the consent process needs to be improved. A prospective ongoing audit has been discussed and agreed. Re-audit has been added to the 2016/17 audit programme.
55	NICE CG 55 - Audit of Intrapartum Care Management	04/02/2014	Partial	There is a lack of written information and documentation. The new notes that are now in place are already addressing these issues therefore on re-audit these criteria should be achieved. Re-audit has been added to the 2014/15 audit programme.
62	An audit of Indications for Growth USS	31/10/2013	Partial	Proforma to be used as guidance when requesting growth USS, dopplers or serial scans. Re-audit to be carried out when the implementation of the proforma is completed.
63	NICE CG63 - Re-audit of Management of diabetes in pregnancy	27/11/2013	Partial	Better documentation.Presence of an intrapartum care plan for all diabetics when appropriate and better documentation of blood sugars of gestational diabetics during labour Better documentation of a postpartum care plan for all diabetics required. Re-audit has been added to the 2015/16 programme.
89	NICE CG 89 - A documentation audit of children suspected of abuse or neglect	02/08/2011	Non-compliant	Audit completed November 2013, partially compliant. A check list to be attached to notes of any child with suspected abuse or neglect. Re-audit added to the 2015/16 programme.
92	Re-audit of Maternity Venous Thromboembolism (VTE); Risk assessment and management	18/06/2013	Partial	Re-audit due to take part as audit of CNST but abandoned as directorate decision that no audit assurance needed
107	Hypertension in pregnancy	20/06/2012	Partial	Re-audit was due to start November 2013 but awaiting completion of actions before takes place. Currently with directorate, awaiting info.
154	An audit of the management of Ectopic Pregnancy & Miscarriage within the trust	30/04/2015		Audit not due to start yet
43	Antenatal care, delivery & outcome for women with a raised BMI	30/05/2014		Audit at the action plan development stage
55	Re-audit of Management of Intra-partum care	31/12/2014		Audit not due to start yet
62	An audit of the management of Antenatal Care within the	28/11/2014		Audit not due to start yet

	trust			
70	Re-audit of the management of Induction of Labour (IOL)	29/05/2015		Audit not due to start yet

Part 5
Stakeholder feedback

- **West Kent Clinical Commissioning Group**
- **Health Overview and Scrutiny Committee – Kent County Council**
- **Healthwatch Kent**
- **Independent Auditors' Limited Assurance Report**
- **Statement of directors' responsibilities**

West Kent Clinical Commissioning Group recommended the following amendments:

- Reference to the jointly facilitated C.Difficile prevention day (page 9)
- Detailing the acronyms for BEST and PANDA staffing tools (page 12)
- Making 7 day working more explicit as part of the Discharge Planning work (page 16)
- Acknowledging challenges for FFT return rates in A&E (page 22)
- Acknowledging the role of the CCG and their engagement as part of the on-going review of the quality of services (page 24)
- Include a reference to the Berwick report under the section on our work for learning from incidents.

Subsequent acknowledgement and support statement received from West Kent CCG on 24th June 2014:

Healthwatch Kent provided feedback with some comments and recommendations. In particular the use of acronyms and the complex nature of the document.

The document has been reviewed to only use abbreviations where they have previously been spelt out in full and the abbreviation noted in brackets after.

The complex nature of this document is acknowledged and the Trust has informed Healthwatch Kent that it intends to produce an easy read version once the draft process is complete, as last year.

West Kent CCG comments on the 2013/14 Quality Account for Maidstone & Tunbridge Wells NHS Trust (MTW)

This has been a productive year between NHS West Kent CCG and Maidstone and Tunbridge Wells NHS Trust. We have an excellent working relationship which is honest, open and transparent.

Joint working with the Trust and other stakeholders has seen a reduction in the rates of C Difficile which has meant the Trust achieved its target for 2013/2014. We will continue this work with the intention of reducing the prevalence further.

There are still concerns about the rates of falls within the Trust and the CCG acknowledges that there are robust action plans in place to address this. These and other Serious Incidents are monitored by the CCG with an emphasis been made on learning from incidents. 'Deep dives' will be used as tool to explore falls and other areas of concerns in the coming year.

I have worked with the staff at MTW on the wards and I have been impressed by the care and compassion that I have been seen. However, we continue to explore the number of complaints that the Trust receive as well as acknowledging the compliments.

Feedback from the Friends and Family Test has been encouraging but the Trust recognises that more work needs to be undertaken to improve the response rates especially in A & E.
We look forward to continue our work with Maidstone and Tunbridge Wells NHS Trust.

Dr Steve Beaumont
Chief Nurse
NHS West Kent CCG

Health Overview and Scrutiny Committee comments on the 2013/14 Quality Account for Maidstone & Tunbridge Wells NHS Trust (MTW)

The HOSC has received a number of draft Quality Accounts from Trusts providing services in Kent, and may continue to receive more. I would like to take this opportunity to explain to you the position of the Committee this year.

Given the large number of Trusts which will be looking to the HOSC at Kent County Council for a response, and the standard window of 30 days allowed for responses, the Committee does not intend to submit a statement for inclusion in any Quality Account this year.

Through the regular work programme of HOSC, and the activities of individual Members, we hope that the scrutiny process continues to add value to the development of effective healthcare across Kent and the decision not to submit a comment should be interpreted as a negative comment in any way.

As part of its ongoing overview function, the Committee would appreciate receiving a copy of your finalised Quality Account for this year and hope to be able to become more fully engaged in next years process.

Kind regards

Robert Brookbank
Chairman
Health Overview and Scrutiny Committee
Kent County Council

Healthwatch Kent comments on the 2013/14 Quality Account for Maidstone & Tunbridge Wells NHS Trust (MTW)

Healthwatch Kent response to the Quality Account for Maidstone & Tunbridge Wells NHS Trust

As the independent champion for the views of patients and social care users in Kent we have read the Quality Accounts with great interest.
Our role is to help patients and the public to get the best out of their local health and social care services and the Quality Account report is a key tool for enabling the public to understand how their services are being improved. With this in mind, we enlisted members of the public and Healthwatch staff and volunteers to read, digest and comment on your Quality Account to ensure we have a full and balanced commentary which represents the view of the public.
On reading the Accounts, our initial feedback is that the accounts are very lengthy and complex making this hard for the general public to read, understand and digest. This is not a problem unique to the Trust as we have seen similar issues with all the Quality Accounts from Kent providers. For future reports we would like to work with you, and other providers, to ensure the reports are accessible and understandable for a wider audience. For this year, a list of acronyms would help.
Healthwatch Kent has recently signed a Memorandum of Understanding with Maidstone & Tunbridge Wells NHS Trust. The agreement pledges our support to help the Trust develop a meaningful conversation with the public. As part of that we would like to offer our help and support to develop a better, more meaningful Quality Account for next year which can truly help the public understand your achievements and priorities. We have a group of volunteers who could be a willing test bed for this.
In summary, we would like to see more detail about how you involve patients and the public from all walks of life (including seldom heard communities) in decisions about the provision, development and quality of the services you provide. We hope to continue and develop our relationship with the Trust to ensure we can help you with this.

Healthwatch Kent June 2014

Independent Auditors' Limited Assurance Report to the Directors of Maidstone and Tunbridge Wells NHS Trust on the Annual Quality Account

INDEPENDENT AUDITOR'S LIMITED ASSURANCE REPORT TO THE DIRECTORS OF MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required by the Audit Commission to perform an independent limited assurance engagement in respect of Maidstone and Tunbridge Wells NHS Trust's Quality Account for the year ended 31 March 2014 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 ("the Act"). NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter
The indicators for the year ended 31 March 2014 subject to limited assurance consist of the following indicators:

- the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period
- the rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged two or over during the reporting period

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

Respective responsibilities of Directors and auditor
The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

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

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

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2013/14 issued by the Audit Commission on 17 February 2014 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period April 2013 to June 2014;
- papers relating to the Quality Account reported to the Board over the period April 2013 to June 2014;
- feedback from the Commissioners dated 30/05/2014 and 24/06/2014;
- feedback from Local Healthwatch dated 27/06/2014;
- the Trust's 2013/14 complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009; dated June 2014
- feedback from Kent County Council Health Overview and Scrutiny Committee dated 27 June 2014;
- the latest national patient survey in September 2013 to January 2014;
- the latest national staff survey in 2013;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 17/04/2014;
- the annual governance statement dated 28/05/2014;
- Care Quality Commission Intelligence Monitoring Report dated 13/03/2014; and
- Care Quality Commission Inspection reports dated January 2014 and April 2014.

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

This report, including the conclusion, is made solely to the Board of Directors of Maidstone and Tunbridge Wells NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Maidstone and Tunbridge Wells NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

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

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

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

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

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

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

Grant Thornton UK LLP

Grant Thornton House, Melton Street, Euston Square, LONDON, NW1 2EP

27 June 2014

Statement of directors' responsibilities in respect of the Quality Account

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

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

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

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

By order of the Board

Glenn Douglas
Chief Executive

Date: 30 June 2014