Maidstone and Tunbridge Wells NHS Trust

# Quality Accounts

## 2014/15

# Quality Accounts

## 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 2014/15 highlight the progress we have made against key priorities for the year to improve services for our patients and presents those areas that we will be focusing on as priorities for 2015/16.

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.

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 Quality Accounts (QA) for Maidstone and Tunbridge Wells NHS Trust. As well as being a retrospective review of the standards of care we provided our patients during 2014/15, the QA is also a forward-looking document that sets out our objectives to further improve our patient experience over the coming year.

This is our sixth annual care review. We once again welcome this important opportunity to work closely with our patients and many partner organisations in an open and transparent way to further improve patient care.

The information contained within our QA is drawn from actual patient experience, collated throughout the year in a range of ways including daily patient experience surveys and reviews of patient care against key national standards. I would like to thank our patients for sharing their experiences with us and helping inform our on-going journey of improvement.

Earlier this year we became one of only a handful of hospital Trusts throughout the country to be chosen by two leading cancer charities to help improve the experience of people diagnosed with secondary breast cancer. The first and most important step towards achieving an ever-improving service for patients locally and nationally is to listen to their experience. Our patients are at the centre of everything we do and we continue to listen closely to them.

Towards the end of 2014 and early 2015 it became clear locally and nationally that the NHS faced unprecedented demand for unplanned, emergency services. As a consequence we saw many more patients requiring prolonged unplanned (emergency) stays in hospital. A high number of these patients had complex discharge requirements and needed external support to leave hospital. We are continuing to work with our partners in the local health economy to address our changing patient needs now and in the future.

Unfortunately, despite the best efforts of our clinical teams who have worked tirelessly throughout the year, it was not always possible to meet all of our waiting time standards for all of our patients. This was mainly, and most evidently the case, as demands for unplanned emergency care grew during the winter months. As a consequence, the Trust assessed, treated, admitted (to hospital) or discharged (home) 92% of patients in A&E within four hours during the year against the national standard of 95%. We did, however, meet the national standard for ensuring 95% or more of patients are assessed within 15 minutes of arrival in A&E.

Despite the incredible demands on our service, and to the credit of our clinical teams, we have consistently achieved good outcomes and kept our patients safe throughout the year. This is reflected in many areas but perhaps none more so than in our ever falling levels of hospital acquired cases of the Clostridium difficile infection. This is a reflection of excellent clinical practice.

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.

We were disappointed to be rated 'Requires Improvement' following our Care Quality Commission review in October 2014. However, we have used this review proactively to support further improvements. It was pleasing to note that our staff were universally found to be caring.

As a result of our overall review of patient care and safety at Maidstone and Tunbridge Wells NHS Trust throughout the year, our priorities for 2015/16 are:

**Patient Safety**

- To improve the system of incident reporting and learning lessons from incidents, complaints and claims.
- To improve the patient safety culture within the organisation to ensure the organisations and all staff are responsive to learning
- Improve patient flow through the Trust
- To improve the quality of stroke care

**Patient Experience**

- To meet the needs of our patients with due regard to their cultural and linguistic backgrounds
    - Review and improve linguistic translation services
- Implement Friends and Family Test for Outpatient Services and improve learning and action taken in response to Friends and Family feedback
- The ensure meaningful patient and public involvement in all services improvements

**Clinical Effectiveness and Governance**

- Ensure clinical governance frameworks and processes throughout the Trust and at speciality level are effective
- Review and improve the effectiveness of Morbidity and Mortality meetings and reviews
- To ensure that systems and processes as well as support for our staff is in place to discharge our responsibility to be honest, open and truthful in all dealings with patients and the public.

We will continue to support our highly skilled staff to help achieve the improvements we have set ourselves, as part of our on-going 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 2014/15 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

In this part of the report, we tell you about the areas for improvement in the next year in relation to the quality of our services and how we will intend to assess progress throughout the year. We call these our quality priorities and they fall into three areas: patient safety, patient experience and improvements in clinical effectiveness by focussing improvements in our governance structures.

The quality improvement priorities are only ever a small sample of the quality improvement work undertaken across the Trust in any one year. The initiatives selected in previous years will almost always continue into subsequent years, although the focus may change accordingly to need. By selecting new initiatives each year it ensures that a wide breath of areas are covered and prioritised each year.

We have chosen ten quality priorities in 2015/16 which represent the views of our stakeholders, but are also in line with the Trust's overarching strategy for quality improvement. The priorities are aligned to the Quality Improvement Plan developed following the recent Chief Inspector of Hospitals' Care Quality Commission inspection and our Safety Improvement Plan. We have also considered internally generated data such as complaints, patient safety incidents and important national reports such as the Morecambe Bay Investigation[1] and the Keogh Mortality Review[2] and the Berwick review[3] into patient safety.

## Quality Improvement Priorities 2015/16

### Patient Safety

- To improve the system of incident reporting and learning lessons from incidents, complaints and claims.
- To improve the patient safety culture within the organisation to ensure the organisations and all staff are responsive to learning
- Improve patient flow through the Trust
- To improve the quality of stroke care


### Patient Experience

- To meet the needs of our patients with due regard to their cultural and linguistic backgrounds
    - Review and improve linguistic translation services
- Implement Friends and Family Test for Outpatient Services and improve learning and action taken in response to Friends and Family feedback
- The ensure meaningful patient and public involvement in all services improvements

[1] Kirkup B. 2015. The Report of the Morecombe Bay Investigation. Morecombe Bay Investigation. The Stationary office.
[2] Keogh B. 2013. Review into the quality of care and Treatment provided by 14 hospital trusts in England: overview report. NHS England
[3] Berwick D. 2013. A promise to learn – a commitment to act. Improving the safety of Patients in England. National Advisory Group on the safety of Patients in England. Crown Copyright

## Clinical Effectiveness and Governance

- Ensure clinical governance frameworks and processes throughout the Trust and at speciality level are effective
- Review and improve the effectiveness of Morbidity and Mortality meetings and reviews
- To ensure that systems and processes as well as support for our staff is in place to discharge our responsibility to be honest, open and truthful in all dealings with patients and the public.

We will monitor our progress against these subjects through our Directorate and Trust-level governance structures. This report and assurance of our progress against it will be presented at the Trust Management Executive (TME), Quality and Safety Committee and the Patient Experience Committee.

In addition we will provide an update on progress to our health care commissioners every 2 months.

During 2014/15 we focussed on the following:

## Patient Safety

- Reducing the number of avoidable harms with a focus on:
    - Hospital acquired infections, in particular MRSA and 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

**In part 3 we reflect on the progress that we have made against these areas and provide a summary update**

# Patient Safety

**Ensuring we keep patient safety as a top priority in the organisation, with a focus on the following:**

- To improve the system of incident reporting and learning lessons from incidents, complaints and claims.
- To improve the patient safety culture within the organisation to ensure the organisations and all staff are responsive to learning
- Improve patient flow through the Trust
- To improve the quality of stroke care

# To improve the system of incident reporting and learning lessons from incidents, complaints and claims

Developing and improving care and as a result of lessons learnt from incidents, complaints and claims is at the heart of good governance. Whilst the organisation has had a system for incident reporting for many years this is an area where improvement is required, as identified from a recent internal staff survey and in the Care Quality Commission (CQC) report published in February 2015. Similarly the organisation has a system for sharing lessons learnt from incidents, complaints and claims and it is recognised that this could also be improved both in terms of organisational wide learning and in evidencing that this learning ensures sustained improvements in delivering safe patient care.

## Aim/goal

To make the process of reporting incidents quicker, easier and more accessible for all staff
To engage all staff groups to report incidents
To improve the current system of sharing the learning from incidents, complaints and claims

## Description of Issue and rationale for prioritising

The organisation is committed to improve the reporting of incidents and the learning from them, together with the learning from complaints and claims in order to make sustained improvements to the services and care we deliver. There is a system in place for reporting but it is recognised that this needs improvement and work has commenced on this following a staff survey undertaken in November 2014.

## Identified areas for improvement and progress during 2014/15

The following actions have been undertaken in 2014/15

- The establishment of a 'Governance Gazette' newsletter sent to all staff areas that shares lessons learnt from incidents, complaints and claims
- The upgrade of the incident reporting system (DATIX) to improve usability
- The establishment of a multidisciplinary DATIX review group to review and suggest further improvements to the reporting system and thus its usage by staff and feedback to staff who report incidents.


## Initiatives for further action for 2015/16

- Incident reporting process to be developed to be easier, quicker and more accessible for all staff
- To develop a programme of staff engagement events identifying and engaging staff groups who currently are low reporters of incidents
- To publish a summary of learning from every serious incident in our Governance newsletter
- To implement a methodology for triangulating lessons from incidents, complaints and claims more effectively in order to identify overarching themes and organisational learning.
- To review the current communication pathways for lessons learnt from incidents, complaints and claims and, with the informatics and communication teams consider and implement more effective ways to get messages of learning to staff and the public.

**Executive lead: Avey Bhatia, Chief Nurse**
**Board Sponsor: Avey Bhatia, Chief Nurse**
**Implementation lead: Jenny Davidson, Assc Director Quality, Governance & Patient Safety**

**Monitoring: Clinical Governance Committee**

# To improve the patient safety culture within the organisation to ensure the organisations and all staff are responsive to learning

Developing a culture of patient safety is a central tenant of quality care. Real, meaningful and sustained changes and improvements can only occur within a culture of collaboration, trust, support and openness. This 'just' culture enhances learning in a way that a 'blame' culture cannot and it is the aspiration of this Trust to make significant improvements through the organisation. The Berwick report highlighted with clarity that the NHS must become a '*system devoted to continual learning and improvement'* and that '*fear is toxic to both safety and improvement'*. In this way a culture that abandons blame as a tool and that '*culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime'* (pages 8, 9, 10)

## Aim/goal

To engage all staff in developing a 'just' culture that is understood, practiced and owned by everyone

## Description of Issue and rationale for prioritising

A considerable amount of work has already been undertaken to start to understand, benchmark and improve the culture around patient safety and engaging staff in learning and embedding change. We have good evidence that local level improvements do occur as a result of lessons learnt from incidents, complaints and claims, but this has been more of a challenge at organisational level, which was identified in the recent CQC report

## Identified areas for improvement and progress during 2014/15

The following actions have been undertaken in 2014/15

- The establishment of a 'Governance Gazette' newsletter sent to all staff areas that shares lessons learnt from incidents, complaints and claims
- Organisational Staff Survey on patient safety culture undertaken in November 2014
- Establishment of a multidisciplinary Patient Safety Think Tank group that considers and discusses patient safety culture and systems issues and offers possible solutions.
- Establishment of an accredited Patient Safety education programme for staff

## Initiatives for further action for 2015/16

- To implement an engagement campaign called 'Step up to Safety' with the aim of raising awareness and engaging staff sign up to a 'just' culture
- To host a patient safety culture focussed conference for MTW staff
- To engage staff is making a patient safety film that is then used to educate staff on the importance of 'just' culture and accountability.


**Executive lead: Avey Bhatia, Chief Nurse**
**Board Sponsor: Avey Bhatia, Chief Nurse**
**Implementation lead: Jenny Davidson, Jenny Davidson, Assc Director Quality, Governance & Patient Safety and members of the Patient Safety Think Tank**
**Monitoring: Trust Management Executive and Quality Committee**

# To improve patient flow through the Trust

Patients should be treated in the right place, by the right staff at the right time. This has been incredibly challenging for the organisation especially during the last six months. Ensuring effective and efficient flow through the hospital is essential for delivering safe timely care in the right environment.

## Aim/goal

To have effective flow throughout the hospital, that enables patients to be cared for in the right environment by the right staff at the right time.

## Description of Issue and rationale for prioritising

The last six months have been incredibly challenging for the organisation. There have been extreme difficulties with managing patient flow through the hospital and discharging patients out of hospital due to lack of capacity both in hospital and in the community. This has resulted in the organisation having to use several escalation areas, increased usage of temporary staff and the organisation being unable to deliver the Accident and Emergency 4 hour standard. This has also put our staff under incredible pressure but their commitment and tenacity has ensured that patients have been managed safely.

## Identified areas for improvement and progress during 2014/15

Despite these challenges remaining the issues could have been more challenging had various initiatives not been in place. The Trust and commissioners have worked closely together to develop pathways to ensure that some patients can be assessed quickly and put appropriate arrangements in place to prevent patients from being admitted. One of the very successful initiatives is Therapy Assisted Discharge Service (TADS).

## Initiatives for further action for 2015/16

The Trust is fully committed to continuing its intense work on reducing length of stay and working with our commissioners and social services to reduce delayed transfers of care. The initiatives developed over the previous years will also continue.

- 50% reduction in delayed transfers of care from MTW in the next 12 months
- Review of wards at MTW to improve efficiency and flow through ward location and co-adjacencies
- Creation of additional capacity at the Tunbridge Wells Hospital (30-39 bed unit)

**Executive lead: Angela Gallagher, Chief Operating Officer**
**Board Sponsor: Angela Gallagher, Chief Operating Officer**
**Implementation lead: Lynn Gray, Associate Director Nursing, Emergency and Medical Services**
**Monitoring: Trust Management Executive**

# To improve the quality of Stroke care

Stroke care and services have been under national and local review for some time and this has been a focus for quality improvements for the last 18months. It is intended that this work continues to be a high priority in the organisation.

## Aim/goal

The Trust intends to continue work on the improvements the stroke service by ensuring access to a stroke bed within 4hrs of attendance to Emergency Department, ensuring a CT (computerised tomography) scan within an hour of arrival at the hospital and the provision of a 7 day Transient Ischaemic Attack (TIA) service. These will have significant impact on the safety of patients requiring stroke care.

## Description of Issue and rationale for prioritising

There is a national review of hyper-acute stroke service. MTW stroke service has fallen below the expectations of the Trust evidence by both the Maidstone and Tunbridge Wells site achieving level E on the national SSNAP data (national benchmarking). Over the last 18months significant work has been undertaken and improvements have been made, however the Trust continues to strive for further improvements to ensure excellence of care. In preparation for the national review being undertaken the Trust has engaged in an active engagement with local stakeholders. It is expected that the national review will give further clarity now that the period of purdah has concluded.

## Identified areas for improvement and progress during 2014/15

The following actions have been undertaken in 2014/15

- The Trust has set up a Stroke Improvement Board, chaired by the medical director
- A stroke Clinical Nurse Specialist has been employed
- Stroke plan has been developed with stakeholders, under the programme board, along with a review of current service s and options for future service provision
- Tangible improvements seen in the Sentinel Stroke National Audit Programme (SSNAP) data (Maidstone site stroke services now re-assessed as C, Tunbridge Wells site stroke services now reassessed as D)

## Initiatives for further action for 2015/16

- To further improve the stroke service the Trust will
    - Ensure that patients are admitted to stoke bed within 4 hours of arrival, with a measure of MTW achieving a position in the upper quartile of SSNAP national data set.
    - Ensure that a CT scan is performed in under an hour of arrival, with a measure of MTW achieving a position in the upper quartile of SSNAP national data set.
    - Provision of a high risk TIA service 7 days /week (daytime)

**Executive lead: Paul Sigston, Medical Director**
**Board Sponsor: Paul Sigston, Medical Director**
**Implementation lead: Lynn Gray, Associate Director Nursing, Emergency and Medical Services**
**Monitoring: Quality Committee**

# Patient Experience

**Ensuring we continue to review and improve the patients experience, meeting their individual needs, responding to feedback and enabling collaborative approach to service development with a focus on the following:**

- To meet the needs of our patients with due regard to their cultural and linguistic backgrounds
    - Review and improve linguistic translation services
- Implement Friends and Family Test for Outpatient Services and improve learning and action taken in response to Friends and Family feedback in all areas
- To ensure meaningful patient and public involvement in all services improvements

# Meeting the needs of our clients with due regard to their cultural and linguistic backgrounds

The NHS has clear values and principles about equality and fairness as set out under the NHS constitution[4] and laws under the Equality Act 2010. This means all people have the right to be treated fairly and without discrimination and all patients should be treated as an individual and with respect and dignity.

## Aim/goal

To meet the needs of all clients with due regard for their cultural and linguistic background.
To ensure our services meet these needs effectively by undertaking a review of the linguistic translation services and improving the service

## Description of Issue and rationale for prioritising

The organisation recognises that meeting an individual's linguistic needs is an important part of the service provided. A linguistic translation service should be efficient, easy to access and available to all staff and service users at any time, but we currently are not able to fully meet this standard. There is no Equality and Diversity lead currently in post to lead and direct the Trust in developing a clear strategy and provide focus and expertise in this area, this is recognised and is being addressed.

## Identified areas for improvement and progress during 2014/15

As a new priority area for the organisation for 2015-16 the focus thus far has been on improving the translation services for our patients.

## Initiatives for further action for 2015/16

- Recruitment of an Equality and Diversity lead for the Trust
- Implement the tender process for linguistic translation and adopt an efficient system that meets patients and service needs
- Implement a staff flag project, where staff who speak other languages wear a flag of this country on their name badge
- Development of an Equality and Diversity awareness programme for all staff
- Development of a MTW Equality and Diversity strategy

**Executive lead: Paul Bentley, Director of Workforce and Communications**
**Board Sponsor: Avey Bhatia, Chief Nurse**
**Implementation lead: Richard Hayden, Deputy Director of Workforce and John Kennedy. Deputy Chief Nurse**
**Monitoring: Workforce Committee and Patient Experience Committee**

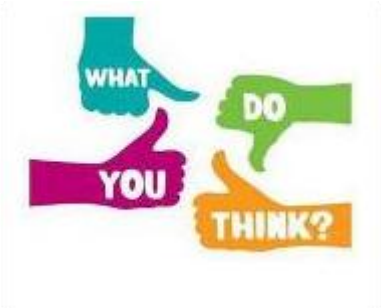
[4] The NHS Constitution. The NHS belongs to all of us. March 2013

# Fully implement Friends and Family Test for Outpatient Services and improve learning and action taken in response to Friends and Family test

The Friends and Family test from NHS England was introduced in 2013 as an opportunity for patients to provide feedback on services. Initially implemented in Emergency Department, inpatients and maternity services it has provided the Trust with an opportunity to receive information from service users that can guide the development and improvement to services and care.

## Aim/goal

The aim is to expand the friends and family test to service users at all MTW outpatient departments and use this information to improve learning and implement improvements.




## Description of Issue and rationale for prioritising

The Friends and Family test is an opportunity for services to reflect on their care, celebrate positive feedback and consider how and where to improve. It also provides the Trust with a way of benchmark the quality of its services both internally and with other Trusts to provide assurance and focus for developments.

Viewed as a valuable feedback tool the Trust is keen to roll this test out to service users in outpatients services, where currently only internal quality surveys are undertaken.

## Identified areas for improvement and progress during 2014/15

- Friends and family test has been implemented in outpatients
- Return rates have been much improved over 2014/15, with a concerted effort from all front line staff in these areas
- There has been improved analysis of the results in all clinical areas however more work is required.
- Whilst significantly improving the response rates the satisfaction net promoter score has remained above the national average.

## Initiatives for further action for 2015/16

- Include outpatient services in overall Friends and Family report
- Establish a robust feedback loop where learning and improvements can be identified and changes implemented
- Triangulate results with themes from incidents and complaints, identify areas of good practice and where development should be focussed
- Ensure results, learning and changes are publically displayed in outpatient areas and kept up to date

**Executive lead: Avey Bhatia, Chief Nurse**
**Board Sponsor: Sylvia Denton, Non-Executive Director and Chair of Patient Experience Committee**
**Implementation lead: John Kennedy, Deputy Chief Nurse**
**Monitoring: Patient Experience Committee**

# The ensure meaningful patient and public involvement in all service improvements


The Trust has a number of ways of involving patients and the public in service improvement including local and national surveys, the friends and family test, the patient experience committee and service user groups such as the Maternity Services Liaison Committee (MSLC). We do, however recognise that more can be done to make this engagement more meaningful and consistent throughout the organisation.

## Aim/goal

The aim is to undertake a review of current patient and public involvement processes, identify effective practice, identify areas for improvement and implement a cohesive approach and strategy.

## Description of Issue and rationale for prioritising

There are a considerable number of diverse ways patients and the public get involved in providing feedback and contributing to shaping service developments, however it is not consistently seen throughout the organisation. We feel patient and the public provide invaluable contribution to service development so prioritise a review to identify where we can improve and develop in this area.

## Identified areas for improvement and progress during 2014/15

During 2014/15 we worked hard to increase our response rates to the Friends and Family Test with good success across all areas. We revised our Care Assurance Programme and implemented the Quality Road Map. We have undertaken pre consultant public engagement for reviewing stroke services and involved patients in other service improvement like the fractured neck of femur pathway. We have also commenced a review of the Patient Experience Committee.

## Initiatives for further action for 2015/16

- Review of all patient and public involvement activities in the Trust including all local and national patient experience surveys to identify good practice and areas for development.
- Include service user representation at meetings where service improvement is on the agenda.
- Conclude review of Patient Experience Committee.
- Focus on Children Services feedback.

**Executive lead: Avey Bhatia, Chief Nurse**
**Board Sponsor: Sylvia Denton, Non-Executive Director and Chair of Patient Experience Committee**
**Implementation lead: John Kennedy, Deputy Chief Nurse**
**Monitoring: Patient Experience Committee**

# Clinical Effectiveness and Governance

**Ensuring we have transparent, effective and consistent clinical governance frameworks, processes and culture within the organisation, with a focus on the following:**

- Ensure clinical governance frameworks and processes throughout the Trust and at speciality level are effective.

- To ensure that systems and processes as well as support for our staff is in place to discharge our responsibility to be honest, open and truthful in all dealings with patients and the public.

- Review and improve the effectiveness of Morbidity and Mortality meetings and reviews

# Ensure clinical governance frameworks and processes throughout the Trust and at speciality level are effective

Effective clinical governance is central to the achieving the safe and high quality care we strive to give. Understanding what good governance is, reviewing our current clinical governance frameworks, processes and culture, and identifying where changes can be made and then implementing a clear framework is a key priority for the coming year.

## Aim/goal

To undertake an organisational review of Ward to Board clinical governance framework, processes and culture in order to identify effective practice and areas of improvement. To implement changes where required and measure improvements.

## Description of Issue and rationale for prioritising

Good clinical governance is a central part of safe and effective care. The recent CQC report and other internal reviews suggest there are inconsistencies around clinical governance within the organisation and improvements are required. There are some examples of excellent clinical governance but the overall framework needs strengthening to support a more consistent approach.

## Identified areas for improvement and progress during 2014/15

The following actions have been undertaken in 2014/15

- The establishment of an Patient Safety Think Tank, a multidisciplinary group set up to consider the current position and future aspirations for patient safety within MTW
- An internal review of Directorate clinical governance processes to establish current position of meetings and processes in place
- A patient safety culture survey was undertaken in November 2014 which provided sufficient intelligence to inform and develop the patient safety and culture priorities
- The implementation of a MTW 'Governance Gazette' newsletter which shares governance related information with staff in the organisation.

### Initiatives for further action for 2015/16

- An external supported review of organisational clinical governance to identify good governance and culture, identify areas for improvement and implement new governance framework within the organisation.
- Establishment of a consistent organisational governance framework that supports effective Directorate level clinical governance.
- Establishment of a system of intelligent monitoring that will enable more effective measurement of quality and safety.

**Executive lead: Avey Bhatia, Chief Nurse**
**Board Sponsor Avey Bhatia, Chief Nurse:**
**Implementation lead: Jenny Davidson, Assc Director Quality, Governance & Patient Safety**
**Monitoring: Quality Committee**

# Review and improve the effectiveness of Morbidity and Mortality meetings and reviews

In July 2013 Sir Bruce Keogh published his Review into the quality of care and treatment provided by 14 hospital Trusts in England. This review provided an opportunity for learning and reflection for all Trusts to consider a more rigorous and meaningful approach to mortality reviews.

## Aim/goal

The aim is to further develop our existing mortality review process and demonstrate how this process can lead to care and service improvements through openness and shared learning

## Description of Issue and rationale for prioritising

The current mortality review process is still in its infancy and requires development and progression to make it more effective. The CQC report published in January 2015 highlighted the need for further work in this area. An effective mortality review process will provide better opportunities for identifying good practice and where things could be improved. Further, triangulating this data with other quality measures such as Dr Foster data, complaints, patient safety incidents and claims will mean moving to a more proactive risk management approach.

## Identified areas for improvement and progress during 2014/15

The following actions have been undertaken in 2014/15

- The establishment of a Mortality review process and Trust Mortality Review Group
- Monthly meetings of the Trust Mortality Review Group to review mortality forms submitted from the Directorates
- Establishment of Mortality review discussion at some clinical governance meetings at Directorate level

## Initiatives for further action for 2015/16

- Review of current governance process against new CQC Well – led Domain
- In collaboration with Directorate leads and external partners agree an improved mortality review process that is documented as a standard operating procedure
- Review membership of the Trust Mortality Review Group to ensure representation within and external to the organisation
- With data analysts and informatics department, consider ways of automating the Mortality Review process that would make for a more timely and efficient process
- With data analysts, consider and implement a triangulation system to ensure the data is being used more effectively in proactive risk management
- Publication of summary reports on the intranet to demonstrate transparency and ensure shared learning across the organisation

**Executive lead: Paul Sigston, Medical Director**
**Board Sponsor: Paul Sigston, Medical Director**
**Implementation lead: Jenny Davidson, Assc Director Quality, Governance & Patient Safety**
**Monitoring: Quality Committee and Trust Board**

# To ensure that systems and processes as well as, support for our staff is in place to discharge our responsibility to be honest, open and truthful in all dealings with patients and the public.

From October 2014 all NHS providers have been required to comply with statutory Duty of Candour that was one of the recommendations form the Francis report[5]. This means that all health and social care providers in England now have a legal duty to be open and honest with patients and families about their care and treatment, including any mistakes that may have caused avoidable harm. We are keen that this essence of honesty, openness and truthfulness is adopted as routine for all dealings with patients and the public.

## Aim/goal

The aim is to ensure all systems and processes follow the requirements and the essence of the statutory duty of candour.
To implement a support system for staff to discharge their responsibilities to be honest, open and truthful in al dealings with patients and public

## Description of Issue and rationale for prioritising

Whilst there has been some considerable work on implementing the statutory requirements of Duty of Candour and processes are in place, this work is ongoing. The current process needs refinement to ensure that we not only meet all the requirements to their full extent but also that we can evidence that we are doing so to provide assurance. Cultural change and staff confidence to support this is an area for priority and focus over the coming year.

## Identified areas for improvement and progress during 2014/15

The following actions have been undertaken in 2014/15

- The establishment of a Duty of Candour process to meet the requirements
- Staff training programme implemented
- Inclusion in induction programme for all new staff
- Commencement of evidence log for assurance

## Initiatives for further action for 2015/16

- To update the 'Being Open' Policy to include the Duty of Candour requirements
- To further extend the training programme in place for all staff
- To further develop resources to assist and support staff when undertaking duty of candour in the clinical setting
- Along with the 'Cultural change' programme and 'Step up to Safety' campaign, implement a strategy to further embed the 'Honest and open' culture
- Develop a more robust support process for patients, relatives / carers and staff who have been affected by an incident that causes harm
- To implement an internal assurance process to provide continuous evidence of meeting the statutory requirements

**Executive lead: Paul Sigston, Medical Director**
**Board Sponsor: Paul Sigston, Medical Director**
**Implementation lead: Jenny Davidson, Assc Director Quality, Governance & Patient Safety**
**Monitoring: Quality Committee and Trust Board**

[5] Robert Francis QC. 2013. The Mid-Staffordshire NHS Foundation Trust Public Enquiry

# In this following section we report on statement relating to the quality of the 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 Maidstone and Tunbridge Wells 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 (at both hospital sites)
- Family planning services (at both hospital sites)
- Surgical procedures (at both hospital sites)
- Diagnostic and screening procedures (at both hospital sites)
- Treatment of disease, disorder or injury (at both hospital sites)
- Termination of pregnancies (at Tunbridge Wells Hospital only)

No conditions were applied to the registration.

During 2014/15 the Trust provided and/or subcontracted the full range of services for which it is registered (during 2014/15 the Trust provided and/or sub-contracted 101 NHS services). All the data available on the quality of care in these NHS services has been formally reviewed (with commissioners).

The income generated by the NHS services reviewed in 2014/15 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2014/15.

## Reviewing standards

To ensure that we are providing services to the required standards the Trust supported a number of reviews of its services during 2014/15, undertaken by external organisations such as:

- Care Quality Commission – 1 inspection (October 2014)
- Healthwatch - Enter and view visit (August 2014)
- Ofsted and the Care Quality Commission safeguarding children inspection (April 14)
- Kent, Surrey & Sussex Local Supervising Authority (statutory supervision of midwives) – inspection September 2014)
- South East London Kent & Medway Trauma Network - Review of Trauma Services (September 2014)
- Care Quality Commission IR(MER) – General inspection (October 2014)
- Counter Terrorism Security Advisers (CTSAs) – Inspection (September 2014)
- Clinical Pathology Accreditation (CPA) & ISO 15189 accreditation - Microbiology (July 2014)
- Human Tissue authority – Tunbridge Wells hospital mortuary (January 2015)
- Kent police – Counter Terrorism Crime and Security Act - Inspection (September 201ISO accreditation 9001:2008 E.M.E. Services (April 2014)
- Pharmacy - Aseptic Units - Regional Quality Assurance – 2 visits (2014)
- Annual Cancer Review (July 2014)
- Patient Led Assessments of the Care Environment (PLACE) – (March and May 2014)

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

- Care assurance audits
- Internal PLACE reviews
- Infection Control including hand hygiene audits
- Trust Board member “walkabouts”

The outcomes of these are included within our triangulation process to review clinical areas and identify anywhere 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 audit is mandated and provides an opportunity to stimulate quality improvement within individual organisations and across the NHS as a whole.

During 2014/15, MTW participated in 100% of relevant confidential enquiries and 100% of all relevant national clinical audits. During the same period, MTW staff successfully completed 162 clinical audits (local and national) to action plan stage from 462 audits on the programme to be undertaken. The remaining audits are at various stages of completeness and will be continued through to completion.

The national clinical audits and national confidential enquiries that Maidstone and Tunbridge Wells NHS Trust participated in during 2014/15 are shown in Table 1 as follows-

| **National Clinical Audits for inclusion in Quality Accounts 2014/15** | ***Participation*** Y, N or NA | ***No of cases submitted*** | ***% cases submitted*** | ***Comments*** |
|---|---|---|---|---|
| **Recruited patients during 2014/15 (Any period during 01/04/2014 to 31/03/2015)** | | | | |
| ***Peri and Neonatal*** | | | | |
| Neonatal Intensive and Special Care (NNAP) | Y | 694 | 100% | |
| Maternal, Newborn and infant clinical outcome review. (MBRRACE-UK) | Y | 20 | 100% | Stillbirths 17 Neonatal Deaths 3 |
| ***Children*** | | | | |
| Paediatric Inflammatory Bowel Disease. (Round 4) (IBD Programme) | Y | 5 | 100% | 6+ patients to be included within the report |
| Epilepsy 12 (Childhood Epilepsy) | Y | 22 | 100% | |
| Paediatric Diabetes (NPDA) | Y | 1230 | 100% | |
| Paediatric Intensive Care (PICANet) | NA | | | MTW does not provide this service |
| *Acute Care* | | | | |
| National Cardiac Arrest Audit (NCAA) | Y | 223 | 100% | |
| Adult Critical Care Case Mix Programme (ICNARC) (Round 2) (CMP) | Y | 968 | 100% | |
| Emergency Laparotomy Audit (NELA) | Y | 125 | 100% | Data collection still open and data being submitted. |
| Adult Community Acquired Pneumonia | Y | Part 1 60/60<br>Part 2 26 (all patients that met the criteria) | 100%<br>100% | Data collection still open and data being submitted. |
| Pleural Procedures | Y | 15/17 | 88% | Unable to obtain notes |
| Fitting child (care in emergency departments) | Y | 50/50 | 100% | |
| Mental health (care in emergency departments) | Y | 100/100 | 100% | |
| ***Long Term Conditions*** | | | | |
| National (Adult) Diabetes Audit (NDA) | Y | 3783 | 100% | |
| Inflammatory Bowel Disease (IBD) Programme - Biologic Therapy only | Y | 80 | 100% | Data collection still open and data being submitted |
| National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme | Y | 119 | 100% | |
| Rheumatoid and early inflammatory arthritis | Y | 12 | 100% | |
| National Audit of Intermediate Care | NA | | | Audit not applicable |

| National Clinical Audits for inclusion in Quality Accounts 2014/15 | *Participation* Y, N or NA | *No of cases submitted* | *% cases submitted* | *Comments* |
|---|---|---|---|---|
| | | | | to the Trust. |
| Chronic Kidney Disease in Primary Care | NA | | | MTW does not provide this service |
| Renal Replacement Therapy (Renal Registry) | NA | | | MTW does not provide this service |
| ***Elective Procedures*** | | | | |
| Elective surgery (National PROMs Programme)<br>Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein | Y | Hip: 161<br>Knee: 195<br>Groin: 44<br>Varicose: N/A | | |
| Coronary angioplasty/ National audit of PCI | Y | 229 | 100% | |
| ***Older People*** | | | | |
| Older people (care in emergency departments) | Y | 158/200 | 79% | Mix up with junior doctor re numbers required per site |
| Sentinel Stroke National Audit Programme (SSNAP) | Y | 1. Organisational Audit<br>2. Clinical Audit – 567 | 100% | 1. Organisational data submitted.<br>2. data collection still open and data being submitted |
| ***Cardiovascular disease*** | | | | |
| Acute coronary syndrome or Acute myocardial infarction (MINAP) | Y | TWH: 201<br>Maidstone: 251 | | Data collection still open and data being submitted. |
| Heart failure | Y | 301 | 100% | Data collection still open and data being submitted. |
| Cardiac Rhythm Management (CRM) | Y | 407 | 100% | |
| Adult Cardiac surgery | NA | | | MTW does not provide this service |
| Congenital heart disease (Paediatric cardiac surgery) | NA | | | MTW does not provide this service |
| Pulmonary Hypertension | NA | | | MTW is not a Specialist PH centre. |
| National Vascular Registry | NA | | | MTW does not provide this service. |
| ***Cancer*** | | | | |
| Lung Cancer (NLCA) | Yes | 240 | 100% | Data collection still open and data being submitted |
| Bowel Cancer (NBOCAP) | Yes | 274 | 100% | Data collection still open and data being submitted |
| Head & Neck Cancer (DAHNO) | Yes | 31 | 100% | Data collection still open and data being submitted |
| National Prostate Cancer Audit | Yes | 360 | 100% | Data collection still open and data being submitted |
| Oesophago-gastric cancer (NAOCG) | Yes | 88 | 100% | Data collection still open and data being submitted |
| ***Trauma*** | | | | |
| Falls and Fragility Fractures Audit Programme (FFFAP) pilot | 1. NA<br>2. NA | 1. Falls<br>2. Fracture Liaison Service Database<br>3. National Hip Fracture | | 1. No data collection this period.<br>2. MTW does not provide this service. This is a community |

| National Clinical Audits for inclusion in Quality Accounts 2014/15 | *Participation* Y, N or NA | *No of cases submitted* | *% cases submitted* | *Comments* |
|---|---|---|---|---|
| | 3. Y | Database = 420 | | service. |
| Severe Trauma (Trauma Audit & Research Network) TARN | Y | 320 | 100% | |
| National Joint Registry (NJR) | Y | 983 | 100% | |
| ***Psychological conditions*** | | | | |
| Prescribing Observatory for Mental Health (POMH) | NA | | | MTW does not provide this service |
| Suicide and homicide in mental health (NCISH) | NA | | | MTW does not provide this service |
| ***Blood transfusion*** | | | | |
| (National Comparative Audit of Blood Transfusion Programme) National comparative audit of blood transfusion of patient information and consent 2014 | Y | 15 | 100% | |
| ***National Confidential Enquiries*** | | | | |
| Sepsis | Y | 6/6 | 100% | Data collection still open and data being submitted. |
| Gastrointestinal Haemorrhage | Y | 7/8 | 88% | Case notes unavailable |

**43 national audits** were published in 2014/15 with actions taken to address areas of non- or partial compliance. A number of improvements have been made in line with national recommendations, including-

**1. National review of asthma deaths.**

All people with asthma are now being provided with written guidance in the form of a personal asthma action plan (PAAP) that details their own triggers and current treatment plan. This will ensure people at high risk of severe asthma attack are aware of factors that exacerbate or trigger asthma so that measures can be taken to reduce their impact.

2. **National audit of Dementia Care in General Hospitals 2nd Round.**

'This is me' document now available and used on all patients admitted with or diagnosed with Dementia. This will ensure that person centred care is practiced throughout the Trust. Maidstone and Tunbridge Wells Trust now signed up to Dementia Action Alliance as dementia friendly.

3. **British Thoracic Society Bronchiectasis 2012.**

New bronchiectasis dedicated clinic running at Tunbridge Wells Hospital to assist with sputum culture and sensitivities and enable patients to be reviewed by a chest physician.

4. **National adult Diabetes Inpatient Audit 2013.**

A new universal Diabetes Foot care Assessment form to be completed for all known and newly diagnosed diabetic inpatients. This will ensure ongoing monitoring of feet and early identification of potential foot problems. Hypo boxes are now available on all wards to ensure hypoglycaemic episodes are treated promptly.

5. **Paediatric Inflammatory Bowel Disease (IBD) Round 4.**

A new IBD database is being developed within the Trust to capture all IBD clinical data. This will ensure better recording of the key clinical areas that need monitoring in the IBD patient.

6. **Epilepsy 12 (Childhood Epilepsy).**

   A business case has been submitted for an Epilepsy Specialist nurse to be employed within the Trust. This will enable an increased clinic capacity.

7. **BTS National Paediatric Asthma Audit.**

   Clinic staff are being trained to check Inhaler techniques for asthma patients before discharge. Patient Information Leaflets and written asthma plans are being produced to improve information given to patients and recording clinical documentation.

8. **National Paediatric Diabetes Audit (NPDA).**

   The installed the Twinkle database system, which enables participation in future NPDA audits and full completion of the required clinical patient data.

**9. BTS National Paediatric Pneumonia.**

   A more judicious allocation of IV antibiotic therapy for community acquired pneumonia was implemented following a review of antibiotic routes used for the administration of antibiotic therapy to bring it in line with recommendations.

**Please see Appendix A for full details of progress against each of the reported national audit results 2014/15.**

A number of service improvements have been made as a result of the **120** local clinical audits completed to action plan stage, across all Directorates, in 2014/15. 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 |
|---|---|
| Tissue Viability | Additional staff training sessions together with continual monitoring systems (via DATIX) and investment in pressure relieving boots and other pressure relieving systems and equipment has continued the trend of reducing the incidence of hospital acquired damage to (2.0%) this is significantly below the national average. |
| Physiotherapy | A joint venture between the Accident and Emergency (A&E) and physiotherapy departments, saw the beginning of an innovative service where physiotherapists would be based within the Accident and Emergency departments at Maidstone and Tunbridge Wells Hospitals. 96% of patients were seen by the physiotherapy practitioners within 1 hour of presentation in the Accident and Emergency department. |
| Medicine<br>(Falls / Stroke) | After the first audit a falls pro-forma was introduced to aid assessment of older people admitted with falls.<br>Following the second audit “medication review” stickers were introduced to go on drug charts alerting healthcare professionals to patients at high-risk. A Falls Co-ordinator has also been employed to improve the management of patients at risk of falls. |
| Radiotherapy | In order to ensure timely radiotherapy treatment for cancer patients, teams were informed of the need to adjust the “ready to start date” when the planning process is delayed due to clinically accepted reasons.<br>Breast specialist radiographers now liaise with the physiotherapy team with regards to adequate recovery for Seromas which can be built into the breast pathway.<br>Patient pathway has been revised by breast specialist and physiotherapist. Operational standards have now been met. |
| Medicine | EGC labelling across wards has significantly improved following the introduction of laminated cards attached to each ECG machine. This has reduced the potential for incorrect prescribing of medications, |
| Surgery | The initial audit led to the implementation of electronic prescribing. The re-audit has shown that there were no prescribing errors. |
| Midwifery | A re-audit of maternity documentation has shown a marked improvement with the documentation at the Birth Centre with fully compliance now achieved. This is important as good documentation impacts on achieving a smooth handover of care, if a woman requires transfer to Tunbridge Wells Hospital in an emergency, ensuring that potential risks and problems are communicated appropriately. |
| Sexual Health | Changes in staff training, updated local treatment guidelines and clear Pelvic Inflammatory Disease (PID) clinical management pathways have resulted in improvements in clinical care for this group of patients treated in the GUM clinic. All aspects of the clinical management pathway are now being |

| Actions taken following local audits | Trust Actions |
|---|---|
| | met thus improving patient treatment. |
| Critical Care | A patient survey into the current epidural service has shown a high level of patient satisfaction with the information provided and the pain relief achieved. |
| Trauma & Orthopaedics | An audit looking at the recording of operations on booking forms for the "removal of metalwork" has led to improvements in surgeons planning, in advance, the equipment necessary for theatre. This means less wasted time in theatre looking for equipment mid procedure, quicker operations and less anaesthetic. This is safer for patients and prevents operative complications. |
| Orthoptics | A patient satisfaction survey carried out on all hospital clinic sites where this service is provided has shown an overall satisfaction level of 99.5%. Improvements implemented as a result of patients comments from the previous survey include: more signage relating to availability of refreshments in the waiting areas; a white board purchased to keep patients informed of any delays to clinic waiting times; improvements and additional equipment was purchased for the children's play areas and a television was installed in the waiting area. |

# NICE Guidelines

Every year the National Institute for Health and Care Excellence (NICE) develops guidelines for the NHS to review and implement to enhance practice and the care of patients. As at the end of 2014/15 there have been **979** NICE guidance documents disseminated to the specialty leads throughout the Trust. Of those, **883** (**90.2%**) have been evaluated. **343** (**38.8%**) of the evaluated guidance are relevant to the Trust. The breakdown is shown in the table below.

| Guidance Type | Published | Evaluated | Relevant |
|---|---|---|---|
| **Clinical Guidelines (NICE CGs)** | **193** | **171** | **106** |
| **Interventional procedures (NICE IPGs)** | **450** | **406** | **77** |
| **Technology appraisals (NICE TAs)** | **336** | **306** | **160** |
| **Totals** | **979** | **883** | **343** |

**Please see Appendix C for full details of Trust compliance with guidance that has been audited and completed during 2014/15.**

# Research

## Participation in clinical research

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

MTW Research team

During 2014/15, Maidstone and Tunbridge Wells NHS Trust made significant strides in delivering key local and national strategic initiatives to benefit patients.

### 1. Increasing the number of research participants year on year

During 2014/15 Maidstone and Tunbridge Wells NHS Trust recruited over 2,000 patients and volunteers to research trials at MTW- a rise of 33% on the previous year. Patients and volunteers were recruited to a wide range of studies, including drug studies, interventional and observational projects. Maidstone and Tunbridge Wells NHS Trust met the recruitment target of 1,100 for 2014/15 as set by the Kent Surrey and Sussex Clinical Research Network.

### 2. Increased research funding

In the summer of 2014, Maidstone and Tunbridge Wells NHS Trust secured a significant research grant to support surgical surgery at the Trust of over £300,000. This funding is to support a project looking at the impact of isometric exercise both pre and post abdominal surgery on patient recovery. The study is due to start in early 2015. A number of consultants were all successful in being awarded smaller grants to support research which have been used to buy key medical equipment and research staff.

### 3. Widen the expertise of the Research and Development Team

Increased funding has enabled the Trust to employ key specialists to the Research and Development Department including a microbiologist, a Research Associate and a Clinical Support Worker. These posts have widened the scope of projects that MTW can participate in, especially microbiological, respiratory and community-based studies. The Research Department also welcomed several new nurses to the department to support oncology, respiratory, ophthalmic and surgical research.

### 4. Increase the diversity of research projects

There are presently 308 studies open at Maidstone and Tunbridge Wells NHS Trust, inclusive of randomised clinical trials, observational studies, MTW investigator led and student projects. Increasing participation in clinical research demonstrates Maidstone and Tunbridge Wells NHS Trust's commitment to improving the quality of care on offer and to making a contribution to wider health improvement. Research staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

### 5. Appointed England's first dedicated Patient Research Ambassador

Frances Mossie, Patient Research Ambassador

Early in 2014, Maidstone and Tunbridge Wells NHS Trust appointed England's first dedicated Patient Research Ambassador (PRA). The voluntary role is designed to provide a strong link between Trust research staff and research patients and volunteers. Over the past 12 months, the PRA has worked tirelessly to provide information, support and reassurance to many research participants and has significantly contributed to the delivery of the Trust's Patient and Public Involvement in Research strategy.

### 6. Develop research expertise in support services

Over 300 clinical staff participated in research approved by a research ethics committee during 2014/15. 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 senior nursing staff, therapeutic and service support staff. The aim for the forthcoming year is to widen the opportunities for support service staff further, particularly within pharmacy and microbiology.

### 7. Increase awareness of the importance of research.

With the support of the PRA, Maidstone and Tunbridge Wells NHS Trust has focused on ensuring the public, both locally and nationally, is provided with information relating to research. Over the past 12 months, the Research and Development Department has opened a Facebook page, joined Twitter and invested in producing educational resources to aid understanding. Educational blogs and videos, featuring members of the Research and Development Department, are available for the public to view on the National Institute for Health Research website.

In May 2015, the Research Department will share with a wide audience the improvements made in delivering the Research Patient and Public Involvement Strategy at the National R&D Forum in

Manchester. MTW research staff will run a workshop to highlight the importance and the benefits of including the public in developing and delivering research.

Since 2008/9, over 250 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

### 8. Strengthen research governance

During the summer of 2014, the Kent Oncology Centre Clinical Trials Unit (KOC-CTU) at Maidstone Hospital came under the line management of the central Research and Development Department and became fully embedded into the central governance processes. This move has allowed for greater support of staff within the CTU and supported the development of one central research facility. This central facility is more efficient and effective for staff as well as patients.

The oncology centre continues to expand its portfolio of cancer trials ensuring that all cancer patients have an opportunity to participate in the open trials at MTW.  New appointments were made to the department to increase haematology related research and expand opportunities to recruit patients at Tunbridge Wells Hospital.

# 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 2014/15 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 2014/15 and for the following 12 month period are available electronically at www.mtw.nhs.uk

Within the commissioning payment framework for 2014/15 quality improvement and innovation goals were set as indicated in the table below.

| | Target | *Achieved (local data) | RAG Rating |
|---|---|---|---|
| National CQUINS | | | |
| Friends & Family Test - Implement Staff FFT Test from 1st April 2014 | **Implement** | Implemented | Green |
| Friends & Family Test - Phased Expansion of Staff FFT - Jan 15 | **Implement** | Implemented | Green |
| Friends & Family Test - Early Implementation National Timetable for Outpatients - April 2015 | **Implement** | Implemented | Green |
| Friends & Family Test - % response rate for Inpatients Q4 | **30%** | **30.7%** | Green |
| Friends & Family Test - % response rate for A&E | **20%** | ***17.6%** | Amber |
| Friends & Family Test – % response rate for Inpatients in March only | **40%** | ***29.6%** | Amber |
| Safety Thermometer: Falls Rate per 1,000 Occupied Beddays | **6.75** | **6.16** | Green |
| Safety Thermometer - VTE - SI Related | **3** | **4** | Amber |
| Dementia Screening - % patient of patients screened | **90%** | **98.9%** | Green |
| Dementia Risk Assessment - % of those screened who had a risk assessment completed <72hrs after admission | **90%** | **99.3%** | Green |
| Dementia – referral for specialist diagnosis | **90%** | **100%** | Green |
| Named Lead clinician for Dementia and Training | **Yes** | **Yes** | Green |
| Ensuring Carers feel supported - monthly audit | **Yes** | **Yes** | Green |

| | Target | *Achieved (local data) | RAG Rating |
|---|---|---|---|
| **Local CQUINS** | **Target** | **Achieved** | |
| Reducing Incidence of AKI - Implementation of Education Programme | **Yes** | **Yes** | Green |
| Reducing Incidence of AKI - Compliance to all 4 numerators | **68%** | ***74.6%** | Green |
| 15% reduction in the number of AKI 3 patients identified compared to 2013/14 baseline | **497** | ***416** | Green |
| Improve the use of Cardiac rehabilitation service - For 90% of eligible patients the programme is offered - within the agreed timescales | **90%** | ***100%** | Green |
| Improve use of the cardiac rehabilitation service- Increase Uptake of cardiac rehabilitation service for all eligible patients to 65%. | **65%** | ***39%** | Red |
| Improve use of the cardiac rehabilitation service - 88.5% completion rate for all eligible patients commencing cardiac rehabilitation. | **88.5%** | ***92%** | Green |
| Implementation of the Interface Formulary - % of items prescribed from the Formulary Q3, 90% for Q4 | **90%** | **90%** | Green |
| Ophthalmology - Repatriation of stable condition glaucoma patients | **500** | **606** | Green |
| Reporting of Medication-related safety incidents | **450** | **476** | Green |
| Emergency Paediatric Pathways - Number of paediatric patients attending A&E that are reviewed by a paediatric nurse (Q4) | **Implement pathways** | **Completed** | Green |
| Falls Screening in hospital settings for >75yrs if appropriate (Q4) | **90%** | **93.4%** | Green |
| Rate of Surgical site infections per 10,000 specified orthopaedic operations (April 14 to March 15) | **75** | ***99.3** | Red |
| Patient Experience Survey - Nov, Dec and Jan - Improvement from 2013/14 for Inpatients, Outpatients and A&E for each question by Site. | **Data not yet available** | **Data not yet available** | |

* *Figures shown are the latest available data – this is because some of the data will not be available until after publication of performance.*

## Commentary

In this section we highlight some of the CQUIN improvements and developments in 2014/15, including what we achieved and what challenged us.

Friends and family test: This CQUIN focussed on extending the friends and family tests FFT to all staff in the Trust. All MTW staff now has the opportunity to feedback their views on their organisation at least once per year. This is in line with the Trust's strategy of engaging staff to promote a cultural change where staff have confidence to speak up, and where the views of staff are heard and are acted upon. This will help us deliver a reputation for positive patient experience which the Trust believes will lead to greater productivity, more investment and long-term sustainability. Cultural change workshops are scheduled thought out the year to support this cultural change.

Safety Thermometer: This CQUIN focussed on reduction in the rate of falls, Reduction of SI related and hospital acquired venous thromboembolisms (VTE). The reduction in number of patients falling in hospital was a huge success; the Trust reduced the rate of falls by 10% when compared to last year.

The Trust delivered its target of ensuring that at least 95% of patients were given a VTE risk assessment in 2014/15. The Trust managed to maintain the number of VTE related SIs at four (same as in 13/14) but failed to achieve the reduction by one that was required to deliver the CQUIN. Despite extensive work by clinical teams, the number of hospital acquired VTEs increased in the last year. Reporting of VTE assessment has improved across the Trust as a result of greater staff awareness which is important for continued improvement. This will continue to be an area of focus for the Trust.

Dementia: This CQUIN focussed on finding, assessing, investigate and referring patients with dementia. The Trust delivered an excellent dementia training programme and that coupled with the excellent clinical leadership and engagement enabled the Trust to exceed the requirements of this CQUIN. This is a significant achievement as it means that more patients with dementia were identified early and supported to help them manage their condition and have a more positive experience with health and social care services. This CQUIN will be further embedded in the next year and this will require continued investment which the Trust is committed to.

Acute kidney injury (AKI): This CQUIN focussed on improving prevention, detection and management of acute kidney injury (AKI) for all hospital in-patients. The Trust made a tremendous success of this CQUIN. As a result of the concerted work by clinical teams, the Trust has significantly improved clinical outcomes and reduced the length of time that patients stayed in hospital. These improvements will ultimately contribute to the reduction in the number of AKI related deaths in our hospitals. This Trust will continue to embed this CQUIN in 2015/16 to further improve outcomes and patient experience for patients with AKI by working more closely with GPs to ensure patients are managed appropriately after their discharge from hospital- this will help further reduce deaths from AKI related complications.

Cardiac rehabilitation: The aim of this CQUIN was to increase the number of eligible patients taking up and completing cardiac rehabilitation programmes. The Trust met the CQUIN target for two of the three measures agreed with the CCG, more than 90% of eligible patients were offered the programme within the agreed timescales and more than 88.5% of those who started the programme completed it. However, the Trust failed to increase uptake of the programme to the agreed 65% because of delays in recruitment of extra staff required to deliver the programme. The Trust and the CCG have worked closely to resolve this issue and progress has been made to recruit the extra staff required to deliver the improvement.

Transforming Outpatients Project: This aim of this project is to enable better clinical management and to improve patient experience by allowing GPs to seek and receive specialist advice without having to refer patients to hospital for an outpatient appointment. The Trust successfully rolled out this initiative to three specialities Orthopaedics, Pain, and Rheumatology ahead of schedule. Feedback from Patients, GPs, and Consultants has been positive and the Trust and the CCG have now formed an Executive led Joint Project Board to expand this innovative project to other areas. There is patient representation on the Joint project Board and this has been invaluable in ensuring that the project remains patient centred.

Ophthalmology – repatriation of stable condition glaucoma patients: The aim of this CQUIN was to enable patients with stable glaucoma that do not need to be treated in a hospital to receive care in the community near where the live. This transfer to the community only happens when the

consultants looking after each patient is fully satisfied that the clinical care appropriate for the patient can be provided safely in the community. This CQUIN will serve patients having to travel to hospital unnecessarily and ensure we make best use of the most appropriate services to treat patients. The Trust discharged over five hundred patients for care in the community in the last year and in so doing met the agreed CQUIN target.

Medication safety incidents reporting: The aim of this CQUIN was to improve the reporting of medication related safety incidents. It is widely acknowledged that within the NHS some fatal, serious incidents and never events involving medication errors may not be reported to the National Reporting and Learning System (NLRS) and therefore a learning opportunity is lost. As a result of the excellent clinical leadership and vigilance of our clinical teams, the Trust exceeded the requirements of this CQUIN. Although the number of incidents reported has gone up the Trust encourages staff to continue reporting these incidents as this will allow everyone to see and act where there is a problem.

Emergency paediatric pathways: The aim of this CQUIN was to ensure the Trust has laid the foundation for ensuring that paediatrics patients receive high levels of care tailored for their needs and clinical requirements. The Trust completed all the required preparatory work including developing paediatric pathways for emergency patients, recruiting paediatric nurses and making physical environment changes required to support the paediatric pathways.

Reducing rate of surgical site infections (SSIs): The aim of the CQUIN was to reduce the number of patients with wound infection following hip prosthesis, knee prosthesis and repair of neck of femur surgery. The Trust failed to deliver this improvement and this will remain an area of focus in the next year. A focus group led by the Clinical Director for Trauma and Orthopaedics has been formed to draw up and implement an action plan to reduce surgical site infections sustainably. The key areas of action identified so far include ringing fencing more T&O beds, supporting pre-operative warming of patients and a review of wound disinfectant regimes. It is recognised that the Trust may have a higher rate of SSIs because of the profile of the Fractured Neck of Femur (NOF) patients admitted to the Trust. Nevertheless the Trust policy is that every SSI is subject to a root cause analysis to ensure learning.

# Statements from the CQC

THE Care Quality Commission (CQC) carried out a Chief Inspector of Hospitals announced inspection of MTW between 14 and 16 October 2014, as part of the process the CQC also undertook two unannounced visits on 23 and 24 October 2014.

A team of 41 CQC inspectors visited Maidstone Hospital, Tunbridge Wells Hospital and Stroke Rehabilitation services provided at Tonbridge Cottage Hospital. The Quality Summit took place on 29 January 2015 and the final reports were published on 3 February 2015. The Trust has been assessed overall as 'Requires Improvement' and was given 29 good ratings; 43 require improvement ratings and 6 inadequate ratings. There is one enforcement action and 18 compliance actions: 'must dos' within the report. There are 49 'should do' actions which relate to the key issues within Directorates and Trust-wide.

Although the Trust was disappointed with the overall results, the report has been welcomed and will be used to drive quality improvements throughout the organisation and improve the services that we provide to our patients. The Trust is pleased that the Caring domain was rated 'good' throughout the Trust and also with the recognition of our caring and compassionate staff.

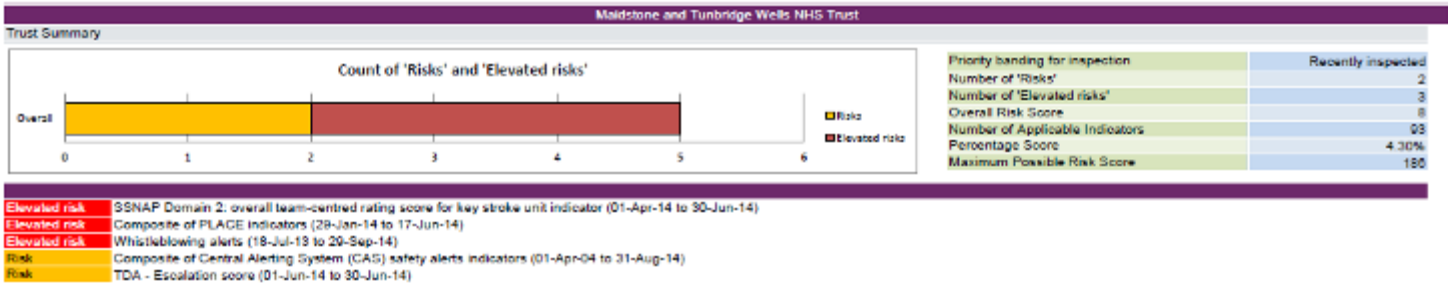
A comprehensive Quality Improvement Plan (QIP) has been developed following extensive discussions with our staff and stakeholders and was submitted to the CQC in March 2015. This plan will now be implemented and overall progress will be monitored monthly at the Trust Management Executive with the Trust Board receiving monthly reports. Progress updates will be published on the MTW website and internally on the intranet.

## 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. 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 approximately every quarter. The last report (at the time of writing these Accounts) was published in December 2014 and the profile is given below. A banding was not given as the Trust had been recently inspected. However a risk score of 8 should correspond to a banding of 4.




The next report will be released in draft form in April 2015 for the Trust to comment. The final report will be published in May 2015. Full reports can be accessed via the CQC website [www.cqc.org.uk](http://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 2014/15 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 2014/15.

The Trust has a Data Quality Steering Group that takes action on data quality issues. Areas identified for improvement during 2015/16 are:-

- Continue to expand the use of the NHS Number within in the Trust as the primary identifier and ensure the small drop in completeness does not recur in 2015/16
- Improve data quality in key areas required to implement the new 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 2014/15 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;
  98.6% for outpatient care; and
  95.0% for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:
  99.9% for admitted patient care;
  99.9% for outpatient care; and
  99.7% for accident and emergency care.

**Information Governance Toolkit attainment levels**
The Trust achieved a 74% satisfactory (Green in the toolkit grading scheme) score against the Information Governance Toolkit Version 12, and achieved 10 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 Data Protection Officer. The Trust Board is kept fully apprised 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 employs 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 2014/15 were as follows:-

| | |
|---|---|
| Primary Diagnosis | 92.5% |
| Secondary Diagnosis | 98.8% |
| Primary Procedure | 99.2% |
| Secondary Procedure | 97.6% |

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.

The lower performance in relation to the primary diagnosis was essentially down to a systems constraint which impacted upon the recording of 5 character ICD 10 codes. This in turn equates to a non-coder error.

# Part Three

# Update on improvement initiatives 2014/15

This section will provide a summary update on the initiatives we prioritised last year:

## Patient Safety - *Reducing the number of avoidable harms with a focus on:*

### Hospital acquired infections, in particular MRSA, C Difficile

**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.

| Planned Actions for 2014/15 | Summary Update |
|---|---|
| Reduction in C. difficile cases to less than 40 | The Trust had 28 cases of C. difficile (35 previous year). This is a 20% reduction from last year's out-turn. The rate of infection was 12 per 100 000 bed days (the national benchmark is 15.7 per 100 000 bed days). |
| Continued focus on robust antibiotic stewardship | Extension of the educational programme for the safe and appropriate use of antibiotics<br>Implementation of the national acute Trust carbapenemase-producing Enterobacteriaceae (CPE) toolkit |
| Rigorous monitoring of deep cleaning programme | The deep cleaning programme is monitored through the Infection Prevention and Control Committee. Progress against the plan is via a written report presented to the February, June and October Committees.<br>Estates present a general report at this time which includes compliance against the routine cleaning standards |
| Sustain relationships and joint working with community colleagues to ensure good progress is maintained for appropriate antibiotic prescribing and management | Agreement across the health economy of methodology for assessment of any lapses of for all C. difficile cases.<br>Working across the health economy to have a whole system approach to the reduction of C. difficile.<br>Review of the MRSA screening programme to support local needs |

## Falls

**Aim/goal:** We aimed to reduce the rate of falls in the year from 7.2 per 1,000 occupied bed days to 6.75 per 1,000 occupied bed days

| Planned actions for 2014/15 | Summary update |
|---|---|
| Overall rate of falls decreasing | Rate of 6.2 per 1,000 occupied bed days at March 2015 |
| Review of Bed Rails assessment | Bed rails assessment review has been ongoing over the last 12 months with an audit planned for April 2015 |
| Review and implementation of revised checking process for selection and condition of alarm mats | Implementation of staff training on use of Falls Sensor alarm (including appropriate checking of sensor pads) with Competency tool developed for staff |
| Consideration of a 'review sticker' to demonstrate medications review has been undertaken | Implemented 'review sticker' to demonstrate medications review has been undertaken |
| Review of Serious Incident investigation and closure process | Review undertaken of Serious Incident investigation and closure process relating to falls, with improvements made |

## 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.

| Planned actions for 2014/15 | Summary update |
|---|---|
| Sustain the reduction in the number of hospital acquired pressure ulcers in line with the current national agenda | 2014/15 has seen a sustained reduction of facility acquired pressure damage (FAPD) of category 3 and 4 - during 2014 there were no category 3 FAPD compared to 8 in 2013/14 ; 1 category 4 FAPD which when investigated was found to be unavoidable.<br>The February 2015 prevalence audit has confirmed that MTW is continuing to maintain the reduction in pressure FAPD |
| 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. | The plan for 2015/16 is to review all patients with facility acquired pressure damage with the lead nurses for dementia care and falls prevention – the rationale for this is to develop internal strategies which should ultimately assist front line staff in delivering quality care to those patient with challenging behaviours – to be arranged. |
| Review the efficacy of the current mattress systems (non-dynamic) to ensure they remain the product of choice | Mattress audits will be undertaken in 2015 dates to be agreed. A mattress audit in 2014 was undertaken at Maidstone however TWH was not |

| Planned actions for 2014/15 | Summary update |
|---|---|
| | achieved due to a shortage of replacement covers and mattresses. To overcome the risk of a mattress not being fit for purpose there is a policy and procedure for the decontamination and maintenance of mattresses in place<br>The current standard hospital bed mattress stock is 5years old and will require replacement to ensure it remains effective in reducing the risk of pressure damage and infection prevention requirements. During 2015 evaluations will be undertaken to review alternative systems available on the market; this process will include EME, Procurement, and Infection Prevention team, Moving and Handling and Tissue Viability – with the ultimate aim to have a preferred mattress for the Trust. The business case for the replacement mattress will re reviewed and resubmitted to the finance director |
| Review the role of the link nurse and the way in which frontline staff gain and maintain pressure damage prevention skills | The link nurse role is reviewed at each link nurse meeting held twice yearly. Competencies have been agreed and reviewed for nurses and Care Support Workers.<br>Education is provided by the tissue viability team - 6 sessions for 2015 have been planned for Pressure Ulcer Prevention and Category Recognition, on the learning and development website. although these sessions have not previously been formally evaluated by the attendees verbal feed back has been positive, written evaluations will completed for each session for 2015 to ensure a robust and effective teaching experience is achieved<br>The Tissue Viability Nurses do maintain a regular visible presence on the wards and are available for help and advice as required. |

## Review and enhance the emergency care provision for children in our Accident & Emergency 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.

| Planned actions for 2014/15 | Summary update |
|---|---|
| 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)*. | An acuity and dependency review has been undertaken for the Emergency Department at Tunbridge Wells Hospital in June 2014. In response to this we are reviewing our nursing establishments in order to ensure safe staffing in line with the draft NICE guidelines published in February 2015<br><br>It is our intention by the end of June 2015 to carry out further acuity and dependency review using the PANDA tool to ensure that paediatric staffing is safe and appropriate |
| Build on the full review of staffing, in line with the National Quality Board recommendations (work already undertaken in 2013/14) | We have now recruited 8 Registered Children's Nurses to work across both sites and ensure implementation of the paediatric pathway through the Emergency Departments (EDs)<br><br>The team of RSCNs will be line managed by an ED band 7 with dual qualification. They will also work closely with the RCN on the paediatric ward and will report to the Paediatric Matron |
| Strengthen communication and supervision links between the A&E Department and Children's Services Directorate | In addition to the close supervision there is a monthly paediatric/ED Liaison meeting that is Matron led and involves both Directorates. It is also attended by the Clinical Directors for both Directorates |
| Review pathways for sick children, ensure they remain appropriate and are consistently followed. | The paediatric pathway has been reviewed through the paediatric/ED liaison meeting and has been agreed at Directorate board for both Directorates |

# Clinical Effectiveness - *To provide an integrated approach to care with our community colleagues with a specific focus on:*

## Dementia

**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

| Planned actions for 2014/15 | Summary update |
|---|---|
| Continue with work commenced last year with the Association for Alzheimer's and Dementia Support Services (ADSS) for the implementation of the dementia buddy scheme. | Work continues with ADSS and the Dementia Buddy Scheme, which is now running on both hospital sites. A dementia buddy coordinator is employed through ADSS and leads on the recruitment and training of volunteers. We currently have 53 volunteers in total, with 36 on Maidstone site and 17 on Tunbridge Wells Site. There are currently 2 wards covered at Maidstone and 1 at Tunbridge Wells with a view to expand as more volunteers are recruited. A day room area has been developed between 2 wards at Maidstone Hospital for the buddies to utilise, and they have run lunch clubs, activity sessions and painting sessions.<br>Parameters for the dementia buddies have been developed with regards to Nutrition and Moving and Handling to assist them in the work they are undertaking. The buddies are also completing evaluation forms of the service provided and this will be presented at the Dementia Strategy Steering Group |
| 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 | Estates and facilities department have been provided with the Kings Fund documentation on Enhancing the Environment for dementia patients in order to assist them in their planning and implementation of 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 | Results of the 'Carers survey' are reported to the Dementia Strategy Group meeting twice a year, and where required actions identified. The results are also disseminated to the ward managers; matrons and dementia champions for further dissemination. |

## Discharge Planning

**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

| Planned actions for 2014/15 | Summary update |
|---|---|
| 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 | Twice weekly conference call with the Clinical Commissioning Group (CCG), Kent Community Health Foundation Trust (KCHT), and Kent County Council (KCC) is in place to discuss and monitor any delays in discharging patients from the acute sector.<br>Evidence – diarized conference calls |
| 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 | Visits have been made to service providers to start scoping the viability of telemedicine within respiratory medicine.<br>On agenda for next Respiratory Meeting to agree how to proceed |
| Development and implementation of Enhanced Electronic Discharge Notification (EEDN) allowing full multi-disciplinary notification of discharge, including community and social care teams | Currently in development stages, IT infrastructure allows for the extension to our current EDN. Electronic Patient Records team are looking at progressing this project over the coming year |
| Review work plans to enable 7 day working across disciplines and specialities | Business Case completed by Emergency & Medical Services Directorate to implement 7 day services in a number of areas |

## Enhance Stroke Care pathway

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

Update: We have achieved this target for 2014/15.

| Planned actions for 2014/15 | Summary update |
|---|---|
| Stroke Steering Group initiated | Stroke Steering Group implemented at a Corporate level with KCHT and CCG input. Minutes available |
| Action Plan developed | Local Stroke implementation groups have been set up on each site and chaired by the Stroke Clinical Nurse Specialists. Minutes of meetings available |
| Ring fenced bed on each acute stroke ward | Implemented and included on daily Site Report. Also discussed at each of the four daily Site Meetings |
| Escalation criteria to be monitored | If Ring Fenced bed is not available due to capacity issues, a key priority from the Site Meeting will be to ensure one is available within the next 4 hours. Cross site working is improving and suitable Stroke patients do now access a stroke bed on the other site in order to ensure they receive appropriate stroke care. |

## Patient Experience

### To improve our ward environments, with particular focus on day rooms and communal areas between wards at Tunbridge Wells Hospital

**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.

| Planned actions for 2014/15 | Summary update |
|---|---|
| Patient Environment Steering Group (PESG) to ensure ward day rooms are prioritised for investment from PLACE funds | Included as part of refurbishment plans for Maidstone Hospital site. Key focus for Maidstone Hospital in 2014 was the revision of way-finding and colour coding signage and hospital zones. Some investment has been made in furniture on both sites, and particular attention has been paid to maximising 'end of ward' space on the wards at Tunbridge Wells by creating small seating areas by the main window |
| 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 | The links between the PESG and the Dementia Steering Group remain strong with clear understanding of the role both groups play in enhancing the environment for both patients living with Dementia and the wider population |
| Set of principles for common areas to be agreed to ensure that they are inviting spaces for all | Key principles in place guided by infection control and hospital design regulations<br>These considerations are kept in mind at all PESG meetings where ward refurbishments are discussed.<br>Colour coding and patient engagement are the key factors, along with the principle of providing a communal space, where possible, in all ward refurbishment |

### To improve management and actions in response to complaints to ensure each is used as an opportunity from which we can learn

**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 apprised 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

| Planned actions for 2014/15 | Summary update |
|---|---|
| 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 | Complaints training open to all staff and focusing on the investigation of complaints and drafting complaint responses was delivered by the central complaints team up until June 2014. Due |

| Planned actions for 2014/15 | Summary update |
|---|---|
| services/Organisational Development programme | to capacity issues within the central team, we were unable to offer training August 2014 to March 2015. One of the team objectives moving into 2015-16 is to review and relaunch the training programme. We are trying to work towards delivering a full day's training, allowing delegates to 'investigate' and 'respond' to a case study. Complaints and PALS case studies have been used in designing a new Trust-wide customer services training programme; the pilot is scheduled to take place on 29 May 2015. |
| 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 | An amalgamated PALS/complaints report has been developed which combines the data captured to highlight recurring themes. This is submitted to the Clinical Governance Committee for discussion and review |
| Report publically the number of complaints received, the number of upheld and actions taken | Annual complaints report provides all this information. |
| 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. | During 2014/15, the Trust Board agreed to hold meetings in public every month (previously this was every 2 months). A 'patient story' is normally heard at every other meeting, and in 2014/15, stories were relayed in person at the Board meetings in May, October and December 2014, and February 2015. Such stories provide invaluable first-hand experience of being a patient of the Trust, and are supplemented by visits of Board members to hospital areas (which are reported to the Board each quarter) |
| To continue to develop and enhance our practice of early engagement with patients and families | In terms of PALS, we launched our Open Day programme in September 2014 to raise awareness of the service and make it easy to capture feedback from patients<br>A programme of PALS ward rounds was launched in March 2015 to gather feedback from inpatients. |

## To improve the quality of written information, particularly in relation to patient information leaflets and letters to General Practitioners.

**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.

| Planned actions for 2014/15 | Summary update |
|---|---|
| Health Records Manager and Communications Department to improve the quality, readability and consistency of patient letters. | Extensive work has been carried out on the letters sent to patients to simplify the content. A standardised format is used by clinical secretaries and information is printed on the reverse |
| Patient Information and Leaflet Group to consider an alternative approach to highlight information leaflets by subject matter, e.g. colour coded stripe | The Patient Information and Leaflet Group reviewed the 'Department of Health' guidance on leaflets. The Trust guidance was amended to allow more than 2 colours within leaflets that are printed within the Trust (core leaflets printed externally will still follow the 2 colour rule). This allows Directorates to adopt local colour stripes to highlight information by subject matter. |
| 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 | We publish the result of the friends and family test in ward areas for staff, patients and visitors to see. These are updated monthly |

## Friends and Family Test

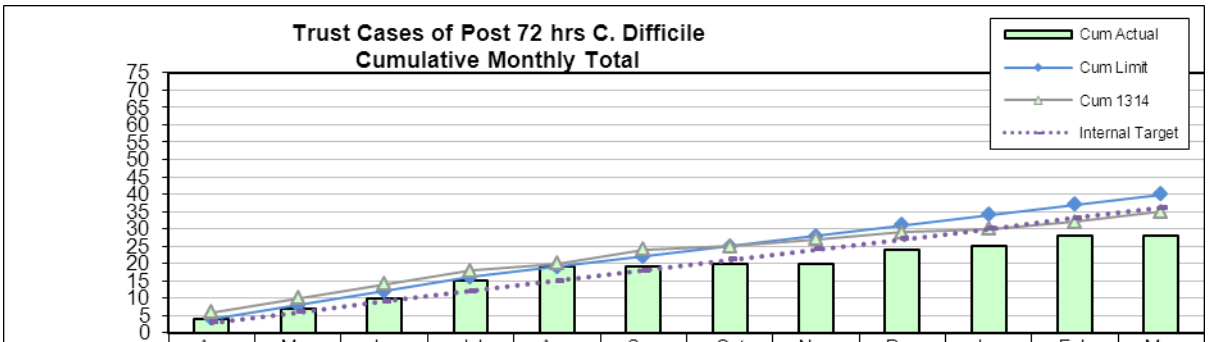
**Aim**: to significantly improve our response rate for the Friends & Family Test (FFT), whilst maintaining our overall net promoter score:

| Planned actions for 2014/15 | Summary update |
|---|---|
| Improved internal awareness | FFT now used routinely as part of the Directorate reports to Quality & Safety Committee<br>FFT returns for A&E noted at Site Operational meetings<br>Use of FFT in the development of service improvements, business planning and staffing reviews |
| Weekly reporting of returns to departments | Weekly return estimates collated and circulated to wards |
| Consideration of alternative means of feedback (e.g. increased use of IT, mobile technologies) | Consideration has been given to the use of IT and mobile technologies and is included in the Trust's IT Strategy.<br>The implementation of NerveCentre will be considered for FFT feedback once the initial clinical care modules have been fully established.<br>Use of text and voice activated technology is being set up for outpatients, with the service undergoing testing in March 2015 and fully live by April 2015. |
| Implementation of FFT for all outpatients | Initial feedback has been via paper survey and on-line survey monkey. The latter has not proved popular. |

| Planned actions for 2014/15 | Summary update |
|---|---|
| | A text/telephone service similar to the Out Patient Department reminder service is being implemented for OPD from April 2015. |
| Implementation of FFT for staff | This is in place as part of the national staff survey, and via a twice yearly local staff surveys. Overall the response from staff has been excellent |

# Review of Quality Performance

**Infection Control – C.Difficile Cases** – The Trust exceeded this standard with 28 cases against a maximum of 40 cases for the year. The number of CDifficile cases throughout 2014-15 was 7 fewer than the number reported for 2013-14 – 20% reduction

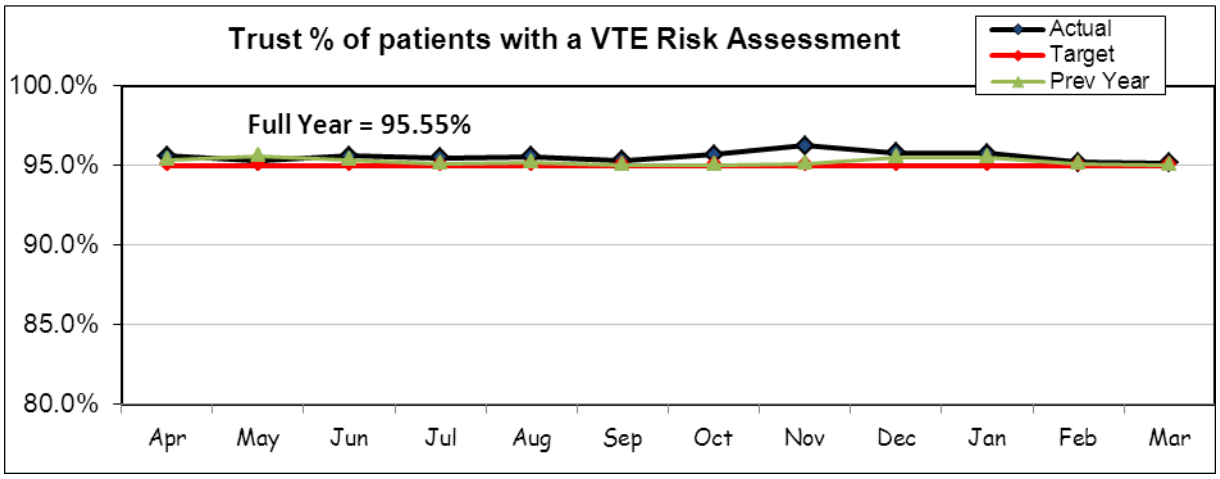



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cum Actual | 4 | 7 | 10 | 15 | 19 | 19 | 20 | 20 | 24 | 25 | 28 | 28 |
| Cum Limit | 4 | 8 | 12 | 16 | 19 | 22 | 25 | 28 | 31 | 34 | 37 | 40 |
| Cum 1314 | 6 | 10 | 14 | 18 | 20 | 24 | 25 | 27 | 29 | 30 | 32 | 35 |
| Internal Target | 3 | 6 | 9 | 12 | 15 | 18 | 21 | 24 | 27 | 30 | 33 | 36 |

**Infection Control – MRSA Cases** – The Trust achieved the standard, with 1 case of unavoidable post 48 hr MRSA bacteraemia through the year against a Trust standard of zero avoidable.

## Prevention of blood clots or venous thromboembolism (VTE)

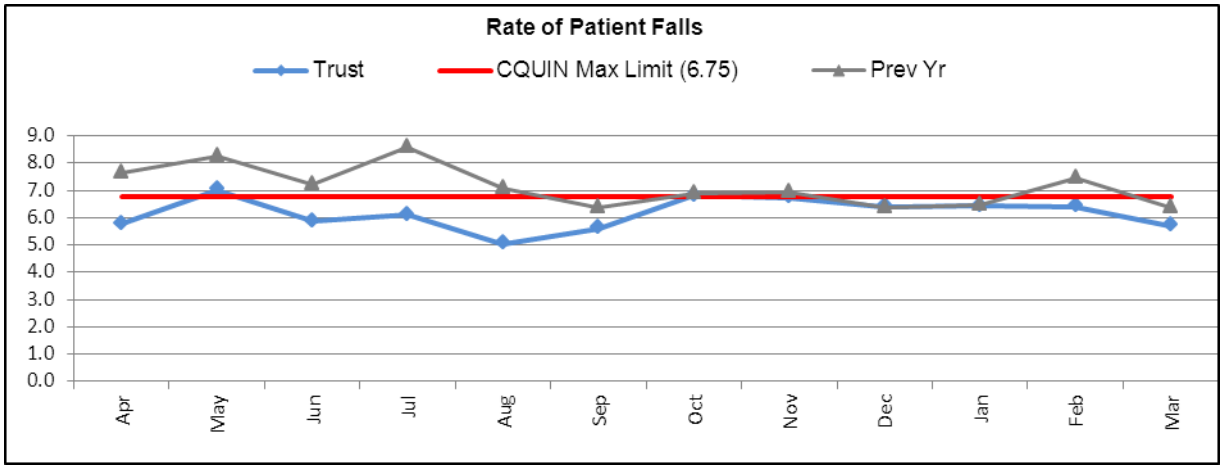
**% Patients VTE Risk Assessment** – The Trust ensured that 95% of patients were given a VTE Risk Assessment in 2014-15.




## Reducing the number of patient falls

*See key priorities for 2014/15 and update summary in section 2*

**Rate of Falls** – The Trust's rate of Falls per 1,000 Occupied Beddays is below the local quality improvement target (CQUIN) of 6.75 at 6.16 for the year (7.1 for the previous year). The number of Falls reported in 2014-15 is a 9.8% reduction (-156) from the previous year.

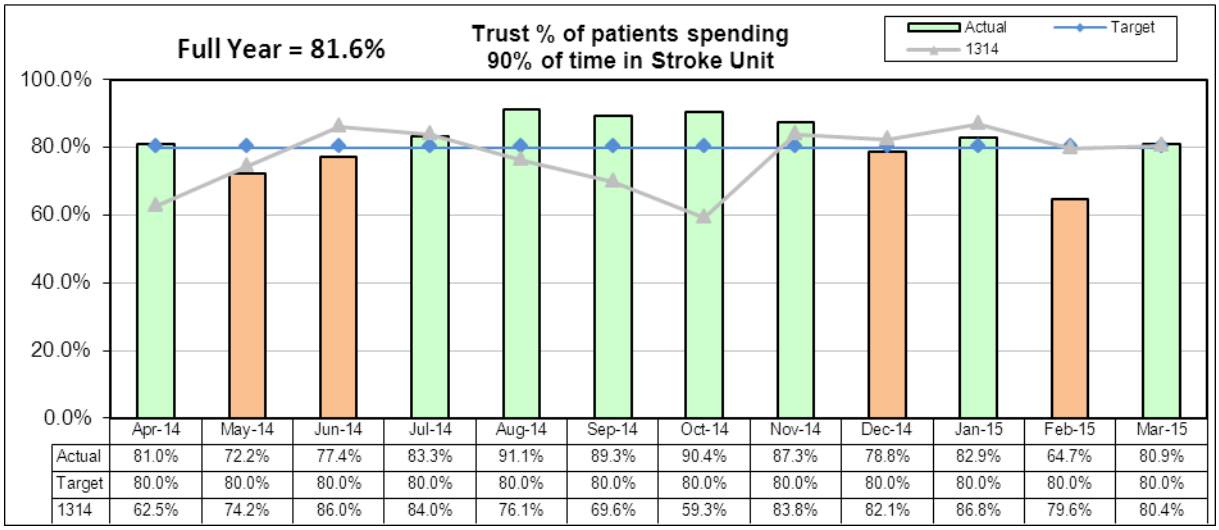


## CLINICAL EFFECTIVENESS

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

*See key priorities for 2014/15 and update summary in section 2*

**80% of patients spending 90% of time on in Stroke Unit -** The Trust achieved this standard of 80% of stroke patients to spend 90% of their time on a dedicated stroke ward in 2014-15.



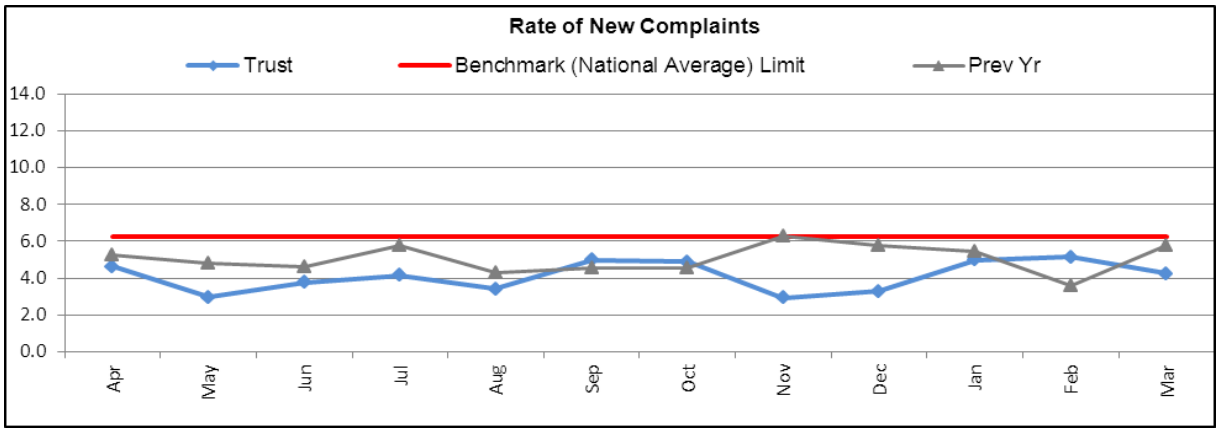

| | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 | Jan-15 | Feb-15 | Mar-15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 81.0% | 72.2% | 77.4% | 83.3% | 91.1% | 89.3% | 90.4% | 87.3% | 78.8% | 82.9% | 64.7% | 80.9% |
| Target | 80.0% | 80.0% | 80.0% | 80.0% | 80.0% | 80.0% | 80.0% | 80.0% | 80.0% | 80.0% | 80.0% | 80.0% |
| 1314 | 62.5% | 74.2% | 86.0% | 84.0% | 76.1% | 69.6% | 59.3% | 83.8% | 82.1% | 86.8% | 79.6% | 80.4% |

## PATIENT EXPERIENCE

*See key priorities for 2014/15 and update summary in section 2*

### Complaints management

**Rate of New Complaints-** The Trust's rate of New Complaints per 1,000 episodes is below the national benchmark of 6.26 at 4.11 for the year (5.07 for the previous year). The number of new complaints received in 2014-15 is a 14% reduction (-79) from the previous year.



**Patient Surveys**

During 2014 the Trust undertook three National Surveys run by Picker Europe and the CQC. They were the following:

- Children's Inpatient and Day Case Survey
- Emergency Department Survey
- Inpatient Survey

The Emergency Department survey runs bi-annually and was previously run in 2012. The Children's Inpatient and Day Case Survey was an additional survey that was added to the CQC survey programme.

As stated in last year's Quality Accounts, the Trust aimed to improve the experience of patients across the organisation through focusing on key areas that were highlighted. Below are the questions that were focused on. This year's results are compared with those of the previous year where possible.

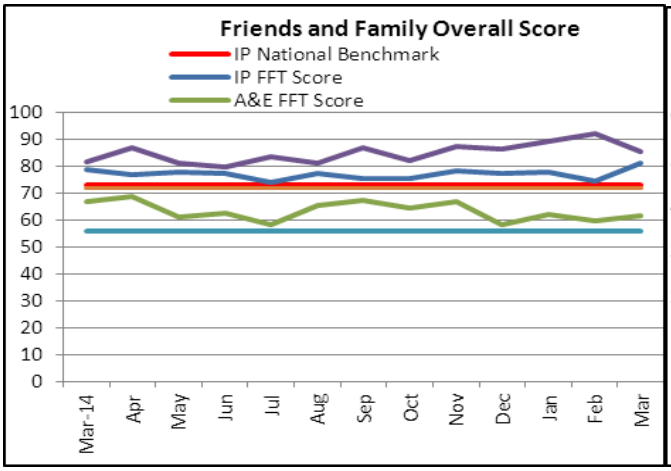
**National Inpatient Survey 2014**

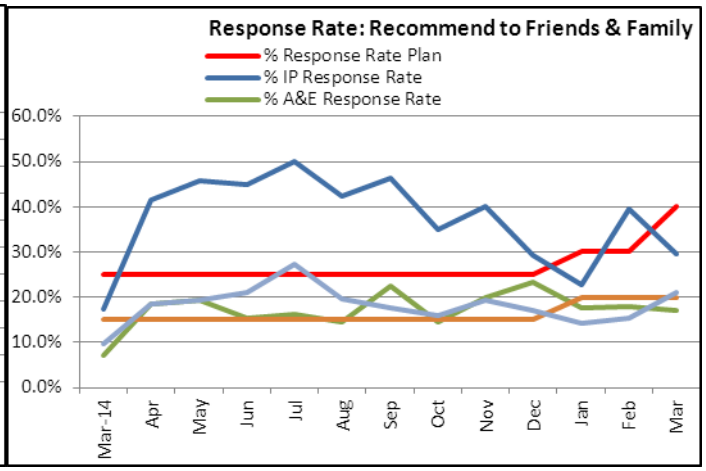
| Focus questions from National Inpatient Survey | | National Inpatient Survey | |
|---|---|---|---|
| | | 2013 | 2014 |
| **1** | Were you involved as much as you wanted to be in decisions about your care and treatment? | 91.2% | 87.5 |
| **2** | Did you find someone on the hospital staff to talk to about your worries and fears? | 45.5% | 47.3 |
| **3** | Were you given enough privacy when discussing your condition or treatment | 97.4% | 95.6 |
| **4** | Did a member of staff tell you about medication side-effects to watch for when you went home? | 43.7% | 42.0 |
| **5** | Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? | 73.6% | 71.4 |

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

The Trust has met the original overall response rates for the year of 25% for Inpatient, 15% for A&E and 15% for Maternity Friends and Family (FFT) however, it is expected that the Trust will not meet the higher target of 30% for Quarter 4 and 40% for March for inpatients and 20% for Quarter 4 for A&E. The Trust is performing consistently on the overall net promoter score, being consistently above the national benchmark for all three areas indicating that patients would recommend the Trust to their Friends and Family.

## MTW Friends and Family scoring




## Learning from Serious Incidents / Never Events

To ensure there is a system of learning from incidents and never events we have robust reporting, investigation and learning process in place. We report all serious incidents centrally to a national system and identify trends and themes to help to reduce risks going forward.

All serious incidents and never events undergo a root cause analysis and an action plan developed to share learning and prevent a similar situation from occurring. All serious incidents and never events are reported to an executive led review panel.

Further to this the Trust established a multidisciplinary Patient Safety Think Tank in August 2014 to review and consider the patient safety culture and processes within MTW. A roadmap has been commenced and developments to improve the systems, education and culture are underway. The 'Step up to Safety' campaign is due to be launched this summer along with a patient safety focussed conference to be hosted in July 2015.

Actions and learning from serious incidents are key to improvements and ensuring patient are safe and provided with high quality care. In 2014/15 learning and actions included:

- Improvements to the recruitment to nurse bank and the induction process for all staff
- An awareness drive to remind staff about the chaperone policy that protects patients and staff
- A review of medical locum packs (with information and signposting to assist and guide locum doctors in their work) ensure they are read, understood and used
- The implementation of a new trauma booklet including a documented handover section
- Strengthening of the fast-track procedure, including additional safeguards for identifying flagged reports
- A system implemented for urgent referrals between radiographers and clinical staff
- A new CT/head guideline produced with a new system of CT scanning for identified higher risk patients
- Head and Neck injury guidelines included at induction for all new medical staff to A&E and in the rolling teaching programme
- Dementia guidelines included at induction for new staff and teaching programmes for existing staff
- Change current procedure of storage of thiopentone. The emergency supply is now be kept in a red sealed drug tray with thiopentone labels placed over the injection port lid of the thiopentone ampoule
- System administrators reminded of the requirement to only use patient level and person identifiable data when appropriate and to always consider pseudonymisation and anonymisation of data

**Never Events**

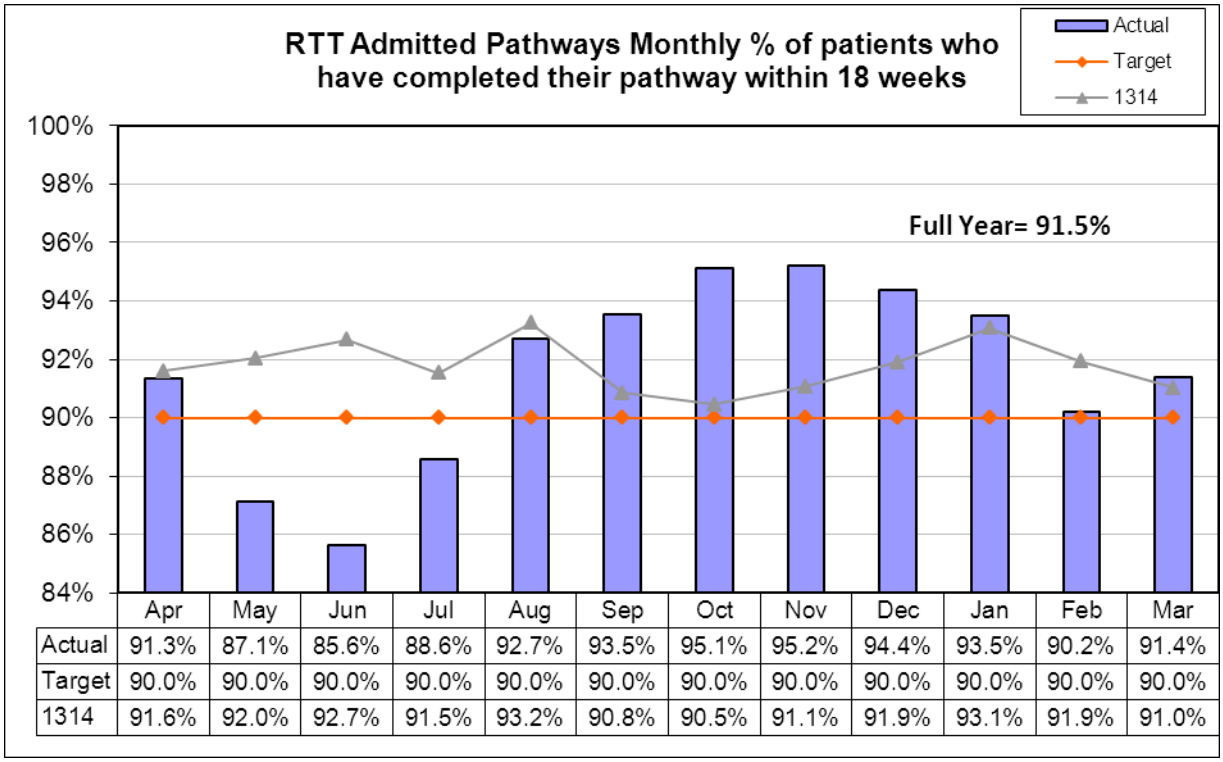
There were 2 Never events during 2014/15. Full root cause analysis was carried out during the detailed investigation and a number of recommendations were implemented to ensure the risk of reoccurrence is minimised.

The first Never event was the wrong insertion of chest drain and subsequent actions include the use of an annotation marker in the primary x-ray image, rather than post-processing electronic annotation markers being used, a chest drain check list implemented in practice and an awareness and education programme for all A&E medical and radiology staff.

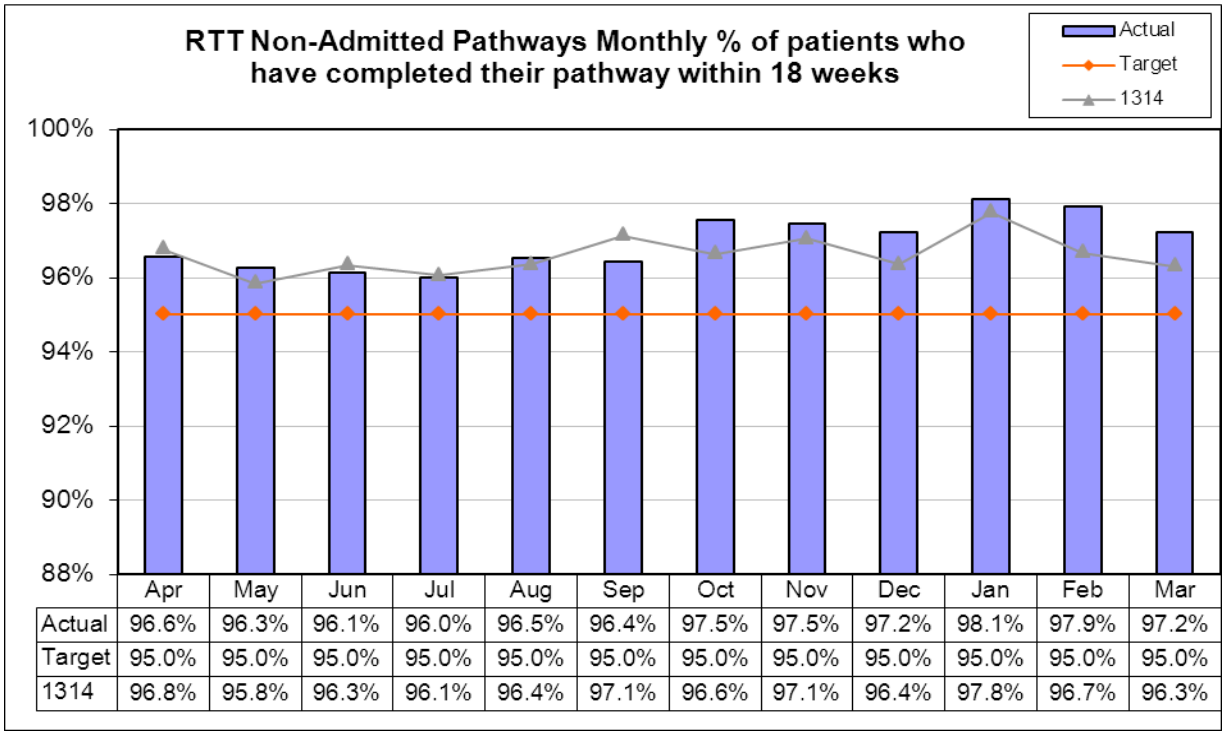
The second Never event was a wrong Prosthesis/Implant. Subsequent actions include the revision of WHO surgical checklists to include a check that correct prosthesis is implanted.

# Other Quality Monitoring and Improvement Measures

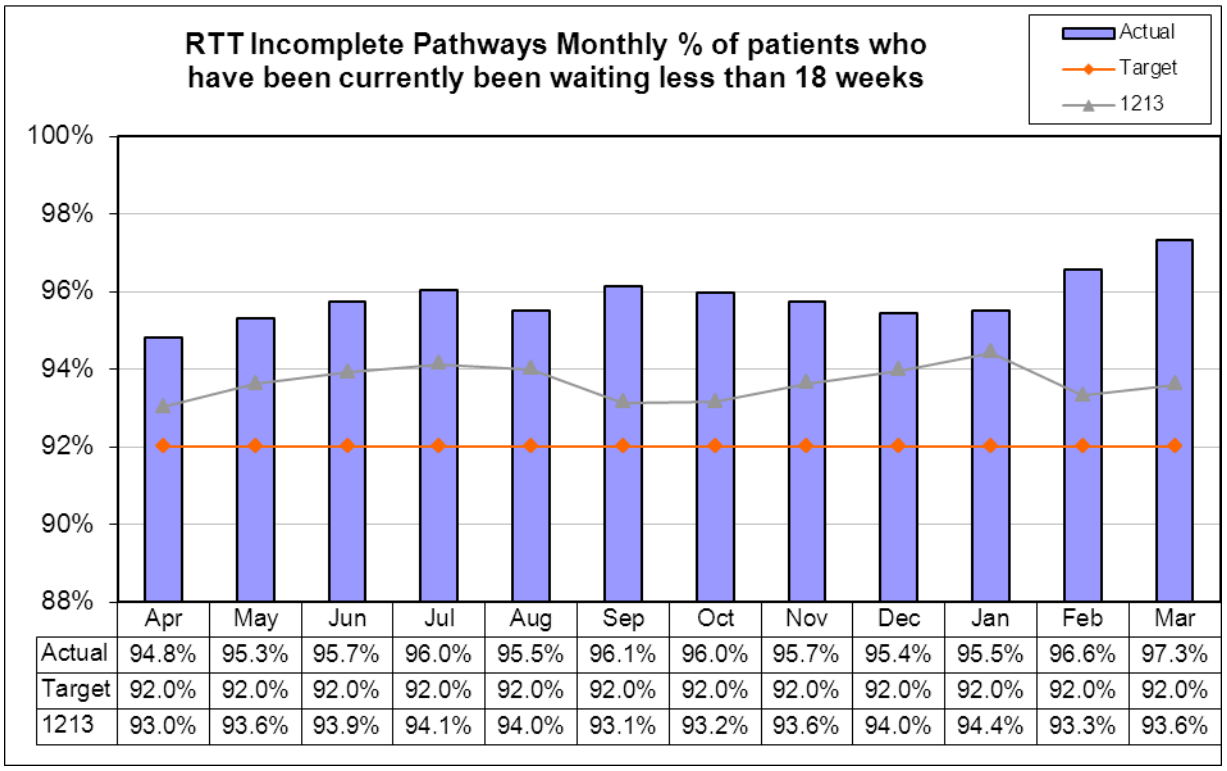
**18 weeks standard** – The Trust achieved this standard at an aggregate Trust level, ensuring at least 90% of admitted patients were treated in hospital following GP referral in 18 weeks. The Trust also ensured that at least 95% of non-admitted patients were seen within the same period and that at least 92% of patients on an Incomplete Pathway had been waiting less than 18 weeks.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 91.3% | 87.1% | 85.6% | 88.6% | 92.7% | 93.5% | 95.1% | 95.2% | 94.4% | 93.5% | 90.2% | 91.4% |
| 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% |
| 1314 | 91.6% | 92.0% | 92.7% | 91.5% | 93.2% | 90.8% | 90.5% | 91.1% | 91.9% | 93.1% | 91.9% | 91.0% |

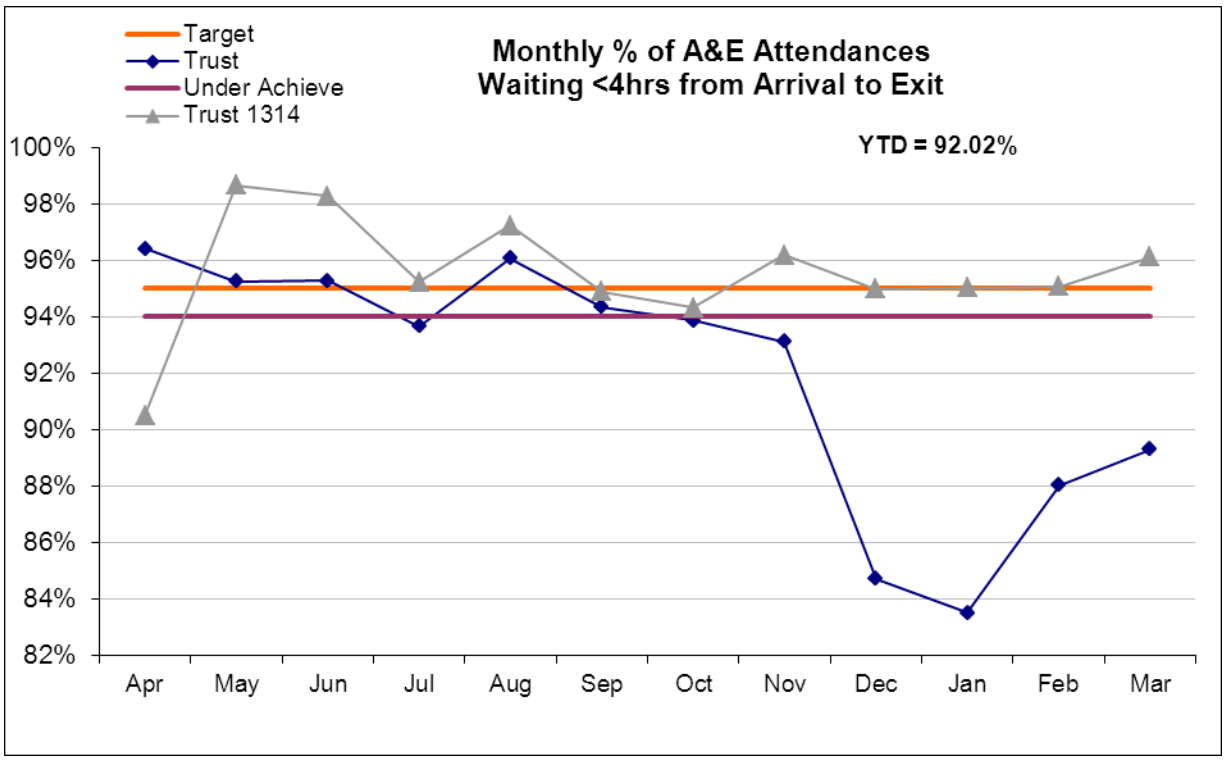



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 96.6% | 96.3% | 96.1% | 96.0% | 96.5% | 96.4% | 97.5% | 97.5% | 97.2% | 98.1% | 97.9% | 97.2% |
| Target | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% |
| 1314 | 96.8% | 95.8% | 96.3% | 96.1% | 96.4% | 97.1% | 96.6% | 97.1% | 96.4% | 97.8% | 96.7% | 96.3% |

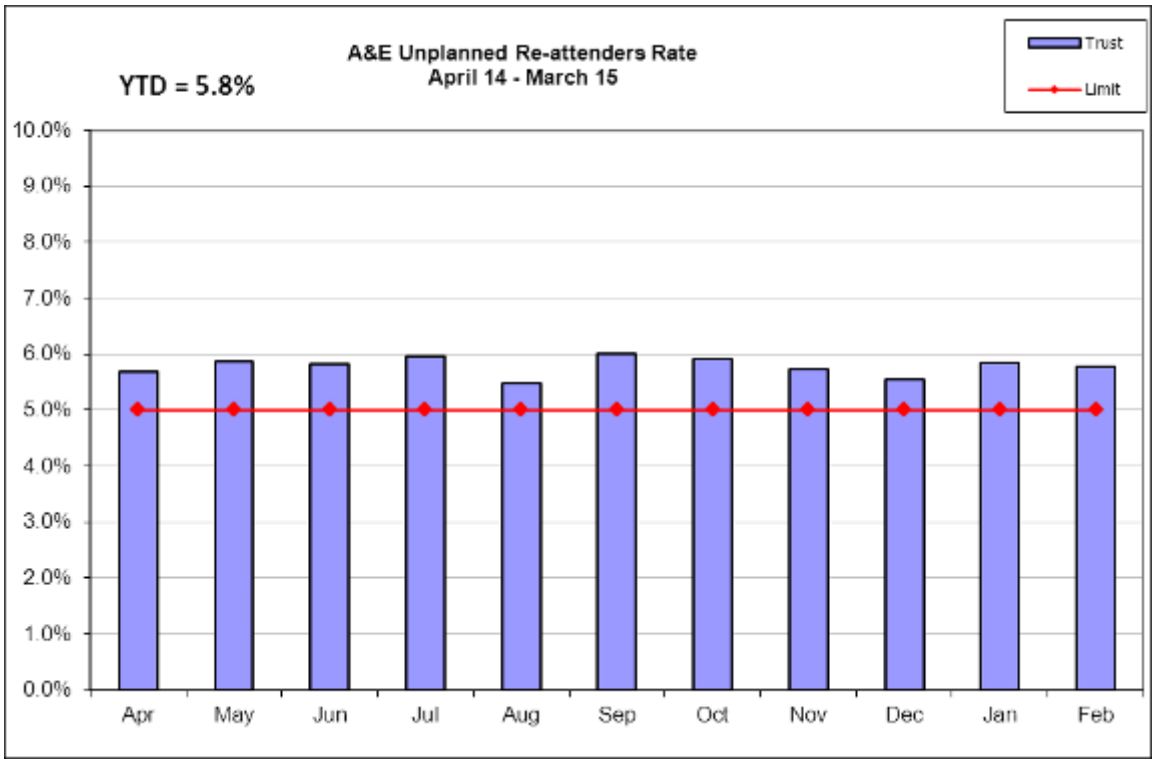



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 94.8% | 95.3% | 95.7% | 96.0% | 95.5% | 96.1% | 96.0% | 95.7% | 95.4% | 95.5% | 96.6% | 97.3% |
| Target | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% |
| 1213 | 93.0% | 93.6% | 93.9% | 94.1% | 94.0% | 93.1% | 93.2% | 93.6% | 94.0% | 94.4% | 93.3% | 93.6% |

**Emergency 4 hour access** – The Trust did not achieve this standard of 95% of patients being seen, treated, admitted or discharged within 4 hours of arrival in its A&E departments in 2014-15 at 92.02%.

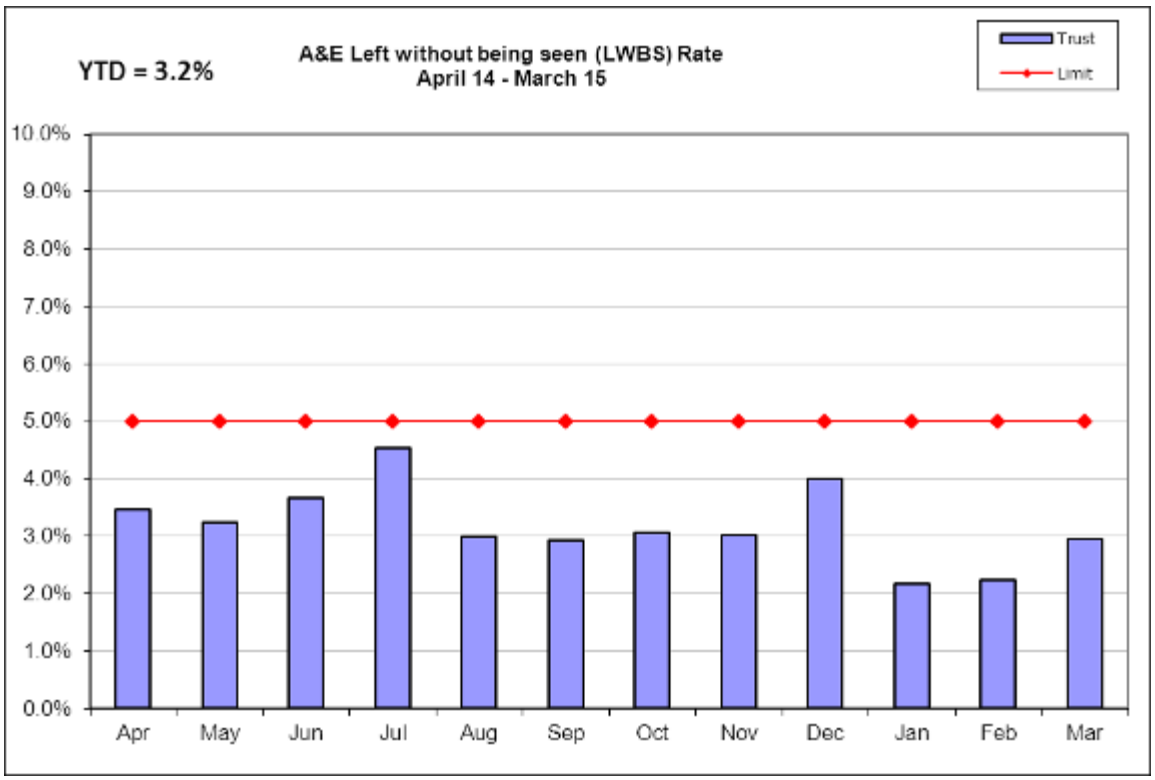


**A&E Unplanned Re-attendance Rate** – The Trust did not achieve this standard of less than 5% unplanned re-attendance rate at 5.8%, however, this is a 1.9% improvement on last year

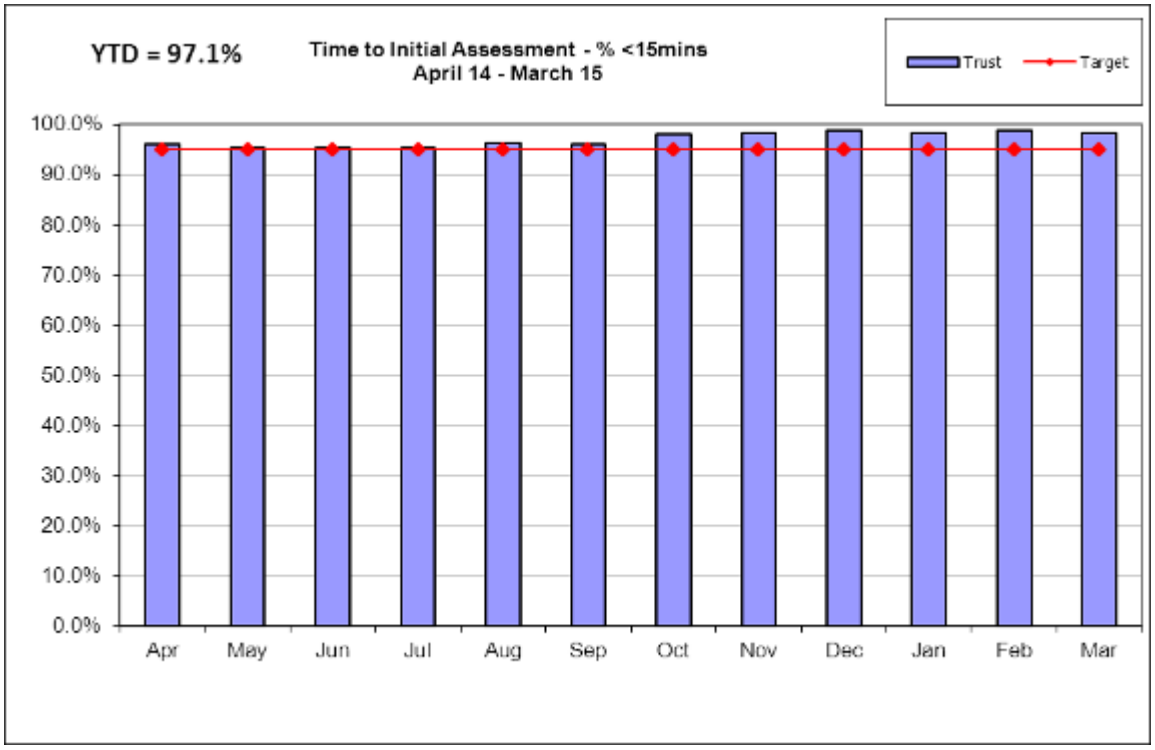



The Trust has in place a System-wide Winter Plan, now extended to end April 2015 with focus on effective and timely discharge of medically fit for discharge patients and clear & rapid escalation of delays involving other agencies. The Trust also has a number of initiatives in partnership with community colleagues for non-elective admission avoidance following trauma, stroke and repiratory conditions. There is a fully operational Urgent Medical Amublatory Unit at Maidstone with a similar service planned for Tunbridge Wells Hospital to enable follow up review of patients initially seen and discharged from the Accident & Emergency Department.

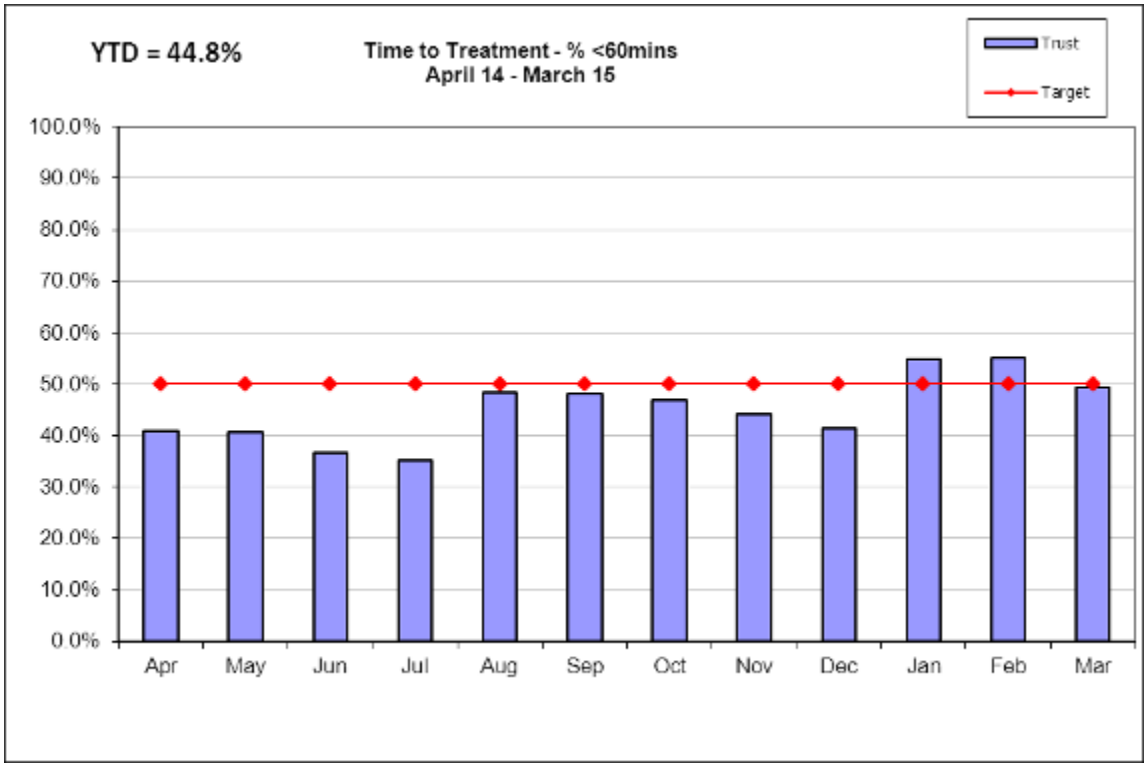
**A&E Left without being Seen Rate** – The Trust achieved this standard, of less than 5% of patients leaving its A&E Departments without being seen at 3.2%.




**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 at 97.1%.

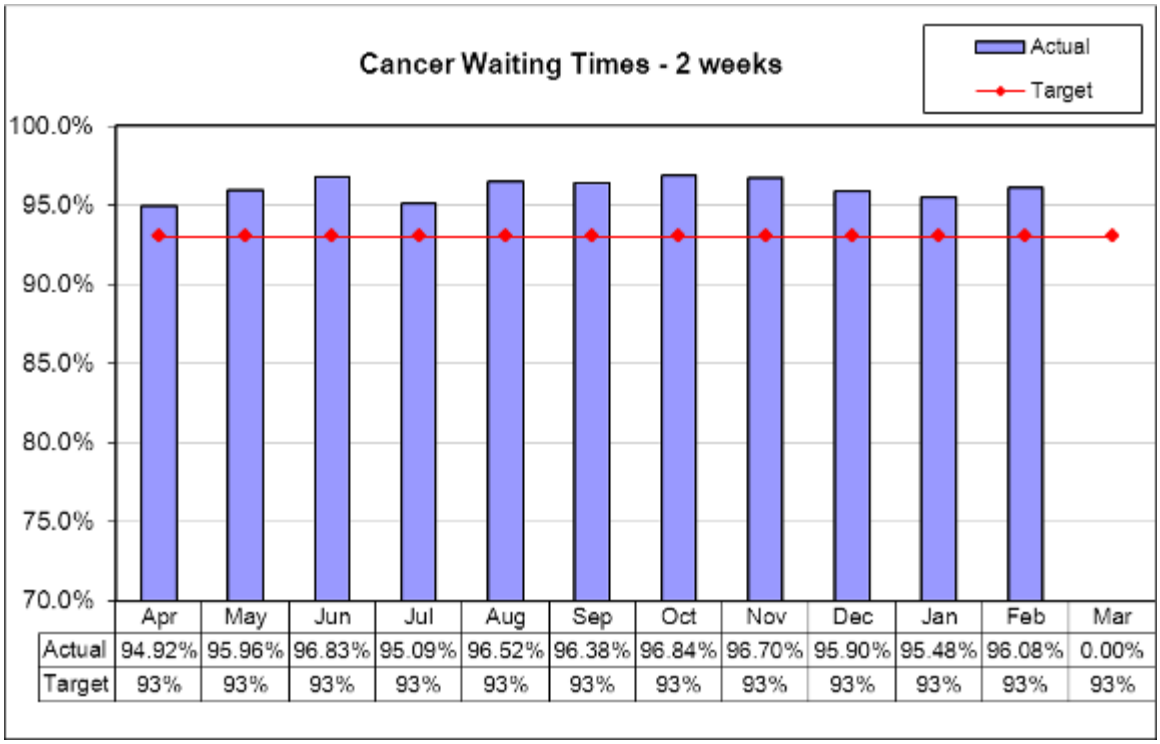


**A&E Time to Treatment <60 minutes** – The Trust did not achieve this standard of 50% of patients arriving in its Emergency Departments being treated within 60 minutes of arrival at 44.8%. This is a 6.5% improvement on last year.



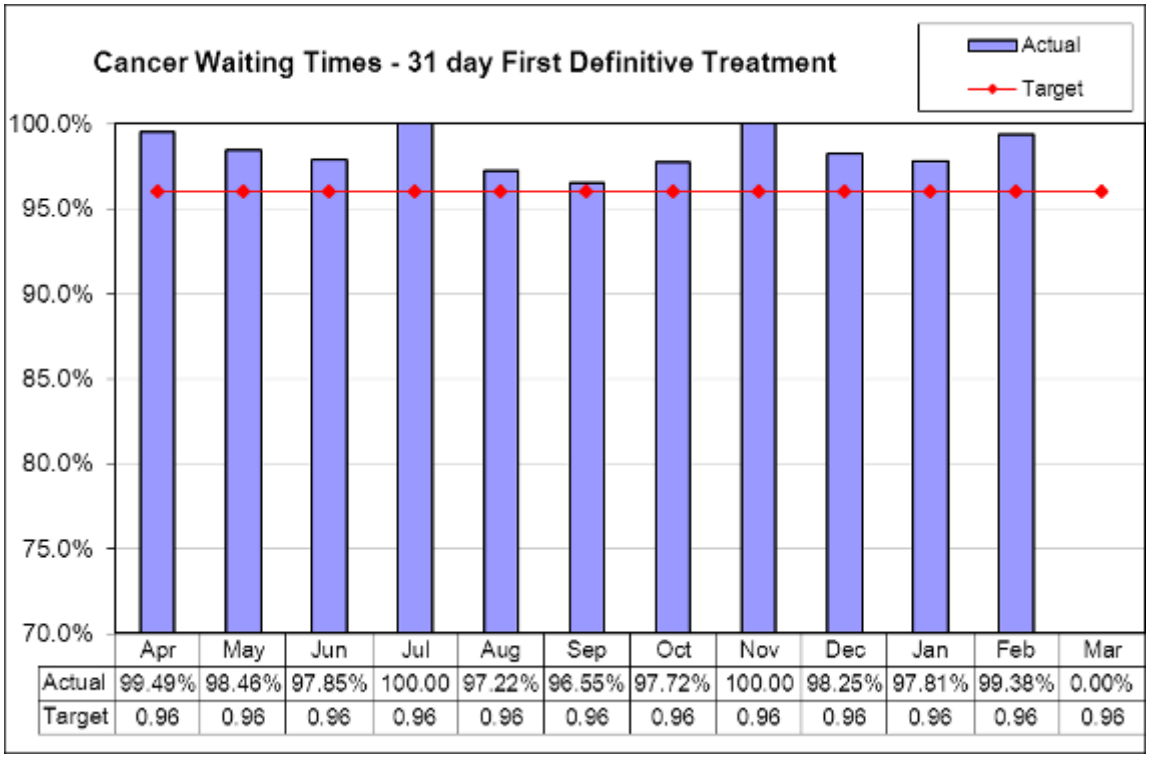

A rapid assessment and treatment model has been implemented to improve the flow of patients through the A&E department and development is underway of frail elderly pathways for emergency presentations

**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.



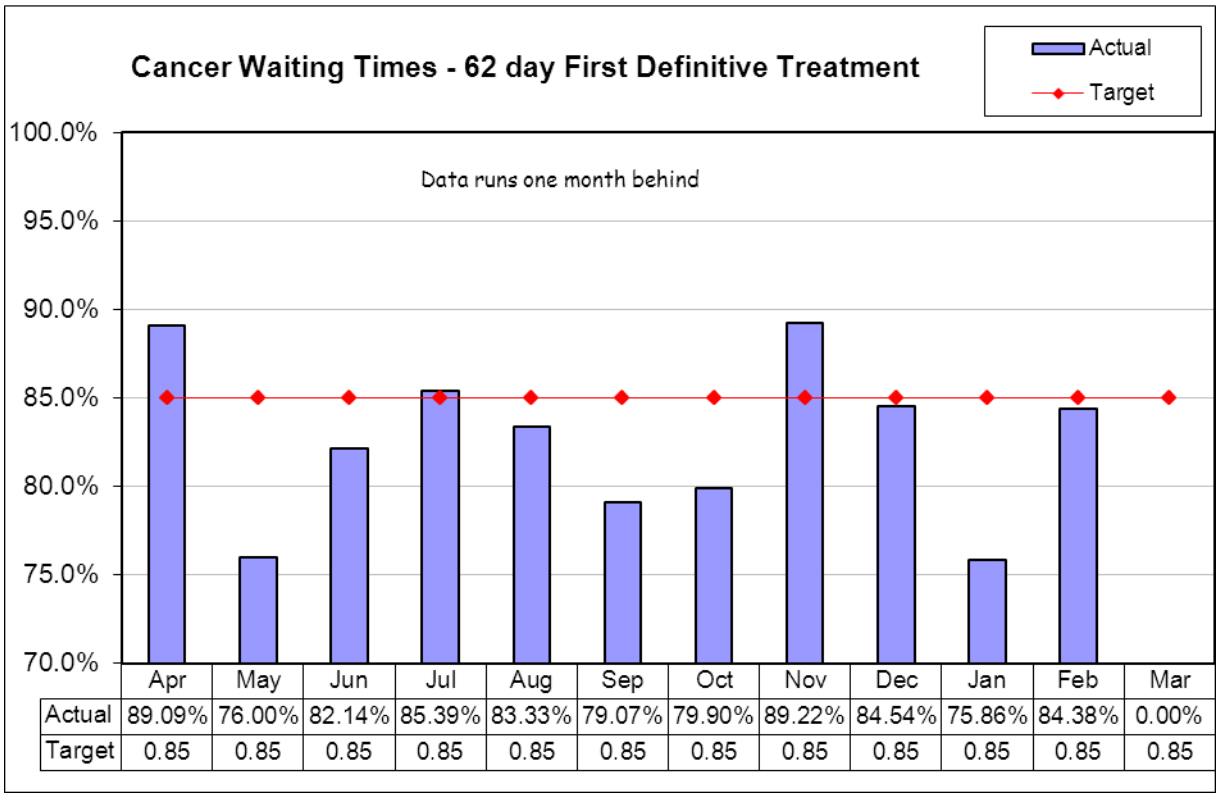

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 94.92% | 95.96% | 96.83% | 95.09% | 96.52% | 96.38% | 96.84% | 96.70% | 95.90% | 95.48% | 96.08% | 0.00% |
| Target | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 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.



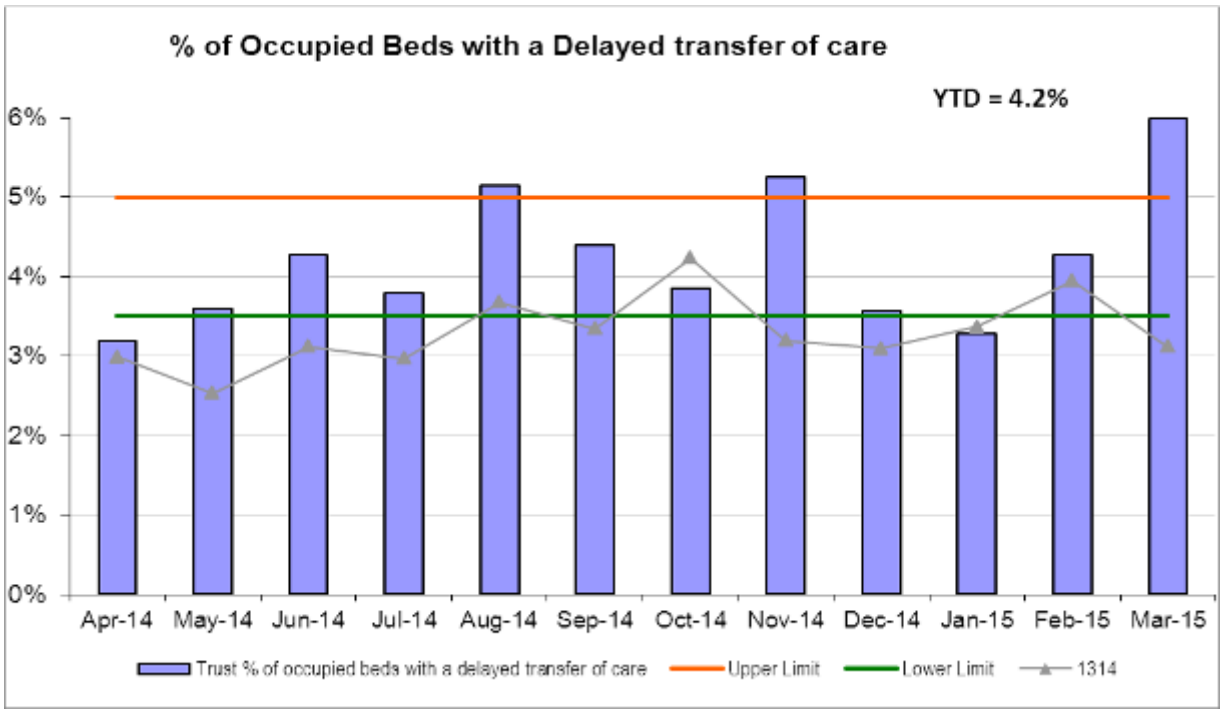

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 99.49% | 98.46% | 97.85% | 100.00 | 97.22% | 96.55% | 97.72% | 100.00 | 98.25% | 97.81% | 99.38% | 0.00% |
| Target | 0.96 | 0.96 | 0.96 | 0.96 | 0.96 | 0.96 | 0.96 | 0.96 | 0.96 | 0.96 | 0.96 | 0.96 |

**Cancer Waiting Time Targets – 62 day First Definitive Treatment** – The Trust did not achieve this standard of 85% of patients who needed to start their first definitive treatment within 62 days did so (expected 82%).

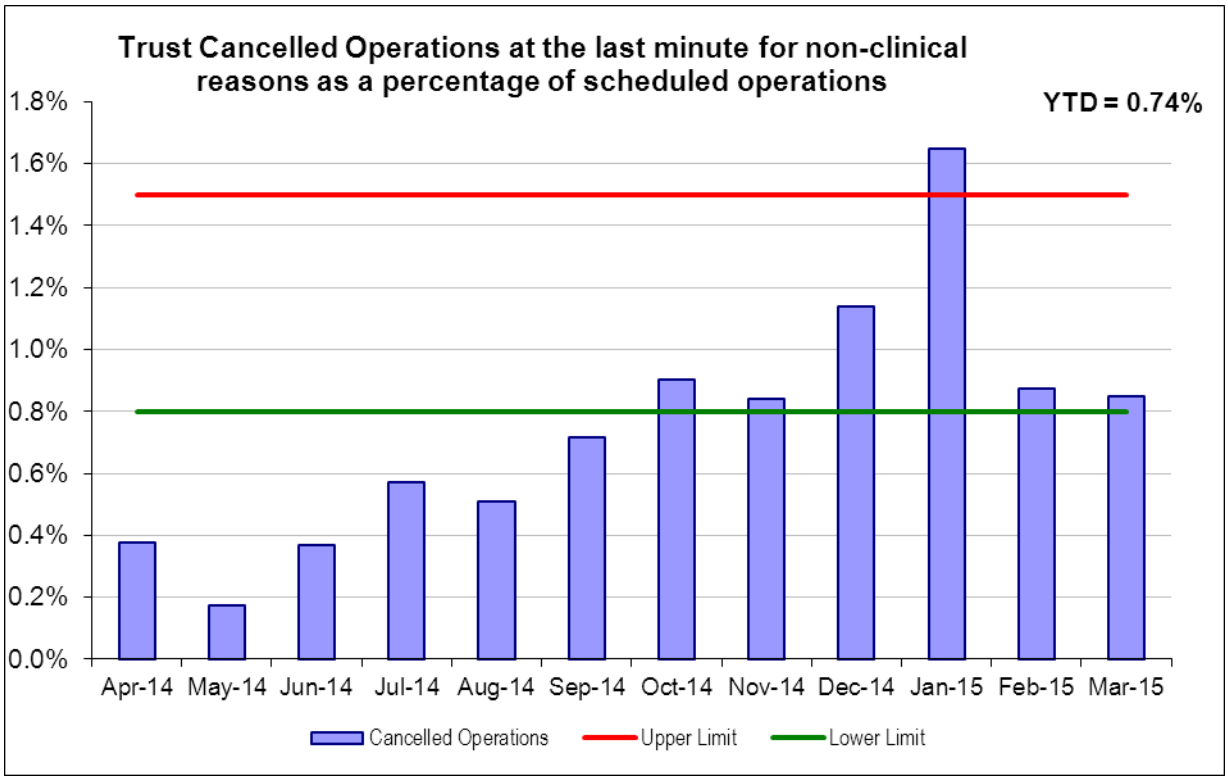



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 89.09% | 76.00% | 82.14% | 85.39% | 83.33% | 79.07% | 79.90% | 89.22% | 84.54% | 75.86% | 84.38% | 0.00% |
| Target | 0.85 | 0.85 | 0.85 | 0.85 | 0.85 | 0.85 | 0.85 | 0.85 | 0.85 | 0.85 | 0.85 | 0.85 |

**Delayed transfers of care** – The Trust did not achieve this standard of Delayed transfers of care remaining below the national limit of 3.5% for the year at 4.2%.



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



# 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**<br><br>**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 —** | **2013/14 local and national data** | **2014/15 local and national data** | **2012/13 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.<br>*The palliative care indicator is a contextual indicator. | 100.30<br><br>Jul 12 – Jun 13 *(Better)* | 101.50<br><br>Jul 13 – Jun 14 (Worse) | National average is 100 |
| 3 | | | | |
| | i) groin hernia surgery | 0.082 | 0.084 | 0.085 |
| | ii) varicose vein surgery | N/A | N/A | 0.225 |
| | iii) hip replacement surgery | 0.433 | 0.440 | 0.438 |
| | iv) knee replacement surgery | 0.280 | 0.304 | 0.318 |
| | during the reporting period<br>*(See below for explanation of reporting data)* | (Apr 11 to Mar 12) | (Apr 12 to Mar 13) | (Apr 12 to Mar 13) |
| 3 | the percentage of patients aged—<br>i) 0 to 14; and<br>(ii) 15 or over,<br>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** 13.1%<br>**Elective** 5.8%<br>**Non-Elective** 11.3% | **Trust** 10.9%<br>**Elective** 5.5%<br>**Non-Elective** 11.6% | (Q1 13/14 position)<br>**Elective:** 6.81%<br>**Non-Elective** 14.10% |
| 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. | 69 | 77 | 77 |

| Domain | Prescribed data requirements<br><br>**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 —** | 2013/14 local and national data | 2014/15 local and national data | 2012/13 National average |
|---|---|---|---|---|
| 5 | the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period | 95.2%**2** | 95.5% | 96.0% (Jan 2015) |
| 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. | 15.7 ***3** | 12.0 | 15.5 |
| 5 | The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period,<br><br>The number and percentage of such patient safety incidents that resulted in severe harm or death.<br><br>*(See below for explanation of reporting data)* | 5743<br><br>2.0% | 6173<br><br>1.6% | |

*1 Local and national data is based on 30 day re-admission.
*2 Q4 not yet published so taken from local data.
*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[6].
**Hip Replacement** – 161 returns of which 142 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.

**Explanation re incidents**
The proportion of patient safety incidents which resulted in severe harm or death for 2014/15 was 1.6% (2.0% 2013/14). 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 6173 (5743 for 2013/14)

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

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 2015 and covers the period of 01/04/14 to 30/09/14, provided a reporting rate of 22.9 compared to 6.04 the same time last year. The rate of incidents reported is per 1,000 bed days. This places the Trust within the lowest 25% 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 mortality data bi-monthly at the Trust's Standards Committee which is chaired by the Medical Director. A Trust-wide Mortality Review Group meets monthly to review mortality by speciality.

C difficile
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.

Serious Incidents
With respect to serious incidents involving severe harm and death; 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.

Scrutiny
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 2014/15

**Enhanced Recovery and Enhancing Quality:** 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 are provided. Orthopaedic improvements include information related to the operation and managing to mobilise within 24 hours of their operation.
A new pathway in Caesarean Section is commencing exploratory work.

The Enhancing Quality pathways of Community Acquired Pneumonia and Heart Failure are matching their improvement targets – Community Acquired Pneumonia (as a new pathway) is currently base lining results from this year to set a target for improvements next year. Heart Failure results show improvement over the last year and matches the improvement target set. More patients are receiving, among other care measures, the right information about their condition and how to manage it at home post discharge. New pathways of Acute Kidney Injury and Chronic Obstructive Pulmonary Disease have commenced data submission with another pathway in Atrial Fibrillation planned.

The Trust achieved their targets for the Kent, Surrey and Sussex (KSS) Quality Award for 2013-14.

Maidstone and Tunbridge Wells Trust has been recognised by Kent, Surrey and Sussex (KSS) Academic Health Science Network (AHSN) for its performances across **ALL** pathways involving EQ and ERP for the period 2012-2014 with the **Award as 'Most Consistent Top Performing Acute Provider' (against all Acute Trusts in KSS)**

**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.

The Trust has seen a sustained improvement in hospital acquired pressure ulcer prevention. Safety Thermometer data puts us well above average nationally.

The Trust has worked with Salford Hospital, as well as publishing in national nursing journals, to share the learning around pressure ulcer prevention.

The Trust has taken part in a national pressure ulcer reporting research project to both contribute to the wider learning, and to gain further assurance that our reporting systems are effective and accurate.

The Trust is also part of the Patient Safety Collaborative under the direction of the Academic Health Science Network and NHS England to ensure that our good practice is shared, and to ensure we can learn further from our colleagues.

**Infection Prevention and Control:** The Trust had 28 cases of C. difficile (35 previous year). This is a 20% reduction from last year's out-turn. The rate of infection was 12 per 100 000 bed days (the national benchmark is 15.7 per 100 000 bed days). As a result of the innovative work done to reduce C. difficile within the Trust, the Infection Prevention and Control team were runners up, and highest performing acute Trust in the Infection Prevention Society's Team of the Year awards in 2014

# Part 4
# Appendices A, B and C

# Appendix A

## 43 National reports were published in 2014/15 with action to be taken in 2014/15

| National Annual reports published March 2014 - April 2015 | Report Received | |
|---|---|---|
| **Peri and Neonatal** | | |
| Neonatal Intensive and Special Care (NNAP) 2013 | Yes | Report received October 2014. Documented consultation with parents/carers needs to be improved within medical notes, so that the information gets transferred onto Badger.net for data submission for NNAP. |
| **Children** | | |
| National Paediatric Asthma Audit 2013 | Yes | Report received April 2014. Asthma awareness training sessions have been implemented; these are attended by all clinical staff working within paediatrics. Patient information leaflets and written asthma plans have been developed and are now in use. |
| National Childhood Epilepsy 12 | Yes | Report received December 2014. With specialty for assessment and action plan. |
| MBRRACE-UK Maternal infant and prenatal programme. | Yes | Report received December 2014. With specialty for assessment and action plan. |
| National Pregnancy in Diabetes Audit 2013 | Yes | Report received August 2014. Patient training on the management of pregnancy with type 2 diabetes to be updated. |
| UK IBD Paediatric Audit | Yes | Report received August 2014. With specialty for assessment and action plan. |
| **Acute Medicine** | | |
| CEM Severe Sepsis and Septic Shock in A&E | Yes | Report received August 2014. New Staff training includes- the need to give and document oxygen administration, prompt IV fluid administration, taking and recording of vital signs, the need to take blood cultures before the patient leaves A&E, monitoring of urine output and prompt administration of antibiotics. |
| CEM Asthma in children in A&E | Yes | Report received January 2015 and with specialty for action plan development. |
| CEM Paracetamol overdose in adults in A&E | Yes | Report received January 2015 and with specialty for action plan development. |
| BTS Pleural Procedures 2014 | Yes | Report received October 2014 and with specialty for action plan development. |
| ***Acute Care*** | | |
| NAP 5 Awareness under Anaesthesia National Audit | Yes | Report received September 2014. Assessment shows that the Trust is fully compliant with recommendations made in the national report.<br>All theatres are equipped with peripheral nerve stimulators to monitor neuromuscular blockade. Monitoring for the depth of anaesthesia is undertaken to ensure that awareness does not occur. There is a policy for the management of any reported cases of awareness under anaesthesia. (No cases were reported from the Trust during this period). Information leaflets are given to patients as part of the consenting process. |
| National Cardiac Arrest Audit | Yes | Quarterly reports are received and reviewed within the specialty.<br>Survival rates at Maidstone and Tunbridge Wells were shown to be considerably above the predicted levels. Mandatory training sessions will continue to be held. |
| National Breast Screening Pathology | Yes | Report received October 2014. With specialty for action plan development |

| National Annual reports published March 2014 - April 2015 | Report Received | |
|---|---|---|
| National Care of the Dying (NCDAH) Round 4 | Yes | Report received May 2014. End of life care steering group chaired by the Chief Nurse. Best practice guidance written and in use included prescribing guidance of medications for the five key symptoms at end of life. |
| **Long Term Conditions** | | |
| National Adult Diabetes Audit 2013 | Yes | Report received January 2015 and with specialty for action plan development. |
| Falls and Fragility Fractures audit | Yes | Report received September 2014. Post-falls assessment checklist developed to assist doctors in patient care post falls. Ad-hoc and formal training for clinical staff on reduction of inpatient falls. |
| National Review of Asthma Deaths | Yes | Report received April 2014. All patients with asthma attending A&E need to be referred to the Respiratory Nurse Specialists and advised to see their GP. All people with asthma should be provided with a personal asthma action plan that details their own triggers and current treatment. |
| National BSR Gout Audit 2013 | Yes | Report received April 2014. Increase use of ultrasound to determine crystal deposits in joints. |
| National UK IBD Biologics 2013 | Yes | Report received August 2014. Ensure sites participate in either the biologics audit or the PANTS research project. New IBD database being set up to allow for monitoring of follow-up and disease activity. |
| National UK IBD 2012/13 Round 4 | Yes | Report received June 2014 and with specialty for action plan development. |
| National Chronic Obstructive Pulmonary Disease (COPD) | Yes | Report received February 2015. Development of the Early Supported Discharge Service as per CCG commissioning. Business case planning to improve spirometry services for 2015/16. |
| Sentinel Stroke National Audit Programme (SSNAP) | Yes | Report received December 2014 and with specialty for action plan development. |
| National Adult Diabetes Inpatient Audit (NaDIA) | Yes | Report received June 2014. Diabetes foot assessment form has been implemented and in use for any patients attending with diabetes. Expanding clinical education sessions to include other clinical areas that do not specialise in diabetic care so that everyone has a general understanding of the management of the adult diabetic patient. |
| **Elective Procedures** | | |
| Adult Critical Care Case Mix Programme (ICNARC) | | Reports received June 2014. With specialty for assessment and reporting |
| National Emergency Laparotomy Audit (NELA) Organisational Report | Yes | Report received and reviewed July 2014. There is full image linking facility with the local vascular, cardiothoracic and neurosurgical units. There are protocols for transfer that are agreed by the CCG and are associated with SLA contracts. Our regional trauma unit is at King's. Patients admitted under the surgical teams care remain under their care at all times until formally accepted by another team and this is documented in the notes and via a "white card" system.<br><br>The on-call teams are encouraged to use predictor of mortality and morbidity both pre and post operatively for all emergency patients. This is not universally used at present and will require further education and reinforcement.<br><br>All emergency activity of any age is audited regularly and the results discussed at the monthly surgical clinical |

| National Annual reports published March 2014 - April 2015 | Report Received | |
|---|---|---|
| | | governance meetings |
| **Cardiovascular Disease** | | |
| National Coronary Angioplasty 2012 | Yes | Report received July 2014. Operators reminded to complete Tomcat data fields for 'risk factors', creatinine levels and 'discharge date/status'. |
| MINAP 2013/14 | Yes | Report received January 2014 and with specialty for action plan development. |
| Cardiac Arrhythmia 2013 (CRM) | Yes | Report received January 2015 and with specialty for action plan development. |
| Heart Failure Audit 2013-14 | Yes | National report still not available on website. |
| Elective Surgery (PROMS) | Yes | Reports received. With specialty for assessment. |
| **Cancer** | | |
| Bowel Cancer (National Bowel Cancer audit Programme)(NBOCAP) 2013 | Yes | Report received March 2015 and with speciality for action plan development |
| Head & Neck Cancer (DAHNO) (8th report) | Yes | Report received July 2014. Plan to improve data entry as detailed in Maidstone and Tunbridge Wells Hospital Head and Neck Multi Disciplinary Team (MDT) 2014 work plan |
| Lung Cancer (National Lung Cancer Audit) 2013 | Yes | Report received March 2015 and with speciality for action plan development |
| Oesophago-gastric cancer (NOGCA) 2013 | Yes | Report received December 2014 and with speciality for action plan development |
| **Trauma** | | |
| Severe Trauma (Trauma Audit & Research Network) TARN 2014 | Yes | Following a successful pilot the Trauma Assisted Discharge Service (TADS) has been expanded to include all trauma patients. This allows patients to return to their own home as opposed to temporary accommodation or community hospitals with the on-going therapy support required for up to 4 weeks.<br>Trauma Physiotherapists now fit all standard TLSO braces and stock is kept on the ward allowing patients to be fitted and treated on the day.<br>An Ortho-plastic service has been set up at TWH with joint operating with Consultants.<br>Template for poly-trauma Electronic Discharge Notification to be developed to identify all injuries on discharge summary. |
| National Joint Registry: Hip and knee replacements 2014 | Yes | Report received September 2014. With specialty for action plan development. |
| Hip Fracture (National Hip Fracture Database) (NHFD) 2014 | Yes | Report received September 2014. Trust-wide action plan produced from the Hip Fracture Working Group.<br>Fast track bloods and diagnostics to enable fast track through Emergency Department to Ward. New patient information leaflets produced. Pressure damage and mortality reviews undertaken to ensure they remain within or below the NHFD national %. |
| Heavy Menstrual Bleeding Audit | Yes | National report received August 2014. With specialty for action plan development |
| **Sexual Health** | | |
| BASH/BHIVA 2013. Survey of partner notification for HIV patients | Yes | Report received May 2014 with specialty for action plan development |
| National audit of management of anogenital herpes | Yes | Report received December 2014. Patients offered treatment at presentation of clinical symptoms began within the last five days. Counselling and support to be offered to patients with suspected clinical herpes. Delivery plan in place. |
| **Patient Surveys** | | |

| National Annual reports published March 2014 - April 2015 | Report Received | |
|---|---|---|
| National Accident and Emergency Department Survey 2014 | Yes | Report published November 2014. Report received and disseminated. With specialties for action plan development |
| **Confidential Enquiries** | | |
| Tracheostomy Study | Yes | Report published 13 June 2014.<br>25 Recommendations- Theatres/CCU, ENT and care on the general wards. A Task and Finish Group has been set up to share and standardise all policies and documentation used in the care of these patients. A programme of training sessions on the care of tracheostomies has been set up. When patients are transferred into the Trust the tracheostomy tubes will be changed to Trust standard sizes as soon as possible upon their arrival. Bedside capnography planned to be made available across the Trust and training programmes set up. A WHO type document specific to the insertion of tracheostomy has been developed for the use on ITU. A tracheostomy "passport" has been developed for use with each patient to record all data – to be used when patients are transferred between levels of care. |
| Lower Limb Amputation | Yes | Report published November 2014. The topic covered by this report is not relevant to the Trust as this group of patients are treated in a dedicated vascular unit.<br>The Trust submitted organisational data.<br>The report was reviewed and assessed - only one recommendation was relevant. If any of these patients are admitted to the Trust via A&E they would be assessed and then transferred to a vascular unit for treatment by a dedicated team within the timeframe specified |

# Appendix B

Updated actions on reports received during March 2013 to April 2014. These have previously been reviewed and action plans developed. These action plans have been reviewed and this report shows which actions have been completed and implemented.

| National Annual reports published March 2013 - April 2014 | Report Received | Improvements |
|---|---|---|
| **Peri and Neonatal** | | |
| Neonatal Intensive and Special Care (NNAP) 2012 | Yes | All babies with a gestational age of <32 weeks or 1501g at birth undergoing 1st retinopathy or prematurity (ROP) results have improved since the use of stickers and the new database. |
| **Children** | | |
| National Paediatric Asthma Audit 2012 | Yes | Patient Information leaflets and written asthma plans have been developed and are now in use. |
| National Patient level Insulin pump audit | Yes | Discussion regarding more consultant hours dedicated to diabetes. A business case is being produced regarding cGMS to be purchased as per the standard. |
| Paediatric Pneumonia 2012 | Yes | A more judicious allocation of IV antibiotic therapy in CAP with a senior review on ward rounds to aim for oral therapy. |
| Child Health (CHR-UK) | Yes | Clinic letters have been made more comprehensive. A business case for a specialist Epilepsy Nurse has been written. |
| **A&E Medicine** | | |
| CEM Feverish Children in A&E | Yes | Report received April 2013. Paediatric A&E card redesigned to ensure recording of blood pressure and GCS (Glasgow Comma Score).<br>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. A&E staff 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.<br>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.<br>Referral form updated to ensure key information available to neurology team. Additional training for medical staff to ensure GCS and temperature recorded and that patients receive a senior review prior to discharge. |
| CEM Consultant Sign-Off in Emergency Departments | Yes | Report received June 2013. 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.<br>To improve rates of organ donation staff education of organ donation with e-learning made compulsory learning for Trust new doctors. E-learning package available on website. Supporting ongoing medical and nursing staff organ donation education. |
| Adult community acquired pneumonia | Yes | National comparative data received July 2013.<br>Education of clinicians to ensure x-ray requests for suspected Community Acquired Pneumonia are clearly marked as urgent. CURB65 scores to be reviewed for each patient to ensure treatment with appropriate |

| National Annual reports published March 2013 - April 2014 | Report Received | Improvements |
|---|---|---|
| | | antibiotics. Educate junior doctors that patients with high predicted mortality need to be referred to a senior clinician to ensure timely and appropriate referral to Critical care. |
| Emergency use of Oxygen | Yes | Report received December 2013. 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.<br>Educate SeCAMB and A&E to ensure no more than 28% oxygen given prior to first ABG. New NIV proforma produced and in use with prompts to ensure ABGs taken at regular intervals, a treatment / escalation plan is in place. |
| **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.<br>Trust now signed up to Dementia Action Alliance as dementia friendly.<br>All staff now receives basic awareness of dementia training on induction days. |
| Adult Diabetes Inpatient Audit (NADIA) 2012 | Yes | Report received October 2013 and with specialty for action plan development. |
| National Parkinson's Disease 2012/13 | Yes | Report received October 2013.<br>New PD nurse appointed to allow for additional clinics so patients can be reviewed at 6-12 month intervals.<br>New consultation checklist produced to endure there is documented evidence of information regarding driving, occupational hazards, end-of-life care issues given to patients. |
| National BSR Gout Audit 2013 | Yes | Report due January 2014 not received until April 2014.<br>Increase use of ultrasound to determine crystal deposits in joints. |
| **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 (e.g. angioplasty) | Yes | Report received August 2013.<br>To improve data completeness, operators are reminded to complete risk factors, creatinine levels and discharge status on TOMCAT system. |
| National UK IBD Biologics 2012 | Yes | Report received August 2013. Appointment of a new Consultant Gastroenterologist with an interest in IBD to be able to increase clinic capacity for review of patients at 3 and 12 months after starting biologic agent. Consultant now in place. |
| National Cardiac Rehabilitation Audit | Yes | Report received September 2013.<br>Wording in patient induction updated to encourage attendance at health education sessions. |
| MINAP 2012/13 | Yes | Report received October 2013.<br>Educate junior staff on the importance of secondary medication and the need to check against the list of 5 |

| National Annual reports published March 2013 - April 2014 | Report Received | Improvements |
|---|---|---|
| | | secondary prevention therapies. |
| Cardiac Arrhythmia 2012 | Yes | Report received October 2013 and with specialty for action plan development. |
| Heart Failure Audit | Yes | Report received December 2013.<br>Continue education of clinical staff to ensure details of contraindications to ACE / ARB and beta blockers are documented. |
| **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 speciality for action plan development. To improve data entry as detailed in Maidstone and Tunbridge Wells Hospital Multi Disciplinary Team 2013 work plan |
| Lung Cancer (National Lung Cancer Audit) 2013 | Yes | Report received January 2014. High level of compliance. Low Median Survival to be reviewed more formally. Develop the Lung Cancer pathway to increase the proportion of patients receiving CT scan prior to Bronchoscopy. |
| Oesophago-gastric cancer (NOGCA) 2013 | Yes | Report received June 2013. Data retained by Upper GI Clinical Nurse Specialist to be analysed. The functioning of the Multi Disciplinary Meetings to be closely monitored. Assurance of the formal basis of the referral service to University College Hospital (UCL) by Directorate business team. Decision about the repatriation of the operative stage of the patient pathway will require a) plan for introducing this level of monitoring of individual surgeon's performance, b) require a strategy for the monitoring of impacts of minimally invasive techniques at the level of the individual operator |
| **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 2013 Trust-wide action plan produced from the Hip Fracture Working Group. Protocol written for fast track beds for #NOF patients on trauma wards. |
| Heavy Menstrual Bleeding Audit | Yes | National report received August 2014. 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 May 2013. Report reviewed but no actions required as data considered old and irrelevant at the time of specialty review. |
| BASH/BHIVA 2013. Survey of partner notification for HIV patients | Yes | Report received May 2014 with Specialty for Action plan development |
| **Patient Surveys** | | |
| National Cancer Experience Survey 2012-13 | Yes | Report published August 2013 Report received and disseminated. Currently sitting with Directorates for action plan development. |
| National Inpatient Survey | Yes | Report published April 2013 Report received and disseminated. Currently sitting with Directorates for action plan development. |

| National Annual reports published March 2013 - April 2014 | Report Received | Improvements |
|---|---|---|
| National Maternity Survey 2013 | Yes | Report published December 2013. Report received and disseminated. Currently sitting with Directorates for action plan development. |
| National Chemotherapy Patient Experience Survey 2012 | Yes | Report published February 2014. Report received and disseminated. Currently sitting with Directorates for action plan development. |
| **Confidential Enquiries** | | |
| Subarachnoid Haemorrhage (SAH) | Yes | Received November 2013 and reviewed in August 2014.<br>These patients are assessed on admission and discussed with King's College Hospital; they are then transferred to a tertiary centre for specialist treatment.<br>King's endeavour to admit patients with SAH within 24 hours of referral and treat within 14 hours.<br>Clinical audits are in progress to review the process of examination, assessment and documentation.<br>Two protocols for the care of SAH have been received from King's College Hospital with a view to standardising the Trust protocol for this. |

# Appendix C

**Summary of local audits undertaken during 2015/15 against NICE Guidelines**

Audits of NICE Guidelines are an ongoing process of implementing change and measuring improvement until full compliance is achieved. The following table shows compliance against NICE Guidelines from local Trust audits and the actions put in place to achieve full compliance. Where partial or non compliance is found, changes will be implemented and a re-audit will be undertaken.

Compliance has been assessed as: Fully compliant if all standards have been met. Partially compliant when >50% of the standards have been met. Non compliance is where less than 50% of the standards have been met.

| NICE guidance | Compliance | Actions taken as a result of the audit/Evidence of compliance |
|---|---|---|
| Falls admissions re-audit Round 3<br>NICE CGs 21 and 161 | Not compliant | A falls proforma has been introduced to aid assessment of older people admitted with falls. “Medication review” stickers were introduced to go on drug charts alerting healthcare professionals to patients at high-risk. A Falls Co-ordinator has also been employed to improve the management of patients at risk of falls. The falls pro-forma has now been integrated into the fractured neck of femur pro-forma and key elements are in the medical pro-forma. |
| NICE CG24 Network Audit of Small Cell Lung Cancer Patients including Patient Pathways and Outcomes | Partially compliant | Since the initial audit significant changes have been made to both the diagnostic pathways and organisation of the MDTs. There is also more capacity in terms of oncologists and chemotherapy to start treatment promptly. The unit is also now giving concurrent chemo radiotherapy in limited stage patients. |
| NICE CG 179 Management of Pressure Ulcers | Compliant | Patients are being risk assessed on admission and regularly reviewed during their hospital stay. All at risk patients are nursed on appropriate pressure relieving systems.<br>This forms part of a bi-annual audit programme into the management of pressure damage. |
| Rehabilitation after Critical Illness NICE CG83 | Not compliant | A risk assessment and trigger tool is being developed for use by therapy services at point of discharge from critical care.<br>A patient information leaflet is being updated detailing information about their critical care stay, their illness, the treatments they have undergone, and the short- and long-term physical and non-physical problems they may experience<br>An ITU Follow up service is now in place<br>This NICE guidance is currently undergoing revision based on evidence that suggests some of the proposed standards do not result in better patient or economic outcomes |
| NICE CG84 - Re-audit of the management of children with Diarrhoea & vomiting | Partially compliant | Improvements have been demonstrated; however there is still a need to practice naso-gastric tube insertion for vomiting children not able to keep fluids down which can avoid unnecessary IV fluid management and less trauma to children. Staff training is in place. |
| NICE GC67 – Lipid Modification | Compliant | No problems identified in relation to Maidstone and Tunbridge Wells Outpatient clinics in respect of lipid management. |
| NICE CG 137<br>The use of EEG in the diagnosis of Epilepsy in Children | Partially compliant | EEGs were done in a timely manner. Some EEGs were felt to be unnecessary, this did not pose any risk to the patients but may lead to further unnecessary expensive investigations being carried out. |
| NICE CG48 - Secondary prevention in primary and secondary care for patients following a myocardial infarction - re-audit | Partially compliant | The main area of non-compliance identified was with the routine prescription of beta-blockade following ‘enzyme-driven’ MIs where patients have sustained minimal myocardial damage. This is a clinically controversial area and whilst recommended as part of NICE guidance the evidence base is very weak and this practice is not supported by a substantial body of cardiologists. |
| NICE TA071 & 152<br>Use of Coronary Stents at TWH - re-audit | Non compliant | The reason for non-compliance with the recommendations needs to be fully documented in the patient summary without this it is difficult to ascertain if there are genuine reasons for any clinical non- |

| NICE guidance | Compliance | Actions taken as a result of the audit/Evidence of compliance |
|---|---|---|
| | | compliance. |
| NICE TA94 - Cardiovascular disease - statins | Compliant | 100% compliance with standard ensuring patients with Cardiovascular Disease are prescribed statin therapy. |
| NICE TA187 - Crohn's Disease - infliximab @ TWH re-audit | Partially compliant | A new Consultant Gastroenterologist has been appointed. A business case for a new Irritable Bowel Disease Clinical Nurse Specialist has been submitted to assist with the workload to re-assess patients at least every 12 months. Fully compliant with remaining clinical guidelines. |
| NICE CG144 - Suspected DVT management and appropriate use of doppler ultrasound - diagnosis only | Not compliant | The audit shows 100% sensitivity in identifying DVTs using the single Wells Score. Trust is currently requesting considerably more scans than required. A new Doppler Ultra Sound request form is being developed which includes prompts to correctly calculate the Two-level Wells Score to reduce the number of unnecessary scans. |
| NICE TA195 - Treatment of rheumatoid arthritis after the failure of a TNF inhibitor (Abatacept only. Criterion 4, 6 and 7) | Compliant | 100% were treated in accordance with the NICE guideline regarding the duration of treatment with Abatacept, frequency of follow-up in clinics and patient response to Abatacept. |
| NICE CG79 - Management of patients with newly diagnosed rheumatoid arthritis re-audit | Partially compliant | GP training sessions have been carried out on the importance of early referral to the Early Arthritis Clinic so patients seek help earlier. An early arthritis pathway is being developed to formalise the treatment of these patients. |
| NICE CG174 - Intravenous Fluid therapy in Adults in hospital | Not compliant | A teaching sessions on IV fluid management as they relate to the NICE Guidelines is being developed. Trust guidelines on fluid management are being updated in line with the NICE guidance |
| NICE CG 92 - Compliance with low molecular weight heparin for VTE prophylaxis in patients with lower-leg immobilization. | Not compliant | Patients with lower limb plasters are not always being prescribed with Low Molecular Weight Heparin (LWMH) when discharged from A&E. Clinicians to use the Trust Lower Limb Mobilisation Pathway and NICE Guideline to identify at risk patients requiring LWMH upon discharge. |
| NICE CG156 Re-audit of Fertility (Hycosy): Assessment and treatment for people with fertility problems | Compliant | Progressive improvements were demonstrated. A new referral pathway has been introduced to speed up the investigation phase. This has lead to improvements in the time patients are seen in clinics and clinics are being more effectively run. |
| NICE CG37 - Audit of the management of routine postnatal care of women and their babies | Partially compliant | The maternity service has appropriate procedures for handover of care and there is a structured programme for supporting breastfeeding. The Postnatal Care Record document is being reviewed and amended to prompt and encourage the documentation of care planning and discussions with the mother, including those relating to advice about signs and symptoms and contact details |
| NICE CG 55 - Documentation of Intra-partum care given to women at Maidstone Birth Centre. Re-audit | Compliant | Following additional training sessions on documentation, this audit demonstrates a significant improvement in documentation at the Birth Centre with all standards now being met. |
| NICE CG 55 - Re-audit of the management of severe (>2 litres) postpartum haemorrhage | Partially compliant | A skills training programme has been developed and is in progress as part of ongoing Patient Safety Measure programme. Full compliance with recording of measures undertaken including surgical measures. |
| NICE TAG 156 - Routine antenatal anti-D prophylaxis for women who are rhesus D negative audit | Compliant | All patients received information leaflets and received Anti-D appropriately. |
| NICE CG 107 -Antenatal care, delivery & outcome for women with a raised BMI | Partially compliant | Local protocol now updated to state that patients with a BMI greater than 30 should have their scan booked towards the end of the 19-20+6 week window for optimal views, using the highest quality machines, optimising settings for obese patients. |
| NICE IPG 144 - An audit of the use of Cell Saver in Obstetrics | Partially compliant | Use of cell saver was shown to be appropriately used, clinically safe and cost effective. |

| NICE guidance | Compliance | Actions taken as a result of the audit/Evidence of compliance |
|---|---|---|
| NICE CG064 - Prophylaxis against infective endocarditis | Partially compliant | Stickers to be put on patients notes to detail written and verbal information given to patient. Clinical outcomes were in line with this NICE Guideline. |

# Part 5
# Stakeholder feedback

1. West Kent Clinical Commissioning Group
2. Health Overview and scrutiny Committee – Kent County Council
3. Healthwatch Kent
4. Independent Auditors' Limited Assurance Report
5. Statement of Directors' responsibilities

# West Kent Clinical Commissioning Group comments on the 2014/15 Quality Account for Maidstone and Tunbridge Wells NHS Trust

NHS West Kent CCG have continued to support MTW in their quality improvements. I consider we have a strong, open and honest relationship that enables us to challenge appropriately with a shared aim to improve patient care.

The past year has seen some really good work on 'Duty of Candour' by the Trust, a statutory requirement in response to the Francis Inquiry. This demonstrates the Trust's keenness to support staff to be honest, open and truthful in all dealings with patients and public. Good work has also been seen in the clinical governance agenda, the publication of the Governance Gazette for staff shows MTW's ambition to have a consistent approach towards clinical governance and sharing of good practice.

The result of the CQC inspection of October 2014 was disappointing as they were assessed overall as 'Requires Improvement'. The Trust held a Quality Summit in January 2015, which the CCG attended. MTW have responded to the report with a robust quality improvement plan which they have been keen to share with the CCG who will, alongside the CQC, have oversight of its completion.

Patient flow has been a significant challenge to MTW over the past 6 months, requiring the use of escalation areas and increased use of temporary staff. The CCG will continue to support MTW and their work with partner agencies to make improvements to the delivery of timely and safe care. The CCG is also keen to support MTW in their improvements to their stroke services.

West Kent CCG Quality Team have been invited to support MTW in their quality assurance by undertaking quality visits to a variety of wards and departments, which we look forward to undertaking in the year ahead. Equally we will continue to attend the MTW quality and safety meetings, and work closely with the Chief Nurse and Quality/Governance Team demonstrating our commitment to work with our partners to support the delivery of safe and effective care.

**Alison Brett**

Acting Chief Nurse
West Kent Clinical Commissioning Group

**12th June 2015**

# Health Overview and Scrutiny Committee – Kent County Council comments on the 2014/15 Quality Account for Maidstone and Tunbridge Wells NHS Trust

Draft Quality Accounts were submitted to the Kent Overview and Scrutiny Committee, Kent County Council. The Chairman, Robert Brookbank, was unable to provide comment but requested that the committee receives a final version.

# Healthwatch Kent comments on the 2014/15 Quality Account for Maidstone and Tunbridge Wells NHS Trust

As the independent champion for the views of patients and social care users in Kent we have read your 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 Kent 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 Account, our initial feedback is that the account is still very lengthy and we would advise that an additional summary document be published separately to make the information more accessible to the public reading it. However, the consistent layout and headings makes it easy to follow and the use of bullet points breaks up the information into manageable amounts which can be digested.

The report references the use of the Friends and Family Test (FFT) to gather patient experience. It is certainly encouraging to know that the Trust is making efforts to hear what the public are saying. However, we are keen to understand the other ways in which the Trust has engaged with the public and involved them in their decision making. We would also welcome further detail on how seldom heard groups are being engaged with and their experiences heard. It is acknowledged that the Trust has highlighted the need for an Equality Lead to oversee a translation service which will help communication with patients.

Furthermore in next year's edition we would like to see how listening to what patients and the public have said has influenced or affected the "Initiatives for further action" and "Areas For Improvement". We think that evidence of how the public and patient voice has impacted on future planning would be well received.

Healthwatch Kent would like to take this opportunity to say that Maidstone & Tunbridge NHS Trust have been very open with Healthwatch Kent and we have worked together on a number of projects this year including talking to patients about their experiences of stroke services. We would like to see the Trust do more engagement with the public and listen to their views of how services could be improved.

In summary, we would like to see more detail about how you involve patients and the public from all 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 support you with this.

Healthwatch Kent May 2015

# Independent Auditors' Limited Assurance Report comments on the 2014/15 Quality Account for Maidstone and Tunbridge Wells NHS Trust

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

We are required to perform an independent assurance engagement in respect of Maidstone and Tunbridge Wells NHS Trust's Quality Account for the year ended 31 March 2015 ("the Quality Account") and certain performance indicators contained therein as part of our work. 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 2015 subject to limited assurance consist of the following indicators:

- Percentage of patients risk assessed for venous thromboembolism (VTE); and
- Rate of clostridium difficile infections.

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

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

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

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

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by DH in March 2015 ("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 2014 to June 2015;
- papers relating to quality reported to the Board over the period April 2014 to June 2015;
- feedback from the Commissioners dated 12 June 2015;
- feedback from Local Healthwatch dated May 2015;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated June 2015**;**
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey 2014;
- the latest national staff survey 2014;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2015;
- the annual governance statement dated May 2015;
- the Care Quality Commission's Intelligent Monitoring Report dated July 2014; and
- the results of the Payment by Results coding review dated January 2015.

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.

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 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 indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

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

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

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

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by 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 2015

- 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
Fleming Way
Manor Royal
Crawley
RH10 9GT

**19 June 2015**

# 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

**Chief Executive**

**Date**: 24th June 2015